SOUTH AFRICAN HEALTH CARE PRACTITIONERS’ EXPERIENCES OF THE CURRENT HEALTH CARE DELIVERY SYSTEM IN UTHUNGULU DISTRICT

By

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Declaration

I declare that this entire study entitled, South African health care practitioners’ experiences of the current health care delivery system in uThungulu district, unless indicated specifically to the contrary, is the author’s original work.

______________________________________________
Signature

JOAN ELLEN STOYANOV
Dedication

“The utterances of the heart – unlike those of the discriminating intellect – always relate to the whole.” Carl Jung

Chris (Dr Christian Ivanov Stoyanov), my wonderful husband and soul mate, thank you for your unwavering support and love, for inspiring me to keep the flames of my dreams alive and from whom I learned to truly understand what it means to work hard. My eternal gratitude for helping keep my faith alive when I had lost it, for teaching me that all things are possible for those who believe. We lit this torch together and we have carried it together over the threshold. My love always.
In remembrance

“As I look up at the night sky you so dearly loved, I imagine that the stars are not really stars, but cosmic waterfalls down which you shine your love on me and light my way.”

Joan Stoyanov, 2015

Dad, Petrus Frederick Roux, my late father; I know you would have loved to share this process with me, although I feel you have often been by my side, whilst I did this work. Thank you for fanning the flames of my inquisitive nature when, as a child, you taught me to never give up, and that questions are worth finding answers for. Thank you for showing me how to navigate by the stars.

“At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us.”

Albert Schweitzer

Professor Humphrey Siphiwe Bafanabenkosi Ngcobo, my original promotor, past supervisor, lecturer, mentor and friend. Although you sadly left this life too soon, thank you for leading the way. I did this because of the vision we shared, to access the experiences of health care practitioners’ lives in the current health care environment in order to make a difference.

My late father-in-law, Dr Ivanov Stoyanov, thank you for the love that you gave me unconditionally. I am so blessed to have had you in my life.
Esteemed acknowledgement

“Both men and ships live in an unstable element, are subject to subtle and powerful influences and want to have their merits understood, rather than their faults found out.”
Joseph Conrad, “The Mirror of the Sea”

Professor Steven Edwards dedicated and distinguished academic, my promoter, mentor and friend, there are few people who I respect more. More than ten years ago, it was you who sprinkled the academic splashes of inspiration over my head and encouraged me on my academic journey. Thank you for your humour, patience, discipline and support, and for reminding me to persevere. I will always be indebted to you for making me feel like a champion when I was not one and for taking the light from Humphrey when the flame of his journey on this Earth went out. My sincere gratitude for believing in me enough to take over at the helm and help me sail my ship into the ocean and on this exciting journey. I dedicate this poem to you and fondly remember when you read it to Chris and me at the start of our life-journey together.
Merlin and the Gleam

By Alfred Lord Tennyson

O young mariner,
You from the haven
Under the sea-cliff,
You that is watching
The grey magician
With eyes of wonder,
I am Merlin,
And I am dying,
I am Merlin
Who follows the Gleam.

Mighty the wizard
Who found me at sunrise
Sleeping, and woke me
And learn’d me magic!
Great the Master,
And sweet the magic,
When over the valley,
In early summers,
Over the mountain,
On human faces,
And all around me,
Moving to melody,
Floated the Gleam.

Once at the croak of a raven
who crost it,
A barbarous people,
Blind to the magic,
And deaf to the melody,
Snarl’d at and cursed me.
A demon vex’d me,
The light retreated,
The landskip darken’d,
The melody deaden’d,
The Master whisper’d
“Follow the Gleam.”

Then to the melody,
Over a wilderness
Gliding, and glancing at
Elf of the woodland,
Gnome of the cavern,
Griffin and giant,
And dancing of fairies
In desolate hollows,
And wraiths of the mountain,
And rolling of dragons
By warble of water,
Or cataract music
Of falling torrents,
Flitted the Gleam.
Down from the mountain
And over the level,
And streaming and shining on
Silent river,
Silvery willow,
Pasture and plowland,
Horses and oxen,
Innocent maidens,
Garrulous children,
Homestead and harvest,
Reaper and gleaner,
And rough-ruddy faces
Of lowly labour,
Slided the Gleam.

Then, with a melody
Stronger and statelier,
Led me at length
To the city and palace
Of Arthur the king;
Touch’d at the golden
Cross of the churches,
Flash’d on the tournament,
Flicker’d and bicker’d
From helmet to helmet,
And last on the forehead
Of Arthur the blameless
Rested the Gleam.

Clouds and darkness
Closed upon Camelot;
Arthur had vanish’d
I knew not whither,
The king who loved me,
And cannot die;
For out of the darkness
Silent and slowly
The Gleam that had waned to
a wintry glimmer
On icy fallow
And slowly moving again to a melody
Yearningly tender,
Fell on the shadow,
No longer a shadow,
But clothed with the Gleam.

And faded forest,
Drew to the valley
Named of the shadow,
And slowly brightening
Out of the glimmer,
And broader and brighter
The Gleam flying onward,
Wed to the melody,
Sang thro’ the world;
And slower and fainter,
Old and weary,
But eager to follow,
I saw, whenever
In passing it glanced upon
Hamlet or city,
That under the crosses
The dead man’s garden,
The mortal hillock,
Would break into blossom;
And so to the land’s
Last limit I came
And can no longer,
But die rejoicing,
For thro’ the magic
Of Him the Mighty,
Who taught me in childhood,
There on the border
Of boundless ocean,
And all but in Heaven
Hovers the Gleam.

Not of the sunlight,
Not of the moonlight,
Not of the starlight!
O young mariner,
Down to the haven,
Call your companions,
Launch your vessel,
And crowd your canvas,
And, ere it vanishes
Over the margin,
After it, follow it,
Follow the Gleam.
Acknowledgements

“This quiet sail is as a noiseless wing
To waft me from distraction.”
Byron, “Childe Harold’s Pilgrimage”

- Professor P.B. Msomi-Mbele, my co-promoter, thank you for your guidance, kindness and support throughout my post-graduate years at the University of Zululand. You demonstrated to me the value of discipline and hard work, and taught me not to lose my sense of humour.

- The research participants: I wish especially to extend my heartfelt thanks to every one of you for your enthusiasm to participate and for believing in this study. Your experiences will no doubt make a valuable contribution to the health care system and my hope is that this research will become a new vessel for positive change.

- My children, Nicholas Roux Scheltema, Zana Scheltema, Jean-Ellen Scheltema, Andrew Poole and Ivan Stoyanov. Thank you for your love and encouragement. I love you always.

- My grandchildren, Daniel Nicholas, Finn Nicholas and Ella Mae, you are so precious to me. I look forward to helping you learn that each day is a gift to be used wisely, to never give up, and the importance of spending time together.

- Jean Vigne, my mother, thank you for being proud of me and for motivating me during the process of this study; it meant the world to me.

- My mother-in-law “Mama”, you’re an inspiration and I thank the universe that you became such an important part of my life. Your courage, determination and love influence me daily.

- Lisa Bensch-Visagie, my dear friend, thank you for your unwavering support.
I wish to make a personal declaration in order to place the research and the part I played in it, into the context of this study and, in so doing, remain true to the principles and paradigms of qualitative, descriptive, social constructionist and interpretive phenomenology used in this study.

In Smith (1996), the psychologist is offered the opportunity to learn from the experts, who are the research participants themselves. The health care practitioners individually, and through their lived experiences, were part of the process of recursive reflection/introspection along with me.

The participants, into whose midst I explicitly entered, became the focus of reflective and subjective processes of interpretation, coupled to each other, in the process of the study and the way in which I chose to interpret and analyse their valuable contributions.

This process of immersion afforded a deeper understanding of the health care environment in the area of the research (uThungulu District) that formal psychological theories of “health behaviours” battled to explain (Flowers, Smith, Sheeran, & Beail, 1997). As such, I am therefore humbled and grateful for those experiences as I tried to make sense of the health care practitioners’ worlds, their own worlds in relation to mine, and as each one of the participants shared their experiences, each in their own distinct ways. These experiences essentially allowed all of us to take “ownership” of the knowledge conveyed and portrayed in the context of the individual and collective.

We, who are the communities that are served by the participants (the health care practitioners) and by the study (in the broader context of society), also become “owners” of these experiences, each creating a partnership or collaboration with self and “other”, i.e. individual, health care practitioner, community and myself. This close co-operation provided a vehicle for meaningful dialogue to be opened with various stakeholders which reflected the societal needs in the area at the
time, with the explicit intention of finding solutions to problems.

This research departs from conventional methods used to study health care and embarks on an interventionist phenomenological and interpretive, social constructive partnership of all stakeholders, without compromising scientific principles, but emanating from a more “demand-driven” departure as it follows on from previous research in 2011 that concentrated on medical practitioners (doctors) only.

Rather than studying pre-identified and quantifiable indicators, in the present study the emphasis was placed on individual health care practitioners’ experiences within a health care society of patients, providers, management, government and so forth. Those practitioners’ needs intersected with their own and interacted with those “others”, and together with them on a daily basis created their experiences, without compromising scientific criteria (Stekelenberg, 2004), whilst providing a “voice” for the participants to do the valuable work in and for the health care delivery system in South Africa. These processes of “humane care, dignity and cultured humanity, which are reached through the process of mutuality, humanisation, socialisation and communal spirituality” (Edwards, 2001, p. 2) are described by the Zulu people as “ubuntu ngumuntu ngabantu”. This literally means “a person is a person through others” and is rooted in humanist African philosophy, with common humanity “you and me both, a oneness, and with community as one of the building blocks of society” (Fejika, 2006, p. 1). “I only become an I through you”, and “I am because we are”, in the “I-Thou relationship “that is the epitome of an inter-human, interpersonal relationship (Edwards, 2001).

I would like to personally introduce myself in order to put myself into the context of study and thereby place placing myself in the social construction of this study that influenced me through the interpersonal encounters and interventions that I undertook in the midst of the health care practitioners’ worlds (Edwards, 2001).

I am a fourth generation South African-born Caucasian woman who grew up in South Africa in a predominantly Calvinistic theological background. Trained informally in alternative healing, divination, other spiritual modalities, animal husbandry and formally in professional nursing, clinical hypnotherapy, clinical
psychology and public administration, my formal academic perspectives were largely shaped by western scientific discourses, whilst informal training encompassed diverse world-views from local, indigenous, eastern and western schools of thought and philosophy.

The contrast in focus that these practices and studies encompassed which may essentially be considered “superficial” in the greater scheme of things, assisted me to reflect on how these influenced me and how they expanded my consciousness towards “mutual person-world opening and cosmic spiritual experiences” (Edwards, 2001, p. 2). In addition, it also provided me with a new sense of social conscience, respect for diverse world-views and cultural practices (both informally and formally), and gave me the vehicles, with which to administer to, care for, heal and serve humanity in my own and in prescribed ways. With these skills, practices, reflections and experiences, I have become absorbed and impressed, at many different levels. Not only by the diversity and the ways in which we, as human beings on this Earth, at this time, can make conscious choices to help, guide, teach, make a difference in the world, but in unique ways and through “filters” that have influenced us to make the interpretations (some conscious, some unconscious) and which are inevitable. As such, personal experience within the health care delivery system in South Africa and abroad from both pre- and post-apartheid era time-frames, would somehow have impacted (whether consciously or unconsciously, subtly or overtly) on the present study. One of the ways to guard against this is reflected in the researcher’s decision to amplify and diversify the analysis in the study, to increase reliability and trustworthiness in order for participants’ responses to reflect accurately what they were saying in their own words, from various vantage points.

I wish also to make known and expand the disclosure of my work experience in the public and private health care sectors as intern and community service clinical psychologist, private industrial nursing sectors (mining, retail and factory), private hospital practice administration and public nursing sector as student initially in my early career. Having visited health care facilities in Eastern Europe, Western Europe, America and various countries in Africa, and learned about their systems, struggles, joys, dilemmas and solutions, has made this research somewhat
personal and “existential” as I entered into the worlds of “others” and they into mine, on this journey.

Although the intention during the present study was to remain “impartial” whilst presenting the research, the intention was always to provide a vehicle for the “voices” of the participants and the means through which to be “heard”. This intention was the same for a smaller and similar study conducted in 2011, but which specifically focused on the experiences of medical practitioners (doctors). The present study built upon this, explicating a wider spectrum of health care practitioners to ascertain what their experiences were within the South African health care system.

In conclusion, being born in South Africa during the 1950s made it nearly impossible not to become aware that separation at all levels of society resulted in fractured relatedness on every level. It also made it nearly impossible to gain some notion, without sounding presumptuous, that the lack of social justice and social conscience began to affect me from a very early age. The purpose of this exposé was not to colonise the community spirit of “ubuntu” from a “white”, western perspective or even to try to claim “ownership” of the term “ubuntu”, save to reflect respectfully on the warm and caring people who loved me and whom I loved. Those people also shaped the identification with this philosophy in a country, which I call my own and to which I feel I belong on all levels, body, mind and spirit.

In this respect, the present study may unintentionally have reflected the prejudices of a “white”, “previously advantaged” person. This has not been my intention, even if it may appear this way. The topic for the present and my previous 2011 study on health care was inspired by my mentor and friend, Professor H.S.B. Ngcobo, with whom I had many conversations over the years that we knew each other, and who, I believe, had faith in the value of this research. I have endeavoured, in the spirit of this collaboration, to read and re-read the study’s scripts repeatedly and recursively, while reviewing and identifying the possibility that my personal filters may have clouded the results.

Therefore, the motivation for the present study was a personal one, which still
finds me, in 2016, experiencing our society as continuing to have deeply stratified and divisive structures and segregation, particularly in the health care sector.

The present study enabled me to learn from the experiences of health care practitioners, who work in this country’s diverse communities within its “melting pot“ of different cultures, languages and world-views, and have deepened my resolve, which was essentially to facilitate a dialogue and to care about the future of health care in this country.
## Abbreviations/Acronyms used

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>African National Congress</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>BP</td>
<td>blood pressure</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CODESA</td>
<td>Convention for a Democratic South Africa</td>
</tr>
<tr>
<td>COHSASA</td>
<td>Council of Health Service Accreditation for Southern Africa</td>
</tr>
<tr>
<td>COSATU</td>
<td>Congress of South African Trade Unions</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HNP</td>
<td>Herenigde Nasionale Party</td>
</tr>
<tr>
<td>HOD</td>
<td>head of department</td>
</tr>
<tr>
<td>HPCSA</td>
<td>Health Professions Council of South Africa</td>
</tr>
<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
</tr>
<tr>
<td>MDRTB</td>
<td>Multi-drug resistant tuberculosis</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>NHI</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OSD</td>
<td>Occupation Specific Dispensation</td>
</tr>
<tr>
<td>PAC</td>
<td>Pan Africanist Congress</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHO</td>
<td>Primary Health Organisation</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PHSDSBC</td>
<td>Public Health and Sectoral Bargaining Council</td>
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<tr>
<td>SAMA</td>
<td>South African Medical Association</td>
</tr>
<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Abstract

“…Since we never reckon that we understand a thing till we can give an account of its ‘how and why’, it is clear that we must look into the ‘how and why’ of things coming into existence and passing out of it.”

Aristotle, “The Physics"

Health is a human need and considered to be a human right across all societies. Access to health care services is not a problem for those who can afford it, but, for those who cannot provide for themselves, legislation needs to protect their rights. Although there is legislation in place to protect these vulnerable populations, it is ultimately the health care practitioners’ job to protect and improve the health of their communities. It is these health care practitioners who were the inspiration for and focus of the present study.

The present study emerged as a separate, but expanded version of the researcher’s limited 2011 study, which specifically focused on medical practitioners’ experiences of the current health care delivery system. Results from this 2011 study suggested that a broader spectrum of health care practitioners may be similarly affected by the current health care system and that their experiences may ultimately contribute towards a better understanding of the dynamics within which health care practitioners work and function. Therefore, the present phenomenologically-oriented study aimed to describe, explicate, interpret and analyse the experiences of a broad sample of health care practitioners through their lived, day-to-day realities in both the public and private health care sectors.

Data were collected from a non-probability, purposive, convenience sample of 30 adult registered health care practitioners in public and private hospitals, clinics and private practices in the uThungulu District of Kwa-Zulu Natal, South Africa. There were 15 participants from the public and 15 from the private sector. An open-ended questionnaire was used to ascertain and understand their experiences, knowledge and exposure to the relatively new national health insurance (NHI) system, what they perceived as key objectives for effective transformation of the South African health care system, possible reasons for considering emigration in light of the current staff shortages and their views on the new NHI policy, in order
to find solutions to problems. The overall data analysis consisted of three levels of subsidiary data analysis, descriptive, social constructionist and interpretive paradigms, each contributing to the whole, both “vertically and horizontally”, where participants’ experiences were described, explicated and interpreted.

Research findings indicated persisting large divisions and fragmentation in and between the public and private health care sectors. Yet there was unity in responses concerning the poor and disadvantaged members of society and the challenges of their access to health care services. Sensitivity to human rights standards, past socio-political influences and awareness of health as a human right and need were evident in all participant responses. Valuable solutions to improve the health care delivery system were offered by health care practitioners as key stakeholders in the future of health care delivery in South Africa.

Public health care practitioners’ experiences were dominated by overall expressions of unhappiness, anger and frustration related to poor service delivery, lack of resources, inadequate management structures, wages, inadequate consultation, fear for personal (and family) safety and the future of health care. Concern for the poor, vulnerable and the majority of citizens who use health care services, coupled with the burgeoning burden of disease, were perceived as a major stressor and source of anger towards the government and bureaucracy in general. Chronic stress and anxiety, suggestive of burnout and other negative psychological states, were also apparent. The inability to service long patient queues, inadequate communication structures/channels and lack of cohesive team practices, ethics and standards created a sense of emotional overburden and other negative affective states. These, and the uncertain future of health care under the new NHI, exerted extra stress on already overworked health care personnel. Education and effective consultation about the NHI were expressed as being inadequate and incomplete. Despite these factors, health care practitioners offered various valuable solutions and suggestions for the improvement of health care service delivery. Despite also being stressed, participants who work in the private sector were generally happier and they evinced less negative psychological states. Although a stressful environment with its own problems, within the private sector the NHI was considered to be a good concept in principle,
although many participants doubted its feasibility and felt that regulatory changes often took place without adequate consultation.

Given the nature and transparency of the present study, across multidisciplinary teams of health care practitioners, the researcher is of the opinion that the present study created a platform for discussion and debate around the context of a changing health care system within South Africa’s culturally diverse society. In conclusion, a critical review of the present study and recommendations for management structures, health care practitioners themselves and future research is provided.
Table of Contents

Declaration ................................................................................................................................. i
Dedication ................................................................................................................................. ii
In remembrance .......................................................................................................................... iii
Esteemed acknowledgement ....................................................................................................... iv
Acknowledgements ................................................................................................................... vi
Personal statement ................................................................................................................... vii
Abbreviations/Acronyms used .................................................................................................. xii
Abstract ...................................................................................................................................... xiv
List of Figures ............................................................................................................................ xxii
List of Tables .............................................................................................................................. xxii

Chapter 1 Introduction .............................................................................................................. 1
  1.1 Background and focus of the study .................................................................................. 1
  1.2 Contextualising the broader research context – South Africa – demographics, challenges and potential ................................................................................................................. 3
  1.3 Narrowing the research context – The uThungulu District of KwaZulu-Natal (the specific research area) .......................................................................................................................... 4
  1.4 Historical overviews .......................................................................................................... 9
    1.4.1 History of KwaZulu-Natal Province ........................................................................ 9
    1.4.2 History of South Africa in brief ............................................................................. 11
      1.4.2.1 Colonisation – Let’s go right back ................................................................. 11
      1.4.2.2 Apartheid – What was it? ............................................................................. 12
  1.5 Motivation for the study .................................................................................................... 15
  1.6 Overall plan for the study ............................................................................................... 16
  1.7 Aims and objectives of the study ..................................................................................... 16
    1.7.1 Primary objectives of the study .......................................................................... 20
    1.7.2 Broader objectives of the study .......................................................................... 20
  1.8 Significance of the study ................................................................................................ 20
  1.9 Implications of the study ................................................................................................ 21
  1.10 Conclusion ....................................................................................................................... 21

Chapter 2 Literature review ...................................................................................................... 22
  2.1 Introduction ...................................................................................................................... 22
  2.2 Central concepts .............................................................................................................. 22
    2.2.1 Care ....................................................................................................................... 23
    2.2.2 Healing ................................................................................................................... 23
    2.2.3 Health .................................................................................................................... 31
    2.2.4 Health care practitioners ..................................................................................... 31
    2.2.5 Teamwork ............................................................................................................. 32
  2.3 Health care/systems/service delivery .............................................................................. 32
    2.3.1 Health care service delivery in South Africa and Africa .................................... 33
  2.4 A brief history of the South African health care system ................................................. 34
    2.4.1 History of health care in South Africa prior to 1994 ............................................ 34
2.14 Health care practitioners and the burden of disease ................................................. 92
  2.14.1 Understanding the epidemic of HIV/AIDS, TB and HIV/TB co-infection ................. 92
  2.14.2 Examples of selected health care systems around the world – taken from the media and public sentiment ................................................................. 97
2.15 Health care practitioners in the context of psychological theories and their application to the health care setting .................................................. 109
  2.15.1 Bronfenbrenner’s ecological systems theory ....................................................... 109
  2.15.2 Maslow’s hierarchy of needs ............................................................................ 115
2.16 Conclusion .............................................................................................................. 118

Chapter 3 Methodology .................................................................................................. 121
  3.1 Introduction ............................................................................................................. 121
  3.2 Phenomenology as philosophical orientation .......................................................... 121
  3.3 Community context ............................................................................................... 122
  3.4 Intention of the study ............................................................................................. 123
  3.5 Purpose of the study .............................................................................................. 123
  3.6 Research process .................................................................................................. 124
    3.6.1 Stage 1: Conceptualisation and permission ....................................................... 124
    3.6.2 Stage 2: Recruitment of study participants, data collection and transcription .... 125
    3.6.3 Stage 3: Process of data analysis .................................................................... 126
  3.7 Triangulation .......................................................................................................... 127
  3.8 Rationale for choice of methodology ..................................................................... 130
  3.9 Research strategy .................................................................................................. 131
  3.10 Sampling and sampling frame ............................................................................ 133
  3.11 Open-ended self-report questionnaire ................................................................ 136
  3.12 Data analysis involving three paradigms and/or levels of description, explication and interpretation of participants’ experiences ....................................... 139
    3.12.1 Description, interpretation and explication of data .......................................... 140
      3.12.1.1 Descriptive paradigm (first level of analysis) ............................................. 141
      3.12.1.2 Social constructionist paradigm (second level of analysis) ................. 145
      3.12.1.3 Interpretive paradigm (third level of analysis) ........................................ 146
    3.12.2 Reflection on the use of the three paradigms/levels of interpretation .......... 147
  3.13 Ensuring the quality of the study ......................................................................... 148
  3.14 Ethical considerations ......................................................................................... 148
  3.15 Write-up and dissemination ................................................................................ 149
  3.16 Conclusion ............................................................................................................ 150

Chapter 4 Findings and discussion ................................................................. 151
  4.1 Introduction ........................................................................................................... 151
  4.2 Descriptive paradigm (level 1 of analysis) ............................................................. 152
  4.3 Social constructionist paradigm (level 2 of analysis) ............................................. 176
    4.3.1 Medical practitioner – Patient relationships ................................................... 177
    4.3.2 Medical practitioner – Nurse “power relationships“ ...................................... 178
    4.3.3 Medical practitioner – Other power relationships ........................................... 179
  4.4 You pretend to manage, I will pretend to work ...................................................... 180
  4.5 Hero-saviour roles .............................................................................................. 182
  4.6 Disempowerment dynamics ............................................................................... 183
4.3.7 Projecting/Externalising/Intellectualising .................................................. 185
4.4 Interpretive paradigm (level 3 of analysis) .................................................... 187
4.4.1 Emerging themes from the five open-ended questions ............................... 188
  4.4.1.1 Anger ................................................................. 188
  4.4.1.2 Frustration ......................................................... 201
  4.4.1.3 Overwork and stress ............................................... 208
  4.4.1.4 Bullying ............................................................ 214
  4.4.1.5 Confusion/poor understanding .................................. 216
  4.4.1.6 Needs ............................................................... 217
  4.4.1.7 Integrity ............................................................. 220
  4.4.1.8 Faithfulness or lack of faithfulness to the calling ......................... 223
  4.4.1.9 Neglect ............................................................. 225
  4.4.1.10 Hopelessness ................................................... 227
  4.4.1.11 Fear, worry and concern ....................................... 229
  4.4.1.12 Positivity/looking on the bright side .................................. 232
4.5 Conclusion ................................................................................................. 236

Chapter 5 Conclusions, limitations and recommendations ......................... 242
  5.1 Conclusion ............................................................................................... 242
    5.1.1 Achieved outcome of the aims and objectives of the study ................. 242
    5.1.2 Theoretical underpinnings and their relevance to the study .............. 244
  5.2 Limitations ............................................................................................... 250
  5.3 Recommendations/Policy implications .................................................... 250
    5.3.1 Recommendations for public and private health care practitioners and
         management structures – The advocates of good quality health care delivery
         services in the uThungulu District .................................................. 251
    5.3.2 Recommendations from the participants themselves to various
         stakeholders .................................................................................... 258
  5.4 “Siphiwe” Recommendations for further development.............................. 264
    5.4.1 The Mnemonic: “Siphiwe” .............................................................. 265
    5.5 Recommendations for future research .................................................. 267

Final personal statement .............................................................................. 269

Final conclusion ............................................................................................ 271

References ....................................................................................................... 273

Addendums ..................................................................................................... 293
  Addendum A: Participant information required and five self-report, open-ended
         questions ................................................................. 293
  Addendum B: Participant information leaflet ................................................ 293
  Addendum C: Informed Consent .................................................................... 295
  Addendum D: Ethical clearance certificate .................................................... 296
  Addendum E: Department of Health, Province of KwaZulu-Natal. Permission to
         conduct research ................................................................. 298
  Addendum F: Ngwelezana Hospital. Permission to conduct research .......... 299
  Addendum G: Transcripts: Public and private health care practitioner responses
         ............................................................................................... 300
  Addendum H: “Batho Pele” Principles ......................................................... 335
  Addendum I: National Patients’ Rights Charter ............................................. 336
  Addendum J: Charter for the South African Health Sector (PMG, 2009) ......... 339
List of Figures

_Figure 1._ Map of South Africa showing the location of uThungulu District (the specific research area) in the Province of KwaZulu-Natal ................................................................. 4

_Figure 2._ WHO African countries that are served by WHO Regional Services for Africa .............. 65

_Figure 3._ Basic components of the framework to guide health-financing system reform .......... 68

_Figure 4._ Key health financing options at different stages of the evolution towards universal coverage ................................................................................................................. 68

_Figure 5._ Proposed funding flows in a universal contributory system ........................................... 74

_Figure 6._ People living with HIV by country, 2013 estimates ..................................................... 93

_Figure 7._ Diagrammatic representation of the five levels of Bronfenbrenner’s Ecological systems theory .................................................................................................................. 113

_Figure 8._ Maslow’s hierarchy of needs .......................................................................................... 117

_Figure 9._ Sub-Saharan African countries with HIV prevalence of the same or more than 5% in adults aged 15-49 or more than one million of the population with HIV (n=17) ....................... 368

_Figure 10._ Loss of medical practitioners to destination countries, compared with burden of HIV in nine African source countries. Size of each bubble represents ratio of estimated compounded lost investment over gross domestic product, and y-axis corresponds to ratio of doctors working in target countries and doctors currently working domestically ....................... 368
List of Tables

Table 1 Wits University, South Africa, medical students take the following modern version of the Oath upon graduating................................................................. 47
Table 2 The traditional Hippocratic Oath, translated by Michael North........................................ 48
Table 3 The Nurse’s Pledge of Service, used in South Africa ..................................................... 49
Table 4 Statistics on Health Status and Human Resources in Nine Sub-Saharan Countries Included in Analysis............................................................... 365
Table 5 Expenditure on Primary and Secondary Schools in Nine Sub-Saharan African Countries, Using the Most Recent Year for which Data were Available........................................ 365
Table 6 Expenditure on Medical Schools in Nine Sub-Saharan African Countries Included in Analysis........................................................................................................ 366
Table 7 Estimated Lost Investment from Training Medical Practitioners in Nine High Prevalence HIV Countries who are Currently Practising in Canada, the United States, the United Kingdom, or Australia........................................................................................................ 366
Table 8 Sensitivity Analysis of Estimated Lost Investment using Variations on Time Working in Destination Countries, Interest Rates, and Cost of Education........................................ 367
Table 9 Policy and Legislative Framework for TB and HIV in Health Care Workers in South Africa........................................................................................................ 369
Table 10 Epidemiological Studies of HIV Prevalence in South African Health Care Workers........................................................................................................ 371
Table 11 Epidemiological Studies of TB in South African Health Care Workers............................ 372
Table 12 Public sector health care practitioner profiles...................................................................... 373
Table 13 Private sector health care practitioner profiles....................................................................... 373
Table 14 Summary document containing main points........................................................................ 374
Table 15 Mann-Whitney test for comparing public and private sector ages...................................... 396
Table 16 Test Statistics....................................................................................................................... 396
Table 17 Mean and standard deviation of age..................................................................................... 396
Table 18 Gender per sector ............................................................................................................... 397
Table 19 Religion............................................................................................................................... 397
Table 20 Language............................................................................................................................ 397
Table 21 Have overseas work experience .......................................................................................... 397
Table 22 Will consider leaving South Africa versus language.......................................................... 398
Table 23 Key issues: experiences........................................................................................................ 399
Table 24 Views expressed by the public and private health care personnel studied........................ 399
Table 25 Views disaggregated by profession .................................................................................... 401
Table 26 Suggestions to improve the health care delivery system in South Africa.......................... 402
Table 27 Responses on whether one had worked outside South Africa by the time of this study 403
Table 28 Participants who had worked outside South Africa disaggregated by occupations........ 403
Table 29 Experiences of those that had worked outside South Africa.............................................. 404
Table 30 Q5.1 Responses from public and private participants ....................................................... 405
Table 31 Q5.4 Considering leaving South Africa (disaggregated by sex and age)............................ 406
Chapter 1

Introduction

“Oh, who can tell, save he whose heart hath tried,
And danced in triumph o’er the waters wide,
The exulting sense – the pulse’s maddening play,
That thrills the wanderer of that trackless way?”
Lord Byron, “The Corsair”

In this chapter, the background of the present study is outlined with particular reference to its background and focus; motivation; aims and objectives; significance; materials; and methods. The broader research context (South Africa as a whole) as well as the narrower specific research area (uThungulu) is then defined. The chapter concludes by providing a brief historical overview of South Africa (socio-political).

1.1 Background and focus of the study

Reflecting on the role of health care practitioners in a holistic context brings forth a consciousness of being a member of a unique community of human beings whose vocation includes the multifaceted role of shaman, sage, priest, healer, teacher, community leader, and/or specialist in cultural knowledge. If the call is authentic and accepted, after appropriate professional training, genuine healers become indispensable members of society, medical practitioners, nurses, social workers, traditional healers, faith healers, therapists, technicians and so forth. In the case of South African health care practitioners, such an ideal and noble calling could undercut peripheral issues such as the economics and politics of professionalism. It could rather provide sincere motivation to work towards a holistic, integrated, academic, professional and applied discipline, a health care system that is directed towards the best interests of humanity, science and the cosmos, which transcends and includes African, European, American and other forms of health care (Edwards, 2014, p. 528).

In contemporary South Africa, most health care is typically carried out by non-professional community helpers who may function at least as effectively as professionals do. There are over one million indigenous, divine healers and/or
faith healers in South Africa at present. Approximately a quarter of the population of around 54 million people belong to African indigenous churches, whose members regularly provide essential community helping resources which may exceed those provided by registered professional psychologists, social workers, medical practitioners (doctors) and nurses. Thus, the importance of networking, collaboration, interventions and research to optimise all health and care resources is a priority (Edwards, 2011).

Twenty-two years after the establishment of democracy, in addition to the formal health care system operating throughout South Africa, an ongoing deeper and more subtle form of healing, beyond truth and reconciliation, is slowly making its way into the experience of generations of people. People are growing up together more freely from childhood, relatively less oppressed, and less divided through colonisation, apartheid and other forms of violence. However, other old struggles do still remain and new struggles emerge, especially against endemic human violence, oppression, corruption, unemployment, poverty, crime and various other illnesses such as tuberculosis (TB) and HIV/AIDS, as well as all related trauma, loss, grief and stress experiences associated with such struggles. These new struggles require the concerted care of the nation and ongoing collaboration of all helping and care resources. Much research and intervention remain needed in this area.

The present study emerged as a separate, but broadened extension of the researcher’s pioneering 2011 Master’s dissertation entitled: “South African medical practitioners’ experiences of the current health care delivery system”, which specifically concentrated on the experiences of medical practitioners (doctors). Owing to the information gathered in this 2011 study, it emerged that a much broader population of health care practitioners in South Africa may be affected similarly by the current health care delivery system and, as such, would find it valuable to share their current experiences as well. Other professions such as radiography, nursing, dietetics, physiotherapy, occupational therapy and psychology were included in the present study in an attempt to broaden the “voices” of those whose wish it was to participate in both studies, in view of the broader good of all, through their experiences, frustration, joys and suggestions.
In this expanded study, it was also hoped that the inclusion of a broader spectrum of health care practitioners' experiences in the uThungulu District of KwaZulu-Natal, South Africa, would facilitate a more detailed understanding of the perceived successes and failures of the health care delivery system at the current time in the country's history. There is much rhetoric being bandied about in the media regarding new and proposed legislation pertaining to health care delivery in South Africa and there also appears to be a “gap” in information and research, in particular pertaining to what health care practitioners actually think, feel, experience and what their day-to-day challenges in the health care settings are.

The literature review which emanated from the researcher’s 2011 master’s dissertation applies in part to this study, in as much as themes that emerged from discourses and narratives gathered in the previous study, informed the present study. It was hoped that the experiences and thoughts gathered from participants in the present study would build upon these existing narratives and themes and thus expand the literature review.

1.2 Contextualising the broader research context – South Africa – demographics, challenges and potential

The Republic of South Africa is the 25th largest country worldwide. It is the world’s 24th most populous nation with approximately 54 million inhabitants who comprise multiple ethnicities and speak 11 officially recognised languages, the highest anywhere in the world (South Africa Info, 2015). The country is situated on the southern tip of Africa and is bordered by neighbouring countries in the north by Namibia, Botswana and Zimbabwe, and on the east by Swaziland and Mozambique (South Africa Info, 2015). South Africa also surrounds the kingdom of Lesotho, which is inside its borders (Wikipedia, 2016). The country’s political and health care history is briefly discussed in chapter 2 of this thesis.

Sustainable job creation is South Africa’s largest challenge and approximately 65% of the working-age population is aged between 15 and 65 years (more than half of them under 25 years). Thus, urgent attention is needed to expand the country’s economic growth and enhance worker potential. This can be done by improving worker productivity, promoting savings, ensuring quality education for the youth, promoting skills development, post-school education and so forth. With
the working population expected to grow by an estimated nine million within the next 50 years, the new democracy, post 1994, presents a unique window of opportunity to improve economic growth. Currently, the country’s unemployment rate officially stands at 25% (11% is the average for upper middle-income countries like South Africa), with approximately one third of citizens either looking for work or not working. Therefore, the country is not currently meeting the needs of the growing number of job seekers who enter the market each year. Most of the jobs which have however been created were in the service-sector (The World Bank, 2015).

A further challenge relates to the country’s high AIDS statistics. According to the 2014 UNAIDS report, there are between 6.5 and 7.5 million South African citizens living with HIV and AIDS, more than anywhere else in the world, a large percentage of these are economically active in age (UNAIDS, 2015). Despite these gloomy statistics, South Africa is a beautiful country, rich in natural resources and with enormous potential. It is in this context, then, that health care practitioners in the present study find themselves.

1.3 Narrowing the research context – The uThungulu District of KwaZulu-Natal (the specific research area)

Figure 1. Map of South Africa showing the location of uThungulu District (the specific research area) in the Province of KwaZulu-Natal
(Source: http://en.wikipedia.org/wiki/UTHUNGULU_District_Municipality)

The present study was conducted in the diverse, peri-urban uThungulu District,
which is situated in the north-eastern KwaZulu-Natal (KZN) Province on the north eastern seaboard of the Republic of South Africa. KZN is the province with the second largest population (10 267 300) in the country, after Gauteng Province (12 272 263) (Stats SA, 2011). It stretches from the agricultural town of Gingindlovu in the south, to the Umfolozi River in the north and inland to the mountainous and beautiful rural Nkandla (uThungulu District Municipality, 2015), which is also the home of South African President Jacob Zuma.

The majority of the population in the u

Thungulu area are Zulu speaking (93.58%), followed by English (3.52%), Afrikaans (2.04%) and smaller percentages of other African languages. The majority of the population in the total KwaZulu-Natal Province as a whole speak Zulu (77.8%), followed by English speakers (13.2%), IsiXhosa (3.4%), Afrikaans (1.6%), Ndebele (1.1%) and the remainder being made up of small percentages of Sesotho, Setswana, Sign Language, Sepedi, SiSwati, Tshivenda, Xitsonga and 0.8% of other languages (Stats SA, 2011).

There are approximately seven percent more females to males in the area with ethnic group distribution comprising 94% black African, 3.6% white, 1.26% Indian/Asian and 0.46% coloured. The largest number of the population are in the age group five to nine years (13.24%), followed by 10 to 14 years (13.17%) and followed by 15 to 19 years (12.62%). (Statistics South Africa: Census 2011).

The uThungulu District offers its inhabitants, visitors and business partners the unique combination of a laid-back coastal lifestyle, combined with the potential for economic and career opportunities (uThungulu District Municipality, 2015). It is also renowned for its large variety of wildlife, game-reserves such as Thula-Thula Game Reserve (www.thulathula.com/) and numerous animal conservation projects, in particular, rhino conservation. The little town of Mtunzini is well known and loved by nature-lovers across the globe for its natural beauty and concentration of over 350 bird species and about 75 water bird species, making it a sought-after bird-watching and recreation area in South Africa. Other significant industries include forestry, commercial agriculture (sugar cane), subsistence agriculture (in the majority of tribal areas), essential oils (geranium) and tourism.
Cultural villages and living museums, such as Shakaland (www.thulathula.com/), offer tourists an authentic experience of the rich Zulu culture and its history. The uThungulu area has been earmarked for development, most especially the development of Richards Bay harbour, the largest deep-water port on the African continent, providing a large industry which is a boost to the economy with affordable labour in the district. Mining of titanium, zircon, rutile, leucoxene and pig iron are also part of the large industrial landscape.

Whilst taking into account the favourable aspects of the uThungulu District, there are significant challenges that the region currently faces, as does the rest of South Africa. For example, the district has the highest number of people between the ages of 20 years and older who have had no schooling whatsoever (Stats SA, 2011). The level of literacy is extremely low and there is a high unemployment rate in the area, especially amongst the rural Black/African population (40% of men and more than 50% of women being unemployed) (Stats SA, 2011).

The percentage of households living in informal dwellings (huts and shacks, not in backyards, for example in an informal/squatter settlement or on a farm) is the second highest in the country, with the highest percentage countrywide living under the thatch/grass type roofs of their dwellings. The province has by far the highest number of people in the country who have no toilet facilities (flush, chemical or pit), energy sources for cooking (electricity, gas, paraffin, wood, coal, animal dung, solar or any other) or refuse removal services per household (Stats SA, 2011).

The World Health Organisation (WHO, 2010) reported that 26.2% of the country’s population lived below the poverty line (less than one dollar a day), bringing into focus the degree of poverty that adds to the burden of health care in general. Socio-economic hardships thus inevitably affect the health and health care systems of the population. Each individual’s own biology, interacting communally between factors, also forms the primary environment for fuelling development in that person’s life. Therefore, difficulties, changes, conflicts, stressors and support systems will ripple through people’s lives and filter into all the “layers” of their development. One could expect, under the circumstances, that feelings of loss of control over their destinies could create psychological consequences such as
anxiety, depression, somatoform disorders and so forth, for the vulnerable members of society. Holistically, the situation would affect all levels of their lives due to the patterning of their environmental circumstances, affecting transitions during their life cycles (Ryan, 2011).

In his State Of The Province Address, February 2015, the Premier of KZN, Mr Willies Mchunu (Mchunu, 2015), addressed the concern regarding shortages of health care professionals in the uThungulu area. He undertook to dispatch 30 candidates to a university in India for specialised training and skills (particularly in the pharmaceutical industry). He reported that inequality and poverty in the area remained problematic, with the percentage of people living below the food poverty line (at R318 per month) rising from 25% to 28% between 2010 and 2014, despite the original optimistic projection for this to have decreased to the desired 18% by 2015. Of those, 60% of the population were considered to be the poorest in the area and measured 17% during 2010 to 2014, well below the target of 19.4% hoped for by 2015. These figures highlight social inequality and poverty as issues that would need to be addressed as part of the challenges faced in the future.

Crime also remains a problem in the area and province, with statistics rising for offences such as murder, attempted murder, assault, stock theft, business robbery, truck hijacking, arson and drug-related crimes, amongst others. With one woman being killed by her partner every six hours in South Africa (61% of those occurring at home) and with 51% of women likely to experience some form of gender violence in their lifetimes, minister Mchunu made it clear that drastic responses were needed to stem the tide of these crimes. This should be done not only through aggressive judicial responses, but also by changing behaviours and social norms that perpetuate and encourage such violence, calling on the help of traditional leaders, religious leaders and civil society (Mchunu, 2015).

Minister Mchunu optimistically declared that the Richard’s Bay harbour (Dube Tradeport) would be declared an official “Industrial Development Zone“ and “Special Economic Zone“ to be promulgated in 2015. This could mean that export capabilities in the area, international investment, opportunities for ocean economy, manufacture, oil and gas energy options, and dedicated container handling facilities would hopefully provide much-needed employment in the region.
However, despite this optimism, he reported that unless current electricity supply constraints (which had resulted in load shedding) and labour issues were addressed, confidence in the competitive industries would be affected, hampering growth in the region (Mchunu, 2015).

Notwithstanding the challenges to economic growth, which inevitably put communities and individuals at risk, the Premier expressed his intention to improve access to social services in order to protect the rights of vulnerable people. These vulnerable people include children, women, youth, the elderly, the disabled and people infected with HIV and AIDS and their families, especially in the underserviced areas of the province of which the uThungulu District forms a part.

Premier Mchunu expressed his optimism that the targets for Vision 2030 in the province were on track, namely, “A prosperous province, with healthy, secure and skilled people, acting as a gateway to Africa and the World.”

His vision, he said, was in line with the five Key National Priorities, namely:

1. Creation of more jobs, decent work and sustainable livelihoods for inclusive growth;
2. Rural development, land reform, and food security;
3. Improved quality basic education;
4. A long and healthy life for all South Africans; and
5. Fighting crime and corruption (Mchunu, 2015).

To summarise, the above-mentioned social, cultural and biological dynamics of the uThungulu District and the province illuminate the challenges affecting the health care delivery system. These challenges, in turn, affect health care practitioners, who are at the “coal-face” of a growing population with increasing health care needs and who are relied upon to deliver health care services that the general population need and expect.
1.4 Historical overviews

The following sections present brief histories of the South African bio-psycho-social contexts and factors that may have shaped health care practitioners’ experiences are discussed with particular reference to:

1. The history of the KwaZulu-Natal Province; and
2. The history of South Africa.

1.4.1 History of KwaZulu-Natal Province

It would be untoward to mention the province without also providing some historical context pertaining to it, in terms of the liberation struggle prior to the collapse of apartheid.

KwaZulu-Natal Province, as it is known today, encompasses the eastern seaboard of South Africa, spanning Mozambique and Swaziland to the north and bordered by the Drakensberg Mountains to the west. At the time of the CODESA (Convention for a Democratic South Africa) negotiations in 1991 (three years prior to the new democracy of 1994), the new boundaries of the province, as it is known today, were drawn. Prior to that time, the province had different shapes and different names, with the most recent history being the apartheid era province of “Natal” that had its roots in the 19th century colonial period. Also, there was the “KwaZulu homeland”, which was established in the 20th century in the areas of the province ruled by Zulu kings during the previous century, prior to democracy (HSRC, 2013).

It is believed that the area was originally populated by the San peoples (who were hunter-gatherers) and then later by the Nguni peoples, who moved south from Africa’s East Coast and united with the Zulu nation after their arrival in the 18th century. During the early 19th century, English hunters and traders began to settle in the Port Natal region, today known as Durban, and who, after defeating the Zulus in the Anglo-Zulu war (mid-1800s), annexed the province as an autonomous district of the Cape Colony. A “Native Reserve of Zululand” (between the Tugela River and Mozambique) was established by the British Administration soon after (HSRC, 2013).
In 1910, the Union of South Africa was formed and the chieftainships were centralised by the administration of the government and controlled by Pretoria. The Black (Native) Administration Act No 38 of 1927 gave commissioners the authority to depose and appoint chiefs, and imposed rules relating to chiefs’ succession, personal obligations and family relations (HSRC, 2013).

In 1951, Bantu Authorities or Bantustans were established, effectively abolishing the last of these African representative institutions by setting up regional local government systems and tribal regional authorities. Chief Mangosuthu Buthelezi was set up as Chief Executive Officer of the “Zululand Territorial Authority” (ZTA) in 1970 and, in 1972, the ZTA was changed to the “KwaZulu Legislative Assembly” (KLA), with Chief Buthelezi as the Chief Minister (HSRC, 2013). Chiefs were appointed by the “KwaZulu” Government (according to the Provincial Constitution) and, in this way, the colonial structures, which regulated chieftainship, were perpetuated. The region’s borders had changed substantially by that time and consisted of scattered fragments throughout “Natal”. After CODESA (Convention for a Democratic South Africa) and just prior to the new democracy of post-apartheid South Africa in 1994, “Natal” and “KwaZulu” were combined into a single province, “KwaZulu-Natal” as it is known today (HSRC, 2013).

KwaZulu-Natal, with the second largest population in South Africa, is the country’s third-smallest province and takes up 7.7% of the South African land area. Together, KwaZulu and Natal comprise one fifth of the country’s total population, with the largest group being of African descent and, of those, 90% are Zulu. It is estimated that about 90% of the white population in the province is English speaking. A significant section of the population is Asian and a smaller percentage is coloured. Most of the forefathers of Indian peoples of South Africa were brought to Natal between 1860 and 1911 to work in the sugar industry and remain a large and integral part of the province (HSRC, 2013).

The history of the province was dominated by resistance and oppression (most notably of the African, Indian and small coloured communities), emanating from their conflicted relationships with early settlers during pre-colonial and apartheid times – the latter part of their histories. Until relatively recently, it also included
conflict between the ANC-aligned organisations and the Zulu nationalist movement, the Inkatha Freedom Party, and the brutality of the apartheid security forces during the struggle for liberation prior to 1994 (HSRC, 2013).

Thus, the socio-political histories and immense dichotomies in the uThungulu District cannot be ignored and must be taken into account when assessing the experiences of health care practitioners within the region. To discount them would be a disservice not only to the participants of this study, but also, more especially, to the poorer and/or underserviced communities in the area, who are struggling with their everyday realities in a culturally diverse environment.

What may be apparent to the eyes of the tourist is, in fact, not the reality for the majority of the population of this region.

1.4.2 History of South Africa in brief

In order to understand the central focus and departure of the present study, it was considered important to include a brief historical contextual sketch to provide an understanding (although limited) of some of the socio-political issues in South Africa and their sequelae, not least of which relate to the country’s current health care system. Reforms that were made to the now out-dated health care system are discussed with the intention of not assuming that history reflects an “absolute truth”, but that history has proved, by way of political texts, which have been over-written with other political texts, each interpreting history in their own way.

The brief history that follows merely provides the “space” and “latitude” to freely ponder the extent to which the historical and current bio-psycho-social circumstances of the diverse peoples of South Africa have been affected and who have, for the first time in decades, started co-existing for better or worse after the demise of the apartheid era.

1.4.2.1 Colonialisation – Let’s go right back

Colonialism refers to the practice of acquiring control over a territory/land/country and usually implies the exploitation of the country/population, especially economically. The colonial-era began for South Africa in 1652 (according to historical reports) with the arrival of the Dutch settlers at the Cape (now the Cape
Town area of the Cape Province) and the subsequent adoption into the Afrikaner
Republics of the Orange Free State and Zuid-Afrikaansche Republiek at that time.
This period saw the ascendency of forced slavery to which many South Africans
bear descendency (SAHO, 2015). The subsequent changes that this era wrought
on the African continent in general, and South Africa in particular, still reverberate
through society today. The speed with which this era developed is considered
unprecedented in South Africa’s history, and that of the African continent, prior to
that time. It saw the re-engineering and altering of societies on a large scale, even
though not all societies were equally transformed. Those who resisted were sent
into forced labour whilst others such as the Khoi-khoi communities of the South
Western Cape totally disintegrated “within a matter of decades” (SAHO, 2015).

Whilst Europeans initiated the now infamous slave trade, which saw Africans sold
or traded to the Americas in numbers estimated at from 9 to 15 million, it is fair to
say that many Africans benefited from their relationship with the Europeans. They
engaged with them on their own terms, most notably also through exchanges of
technology (firearms), which provided the means for increased political power and
control. Tragically, the slave trade also created the greatest “currency” which
became compliant in their preparedness to sacrifice their people. Many people
who were turned into slaves were brought/bought and/or traded between and from
the Cape to Madagascar, Bengal, and elsewhere. This heralded the era known as
the African diaspora, the term used to describe the sheer horror and scale of the
organisation of slave trade by both Europeans and Africans, and which, by
implication, could not have happened without their joint co-operation and
complicity. It can only be described as one of the worst institutions of the last
centuries. Although not all countries and their peoples were equally affected, 400
years of slave trade (SAHO, 2015) and subsequent apartheid history left their
mark on all South African people and shaped South African society to what it is
today.

1.4.2.2 Apartheid – What was it?
The word “apartheid” is an Afrikaans word that means “separation” or “apartness”;
it has been adopted in various parts of the world as an accepted expression of
divisions in society. It loosely means “apart-hood” and can be defined also in
terms of the various laws and acts instituted in 1948 by the Government of South Africa, which divided society strictly along racial lines. It was during that time when South Africa was dominated by the mainly Afrikaans speaking white minority that the African National Congress (ANC), the party that led the liberation movement, was banned following its resistance to these laws. Apartheid in South Africa was a social and racial segregation policy, introduced in 1948 by the ruling Herenigde Nasionale Party (HNP) in South Africa that later merged with the Afrikaner Party to form the National Party in 1951 that became synonymous with apartheid (African History, 2015).

Although South Africa remained under apartheid rule for much of the 20th century, racial segregation had been enforced for decades. From as early as 1910, when the Union of South Africa was formed, the country’s vote/franchise was reorganised by Afrikaner nationalists into the already-incorporated Boer Republics. Although “non-whites” in the then Cape Colony had some representation, this situation did not last for long. The system was supported by Afrikaner “cultural movements” and a variety of Afrikaans newspapers and was well received among the Boers (farmers) and Afrikaner communities of the Transvaal (Zuid Afrikaansche Republick ZAR) and Orange Free State (African History, 2015).

The foundations of apartheid rested on legislation and acts that progressed from segregation of “Blacks”, to include “Coloured” and “Indians”. The acts that were most defining were the Group Areas Act No 41 of 1950, which resulted in more than three million people being forcefully removed and relocated; the Suppression of Communism Act No 44 of 1950, which – due to its ambiguous wording – came to mean that any controversial group could be “banned”; the Bantu Authorities Act No 68 of 1951, which heralded the formation of Bantustans (and eventually “independent” homelands), and the Natives (Abolition of Passes and Co-ordination of Documents) Act No 67 of 1952, which saw the strict enforcement of the “Pass Laws”, despite the wording of the act (African History, 2015).

By the 1960s racial discrimination had broadened into almost all aspects of South African life. The system by then was known as “grand apartheid”, and it was during this time that the Sharpeville Massacre rocked the country, and the ANC and the Pan Africanist Congress (PAC) parties were banned. The South African
Republic was declared, following a referendum in 1961, after departing from the British Commonwealth (African History, 2015).

During the 1970s and 80s apartheid changed, as the country was rocked by political violence on both sides of the colour divide. The unrest, particularly the violence used by the white minority government to maintain its rule, had by then also provoked the condemnation of the world (African History, 2015).

There was increased international and internal pressure, and the country’s economy was faltering. With the end of the Cold War, South Africa could no longer count on the West. By 1985 many sanctions were imposed on South Africa, which saw the departure of numerous international companies. The 1976 Soweto Uprising saw black youths expressing their wrath at “Bantu education”. The political unrest did not quell, despite the tri-cameral parliament (a three-tier parliament to enfranchise the “coloured” and Indian populations) created in 1983, and the abolition of Pass Laws in 1986 (African History, 2015).

The exclusion of the black South African majority who, fuelled by their anger, protested and embarked on significant unrest during the 1980s, drew the attention of the United Nations Commission on Human Rights, which rejected the “new-Constitution”, based on its exclusion of black people from exercising their political rights. This Constitution, however, remained in place, with President FW de Klerk in 1990 releasing Nelson Mandela from jail and unbanning the ANC, followed by the laborious dismantling of the old regime over several years. In 1992, “whites-only” voters approved the reforms through a referendum and thereafter, a new constitution was ratified, giving everyone a right to vote by 1993 (African History, 2015).

Economic inequality had, therefore, consistently been the defining problem of the legacy of apartheid in South Africa (McIntyre et al., 2007). Whilst it is well accepted that economic development in a country as a whole shapes the health sector, the historical, social and economic background shapes the context in which a health system develops (McIntyre, 2010). The history of health care in the Republic of South Africa and associated political, social and legal paradigms will be further discussed in Chapter 2 of this thesis.
The apartheid-era finally ended on 27 April 1994, with the first democratic elections and the formation of the Government of National Unity with Nelson Mandela as President, and Thabo Mbeki and FW de Klerk as Deputy Presidents. The dawn of the new democracy started after 22 million South Africans participated in voting with the ANC winning 62.65% of that vote (African History, 2015). Despite the end of apartheid and reformation of the country, many of the aftereffects are still visible today and subsequently may affect health care practitioners and the country’s health care system in general (the history of the South African health care system is discussed in more detail in section 2.4 in chapter 2).

1.5 Motivation for the study

South Africa is at a critical point in the debate on and implementation of health care changes facing the population and, therefore, the future of health care. It also faces the exodus of valuable human resources towards what are perceived as greener pastures, as health care practitioners become increasingly dissatisfied with government policy, wage negotiations, work-place disillusionment, lack of service delivery, expressions of incidents of corruption and lack of resources. According to Pillay and Kramers (2003), South Africa has faced and is facing large-scale emigration, especially of professional people, commonly referred to as the “brain drain” (the brain drain is discussed in more detail in section 2.13.1 of chapter 2).

Currently there is a severe shortage of health care practitioners in South Africa and, in particular, the public health sector, which has led to an increased workload on already overburdened health care practitioners (AIDS Council, 2012). There has been much debate around government’s National Health Insurance (NHI) initiative (NHI is discussed in more detail in section 2.11 in chapter 2) and the relatively new “Occupation Specific Dispensation” (OSD). OSD is discussed in more detail in section 2.7.1 in chapter 2) which was issued by the Department of Public Services and Administration of South Africa (2007), and which aimed to curb the losses of public sector health care practitioners who were leaving for better options elsewhere (Stoyanov, 2011).
Health sector reform in South Africa has been triggered by political and economic changes rather than by the need for change as a result of the country’s huge burden of diseases. The ANC’s Health Plan indicated the imminence of such reforms, as influenced by political changes in the country (Nkomo, 2013). It postulated that apartheid created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health, which created a fragmented health system and thus inequitable access to health care. This, in turn, affected the most vulnerable groups (Broomberg, 2009). The consequent argument is that the rollout of the NHI in South Africa is a move that has been calculated by government’s central strategy for improving service delivery and achieving equitable health care. Therefore, these reforms are inherently political, with their success hinging on the policies political feasibility. The researcher is of the opinion that those who are implementing these reforms need to consider health care practitioners, who are key stakeholders in the implementation process, as part of its strategy for health care reform (Nkomo, 2013). It is to this end –considering the experiences of South African health care practitioners- that the present study plays a critical role.

1.6 Overall plan for the study

The overall plan for the present study was to expand on the researcher’s 2011 study (Stoyanov, 2011) by including a broader spectrum of health care practitioners from the public and private sectors in the uThungulu District. This was done as Stoyanov (2011) speculated that a broader spectrum of health care practitioners may also be similarly affected by the current health care environment in South Africa.

1.7 Aims and objectives of the study

The aims of the present study were to determine public and private health care practitioners’ understanding and experiences of health care delivery in South Africa, in particular their opinions on the NHI policy, as well as to determine their views on what they perceive as key objectives for effective transformation of the South African health system. This would include determining their views about their roles in the development and implementation of the new NHI policy.
Summarising findings from the Stoyanov (2011) study: Medical practitioners’ experiences of the current health care delivery system

Stoyanov’s (2011) study examined the experiences of specifically medical practitioners in South Africa as well as health perspectives from abroad. A review of the literature suggested that this explication might have been one of the first to investigate the feelings of medical practitioners in the public and private health care sectors. Due to ongoing debate and tension between medical practitioners and the South African Government at the time of the 2011 study particularly in the public health care service, and the governing bodies responsible for service delivery, Stoyanov’s (2011) research was limited to participants who were willing to “break the rules of silence”. Reasons for this included their despondency, frustration and/or anger towards the government concerning working conditions and service delivery in general. Therefore, medical practitioners who worked in the public sector participated after hours and away from their work settings. Private practitioners, on the other hand, were willing to participate freely and openly and without restriction. Both qualitative and quantitative data analysis and explication were presented and discussed in relation to presiding themes of the experiences of the medical practitioners, obtained from open-ended self-report questionnaire responses and the DASS-21 Stress and Anxiety Scales. These scales tested for core symptoms of anxiety and depression to determine whether there was a link between practitioner responses and their levels of anxiety or depression on the DASS. These results were synthesised in order to ascertain differences and similarities. None of the participants presented with elevated DASS scores suggestive of falling within a clinical range for anxiety and/or depression, leading to the researcher drawing the assumption that participants were presenting less with acute symptoms of stress and anxiety, but rather more with insidious, chronic symptoms such as feelings of irritability and hopelessness, suggestive of a “dysthymic syndrome” (group of symptoms related to chronic stress).

Emerging themes/narratives from qualitative responses appeared to be mostly congruent with the DASS-21 responses, with themes such as stress, depressed emotions, anxiety, frustration and anger, negative future orientation, considered emigration and wage dissatisfaction. Pervasive and chronic affective and/or
emotional states led some practitioners to accept their circumstances helplessly and others to experience feelings of anger and frustration, resulting in plans to consider possible relocation. Practitioner’s open-ended responses revealed a more pervasive set of complaints similar to dysthymia and generalised anxiety disorder with public sector participants, in particular, presenting with a collection of vague complaints about not feeling positive about life, feeling irritable, sensitive and tired. Their private health care sector colleagues seemed more content with their professional lives overall and did not wish to emigrate, although they would continue to assess their situations and make relevant changes, if necessary. However, overall, it appeared that all medical practitioners experienced some stress and anxiety symptoms regardless of the health care sector they worked in.

Present study as continuation of the Stoyanov (2011) study

The present study extended and broadened Stoyanov’s (2011) study to include other health care practitioners/health care disciplines in the uThungulu District. Given the nature and transparency of the present study across multidisciplinary teams of health care practitioners, this research intended to create another platform for discussion and debate in the context of a changing health care system within a culturally diverse society such as South Africa. It also provided a valuable opportunity for participants to voice their opinions, feelings and perceptions regarding proposed imminent changes in the health care landscape, the NHI, providing reasons why they would consider emigrating and their proposals for improvements to the health care system.

The intention was therefore not to merely embark on an exposé of negative sentiments, but rather to make a positive contribution aimed at finding solutions to problems. By attesting to health care practitioner’s day-to-day experiences in the workplace and providing a much deeper insight into multiple strata of professionals in public and private health care, it was hoped that the present study would make a contribution which would prove valuable in policy-making collaborations with interested parties who have health care at heart. Thus, it was central and essential in the concern of the present study that health care policies should be developed and implemented by social actors like health care practitioners, through the meanings and interpretations they attached to their
experiences (Nkomo, 2013). Therefore, the present study sought to understand how health care practitioners made meaning in their lives within the system, capturing their views and making way for further studies, using greater populations in South Africa, which would also then stimulate further academic and policy debate in the country.

**Materials and methods (the Stoyanov, 2011) study and the present study**

The researcher’s previous study (Stoyanov, 2011) included only medical practitioners. A non-probability, purposive, convenience sample, using the snowball technique when necessary, was used to access medical practitioners (doctors) from the public and private health care sectors.

The present study expanded the sample to include a broader spectrum of health care practitioners from both the public and private health care sectors. Participants in the present were required to fill in a biographical form indicating their age, gender, occupation, designation/position, home language, nationality and the sector they worked in, being the public or private sector. Data pertaining to their experiences were obtained from five questions in a self-report open-ended questionnaire which was compiled by the researcher (this questionnaire is described in more detail in section 3.11 in chapter 3).

The present study departed from a qualitative, general phenomenological orientation, using three different paradigms: descriptive, social constructionist and interpretive, to analyse and explicate the experiences of the participants as represented and revealed in their responses. This approach provided a comprehensive and holistic framework, considered best suited to the present community psychology-orientated study. Since people interact with each other empathically all the time in normal, natural, day-to-day settings, they get to know things just by being able to speak, look and listen (Terre Blanche, Durrheim, & Painter, 2006). The findings, in turn, stimulated the researcher’s capacity to learn through the joint efforts and to construct joint meanings (Johnson et al., 2007).
1.7.1 Primary objectives of the study

The objectives of the present study were to:

- Reveal the circumstances, feelings and day-to-day lived experiences of health care practitioners in relation to how they currently experience the South African health care System.

- Provide a valuable opportunity for all stakeholders involved in the South African health care delivery system to voice their opinions, feelings and perceptions regarding proposed imminent changes in the health care landscape and the NHI.

- Not to merely be an exposé of negative sentiments, but rather a positive contribution aimed at finding solutions to problems and providing helpful recommendations for all stakeholders involved with health care.

- Determine public and private health care practitioners’ understanding of the new and proposed NHI legislation.

1.7.2 Broader objectives of the study

The present study’s broader objectives were to:

- ascertain the possible and probable reasons why health care practitioners would consider emigrating with a view to curbing the exodus of valuable human resources.

- evaluate health care practitioners’ work experiences abroad and to briefly present media and public commentary about selected health care systems and their problems from countries around the world.

1.8 Significance of the study

South Africa is at a critical point in the debate about the future of health care. With the roll-out of the new NHI, there is much debate and rhetoric in the media and at a personal level regarding the best way forward for an equitable health care service for all South Africans. The present study, which built on the researcher’s previous limited study (Stoyanov, 2011) hoped to create awareness of the
importance of gaining feedback from health care practitioners themselves. Their input should be considered important for all stakeholders who have health care at heart and who follow the principle of “first do no harm” in the interests of human rights and social justice. By adding to the limited existing research and providing practical solutions, another framework for collaboration between academia and health care programmes can be created, which could assist and inform policy-makers who ultimately affect the supply and demand for health care services. The collaborative efforts could then assist with the operationalisation and fulfilment of the WHO 2013 proposals, whose aim it was to foster this type of information exchange (WHO, 2013).

1.9 Implications of the study

Given the nature and transparency of the present study across multidisciplinary teams of health care practitioners, this research sought to create another platform for discussion and debate in the context of changing the health care system within a culturally diverse society such as South Africa.

1.10 Conclusion

This chapter described the uThungulu District, in which health care practitioners in the present study worked, discussed relevant literature pertaining to the health care environment in South Africa, which included brief historical, political, social and psychological factors that were deemed important for understanding the context, in which this study was carried out.

It was hoped that the present study, through the critical exposure of health care practitioners’ experiences, would contribute to the evolution of the health care system at a time when change is imminent. By describing and explicating what health care practitioners’ lived experiences are in terms of service delivery, their knowledge about the new proposed NHI and possible reasons for emigration, it was hoped that solutions to problems would emerge. These, in turn, would inform relevant stakeholders in health, who need to consider preventing the exodus of health care practitioners from South Africa, which would have severe repercussions for health care. This valuable data could also be used to inform further studies in the same field and add to existing knowledge.
Chapter 2
Literature review

“That which comes to be always does so as a whole; so that if a man does not count the whole among realities, he ought not to speak of substance or of coming-to-be as real.”
Plato, Sophist (p. 245 d)

2.1 Introduction

In this chapter, relevant literature which supports and describes the context and social, cultural structures that explain, define, govern and influence health care practitioners in the health care system in South Africa, locally, nationally and globally, are discussed with a view to providing contextual, historical and political background information. The literature places health care practitioners’ experiences into a holistic frame of reference and allows their discourses, narratives and experiences to be understood in context rather than in isolation. Concepts such as what it means to be a healer and various interpretations thereof, which might impact on health care practitioners both locally and internationally, are discussed. Relevant psychological factors that health care practitioners are prone to are described, and bio-psycho-social influences are discussed in terms of their relevance to this study. The chapter concludes by presenting two psychological theories (Bronfenbrenner’s biopsychosocial theory and Maslow’s hierarchy of needs) which are considered relevant to health care practitioners as a context in which to place them in their personal lives, communities and the world. As such, information presented in this chapter was obtained from various sources and reflects the quality of data which is currently available. The researcher also included public comment and rhetoric, the contents of which have not been screened or interpreted for possible inaccuracies.

Key terms and concepts were included as part of the progression of this literature review and are explanatory, providing additional context where further understanding was deemed necessary.

2.2 Central concepts

There are various concepts which are central to the present study and as such require further explanation to clarify their relevance.
2.2.1 Care

Care means to “look after” and is essentially “the provision of what is necessary for the health, welfare, maintenance and protection of someone or something” (Oxford English Dictionaries, 2015).

2.2.2 Healing

The Oxford English Dictionary defines healing as the restoration of health and well-being, being free from disease, or making whole and sound (Plodek, 2005). How or where or why healing occurs is a matter of much debate. It seems reasonable or ethical, therefore, for health care practitioners to honour the individual journeys of their patients/clients without expectations or personal judgements (Plodek, 2005), recognising various healing modalities for what they are, whilst still practicing their own.

However, this is where the simplicity of the definition ends. Among healers themselves (intervention-healers as in self-described healers/energy healers), there is such diversity and little resultant consensus, making the identification of similarities amongst healers a challenge in itself (Levin, 2011).

The word healing or healers most probably brings to mind a “knowingness” of what those words mean without needing further definition. However, paradoxically, those words also conjure up a lot of confusion on second thought. What would one refer to the words as meaning, on a personal basis, and what would they mean in different cultures, healing modalities, professions and more? The questions about what healing is or is not may remain unanswered, save to try to deconstruct some of the meaning that has been attributed to it.

In the South African context, healing/health may be linked with the spirit of “ubuntu“, the African philosophy (but not limited to any specific region or group of people) that “a person is a person through other persons” (Schutte, 1994, p. 29). In order to be healthy, a participatory consciousness frees itself from categories and notions imposed by objectivity and subjectivity. It is in the “re-ordering of the understanding between the self and the other to a deep kinship of “self-other”, between knower and known” (Kotze, 2002, p. 5) that an attitude of participatory consciousness, receptivity, and openness is born (Heshusius, 1994, p. 4). Healing
and care, framed in terms of this philosophy for motivation of care, is no more powerfully demonstrated than by the ideology of traditional South Africa in terms of “ubunthu” (Murithi, 2006).

The Western meaning of healing usually adheres to the concept of healing as being free of pain or disease and/or of being cured. Human beings and their cultures or sub-cultures have their own interpretation regarding the meaning of healing, or to be healed. Many people, for instance, report that they are deeply changed spiritually from a disease that they may have, or have had in the past and as such, may be described as healing that does not manifest physically. An example might be a 46-year old woman with breast cancer metastases, who spent what remained of her life counselling other breast cancer sufferers over the telephone and providing them with positive options for a better life. It seems that once an individual is tested in the extreme, the strengths of their characters may surface; perhaps meaning that illness became a part of the healing process and that healing may be more than just the absence of disease.

Native American and Ayurvedic cultures believe that an imbalance or disharmony with universal energy causes disease or “dis-ease”. It is contended that humans are continuously exchanging energy and matter with one another as open energy systems along the space/time continuum, and unidirectionally. Healing results from a series of fluctuating, rhythmic patterns of energy and not necessarily flowing directly from illness to wellness. Therefore, healing is considered a pattern of unidirectional movement, which is the inevitable result of an open system being in a state of continuous change, rather than healing being seen as a step forward or illness as a step backwards. Therefore, all movement or change is considered to be healing (Plodek, 2005). A basic principle of holistic healing was described by Plodek (2005, p. 5) as “the body having the inherent ability to establish, maintain and restore health; the process being ordered and intelligent: nature heals through the response of the life force.”

Spencer W. Kimball, the seer and prophet, stated,

It must be remembered that no physician can heal. He can only provide a satisfactory environment and situation so the body may use its own God-given
power of re-creation to build itself. Bones can be straightened, germs can be killed, sutures can close wounds, and skilful fingers can open and close bodies; but no man yet has found a way to actually heal. Man is the offspring of God and has within him the re-creating power that is God-given. And through the priesthood and through prayer, the body’s healing processes can be speeded and encouraged (Plodek, 2005, p. 508).

Healers such as Mother Theresa, St Francis of Assisi, Jesus Christ and Saint Padre Pio have been recognised and revered for centuries for the miracles they bestowed on the sick and who then claimed that they had been healed.

Rogers in “personal conversations” spoke of death as being the ultimate healing, as human beings pass through all of their life-stages, being healed continuously along life’s journey (Plodek, 2005). Hands-on energy healing is a worldwide phenomenon, irrespective of religion or culture and is known to have emanated from folk medicine practices and from ancient wisdom traditions (Levin, 2011).

In modern times, newer healing modalities have originated from innovations of individuals who have founded new schools of healing. In the health care category of Western health care, nursing and the allied health sciences, the “holistic approach” is practised world-wide. That is, health care practitioners typically “subscribe to a holistic framework with a focus on health and well-being rather than on diagnosis and curing – and both nurses and healers use touch therapeutically.” The underlying praxis and theory of the nursing profession is more in line with what it is to be a healer in the nursing profession than what the medical profession is, although there is a medical worldview that now “recognises the availability of alternative therapies and differentiates these from biomedicine” (Levin, 2011, p. 15). Dr Dolores Krieger, nursing professor at New York University, and Dora Kunz, her teacher, and a gifted healer and former president of the Theosophical Society, developed a nursing-originated system of energy healing called Therapeutic Touch. This modality is a modern version of the laying on of hands that is attributed to traditional religious practices and is grounded in Indian yogic praxis entailing a multiple, human subtle-energy field that is interpenetrating, much like concepts such as “prana” and “nadis”. Dr Krieger started teaching Therapeutic Touch in 1972 and this is taught to mostly nurses as
part of the curricula of over 90 nursing training institutions (Levin, 2011, p. 15). In
1989, Janet Mentgen, nurse and energy healer, developed the more eclectic
Healing Touch and it is practiced as an alternative in nursing and health care to
Therapeutic touch. It offers a more traditional clinical approach to energy healing,
with some of the techniques being diagnosis-specific and others being highly
intuitive (Levin, 2011, p. 15).

Healers have been in existence from the beginning of recorded history and were
found in the esoteric, mystical spirituality and arcane medical science traditions.
Priest-physicians, adepts and spiritual initiates gained knowledge about healing
from the mystery schools of ancient Egypt, Babylonia, Assyria, Phoenicia, India,
Iran, Greece and Rome. The spectrum of energy healing spanned across East
Asian, Western professional, bioenergy (mostly from Eastern Europe), and
contemporary metaphysical traditions. Varieties of styles and variations in healing
practices exist today, across the spectrum, and employ a large variety of methods
in their healing practices. Therefore, it becomes difficult to ascertain any
similarities, if they do exist, between such diverse arrays of healers (Levin, 2011).

Health care practitioners in the uThungulu District belong to a community that
practises both traditional Western as well as ancient cultural forms of healing
(“traditional healing”) by the indigenous peoples in the area and, as such, they
need to be holistically aware of the healing dynamics to which they are subtly
and/or overtly exposed to either between themselves as colleagues, or with their
patients.

However, despite all the differences, there are core concepts that are common for
healing to take place once one gets past the superficial differences between
mainstream/western health care practitioners and/or energy/traditional healers.
The core themes identified to be essential for both practitioners of medical and
healing arts (and not just among energy and/or traditional healers) are focus,
compassion and intention. Even though different healers might have radically
different professional practice models, at a deeper level, they possess the
essence and “sameness” as the core themes just mentioned. It is true to say, that
in this day and age there are many kind, committed and positive health care
practitioners, and other healing practitioners, who realise that their mind-set and
attitude are essential components in the healing process (Levin, 2011). Dr Mehmet Oz, (well-known Columbia University cardiothoracic surgeon) wrote about the care he took in making his operating theatre a sacred space conducive to healing and assuring that everyone present had compassionate, positive intentions towards the patient. So convinced was he of his convictions that he employed Julie Motz, a Reiki healer, to be present during operations. Despite all the testimonials, it is difficult to convince lay people that many medical health care practitioners still find these methods strange. This may in part be due to the rejection of the idea of human bioenergy or life force by the uninformed biomedical scientists and clinicians. Studies, such as the one by Bodicoat (2013), demonstrated the effectiveness of using Intensive Interaction training methods to improve the attitudes and close observation skills of hospital staff with patients, who had profound learning disabilities, other intellectual disabilities or autism and who improved due to the interventions applied (Levin, 2011).

Who can deny the very real somatic response and deep sense of peace and relaxation one feels in the presence of a wise, good, gentle and kind person – a palpably real experience? It leaves one in no doubt that the subtle energies exchanged, the stilled thoughts experienced, and the lessening of anxiety in their presence, are not just a figment of the imagination and that one was indeed in the company of a person who cared so much and who gave their full attention, advice and encouragement to whomever needed it. Although the word “healer” is considered an established professional category with well-established techniques that can be taught and learned, one perhaps needs to rethink the concept. Perhaps anyone who possesses the required attitudes, motivations, intentions towards healing, service to others, whether innate or whether consciously developed through proper instruction, guidance or spiritual discipline, has taken the essential path on the road towards being a healer (Levin, 2011).

The author and poet, C. JoyBell (The Intensive Interaction, 2014, p. 1) succinctly expressed this concept:

You can talk with someone for years, every day, and still, it won’t mean as much as what you can have when you sit in front of someone, not saying a word, yet you feel that person with your heart, you feel like you have known
the person forever … connections are made with the heart, not the tongue.

It seems imperative then, that health care practitioners, with all the healing modalities they are exposed to and practice in the interests of those they serve, need to seek also to be essentially aware of the person as a biological entity, the person as a social being and with a psychological make-up which together influence the life of that person as a whole, and not just as a part of the whole. Despite this assumption, there is still the perception that many conventional medical practitioners and physicians perceive humans as nothing but “a sack of bones swishing about in a soup of chemicals” (Levin, 2011, p. 24). Conversely, other health care professionals such as psychiatrists, social workers and psychologists usually begin with the assumption that humans are integrated bio-psycho-socio-cultural-spiritual-ecological units, following in the great wisdom or spiritual traditions of Judaism, Hinduism, Buddhism, Christianity, Taoism, Islam, ancestor reverence, and others. By implication, it means that perhaps all healing should include introspection and well as empiricism, if it is about the self and others.

The perspectives recognised as holistic forms of healing still remain predominant in most parts of the world, including most of Southern Africa, and recognise these “different levels of consciousness, from subconscious to self-conscious and beyond” (Edwards, 2014, p. 1). Wilber’s theory, known as Integral Theory, that links African, Western and Eastern understandings of consciousness and which, in terms of any community of people, proposes that living beings inhabit a non-dual universe that is essentially linked by holons (whole/parts that are parts of other wholes). The implications for this theory, which expresses the importance of “wholes” all unfolding together in individual/collective and interior/exterior waves of physical, mental and spiritual consciousness, are that everything in the universe is already perfect and resonates with humanity – until humans intervene. Although it might be paradoxical that humans (and especially so in the healing professions) do intervene, it raises an important ethical rule incumbent on all healers, the imperative and basic moral principle of “first do no harm”. Integral Meta-Theory is based on an integral approach to science, a post-metaphysical, post-modern epistemology and integral methodological pluralism. It holds its own in satisfying
research designs and/or interventions that also transcend and include theoretical, paradigmatic perspectives such as positivism, interpretivism, and social constructionism. All levels and quadrants (AQAL model) such as behavioural, intentional, social and cultural perspectives are integrated and include their respective subjective, objective, intersubjective, inter-objective validity claims of functional fit, truthfulness, truth and mutual understanding (Edwards, 2014).

For the uThungulu District, this has great relevance as it is well acknowledged that a great majority of healing is practiced in the predominantly rural community by traditional healers from non-local realms of consciousness and/or “uMoya”/spirit. Similarly, in any community, health care practitioners may be broadly defined as being committed to heal and/or prevent all types of violence, human rights abuses, injustice, oppression, crime, poverty and other forms of illness (Edwards, 2014, p. 2).

The relevance of being health care practitioners in a multi-cultural health care environment should be that, in all cases, therapeutic decisions should not only be based on the Medical Model of intervention, but should include alternate belief systems and cultures in trying to obtain insights and options for treatment/care. This requires careful consideration with regard to interpreting the information received by the practitioner in order to make decisions based on phenomena presented at a post-rational level of vision/logic to identify the origin and clarify the message. It also needs to be understood that intuition cannot exclude the very important role of professional and ethical training methods, expertise, experience, research, and/or best practice evidence-based methods of treatment, but it does open a bracket. That interventions need not be based on choosing evidence-based versus intuition practices (and should not involve an either-or), is imperative. Rather, the ethically sound healing context should include the appropriate use of post-rational levels of moral consciousness, or “isazela” in Nguni languages, that intuition, in practice, should be assessed in an informed way, in different individuals, groups and different contexts (Edwards, 2014).

Such intuition would apply in appropriate situations such as when health care practitioners come across traditional healers, divine healers, yogis, shamans and others trained in these and other traditions. For example, San healers refer to
intuition as “gebesi” and “kowhedili” or “gut feeling”, and it is referred to as “umbilini” by Nguni people, and amongst certain yoga practitioners as “kundalini”. Assagioli (as cited in Edwards, 2014) postulated that intuition enters a person via the personal and/or collective unconscious therefore it is important to consider each case on its own merits. The value of being culturally aware is none more poignantly exposed than by the reported, real-life example of a misdiagnosed patient in Zululand (of which the uThungulu District is a part) who was diagnosed as being schizophrenic after telling a foreign psychiatrist that she heard an ancestor calling her to become a healer. The “patient” subsequently successfully undertook the authentic “ukuthwasa” or spiritual-cultural conversion experience and is successfully practising as an “isangoma” or traditional healer today. This case illustrates the need for sound intuition, ethical practice, training and individual experience involving hermeneutic discussions and case presentation, where informed members of a multi-disciplinary team could validate and understand the subjective truth, and where similar cases may have been presented in the past, thus informing the practitioner. These discussions may involve further investigations such as CT scans, electroencephalograms and standardised psychological measures in order to establish validity of the presence or absence of organic or functional evidence of schizophrenia, for example. In order for the intuitive calling of the client to be understood in both the social and systemic functional validity constructs, best-practice would have been also then to clarify if indeed the client did undergo successful training and practice as a traditional healer/“isangoma” (Edwards, 2014). The above approach illustrates best practice under multi-cultural and multi-lingual circumstances.

Dr Dan Benor, leading world authority of the scope of scientific research on healing (Levin, 2011), made the following valuable point:

*There are obviously many systems of healing, each with its own strengths and weaknesses. Any may be appropriate as an entry into learning to develop one’s own healing gifts … The individual practitioners, as the vehicles for healing, are the most important aspect of whether healings are likely to be helpful – far more important than the methods they use.*

Whether worldly or religious/spiritual, healing lies within each human being
2.2.3 Health

The WHO does not define health as merely a lack of disease or illness. It views health as a state in which the individual experiences complete social, physical and mental well-being (WHO, 1946). The Director General of the WHO, Dr Margaret Chan, pointed out the importance of health when she said that “the world needs a global health guardian, a custodian of values, a protector and defender of health, including the right to health” (WHO, 2013).

It is difficult to remain healthy in a dysfunctional environment, one that is emotionally and physically so taxing that an average person cannot cope with the strain. According to Pervin and John (1997), a person with low self-efficacy will experience far more anxiety from stressors than a person with higher self-efficacy does. Thus, when health care practitioners are faced with events that they perceive to be unmanageable, they are likely to experience high levels of distress that will, in turn, affect their health negatively. People respond differently to similar stressors, and their sense of feelings of control and mastery may be the key to successfully negotiating difficulties.

Health means different things to different people and therefore is a concept that rather needs to be understood in a multi-cultural context, such as that in which the health care practitioners in the present study lived and worked.

2.2.4 Health care practitioners

The WHO defines health practitioners as people whose job it is to protect and improve the health of their communities (WHO, 2006).

The global profile presented by the WHO in 2006 showed that the 59 million health care practitioners worldwide were unequally distributed within countries. They were found where the need was less severe, in predominantly richer areas and where health needs were less concerning. The numbers of health care practitioners are sadly insufficient to meet global health needs, shortages being in the region of 4.3 million health care practitioners (WHO, 2006).
2.2.5 Teamwork

In the health care environment, teamwork has been described as a dynamic process involving two or more health care practitioners with complementary backgrounds and skills, who share common health goals and exercise concerted physical and mental effort in assessing, planning or evaluating patient care. Teamwork is increasingly encouraged by health care policy-makers as a means by which to ensure safety and quality of service delivery (Dengegetu, 2012, p. 29).

2.3 Health care/systems/service delivery

The WHO describes health care service delivery as being essential and fundamental to the function of any health care system and being intended to provide therapeutic and medical measures to improve and preserve the health condition of patients, with the goals of responding to the population’s expectations. Goals should include: good health, fair financial contribution and responsiveness to the population’s expectations (WHO, 2000) which have often become a contentious issue worldwide, with most countries facing the challenge of limited resources whilst trying to provide these services to their ever-growing populations.

The term “Universal Health Coverage” means affordable quality health care services being made available to everyone. Yet, despite commitments by countries to provide this coverage, the dilemma remains of how to protect all citizens from financial risk, whilst simultaneously providing access to health services to every person and in every setting.

Despite health systems having been conceptualised in various ways, there appears to be a persistent lack of consensus in the development and analysis of health policies. Van Olmen, Marchal, Van Damme, Kegels, and Hill (2012) argue that policy frameworks of health care systems emerge and are ultimately designed from specific discourses constructed according to the agendas of their authors. Therefore, debates and tensions between the actors (often political) in health care delivery systems are often political.

All over the world, a wide range of health-care systems can be found. In some countries, the health-care system planning is distributed among market participants, whereas in others, planning is controlled more centrally by
governments, trade unions, charities, religious, or other coordinated bodies to deliver planned health-care services targeted to the specific populations they serve. Overall, health-care planning has often been evolutionary rather than revolutionary (Gawande, 2009). However, in all cases, adequate planning of health care services require “a robust financing mechanism, well-trained and adequately paid workforce, reliable information on which to base decisions and policies and well-maintained facilities and logistics to deliver quality medicines and technologies” (WHO, 2017).

Across African countries in general, health care services are increasingly placed under stress because of limited budgets and increasing service demands. To address this dilemma, paradoxically, some countries are turning to accredited service approaches such as COHSASA (The Council for Health Service Accreditation of Southern Africa), purported to be “the only internationally accredited quality improvement and accreditation body for healthcare facilities based in Africa” (COHSASA, 1977; Whittaker et al., 1998). South Africa has used COHSASA to implement a programme to assist public and private hospitals to implement services such as catering, maintenance, managerial, clinical and other continuous quality improvement programmes, providing guidelines for meeting professional organisational standards (COHSASA, 1977).

2.3.1 Health care service delivery in South Africa and Africa

In South Africa, the public health care delivery services are under-resourced and over-extended/used, while the mushrooming private sector runs largely on commercial lines, and caters to middle- and high-income earners who tend to be members of medical schemes (18% of the population) and often to foreigners looking for top-quality surgical procedures at relatively affordable prices. The private sector additionally attracts most of the country’s health care practitioners (Stoyanov, 2011, p. 11).

Solutions to problems in the health care systems have been proposed, such as adopting a more people-centred approach to service delivery, which would ensure that services are acceptable to the population affected and not only evidence-based. In line with WHO’s new European health policy, Health 2020, for strengthening health systems’ action across society and governments for well-
being and health, the policy is seen to be an essential goal to revitalise health systems, with a vision of improving health through the “people-centred” solutions using innovative approaches. The policy proposes support for member states in National Health Policy development towards achieving the goals of strengthening their health systems (Van Olmen, Marshal, Van Damme, Kegels, & Hill 2012; WHO, 2013).

Inevitably, interactions between social justice and law form part and parcel of every society’s duty to provide affordable access to health care, whether as part of South African law or laws considered applicable in the global world. Huge inequalities in the health care sector, both locally and abroad, demand sustainable solutions for health care not least for those vulnerable and lower-income members of society who rely on integrative social justice to achieve better health standards.

2.4 A brief history of the South African health care system

South Africa’s broad history was described in chapter 1 in order to provide a contextual background for the present study. Following from this the following sections focus specifically on the history of the country’s health care system.

2.4.1 History of health care in South Africa prior to 1994

For more than 100 years, voluntary health insurance, called medical schemes, has existed in South Africa (Department of Health, 2002). There also existed a range of public sector health authorities which included health departments at national level and associated regional offices. These, in turn, included four such departments, one each for the “African, Coloured, Indian, and White” population groups,¹ within each of the four former provinces (Cape, Orange Free State, Natal and Transvaal) as well as the ten former “homelands”,² and with some at local

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¹ “The use of the terms ‘African’, ‘Coloured’, ‘Indian’ and ‘White’ indicates a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology, but is necessary for highlighting the impact of former apartheid policies on the South African system” (McIntyre et al., 2007).

² “In terms of the 1913 ‘Natives Land Act’, Africans were confined to living in ten ‘homelands’, which were highly fragmented geographic areas scattered throughout South Africa, and established along ‘tribal’ lines. ‘Homelands’ comprised less than 14% of the total surface area of South Africa” (McIntyre et al., 2007).
In addition, curative and preventive primary care services were provided in separate facilities and administered by different health authorities and, until the late 1980s there were separate hospitals and other public sector health care facilities for “blacks” and “whites”. This structure was highly inefficient, with duplication of both administrative functions and clinical services. Prior to 1994 and at the time of the first democratic elections, the health system in South Africa was fragmented and reflected many social inequalities. Government’s health policy maintained political and economic power and assured better living standards for the white population, which was also evident in both sectors of the public/private mix. By 1994, the health sector was mostly hospital based and concentrated in urban areas. Hospitals in the districts were neglected and capacity was poor (McIntyre et al., 2007). Huge inequalities existed in public sector health services with their provision being biased towards historically “white” areas, whilst certain geographic areas (namely rural areas, particularly former “homeland” areas, “township” areas and informal settlements) were systematically under-funded because of “apartheid” policies (McIntyre & Gilson, 2002). These inequities not only affected hospitals but also clinics and health care practitioners.

In terms of health care practitioner numbers, by the early 1980s, about 40% of medical practitioners worked in private practice (McIntyre, Thiede, Nkosi, Mutyambizi, Castillo-Riquelme, Gilson, & Goude, 2007). At that time, there was a subsequent dramatic increase in the number and growth of medical schemes following government legislation and policy of privatisation and deregulation during the 1980s and early 1990s. While the key reason for this policy was the growing government budget deficit, the policy document also expressly based its motivation on international trends towards increasing private sector roles. This trend has continued since and data suggests that in the region of 73% of medical practitioners worked in the private sector by the end of the 1990s. Whilst initially, private hospitals were in rural areas and were non-profit and industry-specific, their profits were made through contracts with the government to provide treatment for long-term psychiatric and tuberculosis patients. General hospitals for profit are a more recent development which now own approximately 84% of all
private hospital beds and are dominated by three large hospital groups, namely, Netcare, Medi-Clinic, and Life-Health Care (McIntyre et al., 2007).

2.4.2 Two-tier system after 1994 (continued division)

After 1994, the public health sector was integrated into a single Department of Health at national level and one in each province. In addition to the restructuring, attention was paid to improving primary health care services, with upgrades of clinics and renovations of hospitals, particularly in the rural areas. Attention was also given to allow vulnerable groups to receive health services free of charge and, most recently, for termination of pregnancy services (McIntyre et al., 2007).

Over the last decade, however, South Africa has faced an escalation of problems in the health care system verging on a crisis, which has been widely recognised. Areas of emphasis are on the burden of disease, the paradox of apparent progress, yet deteriorating health outcomes and critical challenges faced by the health care sector (Kruger, Sanders, & Schaay, 2011). Although the South African post-apartheid Government has implemented extensive health care reforms since 1994, some did not have the required effect because, before real reforms could take place, the country had other unique problems to overcome (Venturina, 2013).

According to the People’s Health Movement of South Africa, approximately 47% of children lived in rural areas, serviced by only 12% of medical practitioners and 19% of nurses, resulting in rural populations often relying on informal healers, such as “traditional healers” and their medicines for solutions to their health problems (Hall, Woolard, Lake, & Smith, 2012: 3).

To put these figures into perspective, KwaZulu-Natal has 10.3 million inhabitants, making it the second-most populous province in South Africa (SAPA, 2012) and, bearing in mind that in the 2011 census there were 51.8 million people living in South Africa, 7 million more than in 2001 (Ntungi, 2012), KwaZulu-Natal further faced the problem of having 16% of its population aged between 15 and 49 years reported to be HIV positive. This, and taking into account that one-fifth of all South African woman are in their reproductive years (South Africa Info, 2012), it is not difficult to estimate the burden of disease that health care practitioners face in the province’s local health care institutions and the need for these to be run effectively and efficiently.
Currently, the public health care sector in South Africa is under-resourced and over-extended, while the private sector has mushroomed and is run largely on commercial lines, catering to the high- and middle-income members of the populations who also mostly belong to medical aid schemes, earn salaries and attract the majority of the available health care practitioners (Health care in South Africa, 2011). Thus, the two-tier health care system consists by and large of the rich (or better-off) minority having private health care covered by private medical aid schemes and the greater population being dependent on tax-funded, under-resourced public health facilities. This situation has seen the divisions between public and private health care sectors widen for the majority in the past 10 years (McIntyre et al., 2007) which has placed health care systems under strain. With the world’s largest HIV caseload and burgeoning TB cases, the health of the South African population is still reflective of a divided and unequal society, public health care facilities face the problems of over-crowding, lack of equipment and medications (Kaiman, 2014, p. 2).

The divisions, the historical influence of colonialism and apartheid, have left the public health care sector battling to meet the needs of around 85% of the population. This is coupled with only about 30% of medical practitioners, dentists, pharmacists, physiotherapists, psychologists and only 40% of nurses, working in the public sector. The remaining health care practitioners work in the private sector, which caters to only about 15% of the population, but which consumes 60% of total health care spending. Private health facilities are currently considered world-class with costs to individuals/patients being cheaper on average than those in other countries, such as Australia, the United States, and Britain. This means that foreigners can afford to come to South Africa and essentially receive treatment at a fraction of the cost, and yet, ironically, those treatments remain beyond the financial means of the majority of South Africans (Kaiman, 2014, p. 2).

With the private sector attracting most of the country’s health professionals (Health care in South Africa, 2011) it is important to try and understand the dynamics which create and sustain this situation. It is hoped that findings from the present study will shed some light on this divide.
2.4.3 Economic inequality

Economic inequality has been the defining problem of the legacy of apartheid in South Africa, which is among the countries with the highest Gini Index (where 0 indicates no equality and 100 indicates inequality), tending to be concentrated in Southern Africa (South Africa 57.8, Namibia at 70.7, Lesotho 63.2, Botswana 63, Swaziland 60.9, Latin America and Guatemala 59.9, Brazil 59.3, Paraguay 57.8, Colombia 57.6 and Chile 57.1) (UNDP, 2005; McIntyre et al., 2007). Therefore, it has become well accepted that economic development in a country as a whole shapes the health sector, and its historical, social and economic background shape the context in which the health system develops (McIntyre, 2012). Taking these index results into account, South Africa’s health care sector performed worse than comparable nations despite spending 8.5% of its GDP on health care in 2012, higher than the WHO’s recommended 5% for countries with a similar socio-economic status (Kaiman, Smith, Anand, Watts, Kingsley, Hooper, Woolf, & Oltermann, 2014, p. 2).

In attempting to address the inequalities in health care service delivery, a shift in the approach of health care services towards a primary health care approach (such as a shift from hospitals to district-based clinics) has been adopted, although this has resulted in other financial cutbacks especially to the severely challenged resources of the public hospitals that are funded entirely by the State (Whittaker et al., 1998). Being a rural area, the uThungulu District is affected by these economic factors.

2.4.4 Budget for public health care

For the public health care sector, the budget grew by just over R1 billion to R27.5 billion in 2012/13. It is expected to have increased by about R6 billion in 2014/15. The human resource budget increased only marginally to R2.1 billion in 2012/13 compared to R2 billion in the previous year. Although these indicators seem positive, inflation was not factored in, which would effectively reduce all growth rate allocations (Ndlovu, 2012). How the budget will be distributed will have implications for uThungulu District health care delivery services in the public sector.
2.4.5 2006 Human resource plan to counter staff shortages/lack of morale

After 1994, the South African Government embarked on a Human Resource Plan in 2006 (Department of Health, 2006), with particular emphasis on the public sector. By 2009, 15 years since its implementation, the main strategies implemented and going forward were the following:

1. Adequate remuneration for health care practitioners relative to other employees in other professional disciplines and not only the private sector. This was probably the most important incentive to keep health care practitioners in the public sector. The effects of the Rural and Scarce Skills Allowances and the Occupation-Specific Dispensation would need to be closely monitored over the next three years.

2. Other material and morale-boosting incentives could reduce the differentials between the public and private sector. They included provision for study leave, preferential admission for specialisation and a work environment respectful of professional autonomy and conducive to personal growth and development.

3. The success of the community service programme suggested that supply could be further strengthened by incentives such as full study bursaries in return for years of work (Harrison, 2009, p. 27).

Despite these measures, shortages of health care practitioners persisted. These were particularly felt in the public health sector and caused increased workloads on already overburdened health care practitioners caring for the country’s poorer socio-economic sector with a high burden of disease (particularly TB and HIV/AIDS), which had a huge effect on the rights of rural communities. Health care suffered, as patients often stood in long waiting lines to receive treatment and many travelled great distances to get to health care facilities (South African National AIDS Council, 2012).

To compound the problem, HIV was documented to be the leading cause of death of health care practitioners in the first five years of their work experience, with an estimated 1 in 10 health care practitioners in African countries such as Malawi.
It can be inferred that this problem is nevertheless not likely to be any less in South Africa. Not only has this affected absenteeism, but also the burden of the workload that has not been compensated by an increase in staff numbers. These factors, resulting in psychological and physical symptoms, such as fatigue and burnout (Mills, Kanters, Hagopian, Bansback, Nachega, Alberton, Au-Yeung, Mtambo, Bourgeault, Luboga, Hogg, & Ford, 2011, p. 2), add considerable stress and strain on health care practitioners.

A district survey revealed that clinic health care workers reported more unhappiness and feelings of over-burden and strain due to patient numbers, than caring for the individual patients themselves. Ironically, patients (who were ill), on the other hand, who had waited in long queues (for AIDS medications), were found to be more content in general than the health care practitioners (Ndlovu, 2012).

Low morale in nurses, in particular, remains a concern in South Africa. According to a five-year survey in Segall (1999), “the single most consistent finding in all parts of the country is that morale among health care practitioners is low, especially among nurses.” Nurses attributed their low morale to overwork, reporting that the problem was more a sense of neglect and lack of support, which appears to be at the heart of the problem. Regrettably, many health reviews of the South African public health care system since then have tended to reach similar conclusions (Harrison, 2009, p. 32).

Staffing problems urgently need to be addressed at government level with efficient resource allocation. This will go a long way to reducing long patient queues or crowded spaces that result in patients often going back home without adequate treatment and care, and will assist towards boosting staff morale.

South Africa falls below the WHO’s threshold for millennium development goals that recommends 230 nurses and medical practitioners per 100 000 of the population. Being a largely nurse-based health system, these figures, according to the WHO criterion, should be used with caution when making comparisons internationally (Ndlovu, 2012). Ironically, there were post vacancies for 23 medical
practitioners and 181 professional nurses per 100 000 people, according to the Health Systems Trust (2008 as cited in Harrison, 2009), who did their assessment in 2006, using the WHO “Workload Indicator of Staff Needs” (WISN) tool. The findings indicated that 94% of those required were nurses, 60% were enrolled nurses, 17% were nursing assistants and 7% were medical practitioners although a lot of variation existed across districts and facilities (Harrison, 2009).

The real problem, therefore, appears to be not only a human resource shortage, but one that is multi-faceted. To presume that an increase in numbers of health care practitioners alone will solve health care service delivery problems would be naïve and focuses only on the symptom rather than the cause of the problem. Factors that cannot be overlooked are:

- The distribution of health care practitioners not being managed effectively (over- or under-staffing in areas, where patient demands are not matched to staff numbers);
- Inadequate training of nurses resulting in the wrong skills for the demands and changes required in health care services affecting patients;
- Loss of health care staff due to resignations, retirement, migration and others which are not replaced;
- The effective training and retention of adequately skilled staff with specific knowledge about the health demands of our society at present.

There is therefore a need to develop new skills which are reflective of society’s health care needs and the changing burden of diseases such as HIV/AIDS. These needs, in turn, inevitably place an increased demand on health care practitioners, especially nurses, who may be inadequately trained and whose skills and distribution is not adequate. Thus, the real issue is not merely one of inadequate human resources but rather a larger set of challenges which need to be assessed continually and adjusted when the need arises (George, Quinlan, Reardon, & Aguilera, 2012).

Despite the struggle of health care practitioners to meet patient demands and
plans by government since 1994 to remedy the deficit in the public sector staffing shortfall (through the Government Resource Plan) (Harrison, 2009), a serious shortfall of more than 80 000 health care practitioners still existed. It is obvious that the country does not have the human resources to treat HIV and TB adequately, with three out of ten medical practitioners in South Africa serving the public sector patients, while the remainder work in the private sector. In rural areas, where 43.6% of South Africans live, only 12% of the country’s nurses and 12% of available medical practitioners serve those populations (SA DOH: Human Resources, 2011). It is not difficult to envisage the current human resources crisis, which health care practitioners in the uThungulu District, and indeed the country, face.

2.4.6 Hints of investigations

The Minister of Health vowed to bring down the costs of private health care through reforms, although currently there is no agreement on what needs to change or, more importantly, how it will change to be sustainable. He has ruffled feathers by suggesting that the uncontrolled private health care sector needed to be regulated and the public health care sector needed to be regenerated – two conditions that he considered mandatory for successful implementation of the NHI. He suggested an investigation later in 2013, through the Competitions Commission, related to the possibility of collusion occurring between health care providers in the private sector. The Minister said that he had a duty to uphold Section 27 of the Constitution, in which health care is defined as a right, claiming that unaffordability in the private sector was contrary to those ideals (Makholwa, 2013).

In a notice published in November 2013, the promised investigation into private health care (defined as “that portion of health care services that is funded by private patients, either through medical schemes, insurance or out-of-pocket payments”) was put into action. The investigation was to be conducted by a multi-disciplinary team with health care knowledge, who would review comments from the consultative process involving, amongst others, public hearings, culminating with a final report, the deadline for which was set for November 2015 (HPCSA, 2015).
The Minister also alluded to rumours that private health care groups might be preparing a High Court case against the government to stop the implementation of the NHI scheme. The Minister foresaw a serious rift with government becoming inevitable, and vowed to fight back against any challenge (Makholwa, 2013).

With a growing number of South Africans finding it difficult to bear the costs of medical aid contributions, simply enforcing regulations through financing intermediaries and regulatory measures is not considered enough to control the spiralling health care or insurance costs. Alternatives need to be explored to extend coverage, amongst other measures, through low-cost schemes, as the proportion of the population available to enter into medical schemes continued to increase (McIntyre et al., 2007). At this stage, about 20% of South Africans, of a population of 54 million, use private health care, with 16% covered by medical schemes. The remainder pay “out of pocket” or cover their hospital costs through hospital insurance cash plans. The Minister of Health, Dr Motsoaledi, claimed that his office was swamped with complaints of rising costs and mismanagement. It has been contended, that complaints around private medical schemes was rather more a symptom of a badly structured health system, which has had the effect of the public taking out insurance or medical aid in order to be covered should they become ill, only to discover when they do, that there are limitations imposed on their benefits and price sensitive issues when they are being treated (Makholwa, 2013).

The above issues around health care, legislation and investigations continue to prevail in the country, due largely to the complex dynamics of its citizens, who have a history of severe social and economic divisions. It is therefore understandable that a balance will be difficult to find.

2.4.7 Practical barriers (limitations and successes)

The practical barriers that still exist in the public health sector relate mainly to the rural population, who cannot afford the transport required to get to the towns and cities. Being under-serviced due to primary health care clinics being situated mostly in towns and cities, and where, in serious cases, the patients often receive their first contact at a primary health clinic and are only thereafter referred to hospitals, results in a less-than-optimal treatment path. This has led critics to
observe that:

- Treatable conditions are not treated on time;
- Preventable diseases are not prevented;
- The government admitting to the need for “radical improvement” and “massive investment” and “fundamental changes in management” in the quality of services;
- Need for radical improvement in buildings, equipment, and changes to management structures.

The Minister of Health, Dr Motsoaledi, told the Mail & Guardian newspaper, “It is a self-defeating prophecy to keep on saying we do not have the means, there are good services in countries with fewer facilities and staff than us” (Kaiman, 2014, p. 3).

However, despite these gloomy statistics, there have been numerous successes in health care provision, for example, essential services such as TB and HIV treatment are free and provided by the government, with patients from the private health care sector on being diagnosed with TB typically being referred for ongoing treatment at public facilities with TB medications free of charge.

The same can be said for HIV and anti-retroviral treatment programmes that came about when the government lost a landmark court case after being accused of “AIDS denialism”. This resulted in South Africa becoming the country with the world’s largest public sector HIV programme, treating 2.5 million of the population and reportedly increasing the life-expectancy from 53 years in 2002 to 60 in 2013 (Kaiman, 2014, pp. 2-3).

2.5 Health care practitioners and ruling bodies (protectors and regulators)

2.5.1 Health Professions’ Council of South Africa (HPCSA)

The HPCSA is South Africa’s regulating body with 12 professional boards. It controls all health care professions in South Africa in accordance with the Health
Professions Act (No. 56 of 1974). The HPCSA’s primary function is to safeguard the public, and indirectly the professions, by way of obligatory registration. Registration is a prerequisite for any health care professional practice. The HPCSA is also the guiding body for professionals’ registration, ethical conduct, ongoing training and adherence to health care standards in the country (HPCSA, n.d.).

2.5.2 South African Medical Association (SAMA) – Public service medical practitioner trade union and public and private sector representative

SAMA is a non-statutory professional association for medical practitioners from both the public and private sectors in South Africa. It is an independent non-profit company and acts as a trade union for the public sector medical practitioners only. It is a champion for patients and medical practitioners alike. Its aims are to empower medical practitioners to bring health to the nation. Approximately 70% of public and private sector medical practitioners whom it supports are registered as members, in terms of advice pertaining to medical law, ethics, labour relations, representation on health matters and monthly scientific journals. SAMA’s principle activities are to provide medical skills, education, knowledge and leadership to medical practitioners, represent their rights, uphold the medical profession’s image, promote research and academic excellence, negotiate health reform and affordable health services for all (South African Medical Association, 2012).

2.5.3 South African Nursing Council (SANC) – Nurses’ representative

The South African Nursing Council (SANC) is a statutory, independent, autonomous body that maintains the standards of nursing education and represents the nursing profession as defined in the Nursing Act, 2005, which also makes provision for all “accreditation and inspection of nursing education institutions, monitoring of assessments conducted by accredited institutions, examinations and granting of diplomas and certificates.” It provides “for the making of regulations relating to qualifications and the conditions to be complied with, which entitle a person to be registered as a nursing practitioner” (SANC, 2015).
2.6 Health care practitioners and ethics

2.6.1 Hippocratic Oath – What does it mean to medical practitioners?

The Hippocratic Oath is one of the oldest binding documents in history. It is traditionally taken by graduate physicians to uphold the ethical standards of their profession, particularly to preserve life above all (Encarta, 2001). Most medical training institutions include an oath in their graduation ceremonies almost as a “rite of passage”, the most popular and oldest of which is the Hippocratic Oath written in the 4th Century by the Greek physician Hippocrates, “the father of Western medicine” (Hulkower, 2010, p. 41). The original 20th century format was historically altered and “upgraded” to include “evolutionary” content and new ideals. Some content that was removed pertained to moral/ethical issues such as the ban of euthanasia, using abortive agents and the proscription of sexual contact with patients. Notwithstanding the evolutionary path the Oath has taken, it still appeals to the medical fraternity, alluding to an ongoing appreciation of who Hippocrates was and what he still stands for today with respect to the importance of patient-oriented medical practice and physicians (medical practitioners) taking the least damaging approach to treatment. The tenet that medicine is a “craft” that should be adhered to in order to “at least do no harm” (Hulkower, 2010) still applies today.

Health care practitioners in South Africa are often held accountable, especially by the media, to the principles of ethics and morality of the Oath, which remains a yardstick for the care provided to those in need of medical services.
Table 1

Wits University, South Africa, medical students take the following modern version of the Oath upon graduating

“As a graduate of the University of the Witwatersrand, Johannesburg, I do solemnly declare:

That I will exercise my profession to the best of my knowledge and ability for the safety and welfare of all persons entrusted to my care and for the health and well-being of the community.

That I will not knowingly or intentionally do anything or administer anything to them to their hurt or prejudice.

That I will not improperly divulge anything I have learned in my professional capacity.

That I will endeavour at all times to defend my professional independence against improper interference.

That I will not employ any secret method of treatment, nor keep secret from my colleagues any method of treatment that I may consider beneficial.

That in my relations with patients and colleagues, I will conduct myself as becomes a member of an honourable profession.

I make this declaration upon my honour”

(Source: WITS, 2015)
Table 2

*The traditional Hippocratic Oath, translated by Michael North*

<table>
<thead>
<tr>
<th>I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgment, I will keep this Oath and this contract:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfil his needs when required to; to look upon his off-spring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart acknowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.</td>
</tr>
<tr>
<td>I will use those dietary regimens, which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them.</td>
</tr>
<tr>
<td>I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.</td>
</tr>
<tr>
<td>In purity and according to divine law will I carry out my life and my art.</td>
</tr>
<tr>
<td>I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.</td>
</tr>
<tr>
<td>Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.</td>
</tr>
<tr>
<td>Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such to be private.</td>
</tr>
<tr>
<td>So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.</td>
</tr>
</tbody>
</table>

(Source: Hulkower, 2010, pp. 43-44)

2.6.2 Nursing pledge of service – “Faithfulness to the calling“

Every year on International Nurses’ Day (12 May), nurses all over the world remember the legacy that Florence Nightingale left. She was born on 12 May 1820 and became an icon for her dedication to the science and art of nursing and its value as being independently recognised. The original “Nightingale Nurses’
Pledge” was composed in 1893 and is an adaptation of the Hippocratic Oath which is taken by physicians (medical practitioners). The Nursing Pledge stresses the importance of “leading by example, exhibiting faithfulness, accountability, accuracy, responsibility, confidentiality, devotion and quality” (SANC, 2015) and is endorsed by the South African Nurses Council, as follows:

| Table 3  
| The Nurse’s Pledge of Service, used in South Africa |
| I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity. |
| I will maintain, by all means in my power, the honour and noble tradition of my profession. |
| The total health of my patients will be my first consideration. |
| I will hold in confidence all personal matters coming to my knowledge. |
| I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient. |
| I will maintain the utmost respect for human life. |
| I make these promises solemnly, feely and upon my honour. |


2.7 Health care practitioners and compensation

2.7.1 Occupation Specific Dispensation (OSD)

According to the Department of Public Services and Administration (2007), “Occupation Specific Dispensation” (OSD) meant revised salary structures, unique to each identified occupation in the public service” and were to be implemented over five years, beginning with medical practitioners, in April 2008. These salary structures would be graded into, and aligned to, the market. The intent was to encourage career pathing models for employees and base wage increases on criteria such as performance, qualification, scope of work and experience. Specialists and professionals’ salaries would be higher than or equal to managers, without them needing to move into managerial or supervisory positions. Government indicated that this move would attract and retain skilled personnel, improve salary structures through large salary increases and reward performance
Health care practitioners in South Africa, who are often frustrated with the actual implementation of the OSD, their working conditions and salaries, embarked on various forms of labour protests, which are described as:

2.7.2 Strikes

Strikes are organised, collective slow-downs or cessation of work by employees to force their employers to accept their demands (http://businessdictionary.com) and are most often embarked on in response to common concerns such as poor working conditions, wages and others. Not unique to South Africa, by all accounts, it appears that strikes also occurred from as far back as the 12th century BC (Dhai, Etheredge, & Veriava, 2011) and are sometimes known locally as “go slows.”

In 2007, nurses embarked on countrywide strikes (some violent) with the main concern being wages and the delays in implementing the OSD policy aimed at linking wages with experience at various professional levels (Dhai, et al., 2011).

In 2009, further health care practitioner strikes ensued related to grievances about poor working conditions in the public service, human resource shortages, deterioration of academic/learning facilities, poor salaries and poor patient conditions in public health care facilities. Some medical practitioners, who chose not to strike, cited the Hippocratic Oath as their reason for remaining committed to patient care, although they did voice their grievances about management capabilities and working conditions. Prioritising patient care was considered by the non-striking practitioners to be more important than their salaries (Dhai et al., 2011). Health care practitioners have been known to be “intimidated” if going to work and deemed to be unsupportive of the “greater cause”, essentially “forcing” unwilling participants to take part.

In 2010, there was widespread anticipation of further strikes, once again based on wages relating to OSD factors that had not been resolved. Health care practitioners threatened to disrupt the 2010 FIFA World Cup, hoping that the high-profile occasion would provide a visible platform for speedy resolution of their
problems (Dhai et al., 2011).

South African laws and strikes

In South Africa, the Labour Relations Act No. 66 of 1995 (as contained in the Constitution) governs strikes. In particular, Section 23 of the Bill of Rights effectively provides for the right of health care practitioners to strike and qualifies that right by imposing a restriction on people who provide essential services.

The exception to the right to strike is, if there is a minimum service agreement (via trade unions) in place, allowing them the right to strike, providing they also attend to minimal services, considered as essential. However, since no agreement had been reached on what the minimum service level was, public health care practitioners may therefore by law, not go on strike and, if they do, will face disciplinary measures (Dhai et al., 2011).

Similarly, patients also have rights, protected by the Bill of Rights, which provides for the rights of citizens to gain access to health services. This, together with the National Health Act and the Patients’ Rights Charter, renders health care practitioners to be in violation of patients’ rights to health care, should they strike.

Despite all the legislation, crippling public sector strikes have captured the headlines and highlighted the negative perceptions that the general public have of strikes, most especially with the resultant effect on the poor (Dhai et al., 2011) and vulnerable. Thus, social and political responsibilities are vested in all health care practitioners’ decisions relating to personal, professional, ethical, revolutionary or otherwise decisions and/or conduct and especially how they perceive going about getting answers to their problems (Betan, 1997; Betan & Stanton, 1999; Gelatt, 1989). What it means to be ethical within a social context (Cottone, 2001), when those decisions might inflict harm on others (Bursztajn, Hamm, Brodsky, Alexander, & Levi, 1991) remains a poignant issue. Health care practitioners often defend their strikes by alleging that they are rendered unable to provide good quality health services because of, amongst other factors, a lack of resources, which they deemed to outweigh the justifications not to strike, according to the law. In this way, they also hold the government “morally responsible” to the people, to uphold the constitutional rights of citizens.
2.7.3 “Toyi-toyi”

The “toyi-toyi” is a name (or a verb) that is commonly used in South Africa and most often means a dance, typical in its presentation, which is understood in quite a diverse range of settings to mean different things. It is most often also associated with heightened emotions, becoming somewhat of a “brand” and a form of solidarity to most of the populations of the country and is often performed during strikes. In action, “it is a type of dance or march, used as a form of protest in which one repeatedly moves one leg up and down followed by the other” (Oxford Advanced Learner’s Dictionary, 2015) and was seen especially during the pre-apartheid liberation movement. Although it was thought to have become a thing of the past, it is still considered a phenomenon, post-democracy in the country, and is witnessed when disgruntled workers “toyi-toyi” as a last resort, often hand-in-hand with industrial action. Nowadays, “toyi-toyi” includes all racial groups, even the white population, which would not have been the case in the past (Twala & Koetan, 2006), indicating a sense of multi-cultural, purposeful “solidarity”. Health care practitioners have “toyi-toyi’ed” from time to time when emotions have been heightened during times of unrest and protest.

2.7.4 Work to rule/“go slow” (another form of strike)

This is a labour protest in which workers (health care practitioners) make a point of adhering strictly to the rules of the workplace so that work will slow down (Encarta, 2001) and could be considered as a type of strike.

In South Africa, wage disputes that have usually been the leading cause of dissent, resulted in health care practitioners feeling justified in resorting to these types of practices as a last resort when other bargaining methods had failed. Members of the public, although understanding of their concerns, perceive the resultant neglect of patients (often critically ill) to be unconscionable and going against all health care and human rights. Because “go-slow”s (and strikes) involve withdrawing services which are normally provided, health care practitioners themselves face moral, ethical and professional dilemmas associated with the law, the Oath and pledges they took related to caring for and acting in the best interests of the community that has entrusted them with their welfare and safety. Optimally, a fiduciary relationship should exist between health care practitioners
and patients (Dhai et al., 2011).

2.8 Health care practitioners and psychological factors

2.8.1 Stress

It may be argued that people always face stressors in life and that it may be impossible to attain complete mental, physical and social well-being. However, while it is accepted that stress need not always be considered unhealthy, it is rather the manner in which health care practitioners evaluate stress, the resources at their disposal to assist and the extent to which they can control those stressors that, to a large extent, control the impact of stress (Baum & Posluszny, 1999). The ideal type of control over stressors may be referred to as environmental mastery, which is a component of psychological well-being (Edwards, Edwards, & Basson, 2004). It is difficult for health care practitioners to remain healthy in a dysfunctional environment, one that is emotionally and physically so taxing that an average person cannot cope with the strain.

According to Pervin and John (1977), a further important indicator of stress-response occurs in people with low self-efficacy (less ability to control stressors), who will experience far more anxiety from stressors than a person with higher self-efficacy does. Therefore, some health care practitioners, when faced with events that they perceive to be unmanageable, are likely to experience high levels of distress which will, in turn, affect their health negatively.

Research suggests that stress among caregivers in the field of HIV and AIDS manifests itself in a wide range of signs and symptoms such as psychological, behavioural and physical sequelae. Although stressors are not of themselves all unhealthy, they may become so if they are not attended to or suppressed/accumulated over time (UNAIDS, 2000).

Common signs of stress (UNAIDS, 2000) in health care practitioners include:

1. Loss of interest in and commitment to work;
2. Loss of punctuality and neglect of duties;
3. Feelings of inadequacy, helplessness and guilt;
4. Loss of confidence and self-esteem;
5. A tendency to withdraw – both from clients and from colleagues;
6. Loss of sensitivity in dealing with clients;
7. Loss of quality in performance of work;
8. Irritability;
9. Difficulty getting on with people;
10. Tearfulness;
11. Loss of concentration;
12. Sleeplessness;
13. Excessive fatigue;
14. Depression; and
15. Bowel disturbance.

2.8.2 Burnout

Burnout is caused by a type of stress that is especially prevalent in professional situations, where, most notably, inter-personal work demands may cause depersonalisation, a sense of reduced personal achievement and emotional exhaustion (Gueritault-Halvins, Kalichman, Demi, & Peterson, 2000). Burn out is especially prevalent in the caring professions and is not a single event, but rather a build-up of stressors which, if not addressed timeously, may eventually negatively affect health care practitioners’ physical and emotional health, subsequently causing relational difficulties (UNAIDS, 2000).

Signs of burnout and factors that might cause it include: profound feelings of loss and grief; repeated exposure to death; fears relating to attachment and loss; feelings of helplessness; ineffectiveness related to anxiety about possessing inadequate medical expertise to care for people with, for example, HIV/AIDS; increased workload; and coping with inadequate social resources for AIDS patients. Symptoms of burnout, such as emotional exhaustion, a reduced sense of personal accomplishment, loss of a positive attitude toward patients and an increased desire to quit the profession (Bellani, Furlani, Gynecchi, Pezzotta, Trotti,
& Bellotti, 1996) highlight how chronic levels of occupational stress often lead to burnout (Pines & Maslach, 1978) and the loss of valuable human resources.

Another feature of burnout, according to Pierre Brouard, a counsellor who counsels other counsellors (UNAIDS, 2000, p. 25), is that chronic stress from caring for severely ill people manifests itself typically as either over-involvement or under-involvement on the part of the caregiver. Over-involvement is a kind of flooding response, where one gets so emotionally connected that one loses all perspective and burns out very quickly. Under-involvement, on the other hand, is a withdrawn, unemotional, disconnected way of working with people. Some get almost brutal or tough because they get “compassion fatigue”. Both are very real dangers. Stressors leading to burnout may also manifest as physical symptoms such as sleeplessness, lethargy, restlessness, loss of concentration, shaking or tremors and bowel disturbances. Behavioural problems such as irrationality, mood swings and depression are common as well. Psychological features such as lack of initiative and enthusiasm, excessive fatigue, frustration, anger, quarrelsomeness and a tendency to complain are commonly observed as signs of stress (UNAIDS, 2000, p. 26). Notwithstanding the fact that the physical demands and exhaustion of the caregiver job can be severe, just being in close interactive situations with patients at all times with “excessive demands, time pressure, and job stress”, causes burnout (Bellani et al., 1996, Goodman et al., 1997). Emotional overload, therefore, being a strong predictor of burnout, poses a serious occupational challenge which ultimately leads to higher levels of absenteeism, staff turnover and reduced productivity at work. When considering these factors in the health care field, the potential impact is devastating (Nesbitt et al., 1996).

### 2.8.3 Anxiety

Anxiety can be described as an unpleasant, vague emotional state that includes apprehension, distress, dread and uneasiness (Reber & Reber, 2001). It is characterised by an uncomfortable and ambiguous feeling, accompanied by undesired changes in one’s physical state, such as dizziness, headaches, stomach discomfort, perspiration, palpitations, an increase in blood pressure, agitation and shaking (Khan et al., 2005). It has the potential to affect an individual’s thinking, perception and learning abilities (Sadock & Sadock, 2007)
and, as such, can become intertwined within the experience of everyday human life (Khan et al., 2005).

The experience of anxiety consists of two components: the awareness of physiological sensations (for example, palpitations, sweating), and awareness of feelings, for example, nervousness and/or fear. Anxious health care practitioners may distort their perceptions, which could potentially render their attention span ineffective, as anxiety can impair cognitive, emotional and occupational functioning, precluding some sufferers from getting the needed social support to improve their symptoms and return to good health. Patients are often unaware of the anxieties which health care practitioners may experience, or its potential effect on their thinking and perceptions (Sadock & Sadock, 2007).

In the USA alone (no statistics appear to be available for South Africa), the combined economic cost of anxiety and depression was approximately 72 billion dollars annually, with 40% of adults suffering from anxiety (Forbes et al., 2008). The WHO research attributed mental illness as accounting for up to 15% of disease worldwide (Streeter, Jensen, Perlmutter, Cabral, Tian, Terhune, Ciraulo, & Renshaw, 2007). This has significant consequences for any health care system, the implications of which could be devastating, especially since chronic anxiety is associated with many physical and psychological problems, impacting on a person’s well-being (Edelman, 2006).

By all accounts, South African health care practitioners face enormous challenges in coping with the stressful demands of a burgeoning health care population in need of their care. If the research is taken seriously, then it is in the best interests of the South African society to address the needs of those whose health is a prerequisite to providing such care.

### 2.8.4 Frustration-Aggression Hypothesis

The Frustration-Aggression Hypothesis proposes that frustration almost always leads to aggression (whether overt or covert) and that aggressive behaviour is always an indication of frustration (Dollard et al., 1939; Reber, 2001). Frustration appears to increase or eventually lead to aggression when the level of frustration is particularly intense, especially if the frustration is perceived as deserved or
legitimate rather than arbitrary or illegitimate (Sadock & Sadock, 2007), serving to remind one of the importance of good communication and consultation.

Hence, frustration remains by far the most potent means of inciting human beings to aggression (Sadock & Sadock, 2007) and should be viewed as one of the major reasons for negative-affect (psychological) states in health care practitioners, which is often overlooked as a cause when dealing with what appears to be simply aggression (covert or overt) or seemingly, without a “cause”.

2.9 Health care practitioners and the law in South Africa

2.9.1 South African Constitution

Section 27 of the Constitution and the Bill of Rights, Chapter 2 and other related health care service delivery laws

South Africa, as a new democracy since 1994, has faced growing criticism about the health care sector and its current problems. The Constitution of 1996 enshrines the right of access to health care (South African Government, 2015), a universally accepted socio-economic human right and one that is guaranteed and protected in Section 27 of the South African Constitution. This obligation, to provide health care on an equal basis to everyone, regardless of income, is juxtaposed against the prevailing public health care system that is currently delivering low-quality health care to the majority of the people (Mabidi, 2013).

Section 27 does not operate in isolation. It is but one – albeit of central importance – among a collection of rights that deal directly and indirectly with health. These rights, which create entitlements and impose both positive and negative obligations on the state, include “the right to bodily and psychological integrity” (Section 12(2), “the right to privacy” (Section 14), and the right “to an environment that is not harmful to their health or well-being” (Section 24(a), with the focus remaining specifically in dealing with “health care services” (Hassim, Heywood, & Berger, 2014, p. 34).

The Bill of Rights is the vehicle that, through laws guided by the South African Constitution, guides the rights of access to health care and has rightfully been called the “cornerstone of democracy”. It regulates health laws in two ways by
recognising the relevant fundamental rights in developing and implementing policies on health, as well as outlining the state’s positive and negative duties concerning those rights, which the courts then enforce. These duties are obligations that the state has to either act in a certain way, or in certain circumstances “not act” in a certain way, and the negative duties involve duties that the state “must do” (Hassim, Heywood, & Berger, 2014, p. 34).

Section 27 of the Constitution ensures that, amongst others:

1. Every person has the right “to have access to health care services, including reproductive health care”;  
2. No person “may be refused emergency treatment”;  

In general, the state’s positive and negative duties are set out in Section 7(2) of the Constitution, which requires the state to “respect, protect, promote, and fulfil the rights in the Bill of Rights.” In relation to health care services, this means that government must:

3. Respect the right of access to health care services by not unfairly or unreasonably getting in the way of people accessing existing health care services, whether in the public or private sector;  
4. Protect the right by developing and implementing a comprehensive legal framework to stop people, who get in the way of the existing access of others;  
5. Promote the right by creating a legal framework so that individuals are able to realise their rights on their own;  
6. Fulfil the rights by creating the necessary conditions for people to access health care, by providing positive assistance, benefits and actual health care services.

It is important to point out that according to Section 27(2), the government must “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of the right. This means taking all reasonable
steps to ensure that the right is protected, promoted and fulfilled, and that, over time, universal access to quality and comprehensive health care is achieved. This can include, but is not limited to, the passing of laws by Parliament and the Provincial Legislatures (Hassim, Haywood, & Berger, 2014, p. 34). This section then, according to popular rhetoric also means that the section referring to the government providing health care services “within its available resources” leaves the door open for debate as to how this could be interpreted.

2.9.2 “Batho pele” – A set of public health care service principles

Health care practitioners in the public service were introduced to a set of principles in 1997, which the Department of Health programme called “Batho Pele”, which literally means “people first” in Sesotho (see Addendum H). The motive behind the implementation of these principles was to improve the South African health care system’s service delivery through this initiative. It was launched soon after the new democracy, at a time when the country had inherited a public service that was not considered “people-friendly”. This public service needed to be re-shaped to meet a new and revised set of skills and attitudes to embrace the developmental challenges after the 1994 transition from the apartheid era (ETU, n.d.).

In particular, emphasis was placed on treating resources with respect, staff work ethics, managers’ support of and boosting of staff morale through creating an environment conducive to effectively interacting with patients and, in general, towards a commitment to improving overall service delivery (ETU, n.d.).

Members of the public were also considered important in holding the public service accountable for the ways in which services were delivered to the people (ETU, n.d.).

The Batho Pele principles are summarised as follows (Addendum H):

1. Consultation – Citizen’s right to full participation in health care services;
2. Service standards – Accountability and education for expected services;
3. Access – Equal access to these services;
4. Courtesy – Communication ethics and caring exchanges with citizens;
5. **Information** – Citizen education regarding public health care services entitlement;

6. **Openness and transparency** – Open health care fiscal policies and hierarchies;

7. **Redress** – Swift empathic responses and remedies to complaints;

8. **Value for money** – Economic efficiency;

9. **Encouraging innovation and rewarding excellence** – Improving health care and being acknowledged for work well-done;

10. **Customer impact** – *Batho Pele* principles understood by everyone and adequately implemented;

11. **Leadership and strategic direction** – Good leadership leads to success (KZN DOH, 2001).


The Department of Health, in consultation with various other bodies, developed a National Patients’ Rights Charter (see Addendum I). The document contained herein was launched by the Minister of Health and agreed to by the HPCSA. It has since been included in the Board’s Handbook for Interns, Accredited Facilities and Health Authorities (HPCSA, 2008, p. 1). It provides benchmarks for the legal and ethical responsibilities which health care practitioners are bound to uphold, not only in society at large, but in their professional lives in public and private hospitals and/or practices no matter what complexities they face in the health care cultures in which they may find themselves. In it, patients also have responsibilities towards taking care of their own health, respecting others and not abusing these services.

Health care practitioners are affected by the Patients’ Rights Charter, with particular reference to the ways in which the history of South Africa has evolved, now ensuring equity in health care delivery, as set out in the South African Constitution (HPCSA, 2008). These rights are realised through following the principles, contained in the Charter and using them as a framework for defending
and upholding patients’ rights.

Patients have a right to:

1. Access to a healthy and safe environment;
2. Treatment with informed consent (or the right to refuse treatment/information about their illness), privacy and confidentiality;
3. Complaints investigated and fully responded to;
4. Receiving emergency care regardless of ability to pay, in life-threatening situations;
5. Be a part of consultations and decisions affecting their health;
6. Choose their health care provider or health care services and be entitled to a second opinion of their choice, whilst being assured of continuity of care (appropriate referral or hand-over); and
7. Be treated by considerate and courteous health care practitioners who identify themselves by name.

2.10.1 The National Health Act, no 61 of 2003 (National Health Act, 2003)

The government adopted the National Health Act of 2003 in order to implement a national health system, aiming to regenerate and expand its regulatory powers to provide the blueprint for a phased/structured health system in South Africa. These were intended to uphold the rights set out in the Constitution, for equitable access to health care services, through a national health system or NHI. This Act would govern public and private health care services.

The Act clarified all the structures that would be instrumental in detailing with (amongst others), who would receive free health care services, what means would be employed to protect children’s rights and other vulnerable groups, as well as the duties, obligations and rights of all health care practitioners (Ossafrika, n.d.). It was planned as a central health system, which would provide government with the powers to influence all areas of health care, controlled by the Department of Health. This would include licensing, economic regulations, community service of
health care practitioners, medical aids, price control and other health related planning.

2.10.2 Draft Charter of public and private health sectors of the Republic of South Africa (effective date 15 August 2005) (PMG, 2009)

In 2005, the former Minister of Health Dr Manto Tshabalala-Msimang, presented a Draft Health Charter (see Addendum J) to the country, saying, “We must ensure our health system reflects the diversity of our society and meets the various health care needs of the total population of South Africa” (Modisane, 2005, p. 1). In it, measures to enshrine “black” economic empowerment and improve health care in South Africa were outlined in a lengthy document that was compiled by a task team with representatives from both the public and the private health care sectors. The terms were, on the whole, well received by stakeholders in the health care sectors, with requests for minor changes to be made. The Minister said, “Due to our sad history, access to and distribution of health care and ownership of health establishments remain grossly unequal and we cannot remain silent about this issue.” Therefore, the Charter hoped to rectify the wrongs of the past by its implementation and it was said that it “… required us to achieve the most efficient use of resources in the health sector, to adequately address the health needs of South Africans.” Other issues that the Charter aimed to address were the growing unaffordability of medical aid schemes and their related administrative costs, equity in relation to ownership, control of service provision and plans to meet human resource needs over the next 15 years. “We have put together programmes for the broader representation of historically disadvantaged groups, including women and people with disabilities, in the workplace” the Minister said (Modisane, 2005, p. 1).

2.10.3 Charter for the South African health sector (PMG, 2009)

Health care practitioners in South Africa and its citizens are affected by the Charter (PMG, 2009) with respect to how legislation would be steered in the facilitation and implementation of the four core principles contained in it to ensure transformation in the health care sector. Key areas were:

1. Access to health services;
2. Equity in health services;

3. Quality of health services;


In order to ensure that these principles would be attainable, it was acknowledged and accepted in the prelude, that South Africa was a diverse country with many health care needs, which needed to be addressed through a reformed national health care sector and which also needed to be efficient and sustainable (PMG, 2009). This would affect public as well as private health care stakeholders, including public/private partnerships, with a view to redressing inequality inherited from previous decades. It was considered to be in line with the Bill of Rights in the current Constitution and international best-practice norms/standards.

2.10.4 The world needs health care guidelines of the highest order to protect its citizens in the event of crises

It is imperative that all health care practitioners, people of the world, nations of the world, policy-makers both in South Africa and abroad, have a definitive set of guidelines of the highest order, for fundamental legal and ethical behaviour in terms of human rights.

History however, proves that achieving these high ideals has not been easy. Unexpected factors such as the global financial crisis which sparked a high-level consultation with the WHO in 2009 are but one example. Intentions were tabled at that time by the industrial countries especially to stop the economic crisis from becoming a social and health crisis and plunging already low-income countries into new hardships that were not of their own making. With the poor being the population that is normally hardest hit, facing loss of income and housing and therefore overall health challenges, made the need for solidarity between countries imperative for managing that crisis (WHO, 2009). One has to remember the handling of the recent Ebola crisis that caused global consternation and for which the world was not prepared.

Unforeseen global crises make it difficult to predict how ready the world is for any crisis, which inevitably has an impact on health care. These issues provoke an
examination of societies’ moral and value-obligations towards each other and the need to act together individually, collectively and globally for social justice. Logically, success can only be achieved, when rapid intervention is achieved through good communication and exchange of information.

2.11 Health care practitioners and world bodies

2.11.1 World Health Organisation (WHO)

The WHO is an international body within the UN, founded in 1948, and has offices in many countries with more than 7 000 people working in defined regions and at their headquarters in Geneva, Switzerland (WHO, n.d.). It comprises 194 member states and is an International Health Organisation. Its working officials in countries around the world, support its primary role of directing, supporting and coordinating international health in both the public and private sectors through working with governments of member and non-member states as well as non-governmental organisations (NGOs) to realise global health objectives (WHO, 2015). The WHO Constitution enshrines the fundamental rights of every human being to the highest attainable standard of health (WHO, 2013). By definition, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946, p. 1).

The WHO fundamental human rights to the highest attainable standard of health (WHO, 2013) and the Declaration of Human Rights, which, in turn, is also in line with the South African Constitution’s Bill of Rights, Chapter 2, enshrines the rights, including health rights, of all people in the world with South Africa affirming the democratic values of human dignity, equality and freedom. All South African citizens therefore have the WHO rights and the enshrined right of access to health care services (SA Government online, 2013).

South Africa’s classification under WHO constitution

South Africa is classified by the WHO (WHO, 2011) as an upper middle-income African region member state. Any countries that accept the WHO’s constitution and are members of the UN Organisation, can become members of the WHO (WHO, 2015). The map below indicates the countries on the African continent who are also members of the WHO.
The principles and amendments of the WHO constitution (WHO, 1946) are relevant to South African health care practitioners, as the country is a member of the WHO.

**Summary of the Principles of the Constitution of the WHO:**

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition;

- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and states;

- The achievement of any state in the promotion and protection of health is of value to all;
• Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger;

• Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development;

• The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health;

• Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people;

• Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures” (WHO, 1946, p. 1).

2.11.2 National Health Insurance (NHI) – On the way to universal health coverage in South Africa and world body principles

In 2005, the WHO called on all countries to embark on the implementation path towards universal health coverage most especially for developing countries, which had the biggest inequalities in health care delivery services (Nevondwe & Odeku, 2014). In the same year, a WHO resolution urged countries to provide access to health services through health financing systems in order to protect citizens from the risk of severe financial consequences by way of preventive, promotive, “curative and rehabilitative services at an affordable cost”, with members of the WHO urged to incorporate risk protection into this, as well as actually naming what would be covered (Carrin, Mathauer, Xu, & Evans, 2008, p. 857). South Africa’s response to this WHO request to implement a health financing system is the so called National Health Insurance (NHI).

It is generally accepted that all countries have differing socio-political contexts and challenges that need to be met. In this regard, the South African Government needs to tailor the NHI exclusively for South Africa, however large the challenge may seem while requiring a great degree of solidarity (through preparation,
research, legislation, and enforcement) to attain universal health coverage in order to re-shape the country’s history (Carrin et al., 2008).

The purpose of health financing should therefore, according to the WHO, “make funding available, and set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care” (Carrin, James, Adelhardt, Doetinchem, Eriki, Hassan, & Zipper, 2007, p. 131). South Africa, essentially shaped by its historical, social and economic past and resultant problems, experiences its health care sector which is, in turn, shaped by the country’s economic development as a whole. While it may therefore be implicitly presumed that the health care sector would reflect any economic upturns or increases in government expenditure, this has not always been the case due to it not receiving explicit attention in the government’s Economic Policy Programmes, meaning that “government health care expenditure has seen slightly smaller increases than overall government expenditure” (McIntyre et al., 2007, p. 6).

Health care practitioners, presuming that they know the scope of local and international law, will find themselves increasingly affected by and exposed to these laws and organisational intentions. Having a past history of divisions, resistance and oppression, these guidelines for change are bound to be “idealistically” accepted after the new-found freedom post-democracy in the hope of an equitable future society. However, if these are not seen to be implemented, there will, no doubt, be some opposition and/or negative sentiments, which may spill over into the workplace.

The following diagrams from the WHO were presented by Carrin et al. (2008, pp. 858-860) as a useful sketch, depicting basic components for guiding health reforms.
Figure 3. Basic components of the framework to guide health-financing system reform
(Source: Carrin, Mathauer, Xu, & Evans, 2008)

Figure 4. Key health financing options at different stages of the evolution towards universal coverage
(Source: Carrin, Mathauer, Xu, & Evans, 2008)

2.11.3 United Nations Organisation (UN)

Ban Ki-moon, then United Nations Secretary-General, said: “Our mission is to build a better world. To leave no one behind. To stand for the poorest and the
most vulnerable in the name of global peace and social justice” (UNAIDS Gap Report, 2014, p. 3).

South African health care practitioners, situated within the ambit of the UN, the WHO principles and the South African Constitution, are part of a shared history of social injustice and unrest, similar to that post World-War II, when “nations were in ruins. World War II was over, and the world wanted peace” (United Nations, 2015). It was this World War that gave rise to the Declaration of Human Rights, which aimed to improve human rights globally.

The UN Declaration of Human Rights

South Africa’s legal/judicial system, which prescribes and governs the laws and policies of the health care sector, is a member of the WHO, which is a body within the UN. As such, South African health care practitioners are a part of the UN’s declarations and principles. By implication, it suggests that, because countries have accepted the declaration for approximately 65 years, it is arguably considered to be a binding customary international law. South Africa therefore accepts the fundamental pledge to co-operate with the UN premises, most notably, that of observing and respecting fundamental freedoms and human rights as set-out in its founding Charter, the Universal Declaration of Human Rights.

The Declaration of Human Rights (see Addendum K) was first drawn in draft, called the International Bill of Human Rights and was drawn up by 18 members from a variety of cultural, political and religious orientations and backgrounds. The wife of President Franklin D. Roosevelt is recognised as having been the driving force for the acceptance of the Declaration adopted in 1948. The intention behind the Declaration was that atrocities such as those committed during World War II should never be allowed to happen again (United Nations, 2015). It was the first time that inalienable human rights were agreed upon in a comprehensive declaration.

In placing South African health care practitioners’ conduct, ethics and observance/compliance under the umbrella of the guiding principles of the UN’s Universal Declaration of Human Rights, the 30 Articles that propose a common code of conduct pertaining to all member states and its individuals (and aims to guarantee
individual human rights everywhere in the world) should consequentially apply. It should affect not only how health care practitioners treat others, but also how they themselves are treated individually and collectively in South African society, communities, civil society and the public and private sectors.

The 30 Articles in the Universal Declaration of Human Rights are a prelude to the pertinent human rights issues which also relate to health care, not only in South Africa, but also worldwide (United Nations, 2015). Human rights violations have, and are, occurring world-wide through unconscionable acts of barbarism, amplifying the need now more than ever for the human family to strive for a world of peace, justice and freedom.

These specified human rights are summarised as follows:

1. Born equal and free
2. No discrimination
3. Safety and freedom
4. We can’t make people slaves, and they can’t make us slaves
5. No hurt or torture
6. You have rights wherever you go
7. Fair and equal treatment by the law
8. The law should protect, if human rights are violated
9. No unfair detention/detainment
10. Fair and public trial/hearing by independent jurors/legal representative
11. Innocent until found guilty
12. Privacy and family life
13. Freedom of movement from and to own country
14. Seek asylum and move, if persecuted
15. Right to nationality/belonging in a country
16. Marriage and family with equal rights in them, even when separated
17. Own and/or share property
18. Freedom of religion, conscience, thought
19. Free opinion, expression, idea-sharing without limits
20. Public assembly and free-association
21. Democracy, public services
22. Social security, dignity
23. Work, fair remuneration, choice to join trade union
24. Leisure, rest
25. Shelter, food, care
26. Education
27. Copyright, participation in learning, science, art
28. World order
29. Duty, responsibility to community
30. Human rights non-negotiable, binding

2.11.4 National Health Insurance (NHI) – The journey from “then to now” – What is the NHI in South Africa today?

National Health Insurance (NHI) in South Africa is a financing system (fund) that proposes legislation and implementation measures towards the realisation of a plan to ensure that all citizens of South Africa (and legal long-term residents) are provided with essential health care, regardless of their employment status and ability to make a direct monetary contribution (Department of Health, 2014, p. 146). The Minister of Health, in 2009, defined it as “a system of universal health care coverage, where every citizen is covered, be they rich or poor, employed or unemployed, young or old, sick or very healthy, black or white” (McIntyre, 2010).

2.12 History of mandatory health insurance and the NHI in South Africa

Contrary to popular belief, the possibility of a mandatory health insurance for all South Africans was initially introduced by some progressive academics at the beginning of the 1990s. It was first introduced into a formal policy document of the
ANC’s National Health Plan (ANC, 1994). The plan included compulsory health insurance contributions by formal sector employees and employers that would cover a package of benefits. Private health insurance would be used by individuals needing to “top up” cover for services that the health insurance did not include (McIntyre et al., 2007).

Until the late 1990s, the proposals put forward by the previous government on different occasions for a mandatory health insurance were opposed by various stakeholders, and were not implemented (McIntyre et al., 2007). A key reason for this was opposition by National Treasury that was concerned that introducing a mandatory health insurance, which is another form of tax, would put pressure on the already overburdened middle-income groups and their tax burden. Additionally, the Treasury was opposed to collecting funds earmarked/ring-fenced for a specific sector, as it interfered with the redirection of centrally collected revenue. Therefore, it was envisaged to pursue a compulsory health insurance as part of a comprehensive social security initiative. Post-colonial South Africa did not, in fact, herald the dawn of democracy in the country, instead, the health system reinforced divisions further through its policies of segregation and divisions between health standards of the urban and rural populations. Medical schemes that were available were private and established by mining companies and other conglomerates to provide health benefits for “white” employees, as they were classified under the former Population Registration Act of South Africa (McIntyre et al., 2008, p. 871).

The Taylor Committee of Inquiry, established in the early 2000s, put together a set of policy proposals for mandatory health insurance and called for a NHI that would be achieved in the long term. It proposed that “South Africa should move toward an NHI system over time that would integrate the public sector and private medical schemes within the context of a universal contributory system” (McIntyre et al., 2007).

The ANC’s 2009 election manifesto proposed an NHI system as a key component of its efforts to address the serious problems afflicting South Africa’s health care system (McIntyre et al., 2007). Key elements were proposals for a new dedicated payroll tax and the establishment of a significant administrative infrastructure to
oversee these funds and purchase health care benefits for the population (Broomberg, 2009).

The public health care sector would remain the mainstay of the entire health care system with the private health care sector possibly increasing levels of funding to above usual tax allocations, but with its activities being closely regulated by the government (McIntyre et al., 2007). The overall vision then, was an NHI (with many funds and a public contributory sector), with the initial division between private medical schemes, and tax funding for the public sector remaining, but which would decrease over time being ultimately replaced by a broader contributory environment that would replace tax funding for health care (McIntyre et al., 2007). The pre-payment for all health care services through a central fund was envisaged with the establishment of the NHI Fund (Matsotso, 2013).

Because of the large divide between the public and private sectors, the NHI would bridge those inequalities by providing access to good quality and affordable health care to everyone, irrespective of their socio-economic status. With a Gini index of 65 in 2011 versus 59.3 in 1993, it was estimated that the continued rise in the economic divide between poor and rich was greater than it was during the apartheid-era government. This, coupled with the low life expectancy (60 years in females versus 57 years in males), high infant mortality (19 per 1 000 live births for 2009), found in a country, which spends 5% of its gross domestic product on the health care system but achieves only poor outcomes, was not the type of health environment anyone would consider a trustworthy system (Weimann & Stuttaford, 2014, p. 2).

The main consensus emanating from international experience was that South Africa’s health care system reforms were well on track and in line with international trends. More specifically, the goal of attaining universal coverage conformed to the global health policy agenda of “good practice”. McIntyre et al. (2007) proposed that South Africans had tolerated an inefficient, inequitable and divided health care system for far too long and change was needed. All stakeholders will need to work together to identify health care reforms that will benefit all South Africans. A proposed funding-flow for a universal contributory system was put forward as illustrated in Figure 5 (below).
At that stage, very little detail was known about the actual NHI proposals. However, key elements of the proposals were reported to include the implementation of a new dedicated payroll tax for health care, along with the establishment of significant administrative infrastructure to oversee these funds and purchase health care benefits for the population. Of some concern was, that while it took countries like South Korea, Australia, Canada and many other European countries decades to establish universal health care access on the scale that the South African Government was contemplating at that time, it was felt that much more could be done in a shorter space of time. However, this would require contributions and collaboration on the part of all stakeholders (Broomberg, 2009).

During 2010, the rollout of the NHI system was in its infancy stages, with much debate and associated rhetoric taking place at all levels of society and with not too much information made available to the public at that time. The initial changes planned for the introduction of a new payroll system and substantial administrative
infrastructure to purchase and oversee health care benefits for the people of the country, were to be key elements in the implementation of the proposals. Therefore, it was also considered important that health care reform in South Africa should be transparent and open to testing through continuous lively public debate (Broomberg, 2009).

According to Shisana (2011), on 12 August 2011, the Minister of Health in the ANC-led Government published a policy paper on the proposed NHI for public consultation and comments before its adoption into policy. The paper did not deviate significantly from the overall structures outlined in the discussion document released after the 2010 National General Council of the ANC, in September 2010. The NHI policy paper stated that four key interventions needed to be made simultaneously for the successful implementation of a health care financing mechanism. Those key elements were (a) complete transformation and provision of health care services and delivery; (b) a total overhaul of the entire health care system; (c) radical change of administration and management; and (d) the provision of a comprehensive primary health care structure (Shisana, 2011).

The policy paper was criticised by health care practitioners as reflecting the political nature of health policy development by government and was perceived as an indication that they were lacking competence in political debates; a perception that they felt had prevailed for far too long. The four key interventions, identified by government for the NHI, were perceived by health care practitioners to have been made without adequate engagement, consultation and input from the health care practitioners themselves, who are surely the affected parties, prior to forming the core driving elements of the proposed policy. It was contended that they (the health care practitioners) had specific knowledge and experience within the health care system, which provided them with unique professional qualities from which to influence policy development (Shisana, 2011).

Preliminary information emerged about the details of NHI proposals after publication of the Green Paper in August 2011 (Minister of Health, 2011), and following a National Health Summit hosted by the Department of Health in 2012, at which a pilot-plan, consisting of eight strategic objectives was planned for implementation between 2013 and 2020. Some of the objectives included
appropriate budget allocation, human resource planning, district-based screening services, research, infrastructure building, adequate equipment and medicines and inter-sectoral collaboration. In particular, the NHI proposed a mental health public awareness campaign to address stigmatisation and adequate health-seeking behaviour. Once approved by the National Health Council, it was planned to be followed by a year-by-year operational plan, giving effect to strategic objectives (Tlou, 2013).

The first five years of NHI implementation would seek to strengthen the public sector in preparation for the system, with an NHI central fund proposed for 2014/15. The Green Paper set out a table for the implementation and measures to assess progress (Matsotsto, 2013). Pilot studies to strengthen the health system would focus on management of health facilities and health districts, infrastructure development, quality improvement, human resources planning, medical equipment procurement and information management, supported by the establishment of an NHI Fund (Department of Health, 2014).

The first eighteen months since the launch of the Green Paper in August 2011 have passed (Minister of Health, 2011). The Green Paper heralded the implementation of a phased set of reforms and South Africa awaited the release of the government’s White Paper on the NHI in consultation with the Treasury, which were planned to become available for consultation and comments during 2013 (Matsotso, 2013). Once policy on the White Paper was finalised, draft legislation would be published for public engagement, where after it would be submitted to Parliament for debate. Once approved in Parliament, the Bill would need the signature of the South African President (Department of Health, 2014).

By 2012, 10 pilot sites in certain districts had been selected for the initial NHI implementation, based on an audit done by the Department of Health and which, it expected, would serve as a testing site that would provide feedback prior to further implementation and rollout into a further 20 districts. In this way, the government planned to strengthen district health structures with each site tasked with managing contracts with designated and accredited providers (Mabidi, 2013).

The NHI was expected to be phased in over a 14-year period beginning in
2012/13, the government acknowledging that vast amounts of money would be required, going beyond its estimates for the next medium-term budget. The Treasury’s suggested funding options included increasing the VAT rate, introducing a payroll tax on employers, increasing the taxable income of individuals, or a combination of these. However, these proposals still required a debate for real sustainability of the NHI, as citizens were already funding large government expenditure through taxes (Ndlovu, 2012).

A solution for health care, envisaged to be in line with the Constitution of South Africa, proposed health care reforms by providing essential health care to everyone, but with people earning above a certain threshold expected to start paying a contribution to the NHI fund. However, this plan attracted much recent debate and speculation with resistance coming particularly from the private sector. Nevertheless, government insisted that the scheme would make the two-tier system (public and private) “blend in a more sustainable manner that benefits the population” (Kayman, Smith, Anand, Watts, Kingsley, Hooper, Woolf, & Oltermann, 2014). The large differences that were apparent between the two-tier health care sectors resulted in there being 500 patients on average to 1 specialist medical practitioner in the private sector, but nearly 11 000 patients to 1 specialist medical practitioner in the public sector. These divides have widened, although some progress has been made to address them. It is not hard to surmise that equity is one of the most pressing health needs to be addressed to reduce the inequities in the public health sector, despite progress in addressing the allocation of health care resources geographically over the past 10 years (McIntyre et al., 2007 pp. 2-3).

At this stage in the evolution of private health care in South Africa, only two of the three main pillars for health care exist, namely, community rating and open enrolment. What is missing is mandatory cover, the proposed NHI being the first building block in that direction (Makholwa, 2013). The Minister of Health, Dr Aaron Motsoaledi, declared his vision for the health care sector (2011/2012) as follows:

> We have a vision to improve access to health care for all and health outcomes in the short- and medium-term, with a particular focus on improving maternal and child health. To realise this vision, we require the human resources to
implement re-engineered primary health care and ensure the service capacity for a health system with improved financing through the NHI. It is necessary to develop and employ new professionals and cadres to meet policy and health needs, to increase workforce flexibility to achieve this objective, improve the working lives of the existing workforce, improve retention, increase productivity and revitalise aspects of education, training, and research (Department of Health, 2011/12).

On 22 September 2015, the Minister of Health made a further announcement at the South African Medical Association’s conference in Johannesburg, which shed some light on the progress of the much-awaited White Paper that he said had been completed and delivered to the Treasury for consideration, after which it would be presented to Cabinet. It contained the map outlining the way in which the NHI would be set out, with the main purpose of the NHI being consolidated for the provision of equitable, affordable medical care for all South Africans and not only for those who could afford it.

South Africa’s health care system continued to be highly fragmented and unequal. In terms of human resources, the medical profession remained highly skewed towards the private sector. More than 60% of the poorest in South Africa had the highest need for health care, yet derive the least from the health system (Mkhize, 2015, p. 1).

With input from the National Development Plan towards the implementation of the NHI, Minister Motsoaledi promised that, by 2030, all South Africans would have access to the health care system and that primary health care would be the cornerstone and “heartbeat” of the country’s health care system. The Minister also gave the assurance that the 14-year plan for NHI rollout was on track and that the first 10 pilot clinics were set up and in place across the country. A lot of work was taking place behind the scenes, he said, with respect to setting up ideal clinics that would have adequate infrastructure, efficient human resources and 134 conceptual elements rendering them efficient. Around the same time, the Minister was due to attend the UN General Assembly, where he said the announcement of three new goals for world health would be on the agenda (Mkhize, 2015).
Where South Africa is today, at the time of this study: White Paper announced for Public engagement (Bendile, 2015)

On December 11, 2015, the Minister of Health, Dr Motsoaledi, briefed the media at a press conference in Pretoria (News24Wire, 2015) with an announcement that Cabinet had adopted the much-anticipated White Paper for the NHI (following on from the Green Paper of August 2011). The document, still to be released for analysis, would outline the steps government would take to implement the NHI (over a period of 14 years). It allayed fears of a sudden transition by stating that “It is not going to be a sprint, it is a marathon; not an ordinary marathon, an ultra-marathon” and one, which would “not classify people according to their socio-economic status but classify them according to their health needs.” “The goal of quality health care being implemented by 2030 was envisaged through a lengthy process, but one which would see an innovative disruption of the health care sector”, the Minister said. He claimed that the private health care sector was “simply unaffordable” and often far from optimal, “there are a lot of patients, who have been removed from the Intensive Care Unit, or even sometimes in a coma, where they just say ‘we have phoned the medical scheme, the money is finished. You need to go to a public hospital’.” Similarly, the Minister said that he was aware that the public health care sector does not provide quality services, but attributed it to “the wrong people who are being appointed in the wrong places; patronage and cronyism (is rife), as well as poor planning development and management of human resources” being the main problems (News24Wire, 2015). Essentially, this meant that the poorer people were forced to use second-rate services, whilst the wealthier elite were receiving the best care – a system that was flawed in its structure (Bendile, 2015).

Taking the country further along in the evolution of the planned NHI, government planned to introduce a compulsory National Medical Aid for all South Africans which would “buy” health care services from public and private hospitals, clinics and health care providers, once accredited (Cullinan, 2015b). The government proposed doing away with medical aid brokers who make in excess of R1.5 billion per annum, leaving the contentious issue of the role that medical aids will play in future still unanswered at the time of the present study. Medical schemes, instead,
may be reduced to covering services not covered by the NHI, which would operate from a central fund, from which medical practitioners could benefit if they chose to participate in the NHI services (News24Wire, 2015). It meant that taxpayers’ contributions would be substantial and would be required over and above their “usual” taxation – this at a time when the economic climate was extremely tough for most citizens (Cullinan, 2015a). The NHI would be compulsory, would most probably include a pay-roll levy for all employed South Africans, an increase in VAT or an income tax surcharge to meet the cost-implication for implementation of an estimated R225 billion by 2025, as confirmed by the Minister of Health, Dr Motsoaledi. Still in the pipeline was President Jacob Zuma’s 2013 proposal for an upgrade to all public hospitals that was to take place via public-private partnerships (News24Wire, 2015).

Reservations about the future of health care were made by businesses and individuals. The CEO of the biggest private health care medical aid scheme, Dr Jonathan Broomberg, said that his company had not been consulted, aside from attending “stakeholder consultation meetings called by the National Department of Health to discuss aspects of the NHI.” He added that it was vexing to know whether most households could afford both public and private medical aid schemes “in the absence of greater clarity on the package of benefits that would be covered by the NHI” (Cullinan, 2015a). Concerns about the future of private health care and the apparent good services they provide, were voiced by well-known South African economist, Dawie Roodt, who was recently stabbed in his home by intruders and who wrote an open letter, in which he praised private health care providers:

The emergency process worked like a dream, well-oiled gears, competent hands, kind eyes. I thought to myself, ‘why would any government even think of changing this to the way the state provides medical support? Why do they not rather change the state’s medical system to what I have experienced?’ I know I do not want to be part of the NHI. I now know it will be just another disaster! Just like Eskom, SAA or PetroSA, and so many more.

He felt that he was speaking for all middle-class South Africans, who felt that the NHI would not help them in cases of emergency or need and that they may
instead end up dying in great pain or becoming disabled (Cullinan, 2015a). If the standard of private hospitals were to be “equalised” to the poorer standards of public hospitals, wealthier patients might go and receive their treatment overseas, thus not subsidising the local hospitals.

Notwithstanding the above, it is impossible to deny the parallel inequitable two-tier health system that the country inherited from the apartheid era which left the poorer members of the South African society faced with a grim reality that offers them often sub-standard care, whilst the wealthier few can afford excellent world-class, efficient care (Cullinan, 2015a). Although the Minister of Health and his family are reportedly treated at a public hospital, it was felt that the treatment he got there was not the same as the average person would receive and that only pockets of good health care were available only in some public hospitals. Most public health care facilities were often lacking medical specialists, had long patient queues, with people reported to wait for a tonsillectomy at Steve Biko Hospital for a year. The waiting period for orthopaedic procedures was even longer, especially in rural areas and poorly resourced provinces (Cullinan, 2015a). Health care practitioners, in general, tend to avoid working in rural, under-resourced hospitals and clinics where their living standards are compromised, where equipment and medication are lacking or in short supply and where infrastructure is not upgraded and/or maintained.

Mental health, in particular, remains one of the least resourced health care sectors. Dentists are also in short supply. Both deficits were highlighted in the results of the 2011/2012 Health Facilities Audit, which additionally produced less than favourable results, especially for clinics. The Minister of Health reported that he was especially aware of the shortcomings of the health care system because patients often called him on his cell phone to tell him their “horror stories”. The Minister had been instrumental though, in the implementation of the Office of Health Standards Compliance (OHSC), established in 2014, an independent body mandated to inspect and certify health care facilities countrywide in both public and private health care. Certificates of compliance were issued, inspections took place no longer than four years apart (and frequently more often) and those that continually did not live up to established standards and norms would “face
prosecution” according to OHSC board member, Professor Stuart Whittaker (Cullinan, 2015a).

The huge “re-engineering of primary health care” in the NHI pilot districts has involved the gradual return of school nurses and door-to-door community health care workers with a view to providing preventive and promotive health in future. General medical practitioners were being employed in public institutions, but many complained of a serious lack of resources with which to carry out their work efficiently and some have resigned. The R300/h rate they receive in compensation was too low, according to a KwaZulu-Natal official, and would only attract those who felt altruistic to “do public service”. South Africa, in order to provide its citizens with a better future, needs a healthy population that might become prosperous enough to afford the top-quality resources that are accessible in the private health care institutions (Cullinan, 2015a).

With the severe shortage of medical practitioners and nurses, too few to meet the needs of an ageing population and with these health care practitioners being in demand all over the world, the task ahead for the NHI will no doubt be a challenge. This task needs to be delicately handled in order to prevent more health care practitioners from leaving the country. The bargaining process that will take place when the details of the White Paper are on the table will pave the way for the biggest revolution in health care that the country has ever seen (Cullinan, 2015a).

The initial implementation of the NHI (to strengthen the public health care sector), the Green Paper (for implementation of assessment measures), and the White Paper (for comments) indicating a major change to health care service delivery structures, management and administrative systems also begs answers to “the most basic questions relating to NHI financing, establishing who pays, how much, on what basis and through which institutions” (Nevondwe & Odeku, 2014, p. 1). It is hoped, that the design of any such health system should not result in citizens suffering financial hardship because of receiving care (Nevondwe & Udeku, 2014). While this largely depends on how the NHI will be funded, if it is successful, the two cornerstones of human rights, namely, the right to health care and the right to dignity, could be adequately addressed through human rights-based practices in
fighting poverty and other ills that it identifies (Mabidi, 2013).

Whatever the future holds for the NHI and its implementation, many stakeholders will be called upon to debate, pave the way forward for, and adjust to, the new political-socio-economic health care reality, which has been the natural progression from the fall-out that occurred from the socially engineered apartheid system and the ills of South Africa’s history. It is sincerely hoped, too, that health care practitioners, who are a major cornerstone in health care delivery, and who provide the day-to-day care of patients in need, will be adequately consulted and included in the evolution of health care, as valuable stakeholders.

2.13 Health care practitioners and human resources

2.13.1 “Brain drain” – At what cost to South Africa and Sub-Saharan Africa?

Brain drain is defined as the migration of skilled/professional workers, who leave their often poorer countries in search of greener pastures elsewhere, usually in wealthy countries (Zimbudzi, 2013).

South Africa has “faced large-scale emigration, especially of professional people, commonly referred to as the ‘brain drain’” (Pillay & Kramers, 2003, p. 52), with the inevitable consequences thereof in terms of “drained“ economies and disadvantaged poor people, who are dependent on public health care (Collier et al., 2004; Padarath et al., 2003). This makes the problem of migration as relevant today as it was prior to 1994, when the country’s new democracy was formed. Most professionals, who left South Africa, have not returned due to political and/or economic crises affecting the continent over the last decades. They cite reasons such as poor social services, low standards of education and health, high unemployment, failing economies and wars/crime (Matume, 2003) as some of the reasons for their reluctance to relocate again. Although the attractions to immigrate to other countries may seem favourable initially, on consideration, many also become disappointed as these advantages are often more a subjective than an objective reality (Asmal, 2004).

It seems economically insensible that medical professionals are trained at great expense by their country (and its tax-payers), only to be attracted to leave their countries (with HIV prevalence of 5% or more) for destinations such as Australia,
Canada and the United Kingdom to bolster those workforces (Sager, 2014), inevitably leaving their home countries’ poorer and sick patients under-serviced. The moral responsibility for this situation not only rests on the health care practitioners who wish to leave, but brings into the spot-light the institutional responsibility to re-shape its policies and ensure that the people left behind are not disadvantaged and that benefits are equitable across the borders (Sager, 2014, pp. 576-577), leaving the researcher to ponder, “where to, from here?”

Because measuring health systems is a complex process, stopping the “brain drain” will require decisive actions by countries like South Africa, not only to retain its teaching staff (who are also emigrating), but to implement measures to retain specialist health care practitioners, expand training institutions and make finances available to support those institutions. Currently, the US is the only country that has a focused health care training policy in terms of providing assistance in a supportive role (Mills et al., 2011).

In 2010, the World Health Assembly unanimously adopted the first code of practice on the international recruitment of health care personnel, which recognised problems related to the global shortage of health care practitioners and called for all countries to mitigate the negative effects of their migration. The code also called on wealthy countries to provide financial assistance to source countries affected by the losses of health workers. The code is particularly important for Sub-Saharan Africa, where, according to the WHO, the majority of countries are experiencing critical shortages of medical practitioners, nurses and midwives. Because many medical practitioners from these countries are lost to developed countries, the problem is exacerbated by the continent bearing the greatest burden of diseases such as HIV/AIDS. Ironically, Africa experiences 24% of the global burden of disease, yet it has only 2% of the global supply of medical practitioners and less than 1% of its expenditure is used for global health (Mills et al., 2011, pp. 1-2). This is a dire situation that needs no further explanation.

**One method adopted by the Department of Health in South Africa to curb the “brain drain“**

In order to attract and retain skilled health care practitioners, the Department of Public Services and Administration introduced the OSD (Occupation Specific
Dispensation), an initiative, which it described as a “revised salary structure that is unique to each identified occupation in the public service” and which provided attractive wage incentives.

Advocate J.N. Matshekga, part-time resident panellist for the Public Health and Sectoral Bargaining Council (PHSDSBC), described the history of OSD as follows:

In 2007, OSD was introduced for public sector employees in South Africa, which is unique to each identified occupation in the public service. The purpose of the OSD was to improve government’s ability to attract and retain skilled employees, through increased remuneration. Previously, employees in the public service were remunerated by a single salary structure, which did not adequately address the diverse needs of occupational categories in the public service. The OSD was introduced through the adoption of a collective agreement, which provided the framework for occupational-specific remuneration and career progression dispensations to address unique remuneration structures, benefit consolidation, and allowances into salary, frequency of pay progression, grade progression opportunities, career pathing, and required levels of performance (performance-based progression) (Matshekga, 2014, p. 1).

Despite these efforts, the unfortunate situation for health care in South Africa is that the very high burden of disease and current shortage of health care practitioners means that it can ill-afford to lose its valuable health care workforce to other countries. These countries, because of their wealth, have attracted high numbers of health care practitioners for their relatively small needs by comparison to Africa, underscoring the urgent need for more ethical and socially just policies both locally and abroad (Zimbudzi, 2013). Best health care procurement practices are essentially a “world-as-community” issue, with differing health care challenges needing to be regulated by policy changes on a global health level, however lofty those ideals may seem at present.

Other ways to stop the brain drain – Nine proposals

In attempting to find ways to stop the brain drain and the resultant effect on the exodus of South African (and African) health care practitioners, nine key proposals formulated from information contained in numerous academic studies were
revealed and led to nine proposals (Zimbudzi, 2013, pp. 19-22). These studies included Eastwood et al. (2005), Gerein et al. (2006), Kirigia et al. (2006), Oberoi et al. (2006), Record et al. (2006), Dovlo et al. (2007), Mullan et al. (2007), Oyere et al. (2007), Pereira et al. (2007), Chopra et al. (2008), Pillay et al. (2008), Wasswa et al. (2008), Wright et al. (2008), Bedelu et al. (2009), Manafa et al. (2009), Shumbusho et al. (2009), Zachariah et al. (2009), Jenkins et al. (2010), Olowu et al. (2010), Mills et al. (2011), Taylor et al. (2011), Benedict et al. (2012), and Zimbudzi (2013).

Further additions by other authors were made to these proposals by the researcher in the context of this study to provide specific and relevant information towards understanding health care in South Africa, and where it appeared relevant to do so.

1. Task shifting

“Not popular across the board”

Health care practitioners, whose qualifications are not internationally recognised, are increasingly being used in African countries that place these practitioners at rural clinics/health care facilities in largely poorer areas and who have delivered particularly valuable services, specifically regarding ARVs (Anti-retroviral medications for the treatment of HIV/AIDS). In Mozambique, for instance, an obstetric clinic, where most of the medical practitioners had left, being serviced by 90% non-medical practitioners was still working after a follow-up study in the area, which revealed a move towards departing from a “doctor-centric” model in order to improve health care delivery services to those types of populations (Zimbudzi, 2013).

The practice/intention to introduce task shifting has been met with strong resistance from professional health care practitioners, most notably because this type of practice would not be able to achieve standardisation for training programmes (Zimbudzi, 2013).
2. Remuneration

By sustainably improving health care practitioners’ salaries, as was done for the public health care sector through the OSD initiative, it was envisaged that valuable and skilled health care practitioners would be less likely to leave the South African health care sector (Zimbudzi, 2013). It has to be remembered, however, that it was not merely remuneration that motivated a number of health care practitioners to leave the country, but a whole range of factors.

3. Regulatory mechanisms

By allowing foreign health care practitioners to become registered in South Africa, an avenue for skills acquisition is opened (Zimbudzi, 2013). Nevertheless, recently rhetoric in the public array saw the HPCSA criticised for not moving fast enough and/or being efficient in processing applications for health care practitioners willing to relocate to South Africa from across its borders (Africa and global) to become registered in the country. Due to the rising criticism, the Minister of Health set up a task-team in 2015 following, as he stated, a spate of complaints since 1997 by saying “I have received a lot of complaints on governance, efficiency, effectiveness, and sometimes even the competency of the management of the HPCSA.” A particular grievance by medical practitioners was a 2007 amendment to the Health Act, which removed medical practitioners’ authority to nominate members of their profession to represent them on the HPCSA medical and dental board. This was essentially interpreted and perceived that the HPCSA was not accountable to the medical practitioners they were representing, but rather to the political figures, who appointed them and subsequently left them feeling “voiceless”, despite being heavily taxed through registration fees they had to pay to the Council. They called for the formation of an autonomous and representative body as a result (Cullinan, 2015c). Providing avenues for health care practitioners to voice their concerns and “be heard” is deemed critical to the future of good health care governance in South Africa.

4. Compensation

Education and training of citizens through schooling, tertiary education/universities and so forth inevitably costs the South African Government billions in revenue,
which is lost when health care practitioners leave for “greener pastures”, essentially draining the local economy (Zimbudzi, 2013). Recipient countries should be obliged, morally and ethically, to compensate the donor countries for the loss of their valuable and skilled human resources for health. Despite some countries alluding that “aid to donor countries is some type of compensation for their gains, it is a challenge to accept that the United Kingdom, Canada, and Australia were not signatories to the Commonwealth Secretariat’s Code of Practice for International recruitment of health care practitioners due to a clause related to the possibility of compensation (Zimbudzi, 2013:21).

The “playing-fields” inevitably are not equal. However, it is in South Africa’s interest to stop medical practitioners (and health care practitioners) from leaving the country. Looking for compensation “after the horse has bolted” is probably a fruitless exercise.

5. Bonding

Bonding means that health care practitioners should work in public health care institutions for a period usually equal to the number of years they were trained, after they have completed their training, with the assumption that the government can also afford to absorb those graduates into the health care work force (Zimbudzi, 2013).

“Community service”, as it is known in South Africa, was an aim of the Department of Health “to ensure improved provision of health services to all citizens of the country.” As such, it became mandatory in 1998 for medical practitioners, dentists and pharmacists (12 months, which has since increased to 2 years) and which in 2003 was expanded to also include physiotherapists, occupational therapists, speech therapists, clinical psychologists, dieticians and radiographers. Research has proved that, although community service health care practitioners gained valuable (although frustrating and difficult at times) experience, they nevertheless still had career plans that they felt were merely delayed by however many years, a disappointing result to a solution that the government had hoped would rather retain them for valuable future contributions to the health care system, than lose them in the end (Reid, 2002, p. 158). Again, it would be more enticing for health
care practitioners to stay in the country if all the conditions around their employment in the public sector were positive such as the availability of correct resources, infrastructure and remuneration.

Government more recently promulgated a law that is known as the “Certificate of Need” in 2014 (Bateman, 2014) whereby newly graduated health care practitioners would need to serve in “areas of need “prior to being granted clearance for emigration (Zimbudzi, 2013). According to a guest author in Health-eNews, June 2014, the law applied to anyone “providing ‘prescribed’ health services, or continuing to operate a health establishment or health agency after the expiration of 24 months, from which date the relevant addition to the Act took effect, or 1 April 2014.” In addition, “all health care ‘establishments’, (i.e. places where health care is rendered and including all practices) had until 1 April, 2016 to apply for it” (Health-eNews, 2014). However, by prescribing where health care practitioners can and cannot practice in order to create equity, professional distribution was perceived in many quarters to be a “legal nightmare” in the making, which it was felt would ultimately and paradoxically, undermine health care delivery instead (Bateman, 2014, p. 459).

6. Political stability

Political stability is an important condition for retaining health care practitioners, who have been known to leave countries and only returning after political transition and “better” leadership in their home-countries (Zimbudzi, 2013) became evident.

7. Importing health staff

Importing (or inviting) health care practitioners to meet the country’s health care and human resource needs, for example, from Cuba, Eastern Europe, provides immediate relief for health care practitioner shortages (Zumbudzi, 2013), but the challenge remains that they may be culturally and psychologically not as invested in South Africa and may become part of the general re-migration trend as well.
8. Training more health care practitioners

Increasing the amount of health care practitioners through additional training was deemed to have potential pitfalls such as “market failure”, whereby health care practitioners, who incur a great deal of expense in their training by the government, accrued the benefits to foreign private health care institutions and/or individuals. One solution would be for destination countries to invest in South African training facilities as compensation for the losses in revenue and human resources (Zimbudzi, 2013, p. 21). However, as alluded to earlier, the major beneficiary countries were not signatories to such agreements.

9. Remittances

“A sum of money sent in payment or as a gift”

If health care practitioners sent a portion of their earnings back to their countries of origin and back into the health care system, the economy would be strengthened. However, most do not make deposits into formal South African banks/accounts and therefore these funds are lost to the economy, prompting the need to ensure that these monies are used to improve the country’s gross domestic product (Zimbudzi, 2013, p. 22). As these health care practitioners need to fund themselves in their new countries and have probably cut all ties with South Africa, it is illusionary to expect them to send money of any kind to South Africa, particularly in view of South Africa’s reasonably poor currency and inflation rate.

2.13.2 Costs of education for medical practitioners and impact/implications for health care

When considering the “brain drain”, considerable emphasis should be placed on the costs to a country concerning lost investment in its human resources.

In a recent study, conducted by, amongst others, the Chair of Global Health, Edward J. Mills and Assistant Professor of Global Health, Amy Hagopian, in Mills et al. (2011), valuable statistics set out in (Addendum L) relating to the costs of training medical practitioners in South Africa and Sub-Saharan Africa, highlighted the financial layout from primary school to medical school and lost investment, should those valuable human resources leave, especially from countries where
the burden of HIV disease is around 5% of the population (in ages 15 – 49), which includes South Africa. The consequential lack of available specialised medical care, not to mention other sequelae such as morbidity and mortality associated with it, brings home the devastating overall health care issues in South Africa at present. Although the study focused on medical practitioners, it recognised that other health care practitioners, such as nurses and pharmacists, appear to present with similar trends of emigration, which needs further research to determine the cost to the country. It was also highlighted that countries such as Canada, the United Kingdom and the United States do not have intentions to invest specifically in the HIV/AIDS pandemic, choosing rather to focus their investments on child and maternal health (Mills et al., 2014).

With South Africa’s relatively high cost of primary school education in relation to other countries in Sub-Saharan Africa (see Appendix K, Tables 8, 9, 10, 11, 12 and Fig. 10), the high burden of disease, inadequate ratio of medical practitioners (in particular) to the population, highest expenditure/government subsidy to train them, and the health system, which is already under strain with staff shortages across the board, the country will need all its skilled personnel for public facilities to be sustainable and/or survive.

Some may suggest that due to the enormously contrasting health systems (public and private) in South Africa, the National Health Act 2003, which aimed to allow government to centrally control the entire health care system (with all its complexities) might appear to an impartial observer as being counter-intuitive as it does not appear to either “recognise the value of the private health care sector to the people and the economy of South Africa, nor the benefit to poor South Africans” (Bierman, 2006, p. 6). It could rather “exchange its role in health care provision for that of funder of health care for the poor, by purchasing care from competing private health care providers” (Bierman, 2006, p. 19) and retain its valuable human resources, to best serve the population. In such a scenario, health care practitioners would no doubt begin to return to South Africa instead of leaving it (Bierman, 2006).
2.14 Health care practitioners and the burden of disease

2.14.1 Understanding the epidemic of HIV/AIDS, TB and HIV/TB co-infection

What is HIV/AIDS?

Although the terms HIV and AIDS are used interchangeably, they are related but not exactly the same thing. HIV (Human Immunodeficiency Virus) is the aetiological agent that results in AIDS, the autoimmune deficiency syndrome. HIV is spread via blood and blood products, mother to child (via intra-uterine, delivery and breast milk), but is primarily a sexually transmitted disease. It is most prevalent in developing countries, with an average of 22.5 million cases estimated in Sub-Saharan Africa alone out of an estimated worldwide figure of 33.3 million infected people, according to a UN report in 2009. More than two thirds of those infected lived in the Sub-Saharan region, even though it is home to merely 10-11% of the world’s population with estimates suggesting that more than 10% of adults between the ages of 15 and 49 are HIV infected. Of those, girls and women account for a disproportionate 60% of the total count of regional infections. Global AIDS deaths amounted to 1.8 million in 2008 and since the discovery of AIDS in 1981, a conservative estimate of total deaths amounted to about 25 million people. With the rollout of anti-retroviral medications (ARVs), along with educational strategies, counselling and behaviour modification, it is expected that there is likely to be a downturn in AIDS deaths. Long term, it is hoped that a vaccine will be discovered, but in the meantime, effective prevention remains the only route to ending the pandemic (Longo, Fauci, Kasper, Hauser, Jameson, & Loscalzo, 2012), where the burden of the disease is large relative to the health care resources available. Research in 2013 estimated that close to 75% of people living with HIV are accounted for by 15 countries, more particularly, South Africa (18%) (UNAIDS, 2013).
Figure 6. People living with HIV by country, 2013 estimates
(Source: UNAIDS, 2013)

Fittingly, in a statement released by the Presidency ahead of World Aids Day on December 1, 2015, Deputy President of South Africa, Cyril Ramaphosa, said that too many South Africans were still being infected with HIV. “The number of new HIV infections is still extremely high, particularly among young women and girls.” Although the country had made great progress in addressing the disease and had the world’s largest HIV treatment programme, with more than “three million of our people on life-saving ARVs”, responsibility and caution in sexual relationships was encouraged. He said “the end of HIV as a public health threat is in sight”, promising that the country’s focus would be to “Rise. Act. Protect” (Deputy President of South Africa, 2015).

Abdool Karim, Churchyard, Abdool Karim, and Lawn (2009, p. 293) summarised the HIV (and TB) situation in South Africa as follows:

1. Worldwide, South Africa has the highest number of people living with HIV/AIDS, representing one quarter of the disease burden in Sub-Saharan Africa and one sixth of the global disease burden.
2. South Africa also has one of the worst TB epidemics in the world, with high disease burden, incidence rates, HIV c-infection rates, growing MDR and XCR-TB epidemics.
3. While South Africa has well formulated and broadly accepted National Strategic Plans for both AIDS and TB, inadequate will and capacity to deliver on many of the urgently needed health care interventions is a major deficiency in the country’s response to the dual epidemics.

4. The AIDS epidemic has already made a lasting impression on and will continue to shape irrevocably the South African health service for decades to come. The successful scale-up of antiretroviral therapy provision, leading to the creation of the world’s largest AIDS treatment programme, is the engine driving innovation to strengthen the overall health service.

5. With the era of governmental denial and complacency, with its substantial cost in premature loss of life, now as in the past, the newly elected South African Government has the opportunity to actively support and adequately resource the implementation of an evidence-based public health policy to turn the tide on the TB and HIV epidemics.

In South Africa, there is currently no single national policy or strategy that comprehensively addresses the need for stricter TB management of health care practitioners in health care institutions and, as such, health care staff are not provided with the resources and tools to adequately enforce policy recommendations such as risk-assessment across the board. If they did, they would be able to address contravened labour laws more swiftly with a view to making health care environments and institutions safer to work in (Gray et al., 2013).

Numerous WHO and South African policies (Addendum L, Table 13), that address varieties of TB and HIV risk management for health care practitioners, have been included in policy and legislative frameworks/formulations and have highlighted the need for a single national approach that could include all of these diseases. Notwithstanding these, the burden of disease remains an enormous challenge for the country, particularly in post-apartheid South Africa. South Africa had one of the world’s highest rates of HIV burden of disease (growing since 2007 estimates of 17%) and one of the most serious TB epidemics globally, whilst comprising only 0.7% of the world’s population, the indicators are clear that health care practitioners, and the sector as a whole, face enormous challenges going forward.
(Abdool Karim et al., 2009).

**HIV and AIDS and prevalence in South African health care practitioners**

As reported in a 2013 study, the scale of the HIV epidemic in South Africa is huge, even though the country’s population is small when compared to China, India and the US even though it is much larger than in its neighbouring countries, Lesotho, Mozambique, Swaziland, Zimbabwe, Botswana and Namibia. It has a combined prevalence of more than all those countries put together that have HIV prevalence rates similar to South Africa’s. It is not difficult to imagine the enormous impact of these on the health of health care practitioners (in this study) as the uThungulu District is in one of the provinces with the highest percentage of HIV prevalence (15.7%) of the population (Grey et al., 2013). In the country as a whole (see Addendum M), this epidemic has resulted in serious loss of human life.

**What is TB?**

TB is a bacterial disease, infecting around 10 million people worldwide annually (WHO, 2005c). Whilst the disease may remain dormant once contracted, it may become active, when the body’s immune system becomes compromised (WHO, 2004a) such as with HIV/AIDS.

One of the main reasons for the huge burden of disease in South Africa has largely been attributed to the exacerbation and spread of HIV and TB disease across Sub-Saharan Africa. It is within this context that health care practitioners in the uThungulu District can be appreciated and understood as they live and work in the milieu of the province with the highest reported number of all types of TB cases and incidents in 2012, in this particularly disease-burdened population (Gray & Vawda, 2014).

**HIV/TB co-infection and emergence of MDR TB (Multi-drug resistant TB)**

A combination of HIV and TB is the most common HIV-related illness in Sub-Saharan Africa (WHO, 2004a). This lethal duo has increased the burden of the disease exponentially and continues to rise in many African countries with 50% of new TB cases being HIV co-infected in South Africa alone, a country that also
ranks within the top ten countries worldwide for TB and “MDR” or multi-drug resistant TB. In rural KwaZulu-Natal (of which uThungulu District is a part), the 2006 outbreak confirmed that, of the 39% MDR confirmed patients (75/185), 53 of them had extensive drug resistant TB, which proved fatal in nearly all cases. Each of those cases was HIV co-infected and these types of cases have continued to increase (Gray et al., 2013).

Currently, there is sparse data available regarding the extent of HIV and HIV/TB co-infection prevalence in South Africa. Without intensive programmes to measure and test for these on a large scale, one can only speculate that the trend for the diseases, which appears to be increasing by all accounts, is set to worsen. These trends would then also increase the risk of the very serious multi-drug resistant strains of TB (MDR) as well as the more serious XDR-TB (Gray et al., 2013).

With the evolution of TB came the appearance of an exceptionally dangerous and extremely drug-resistant strain of TB known as XDR-TB, which has affected health care practitioners in countries with high rates of TB, who are at increased risk, with evidence that they are being hospitalised at greater rates than non-health care practitioners. With treatment outcomes being poor (Gray et al., 2013) and with health care practitioners in South Africa and around the world working in close contact with the dual epidemic of HIV and TB, research supports the predictions that their occupational exposure leaves them especially vulnerable. Therefore, it would be prudent to introduce a sustained effort to tackle the problem at various levels of the health care system, which should include timeous and adequate drug supplies, stock monitoring, and addressing the areas where problems can arise, leading to the spread of infectious diseases (Gray et al., 2013).

**TB prevalence in South African health care practitioners**

It is estimated that approximately 28% of TB infections in the African region of the WHO (most of the Sub-Saharan countries) are ascribed to HIV, with its impact in the increase of the disease (WHO, 2012c) being felt in South Africa, where it was estimated that 60% of TB cases were also HIV infected (Gray et al., 2013). After China and India (which have the largest prevalence), South Africa has the highest TB infection rate in the world, with approximately 1.70 per 100 000 of the
population infected in 2013. The rate appears to be getting larger and is showing no signs of decrease or stabilisation, unlike the trend in India and China (Gray et al., 2013). Therefore, it stands to reason that health care practitioners, who are not only attending to patients, but are also members of their communities, are particularly at risk for acquiring TB infections on account of their exposure to the TB bacilli especially in South Africa, where the burden of disease is so high. This dual-role exposure further highlights the importance for research into the effect of how large their risks are in their occupational groupings. While there is widespread local and international awareness that public health programmes and health systems will be negatively affected by the prevalence of HIV and TB in health practitioners, the resultant weakened health systems may find it increasingly difficult to respond to the challenges these diseases pose. Staff at a hospital in KwaZulu-Natal were, for instance, found to have the second highest prevalence/incidence of TB in the country with an incidence of 690/100 000 (Gray et al., 2013) see Addendum N, Table 15.

2.14.2 Examples of selected health care systems around the world – taken from the media and public sentiment

It is a major task to address every health care need or cover any health care system in depth, as it is beyond the scope of this study. However, it is fair to say that South Africa is not alone in its issues related to health care and faces similar geo-social and/or political challenges such as universal health coverage, health care insurance; burden of disease; sustainable development goals for health care; migration of human resources; and others. Valuable learning opportunities can be gained, however, from examples of various health care systems, such as those, which are well run, like Germany to non-ideal examples such as India, highlighting dilemmas unique to each context, culture and country.

South Africa, Ghana and Tanzania

“Fragmentation from colonial rule.”

Many decades of colonial rule such as was seen in South Africa, Ghana and the United Republic of Tanzania, meant that the best health care was reserved for the ruling “elite” and their sub-servients. Liberalisation from colonialism ushered in an
era of fragmented health care policies and reforms in the three countries, which had profound effects in terms of their health care services not being financed in the same way for different socio-economic groups and the resultant “catastrophic” payments for health care (above average from 59 other countries studied). This was especially true for the South African health care system. Efficiency, affordability and equity are the casualties of any fragmented system, especially for the poor, with the least progress in rectifying fragmentation issues occurring in South Africa, in comparison to Ghana which, at the time of the present study, was coherently addressing its universal coverage policy (McIntyre, 2008).

**Ethiopia**

“Health care spending is low in both public and private sectors.”

According to the WHO (2015), health spending is extremely low in both the public and private health care sector in Ethiopia, which raises the question about whether the country was able to channel its resources to the highest priority diseases at low costs. Notwithstanding the above, areas needing attention, especially related to addressing the management of public health human resources, are implementing decentralisation through government reforms, fiduciary financial expense allocation, budget execution and corrective measures to improve the relationship between public and private health care sectors. The World Bank, together with the Public Expenditure Review, analysed public health care expenditure and the delivery thereof and made recommendations for issues that emerged as critical in reducing the burden of disease (WHO, 2015).

**Egypt**

“A system that doesn’t know how to manage itself” (Kaiman, 2014, p. 5).

A few weeks ago, a woman gave birth in the street outside a public hospital in Northern Egypt. Depending on who you believe, the hospital either did not have enough medics to tend to her – or they demanded money that she could not pay. Hers was another extreme example of the problems with Egypt’s public health service, particularly in provincial and rural areas. Thanks to a decree issued earlier
this year, all Egyptians should get free access to emergency hospital care for at least 48 hours. But, in practice, some state facilities, particularly in the countryside, either cannot provide instant health care – or have to charge for it. Due to a shortfall in government funding, they have no other way of paying their staff and the problem extends beyond that. A state-run insurance scheme nominally provides subsidised non-emergency health care to children, government workers and the families of those workers – a group that the government says totals 54% of the population. However, by the government’s own account, only 8% of those covered by the scheme actually use state facilities. “This in itself denounces the problem,” says Ayman Sabae, a medical practitioner and campaigner for health care reform at the Egyptian Initiative for Personal Rights, a prominent watchdog. “Both the service quality and access to the services are so limited that only 8% of those covered by the scheme actually use state facilities. A government clinic that Sabae visited in rural Qena province recently exemplifies the problem. Similar to about half of Egypt’s 4,000 state clinics, this one is well-equipped, and newly refurbished. However, according to Sabae, there has not been a medical practitioner there for the past four years. Clinicians assigned there might only earn around 1,200 Egyptian pounds a month – about £100, or little more than Egypt’s average monthly wage, whereas they can earn around five times as much in the private sector. So they opt for the latter. “There are a couple of finance employees, maybe a nurse,” says Sabae of the clinic, “but no doctors. And that is very typical – you have a system that does not know how to manage itself. You have the money to renovate the clinic, but not the human resources to manage it.” As a result, half of the population, who are eligible for free health care are often no better off than the half that is not eligible. Most end up paying for their care themselves – in fact, 71.8% of health care spending in Egypt comes from people’s pockets. NGOs, charities and religious groups pick up some of the funding (the now-banned Muslim Brotherhood part-built their influence on their network of clinics). Those who are not covered by the state health care plan can apply for another state-paid treatment – the Programme for Treatment at the expense of the State. But this is only for those with life-threatening diseases, who can show they are incapable of paying through other means. As a last resort, any patient can get free treatment at university training clinics and hospitals. On the plus side, the medical practitioners there are often the best in the country. On the downside,
students observe every operation, the facilities are often unhygienic, and the cost of basic supplies is frequently covered by the patients or the medical practitioners themselves. “When I worked there as a doctor, I was paid 200 Egyptian pounds [about £20] a month, and I would spend more per month from my own pocket to buy blood from other hospitals,” says Sally Toma, another medical practitioner who campaigns for health care reform. “Otherwise, I was told, I would have to choose, who should get blood and who should not” (Kaiman et al., 2014, p. 5).

Brazil

“A huge gap between standards of public and private care” (Kaiman et al., 2014, p. 4).

When more than a million protesters took to the streets of Brazil in 2013, the woeful condition of the public health care system was high among their list of grievances. Inequality of the people and vast distances are the main problem. According to the World Bank, the country has 1.8 medical practitioners for every 1000 people – well below the 3.2 ratio in neighbouring Argentina and significantly below those of Mexico, the US and the UK. On paper, however, Brazil has one of the most comprehensive and generous public health networks in the world. The Unified Health System, or SUS as it is widely known, is universal and free for everyone. It has notched up impressive achievements. Since the turn of the century, life expectancy is up from 68.8 to 74.5, infant mortality is estimated to have fallen to 14.4 per 1000 live births from 17.6, and the government says 95% of children are now fully vaccinated. According to the World Bank, Brazil’s health care spending was 9.3% of GDP in 2012. However, in reflecting on this very unequal society, there is a huge gap between standards of public and private health care. In the state’s capitals, the one-in-four of the population who can afford private services benefit from almost double the medical practitioner-patient ratio. For those in the SUS, there are insufficient beds and waiting times for basic diagnosis and treatment are long. Regional disparities are even more glaring. Residents of the poorest state, Maranhão, have barely a quarter of the “spend per head” as the inhabitants of wealthy Rio de Janeiro. To address this problem, President Dilma Rousseff launched a crash programme in 2013 to fill the gap with thousands of primarily foreign medics. The “Mais Medicos” (“More Doctors”)
programme offers incentives to those who go to medical schools in remote and poor areas, such as the Amazon, so that, in the long term, they can train a new generation of professionals. So far, 4 199 medical practitioners have been dispatched and the plan is to increase this to 11 500 medical practitioners by the end of 2017. The vast majority have come from Cuba. This is politically controversial because the Cuban Government pockets about a quarter of their salaries. When they arrived, Brazilian medical practitioners booed and chanted “slave” at the newcomers and accused them of lacking the necessary qualifications and language skills needed to do a good job. While it is true that the normal diploma requirement has been waived for the Cubans, the government says this is justified because they are only expected to provide primary care, not surgery. According to the Brazilian Minister of Health, “Mais Medicos” is a success because it is serving the public with quality health care and is greatly improving health indicators throughout Brazil, with “fifty million people, who did not previously have primary care, now having exactly what they need most of all” (Kaiman et al., 2014, p. 4).

China

“A soaring demand for quality medical care” (Kaiman et al., 2014, p. 1).

China’s economic and social changes sparked an intensive effort to speed up efforts to upgrade the health care system, even though the efforts of the past decade have not managed to meet the targets due to fast-growing economic, social and human-biological factors. Although the people in China are growing older and wealthier, they face serious environmental challenges such as pollution and various health related sicknesses that affect health-seeking activities, especially quality medical care. During the Maoist era, the 1940s to 1970s, health care was state-supported entirely and far from optimal. In the 1980s, the health care system was entirely dismantled with resultant chaos such as the collapse of Chinese hospitals that were left to administer themselves as economic entities and cutting corners to make ends meet. Many hospitals are still extremely overcrowded, poorly resourced and their staff underpaid, which has led to corruption in terms of income supplementation such as “kick-backs” from drug companies, exploiting patients for cash, amongst other ills, in a deeply stratified
system. Most recently, the Chinese Government has introduced health care reforms and invested in new technologies and training programmes for medical practitioners, speeding up efforts to achieve progress. Although these have improved the system, resulting in about 99% of the rural population receiving some form of health insurance, the rising costs of medical supplies leaves most people paying out of pocket differences and they are therefore not much better off than 10 years ago. China aims to achieve universal coverage by 2020 (Kaiman et al., 2014, p. 1).

India

“Public or private, India’s health system is largely unregulated” (Kaiman et al., 2014, pp. 3-4).

According to the WHO (2015), about 75% of health expenditure in India is government funded and each province/state is responsible for that funding. In 2004, the National Common Minimum Programme advocated for a minimum of 2-3% of GDP to be allocated to health by 2009. One of the major challenges for India’s health care sector is to reduce the amount of out-of-pocket spending. The WHO is actively involved in sustainable financial solutions focused on addressing this issue. The publicly run hospital system in India was so poor that most citizens choose rather not to trust in those services due to “mazes of dingy corridors, outdated equipment and filthy wards, where linen is absent and rats run freely, greeting the desperately poor and sick patients seeking care.” Patients stand in long queues, waiting to see erratically available health care specialists at the All India Institute of Medical Sciences in New Delhi, India’s largest public teaching hospital. Spending only 1.3% of GDP on health, it rates as one of the lowest worldwide, patients are often seen providing their own surgical equipment, bandages, life-saving drugs and blood due to shortages, often overcrowding medical retail outlets due to lack of accommodation options and personal finances. India also has a silent epidemic of TB, with 300 000 lives being lost a year to this illness. This scenario sharply contrasts with New Delhi’s corporate hospitals, which provide excellent levels of care by world standards, at which international patients are seen being attended to, right down to the last sumptuous details, complete with “brightly lit waiting rooms, cleaners, attendants and stacks of glossy
magazines.” Here, diagnostic tests cost a fraction of Western prices, which has seen the rise in medical tourism bringing vast amounts of money into the country’s economy. India’s health care system (public or private) is not well regulated and corruption persists. In May of 2014, an Australian medical practitioner, writing in the British Medical Journal, exposed a “kick-back” perverse incentive scheme, where medical practitioners from one of India’s small hospitals received personal benefits for referring patients for scans, tests and surgeries. With India’s new Minister of Health, the Prime Minister and the formation of bodies to investigate/counter corruption, there are aims and vision for a better controlled and policed system. Universal Health Care is now firmly also in the sights of the new Prime Minister, who, if he achieves it, would arguably make India the country with the largest scheme in the world. Purportedly mirroring similar lines as “Obamacare”, critics have expressed reservations about the system making the public/private divide even larger. Poor treatment options, high medical-related costs and exploitation, if not remedied, will place vulnerable people such as the poor at even greater risk. In a 2011 Lancet medical journal study, it was claimed, “39 million Indians are pushed into poverty every year due to medical costs”, making the British NHS (overcrowded and lacking in many aspects) seem heaven in comparison to their local conditions (Kaiman, 2014, p. 3-4).

Kenya

“Half the population live below the poverty line.”

It was reported by the WHO that currently, more than half of Kenya’s population live below the poverty line, making it a government priority to increase the coverage of quality health care by ensuring that basic health packages for all Kenyans are achieved. People falling ill are most often unable to either pay for their care or get to facilities where they could be served. Kenya’s health system is predominantly tax-funded with a history of policy changes affecting health care since the country’s independence in 1963. A 2004 proposal was made for a National Social Health Insurance Scheme to be introduced, which, it was hoped, would ensure access to good health care for everyone in the country without exception and with a comprehensive benefits package. The WHO participated in the proposed reforms, through technical assistance initiatives and with other
partners, but, by all accounts, the implementation of a well-run National Insurance Health Fund (HSHF) will remain a substantial challenge (Carrin et al., 2007, p. 130-135).

**Lesotho**

“Information is scarce.”

According to a WHO report (2015), Lesotho, with a small population of about 2 million people, is surrounded by the Republic of South Africa and faces the burden of more than half of its population classified as poor. With most medical referrals being sent to the Republic of South Africa, and with out-of-pocket spending very low in comparison to the rest of Africa, measures need to be taken to introduce medical facilities that can cater for those in need. Little information is currently available regarding the country’s private for-profit services, although it was reported that there were approximately 20 or more private medical practitioners and a private hospital in the capital Maseru, with health insurance for those who could afford it. The general trend in the country has been for employers to take out group-based memberships rather than individual subscriptions. Half of the health facilities in the country are government health facilities, with the other half comprising mainly the faith-based health care providers under the umbrella of the Christian Health Association of Lesotho (which received some government funding as well). It was expected, however, that these lowest-level-of-care facilities would be abolished, but information was scarce relating to the nature of those reforms. No doubt, the allure of the relatively higher fee-for-service reimbursements from private health insurance companies would make this option an attractive alternative for the future (WHO, 2015).

**Germany**

“It gives patients a lot of choice” (Kaiman et al., 2014, p. 8).

Germany’s health care system is best understood as a middle option between the British state-run and the American market-led model. In principle, health care cover is universal, as in Britain, treatment of the unemployed is covered by the
state and ordinary patients rarely get presented with a bill after seeing a doctor. Unlike in Britain, however, this universal care is not funded by a centrally collected tax, but by so-called “Krankenkassen” or sickness funds – a system that goes back all the way to Otto von Bismarck’s health insurance bill of 1883. Signing up with a sickness fund is compulsory for every German citizen. Once one has joined, one pays a premium calculated according to one’s income: half of it is paid by the individual, the other half by the employer. If one makes less money, one pays less. If one is lucky enough to have a career that makes one a lot of money – and this is where Germany veers towards the United States model – the person can choose to ignore one of the 131 public, non-profit sickness funds, and go with a private insurer instead. One advantage in comparison with the British system is that one does not end up having to pay double – say, for Bupa and the NHS. In Germany, about 89% of the population is covered by public sickness funds, the remaining 11% are private. One of the big plus points of the German system is that it gives patients a lot of choice; they are not restricted to the nearest general medical practitioner in their post-code, but can sign up with any general practitioner they prefer. General medical practitioners also have less of a gatekeeper function: if the patient knows they have a back problem, they can go straight to see an osteopath. Because the system is less centralised, medical practitioners and nurses do not have to stick to behavioural guidelines. For instance, to foreigners, some German medical practitioners can come across as shockingly informal. “Practitioners enjoy a lot of freedom in Germany,” says Stefan Etgeton, a senior expert of the Bertelsmann Foundation, “but therein can also lie a problem: forcing through new medical standards can be arduous, because some doctors are convinced that their way of doing things is still best.” In Germany, the health care system does not attract the same combination of vitriol and affection that the NHS does – it just works, so that both the left and the free-marketers can see in the system what they want. However, that does not mean that there are no problems eating away at the system. For a start, the per-capita cost of health care has been much higher in Germany than in Britain. Most recent figures, from 2012, show the country spending 11.3% of its GDP on health care – 2% above the OECD (Organisation for Economic Cooperation and Development) average. “As a whole, the German system encourages overspending,” says Edzard Ernst, Exeter University’s German-born professor of complementary medicine. Medical practitioners, who
get charged per item, are incentivised to oversubscribe and patients are incentivised to use the system more than in other countries. There are also concerns about the long-term effects of the dual private-public system. One of the problems is that it provides an incentive for the best medical practitioners to move to urban areas, where there are more high earners who can afford private sickness funds. As a result, rural regions struggle. A public survey in 2012 showed 58% of the population supported scrapping private health insurance altogether (Kaiman et al., 2014, p. 8).

Italy

“A persistent complaint is unfairness.” (Kaiman et al., 2014, pp. 6-7).

Italians by and large regard health as a priority and it shows up in one of the highest life expectancies in the world. In 2012, according to the World Bank, the average new-born Italian could expect to live to the age of 83 – the same as in Switzerland or Japan. However, like many things in a country of contrasts and disparities, the provision of health services varies widely from one part of Italy to another. Last year, a report was published by the parliamentary committee that scrutinises what Italians call “malasanita” (literally “bad health”) which are cases of extreme negligence on the part of medical practitioners or hospital staff. Out of 400 deaths attributable to “malasanita” between April 2009 and December 2012, more than 40% occurred in just two of Italy’s 20 regions, Calabria and Sicily. Italy’s Servizio Sanitario Nazionale was founded in 1978 and modelled in large part on the NHS. But right from the outset, it was only to a limited extent national. The central government fixes the overall budget, determines minimum levels of care and, for example, negotiates drug prices with the big pharmaceutical companies. However, it is the regional governments that administer the system and there are huge discrepancies between them in levels of efficiency and integrity. In parts of Northern Italy, patients receive attention as good as anywhere in Europe. “Customer satisfaction”, however, falls off rapidly in the southern half of the country and the drop goes hand-in-hand with a fall in measures of efficiency. In Sicily, for example, there are roughly 10 hospital medical practitioners for every hospital bed. In the north-eastern region of Friuli-Venezia Giulia, the ratio is half that. Discernible in the statistics are variations in the degree of corruption and the
use of public services to distribute jobs and patronage. Last year’s parliamentary commission report noted that, in Campania, the region around Naples, 383 health officials had been taken on to the payroll, without having to go through a selection process. A persistent complaint among patients is of unfairness. In the southern half of Italy especially, they often move up waiting lists, not according to the date, on which their names were first entered, nor by virtue of the seriousness of their condition, but according to whether they can secure a “raccomandazione” (reference) from someone with influence over the relevant surgeon. By and large, the state has been open-handed in allocating resources to health. In 2012, Italy spent 7.2% of its gross domestic product on the public health system. That was less than was spent by the UK, Germany or France. However, Italy’s economy has scarcely grown since the turn of the century and is under growing pressure from European institutions to trim its spending. Cuts have been made in recent years, but the overall budget for 2015, of almost €111bn (£88bn), was still almost 4% higher than it had been in 2011 (Kaiman et al., 2014, pp. 6-7).

**United Kingdom**

“Voted best NHS in 2014, but with a long way to go.”

In terms of health care provision, Britain’s NHS was judged the best (by the Washington-based Commonwealth Fund) out of 11 wealthy countries with Australia, Sweden and Switzerland also scoring highly. Although different scoring methods are used by different organisations, it remains difficult to compare and judge something as complex as a health care system and there are rankings of excellence that have different conclusions. In this instance, Britain was deemed to score highly in terms of quality, access, value for money and equity and, as such, is providing cost-efficient care, although the NHS does not appear to be in good financial health. It has large shortfalls and battles to implement savings. In terms of serious diseases outcomes, it fares worse than Canada, Australia and Sweden (data from the King’s Fund, London) and struggles to achieve a “near zero harm” score status in any of its institutions, but spends half of what America outlays per person for care; $3 405 per person in Britain versus $8 508 in America. A survey conducted by Bloomberg, using different outcomes for measurement, chose Hong Kong, Singapore and Japan as being best in performance, based on efficiency
and the right for patients to have more choices, as factors instead. Thus, one can see that by changing the “weighting”, the outcome can be different (Mce, 2014).

**United States of America**

“More than 13% of Americans still have no health insurance” (Kaiman et al., 2014, p. 7).

When he announced the news that a medical practitioner returning from Guinea to Harlem, in New York, had been diagnosed with Ebola in October, Mayor Bill de Blasio said that New York had the “world’s strongest health care system.” However, the fact that he referred to the city’s system, rather than the nation’s, is telling. In fact, while the United States can boast some of the best medical practitioners and most advanced medical technology in the world, the US does not really have a coherent health care system. Health care in the US is private insurance-based and decentralised, with most care providers owned locally by private companies and local and state governments controlling access to federal programmes. The public and private health care systems that overlap in some areas, and leave gaps in others, make the US the country that spends the most per capita and as a percentage of GDP of any country in the world, but paradoxically is consistently last among comparable nations in measures of quality of coverage such as infant mortality. Because their cost is decided by private companies, individual procedures can be extraordinarily expensive. A single MRI (magnetic resonance imaging) scan in some parts of the country can cost as much as $2 871 (£1 780); an appendectomy as much as $29 426 (£18 000), and a caesarean-section delivery as much as $26 305 (£16 000), according to a report by the International Federation of Health Plans. Some procedures can be as much as eight times the price of the equivalent operation in the United Kingdom, and a 2013 study by NerdWallet Health showed that medical bills are the biggest cause of bankruptcy in the US. Some of the gaps are filled by government operations. One of these is Medicare, which guarantees health insurance for the elderly. Another is Medicaid, a low-income programme, which the Obama administration have recently expanded, but state governments, especially those controlled by right wing Republican governors, have consistently rejected the expansion, leaving many poor residents without health care. Yet another is the Veterans
Health Administration, which was hit by scandal in April 2014 when it was revealed that at least 40 US military veterans had died while waiting for medical care. Perhaps the core struggle of Barack Obama’s Presidency has been to pass his Affordable Care Act, which would aim to use state online insurance exchanges to reduce the number of people without coverage. However, the Bill has become a political football for the far-right Tea Party, who sees any attempt to close the gaping holes in coverage as unacceptable government overreach. The result has been that, as of the beginning of 2014, more than 13% of Americans still had no health insurance coverage (Kaiman et al., 2014, pp. 7).

2.15 Health care practitioners in the context of psychological theories and their application to the health care setting

Bronfenbrenner’s bio-ecological systems theory and Maslow’s hierarchy of needs

Theories provide explanations for our questions, which in turn allow us to interpret and make sense of the information we collect. They generate new lines of enquiry and debate (Sapsford, Still, Wetherell, Miell, & Stevens, 1998, pp. 49-50) and, through their specific viewpoints, shape and contextualise data that might otherwise be unmanageable (Loxton, 2005). Therefore, this study can be understood and contextualised by using Bronfenbrenner’s bio-ecological systems theory and Maslow’s Hierarchy of Needs. These theories were identified as being important cornerstones in terms of their relevance to health care practitioners’ experiences.

2.15.1 Bronfenbrenner’s ecological systems theory

One of the ways in which to depart from a more individualistic approach to health care practitioners’ experiences in the current health care system was to adopt a community psychology, ecological focus/approach leaning rather towards a paradigm, in which the individuals develop in their own context (Visser, 2007, pp. 102-116). This approach would provide for a more in-depth understanding of the lives of health care practitioners, each in their own unique environment or context, in which they engage on a daily basis with colleagues, patients and the health care system. It will also provide an understanding of the system as a whole, in all
its complexity and with numerous unique nuances, including the researcher’s. Although health care practitioner’s responses may in part appear to be individualistic, one cannot separate these responses from the social world in which they find themselves, reflecting on their experiences. Therefore, these experiences can be further translated into deeper, perhaps unconscious filters that they apply to their world in order to make sense of it and to adapt to their circumstances. Therefore, the patterns of their responses need to be interactively understood, as they perform their duties and tasks in a multi-disciplinary health care environment.

Bronfenbrenner’s (2005) revised bio-ecological systems theory emphasises as its central premise the development of the self, which occurs within the context of the everyday environment within which health care practitioners live and work. As they work and interact with their environment, they are being influenced and influencing the context in which they exist. One can describe this process as a dynamic bidirectional or two-way interaction, where health care practitioners influence and reorganise their environment while simultaneously being influenced by the environment in which they find themselves (Loxton, 2005). Therefore, it is an evolving systems theory that focuses on integrative and interdisciplinary processes, which shapes development for the duration of the life course (Bronfenbrenner, 1979, 2005). This underscores the interdisciplinary nature of work in the health care environment and highlights the crucial part that Bronfenbrenner refers to concerning how reciprocal relationships with others shape an individual’s development.

In the context of the present study, the socio-emotional levels of functioning of the health care practitioners could be said to affect their responses, immediate environments, working conditions and socio-political experiences recursively in a feedback loop, which inevitably affects how they might relate in terms of their responses in the present study. The debates about health care and service delivery, amongst others, highlights “one of the most vital contributions of theory” in this study in that “it can offer a deeper understanding of what is at stake in political and social conflicts that have a very real existence” (Craib, 1992, p. 249).

The recursive and interactive context that Bronfenbrenner (2005) and Ryan (2001)
described in their theory, views the social context in which health care practitioners work and live in terms of five concentric systems or levels:

1. The micro-system (is the health care practitioner’s immediate environment which includes their emotional, cognitive, and biological make-up);

2. The meso-system (inter-related components of the health care practitioner’s micro-system, e.g. family, work place, religion, neighbourhood, and peers, etc.);

3. The exo-system (outside the immediate environment of the health care practitioner, but still significant, e.g. community, economic system, education system, government system, political system, etc.);

4. The macro-system (society and cultural, e.g. values, customs and laws);

5. The chrono-system (this interaction occurs in the dimensions of time and its relation to health practitioners’ environments, either external or internal, e.g. psychological changes due to ageing or death of a significant person) (Craig, 1999; Berk, 2000).

Although Bronfenbrenner’s theory initially focused on child development, he later used his socio-ecological model to provide a clear picture of the problems one sees in workplaces and families due to changes in society from, for example, an industrial model to a technical model. Technology has changed society yet the patterns of relating and policies in the workplace continued to rely on the factory work ethic (Bronfenbrenner, 1990). Also of concern to Bronfenbrenner was the “deficit” model used to determine a yard-stick for measuring how “deficient” someone was in order to qualify for help. A larger degree of failure or complaining could mean larger support, expecting individuals to hold their hands out from inside a hole of helplessness while still expecting them to have the psychological fortitude to climb up the thin rope that was thrown down.

In the context of the South African political landscape and the societal divides that the apartheid system created, one could argue that, in order to understand something fully, it needs to be understood in terms of its parts in relation to the
whole. The health care delivery system can also be described as a structure comprising interrelated, interacting or interdependent elements that form a whole (Susser & Susser, 1996). A system is a community within an environment. Individuals are central to socio-ecological systems and, as such, are applicable in the life-long course of health care practitioners’ development in relation to their environments.

Drawing partially on the socio-ecological model to explicate health care practitioners’ experiences in the public and private health care sectors, one can address the psychological health of these practitioners as being critically important to the strategic alignment of policy and services across the continuum of the population’s health needs (White, Stallones, & Last, 2013), of which they form a part of the whole.

Universally, it is appropriate to recognise that the development of health care systems should be better described as “health in all policies”, as the major framework for health begins with public health, primary health care and community services across the spectrum and ends with long-term care and end-stage inevitabilities. Although this idea may seem well grounded and logical, in reality, the scenario is different in most settings and there is room for improvement globally (White, 2015). All things being equal, according to Bronfenbrenner’s theory, when the relationship between different systems is compatible, then development and progress will be smooth.

Bronfenbrenner’s ecological systems model provided the researcher with a meta-framework, within which the experiences of health care practitioners in the uThungulu District can be understood. Their experiences are influenced by or can originate from any of the five systems individually or by interaction between the various systems, but essentially stress person-context interrelatedness (Tudge, Mokrova, Hatfield, & Karnik, 2009). Bronfenbrenner, in his later work, definitively included the role that people themselves play in their own development (biopsychosocial) and did not only stress contextual factors (Tudge et al., 2009). However, the main influence of his theory in the present study was based largely on his earlier theoretical constructs, whilst still taking into consideration his later revisions.
Zulu culture and traditional healing as interpreted within the context of Bronfenbrenner’s bioecological model

There are dynamic processes involved in the interaction between patients, staff, traditional healers and the environment, which Bronfenbrenner (2005) referred to as proximal processes or processes that drive the behavioural interaction of people in their environments, forming the core of the bioecological approach. An important assumption about the community in African settings is that practices that have a long-standing historical origin influence social behaviour, and although external and modernising influences have evolved in those communities, some of the customs have been passed from generation to generation and continue to be valued by the community (Ratele, Duncan, Hook, Mkhize, Kiguwa, & Collins, 2004).

It is well accepted that community health care workers are internationally known for their “short stays” and high turnover in communities, usually due to scarce resources or overload. As such, their work is adversely affected because they are unable to immerse themselves in the diversity and complexities of the dynamics of
the local community (Naidoo, Duncan, Roos, Pillay, & Bowman, 2007).

The research participants in the present study came from diverse backgrounds, local and international, and, as such, it was anticipated that their responses would reflect the world-views of their cultural origins. The researcher, having lived and worked with local populations at a hospital and clinic in the uThungulu District, is aware of indigenous knowledge systems that form an integral part of the social, cultural and traditional ways of the local population. Although these “healing” practices might or might not be consensually validated scientific methods, or based on evidence, they are time-honoured ways of employing local knowledge for survival, which are indigenous knowledge systems of global interest due to their heuristic, creative practicality and contextualisation. Whether traditional, conservative, dynamic, and/or activist in intent and effect, products of such systems inevitably originate in oral communities in the absence of writing (Edwards, 2013, pp. 264-265).

In traditional Zulu cosmology, there is a divine ancestral consciousness involving reverence and communal spirituality that extends to divine healing or holistic healing. The divine healer is considered by the community as a sanctioned mediator between the ancestors and the spiritual world. Healing, by way of culture and traditional belief systems, can take place in the personal or communal settings of home or the diviner’s home.

The transformation of the psyche ("psyche" literally means breath, spirit or soul) and corresponding metaphor in Zulu terms “umphefumulo”, “umoya”, and “uBukhona” (breath /soul, spirit, and presence/being) is the domain of divine healing, and the healing can take place on different levels of the psyche (Edwards, 2013, p. 269).

While the researcher worked as community service clinical psychologist in a local hospital in the uThungulu District, patients regularly encountered Zulu spiritual healers at their bedsides which were usually cordoned off by nursing and other staff in the wards who accepted and sanctioned these practices in the interests of the health and mental well-being of the patients to whom these practices were significant. It was not uncommon for lengthy prayers to be delivered and singing to
take place for the patient's benefit, while the researcher waited her turn with the patient, for a more Western version of psychotherapeutic intervention. It is for this reason that the researcher felt it would be an omission not to document that traditional healers diagnose and manage illnesses for interpersonal transformation in an effort to heal. It appeared as if these practices had a profound effect on the patients, who all reported feeling supported by their cultural/religious intermediaries. After all, modern medicine emanated from traditional herbs and plants and, although divine healers do not necessarily treat with these, they usually have an excellent knowledge of medicinal plants as well (Edwards, 2013).

As defined above, the Who's definition of health not merely meaning the absence of disease, but a state of complete physical, mental and social well-being (WHO, in Edwards, 2011), resonates locally with the use of the Zulu term “impilo”, which implies that health and vitality have a positive energised meaning (Edwards, 2011) to those who consider its importance in the health care setting. The way in which Bronfenbrenner’s systems impact on each other, often in subtle ways, is relevant for the lives of the health care practitioners who took part in the present study as well as the life of the researcher, with particular reference to the multi-cultural setting with multiple belief systems.

2.15.2 Maslow's hierarchy of needs

Health care practitioners and Maslow's hierarchy of needs

In order for health care practitioners to function optimally as individuals within the health care system, their needs also should be met. Whilst Maslow's theory contends that not all needs can be met at any one time, it is essential that at least the basic needs of the health care practitioners are met so that they can make optimal contributions towards their professions and have balanced family/work relationships. This implies starting with physical and biological needs (such as food, sleep, warmth) and moving up hierarchically to include safety needs at the next level, followed by social needs (love and belonging), followed by esteem needs and finally, self-actualisation.

Maslow believed that people are motivated by a set of motivation systems or needs that are unrelated to unconscious desires or rewards (McLeod, 2014). He
stated that, in order to achieve certain needs, often depicted as levels within a pyramid (see diagram below), certain criteria applicable to each level (from physiological to self-actualisation needs) needed to be achieved, starting at the bottom of the pyramid and becoming progressively fulfilled as the prior level was attained.

Maslow’s five-stage model was divided into basic (or deficiency) needs such as physiological, safety, love and self-esteem and growth needs (self-actualisation). If the basic needs (deficiency needs) were unmet, it would motivate people to have them met and this would become much more pervasive and dominant the longer they were denied. For example, if people were starving, the need for food would increase the longer they were starving. They would think of nothing else. Although everyone is capable of self-actualisation and has the desire or motivation to move up the hierarchy, their progress is often frustrated or thwarted by factors that Maslow called “preconditions for the basic need satisfactions”. These include:

freedom to speak, freedom to do what one wishes, so long as no harm is done to others, freedom to express oneself, freedom to investigate and seek for information, freedom to defend one’s self, justice, fairness, honesty, and orderliness in the group (Maslow 1943, p. 384).

Experiences such as job loss, divorce, sudden changes and so forth may result in an individual fluctuating between the various levels in Maslow’s hierarchy. Maslow stated that normal people were, at any one time, only partially satisfied or unsatisfied in all their basic needs at the same time. It was normal not to have an all-or-nothing percentage on the scale of needs. As the percentage of need gratification increased, so did the gradual emergence of the next highest need, which would then dominate (Maslow, 1943).
Maslow’s theory has implications for health care practitioners, who may not have had the pre-conditions for need-fulfilment, and it would perhaps be fair to say that historically discriminating practices, such as those seen in South Africa, may have led to a society that developed certain psychopathology in response. Maslow (1943) contended that people, whose basic needs were met, especially in their early years, developed great resilience to withstand current and future adversity, specifically because a healthy character structure was developed that resulted in basic satisfaction of their needs (McLeod, 2014).

Maslow conducted studies on people who he considered to be self-actualised and had reached their potential. He contended that only a very small percentage of the population would reach the ultimate state of self-actualisation, even though theoretically, he considered that everyone was capable of it. Part of the reason for
this was his belief that society placed more emphasis on lower-level needs and did not reward higher-level needs adequately (McLeod, 2014).

Maslow (1970) adopted a holistic approach to learning, which he said was affected by physical, emotional, social and intellectual attributes of an individual, rather than reducing behaviour to a response in the environment. Therefore, if applied in the health care environment, it can be presumed that, before the cognitive needs of health care practitioners can be met, physiological/basic needs must be fulfilled. For example, an exhausted health care practitioner will find it taxing to focus. Similarly, a practitioner also needs to feel physically and emotionally safe in the work environment, respected and valued in a supportive environment, both at work and at home. If these needs are met, they are able to progress, work, be happier and reach their full potential, according to Maslow’s (1968) hierarchy of needs theory.

Conversely, health care practitioners with low self-esteem are unlikely to progress optimally until their self-esteem is strengthened. The steps towards self-actualisation are paradoxically sometimes not observed in some impoverished cultures (for instance in India), where it appears that some individuals, although living in poverty, still appear to have higher-order needs such as belongingness and love (McLeod, 2014). Hundreds of studies support the motivational force of physical, safety, love and esteem needs (Griffin, 1991).

2.16 Conclusion

This chapter commenced by discussing various concepts which were central to the present study. Local and international spiritual and cultural practices, with a view to achieving the highest attainment of human rights, were discussed in order to place healers at the centre of it may mean to "care" and to "heal". These concepts provided the context, guidance, background and/or landscape for understanding some of the dynamics and diversity which influences the lives of health care practitioners and their patients individually and collectively. Being sensitive to others’ diversity makes healers transcend the limitations of their singular perspectives and aims to foster a better understanding of others’ beliefs and practices. This is what the spirit of “Ubuntu “really means. “We are, because
of others. “Thereafter a brief history of the evolution of the South African health care system from pre-apartheid to the current times with specific reference to the two-tiered health system, economic inequality, health care budget, human resources, investigations and practical barriers to achieving optimal health care services was presented. The political history of South Africa was briefly described, placing the new NHI initiatives into context and also in terms of redressing the legacy of apartheid, which divided the population on all levels of society and still reverberates in its effects, to this day. The literature placed health care practitioners individually and collectively as part of the community, society and world in a holistic framework by describing the laws they are governed by, ruling bodies they prescribe to (HPCSA, SAMA and SANC) world bodies such as the WHO, the United Nations Organisation and implications for health, social justice, and moral and ethical principles that affect them. Ethics, which forms an essential “social conscience” aspect to professional practice, were discussed with particular reference to international pledges and oaths (the Hippocratic oath and nursing pledge of service) which health care practitioners adhere/aspire to as part of their dedication to ensure best-practices and “first do no harm” to patients. Disputes and unhappiness in the public health care sector were presented in relation to their meanings and relevance to, for example, wages, strikes and go-slowswith resultant negative effects on human resources and service delivery in the country. Psychological problems commonly associated with high demand work, such as stress, burnout, anxiety, frustration and aggression, were defined and discussed in relation to the effect they have on the health care practitioners own health and how they may affect self-actualisation. South African laws pertaining to governance, principles and their relevance for health care practitioners was explored in terms of the South African Constitution, the Bill of Rights, “Batho Pele” public health care service principles, the National Health Act and the South African Patients’ Rights Charter. Health care practitioners’ rights as well as patients’ rights were presented in order to place people as individuals and collectives into the health care landscape as a whole; one not being able to function effectively without the other. Brief opinion pieces of various health care systems around the world placed the health care service in South Africa into a more global/holistic context, providing opinions about challenges and triumphs other countries’ experience. The international context was considered important, relevant to the
“brain-drain” currently experienced in the country for what health care practitioners perceived as “greener pastures”. Diseases such as HIV/AIDS, TB and related burdens of disease were presented in order to understand the current rise in the population needing treatment and the resultant exposure to those diseases of health care practitioners caring for them. These inevitably also affect the health care practitioners and result in losses of valuable human resources. Loss of personnel through other factors such as the “brain drain”/emigration, job dissatisfaction, essential services breakdowns, grievances and poor working conditions were also presented and highlighted with particular emphasis on the costs to the country of training health care practitioners. The chapter concluded by discussing relevant psychological theories and their relevance to health care practitioners’ lives in the uThungulu District community. The two theories (Bronfenbrenner’s bio-ecological systems theory and Maslow’s hierarchy of needs) provided the context within which the socio-emotional circumstances and needs of health care practitioners as individuals and as part of a community may be placed in order to provide a framework of reference/understanding for good quality-of-life criteria deemed important for community and/or individual psychological health. This chapter provided the details of, and contextual reality in which to holistically get “a sense of” and conceptualise the landscape in which the experiences of the research participants occurred, not only within the uThungulu District and health care system, but in South African society and the world. There are often complex bio-psycho-social factors which may not be properly understood without some explanation and especially in a populated rural community such as the one in this study.
Chapter 3
Methodology

“It is not what your ship will not do that you want to know, to get on terms of successful partnership with her; it is, rather, that you ought to have a precise knowledge of what she will do for you when called upon to put forth what is in her by a sympathetic touch.”

J. Conrad, the Mirror of the Sea.

3.1 Introduction

This chapter presents the philosophical orientation, the research process, research methods, data collection process and three-level process of analysis which was used in the present study. Bracketing/additional information was included where it was felt relevant to the holistic understanding of the study and methodology. The present study departed from a qualitative, general phenomenological orientation. Data were obtained from a non-probability, convenience sample of 30 health care practitioners in the uThungulu District of KwaZulu-Natal. Participants responded to five questions on a self-report open-ended questionnaire which was compiled by the researcher. Data analysis consisted of three levels of subsidiary data analysis, as per the descriptive, social constructionist and interpretive paradigms. Thus, at each of these three levels, participants’ experiences, as reflected in their written responses to the five research questions, were described, explicated and interpreted. In other words, the more abstract term/concept of “analysis” as it is used in the present study “refers mostly to “data analysis” holistically, as well as the different levels as per the three paradigms. Therefore, terms such as “description, understanding, explication and interpretation” refer and are especially relevant to how the data was actually analysed. This multi-level analysis increased the overall reliability, validity and trustworthiness of the study and provided a holistic, deeper understanding of the data.

3.2 Phenomenology as philosophical orientation

Through the present study’s focus on participants’ individual experiences, feelings, convictions, perceptions and beliefs, its orientation was therefore felt to best describe, reflect and reveal the “subjective realities” of participants and how their responses could best be understood. A holistic context, encompassing reflexive
description and explication of the data from the relatively more superficial of the three paradigms, the descriptive paradigm (as “coarse sieve”), followed by the social constructionist and interpretive paradigms, facilitated an overall interconnected and synergistic process of analysis.

At the first level of analysis, data were described and explicated with the intention to reflexively “consciously suspend any assumptions” to allow participants’ original experiences to be reflected and “open into” the realm of this study not only to learn from them, but also to mutually influence each other. “Our unique existences are essentially intersubjective and radically social”, inevitably allowing us to “see original, new worlds with new eyes” and “in a new way of living in a new world” (Edwards, 2001, p. 2). The researcher, having previously worked in the health care sector, held her own opinions from her experiences, which in turn informed her beliefs and perceptions of the South African health environment. As such, her experiences became the inspiration for the Stoyanov (2011) study, followed by the present study, which encompasses a broader spectrum of health care practitioners who, she thought, were similarly affected by the South African health care system. The researcher made every attempt to bracket out all biases and suspend her own assumptions and prejudices, so as to faithfully reflect the experiences of participants in their original fresh reality, while still remaining conscious of her experiences prior to this research while analysing the data and writing-up the findings and discussion.

3.3 Community context

According to Holloway and Wheeler (2002, p. 34), context is a significant part of qualitative research and incorporates the “environment and conditions, in which the study takes place, as well as the culture of the participants and their location.” Participants in the present study were a part of the community in terms of their “belongingness “in the district health care settings and their relevance to the two psychological theories described in this study, being a community psychology study (these two theories include Bronfenbrenner’s bio-ecological systems theory and Maslow’s hierarchy of needs, which are described in more detail in section 2.15 of chapter 2).
Thus, the research could not be explored or studied outside of a community context and remaining mindful of the purpose of this research, which was to take a “snap-shot” of participants’ experiences in the current health care delivery system in South Africa, the selection was deemed adequate. Therefore, the important consideration was the timing and the context of participants’ lived or day-to-day experiences, their perceptions, thoughts, feelings and responses in order to elicit the richest response material, reflective of their sense of place in the community they served.

3.4 Intention of the study

The present study was exploratory in nature as there is currently very little researched information available relating specifically to health care practitioners’ experiences of the health care delivery system in the uThungulu District and indeed in South Africa. The researcher’s previous 2011 study (Stoyanov, 2011) concentrated on the health care experiences of medical practitioners only and it was therefore the intention to expand the sample. Through this exploration, a broader spectrum of health care practitioners’ experiences would become exposed, “heard“, “seen “and understood. The present study thus provides a valuable outlet and opportunity for health care stakeholders to understand the contexts in which health care delivery takes place, especially in terms of its valuable human resources, the health care practitioners, who are the very people on whom South Africans rely for health care and service delivery.

3.5 Purpose of the study

The purpose of the present study was firstly, to follow up on the limited Stoyanov (2011) study and secondly, to enlarge and diversify findings through targeting different professions found in the health care system in order to generate accounts of their experiences in their work settings, with a view to finding solutions to problems.

In building on the Stoyanov (2011) study, answers to questions such as whether other health care practitioners had similar experiences as medical practitioners and what those were, would be considered valuable in terms of knowledge-sharing as well as gaining views from health care practitioners themselves. Thus,
the research is triangulated, reflective of both studies (the 2011 and present study) existing on a continuum. These “snap-shots” provide progressively deeper insights, albeit from a small area in South Africa, into the perceived status of health care and salient issues affecting the general population who use health care services.

3.6 Research process

The present study was carried out in three stages:

1. Stage 1: conceptualisation and permission
2. Stage 2: Recruitment of study participants, data collection and transcription
3. Stage 3: process of data analysis

3.6.1 Stage 1: Conceptualisation and permission

At the conceptual stage of the present study, the topic was discussed with the original promotor, Professor H.S.B. Ngcobo, and the methodology was conceptualised and approved by a committee of professors and lecturers affiliated to the University of Zululand during their selection process for doctoral students. Thereafter, the study’s protocol was submitted to and approved by the Ethics Committee of the University of Zululand (Addendum D). A letter of support was sought and granted from the largest hospital in the uThungulu District, Ngwelezana Hospital (Addendum F). Permission was sought and received from the KwaZulu-Natal Provincial Administration to conduct the research (Addendum E) with a proviso of a progress update (which was fulfilled) and for feedback, once the study was completed. There was no pre-requisite or restriction incumbent on the researcher to acquire permission from private sector participants and non-governmental organisations for the research. There were no restrictions regarding contact with health care practitioners outside of working hours and away from their places of work. Identities of participants and places of work and personal details were kept confidential for the purposes of this research, as it was felt that identifying and/or “exposing” participants would hamper the openness of their responses and willingness to participate. Hence, in all transcripts and other research material participant’s biographical details are replaced with symbols
3.6.2 Stage 2: Recruitment of study participants, data collection and transcription

The questionnaires and related information, such as participant information required, open-ended questions, information leaflets and consent form (Addendums A, B and C) were distributed to participants in the public and private health care sectors over an eight-week period (from May to June 2013) and collected during the month thereafter (July 2013). No manipulation of the data occurred and it was purely qualitative in nature. Some of the participants in the sample were recruited by way of a snowballing technique which enabled the researcher to identify less visible participants for the study (Mack, Woodsong, Macqueen, Guest, & Namey, 2005). Participants were approached personally and telephonically by the researcher or were contacted by colleagues. The open-ended questionnaire, description of the research, research topic, contact telephone number of the researcher, and consent form were given to participants in sealed, numbered and coded envelopes. The research concept was explained to each participant and the same processes were followed in accordance with ethical considerations for the study. Approximately half an hour was spent with most participants and/or participants responsible for handing the research to colleagues, at a convenient time such as after hours or during lunch or tea breaks. Opportunities to ask questions were provided and participants understood that they were able to withdraw from the study and/or contact the researcher at any time. Participants were informed that their data would either be collected from them or they could deliver it to the researcher if it suited them better. Some participants delivered their responses to the researcher personally or to a third party, who delivered them, sealed, to the researcher. Most participants expressed their interest in the outcome of the research, felt it was valuable and hoped that their contributions would make a positive contribution to the lives of all health care practitioners and the people they served.

The responses to the self-report open-ended questionnaires were transcribed verbatim (Addendum G), typed and stored safely. Every attempt was made to ensure, as far as possible, that no meaning was lost in relation to the data as it
was transcribed and explicated. Participants communicated competently with the researcher in English. Though some of the participants spoke English as their second language, they still chose to speak English to the researcher as it was comfortable for them. None of the participants requested or required an interpreter or translator. The researcher is fluent in English and Afrikaans, and has learned to understand Zulu and can communicate in Zulu on a basic level. The researcher has attended cross-cultural workshops and also made use of a Zulu/English health care translation book for health care practitioners working in the health care environment. Living in the predominantly Zulu-speaking regions of KwaZulu-Natal for the past 30 years helped the researcher to foster cultural sensitivity and interpretation. Thus, in the interests of the meanings of participants’ experiences being interpreted and where minor grammatical errors occurred, some meaning could have been lost or overlooked, but it is the sincere belief that this did not happen at all. Participants appeared to understand the research information easily and were able to seek clarity at any stage of the research and, as such, it was assumed that the responses in the transcripts reflected the true meaning and intention of participants.

3.6.3 Stage 3: Process of data analysis

Prior to commencement of the analysis, the researcher suspended and bracketed out all biases, as she had previously worked in the health care environment. Thereafter, reflexivity was used in the analysis and explication process, in order to remain faithful to the experiential data in the most effective way. A line-by-line analysis, using a similar approach to that described in Vaughn, Schumm, and Sinagub (1996) was used. Analysis was conducted in four phases, including: (a) identifying the overarching ideas; (b) unitising the information; (c) categorising the units; and (d) identifying narratives, themes and discourses.

Phase 1 – Identifying overarching ideas, discourses, narratives and themes

The researcher read the transcripts many times in order to gain a greater understanding of the textures and layers of the health care practitioners’ experiences as they became revealed and exposed to her. The process of reading and re-reading recursively and reflexively refined the process of analysis and explication and became more focused as the process progressed, allowing for
meanings and abstract meanings to reveal themselves. The process of reading and re-reading is often described as detective work because of the process of scrutiny that is involved (Vaughn et al., 1996).

**Phase 2 – Unitising, grouping and processing individual information**

After identifying the overarching ideas, discourses, narratives and themes (Phase 1), care was taken to be as objective as possible in searching the responses. Responses were analysed in a line-by-line manner, with experiences being grouped into individual meaning units. The main goal of this process was to individualise each participant’s unique set of data (Vaughn et al., 1996) and remain faithful to them.

**Phase 3 – Categorising units into themes, narratives and discourses**

The researcher implemented phase 3 by grouping or categorising the identified individual units from Phase 2 into themes, narratives, discourses or categories that were meaningful to each of the individual participants. These were then grouped together in order to ascertain whether they were related to the same overarching idea of Phase 1. In this manner of selective processing, the researcher began to form initial headings that were used as an outline or a “road-map” to classify the data even further (Vaughn et al., 1996).

**Phase 4 – Identifying the themes, narratives and discourses**

The last phase of the process of analysis was the completion of identification of themes, narratives and discourses. This involved further re-examination of the overarching ideas (Phase 1) to determine whether there was sufficient support for the units of individual information of Phase 2 and units of categorisation of Phase 3. Similarly, this phase examined whether there were any contradictory narrative categories or themes in relation to Phases 1, 2 and 3.

**3.7 Triangulation**

On the first level of analysis which involved the descriptive paradigm, a mixed methods research approach, using the convergence model, was adopted (Creswell & Plano-Clark, 2007). “Mixed methods research is the class of research,
where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study or set of related studies” (Johnson, Onwuegbuzie, & Turner, 2007). It is argued that the convergence of results/findings by combining two or more methods “enhances our beliefs that the results are valid and not a methodological artefact” (Johnson et al., 2007).

Johnson et al. (2007, p. 210) stated that:

All research is interpretive, and we face a multiplicity of methods that are suitable for different kinds of understandings. So, the traditional means of coming to grips with one’s identity as a researcher by aligning oneself with a particular set of methods (or being defined in one’s department as a student of “qualitative” or “quantitative” methods) is no longer very useful. If we are to go forward, we need to get rid of that distinction.

Therefore, the rationale for choosing a triangulated, mixed methods research approach was in the expectation that it would produce superior outcomes and findings in the present study (Johnson et al., 2007), as these mixed-methods helped to deepen and thicken the explication of the findings. In the present study, the use of three paradigms: descriptive, social constructionist and interpretive, or ways of viewing the participants’ experiential data were considered unique and appropriate. Because the researcher had previously worked in the health care sector, this multi-level analysis was deemed to provide/promote greater validity, reliability, trustworthiness, honesty and integrity in her interpretation, whilst simultaneously facilitating a “richer tapestry” of participant experiences in different contexts. According to Ragin (1994), qualitative data enhances analysis by adding more detail, whilst quantitative analysis condenses data in order to reveal patterns in general. In the present study descriptive statistics (quantitative data) were obtained in two ways: a) by means of assistance from a statistician, Dr H. Moolman, and b) through the employment of NVivo application software. These strategies also served to reduce potential investigator bias. Participants’ biographical data, i.e. personal details, were collected as supporting and basic data to enhance the critical exposure focus as part of the descriptive analysis.

In that sense, the present study was not only an extension of the researcher’s
previous 2011 study, but a triangulation of the data that also served to consolidate the two studies (the 2011 and present study) as existing on a continuum and therefore becoming complementary to, rather than opposing each other. Therefore, instead of relying on the strengths and weaknesses of single method designs, the present study employed a “combination of methodologies to study the same phenomenon (i.e. the experiences of health care practitioners).”

Greater accuracy, from multiple viewpoints, is likely to be obtained if one follows the principles of basic geometry (Jick, 1979) developed by Campbell and Fiske (1959). They proposed the concept of “multiple operationism” and argued, “more than one method should be used in the validation process to ensure that the variance reflects that of the trait and not the method”. Thus, the convergence or agreement between two methods “enhances our belief that the results are valid and not a methodological artefact” (Jick, 1979).

If one uses triangulation within a study (such as descriptive, social constructionist and interpretive paradigms), internal consistency or reliability is involved and if one uses the method between comparison groups to attain further confidence in emergent narratives and experiential themes, triangulation tests the degree of external validity. A further aspect of triangulation that can be considered important and which is beyond measures for variance, is the capturing of rich, holistic and contextual information, offering unique variances that single methods would not, thereby examining the same data or phenomenon from many perspectives and allowing deeper facets of understanding to emerge. This also allows for the weaknesses in one paradigm to compensate for the weaknesses in another and then being able to decide whether or not results have, in fact, converged. Although replication of results is very difficult to attain (Jick, 1979), the point of the present study was not to try and replicate the previous 2011 study, but to offer a deepening of insights, in order to better define the previous findings.

Thus, because reality can be construed as a “confused reality”, in that it is difficult to investigate or explore a phenomenon in its totality, the complex realities of the health care practitioners in the present study were thickened by the use of triangulation, or multiple methods of analysis. In so doing, it offered a partial solution (Borg & Gall, 1989, p. 393) to the critical analysis around health care and
related health care practitioners’ experiences.

3.8 Rationale for choice of methodology

Qualitative research was aptly described by Burns and Grove (2003, p. 19) as “a systematic subjective approach used to describe life experiences and situations to give them meaning.” In order to gain an in-depth “snapshot” from of a sample of health care practitioners in South Africa, a qualitative enquiry was best suited, as the process of developing an understanding of an individual’s personal experience is fundamental to qualitative research. The explication of the data was therefore progressively deepened by means of multi-level analysis using the descriptive, social constructionist and interpretive paradigms to explicate the findings.

Because the social world is extremely complex and, as such, a great number of factors and patterns interact with each other in a complex way, it is often difficult to reduce the intricate social phenomena of the health care practitioners’ worlds by using only univariate statistical methods (Terre Blanche et al., 2006, p. 242). To support this statement, there has been a recent debate about the shift in psychology discourses away from empiricism towards social constructionist approaches. This was prompted partially by the realisation that psychology subject matter best requires the researcher to apply more of a productive interpretation process than simply a descriptive one. Therefore, by moving from empiricist to social constructionist epistemology, psychological researchers also reject individualistic, dualistic and mechanistic understandings of the subjects or objects of their study (Durrheim, 1997, p. 15). In so doing, the present study aimed to describe and explain how certain concepts of the way in which health care practitioners experienced their realities, become passed on as truth, becoming their fixed realities as a result (Durrheim, 1997).

The process of data analysis which is considered to be specific and unique to the present study, did not view each level of description and explication in terms of a single methodological research paradigm, but rather as a synergistic and systematic process of deepening of and/or exploration of participant experiences by using three accepted phenomenological paradigms: the descriptive, social constructionist and interpretive. Metaphorically, this holistic process of data
analysis can be described as “Russian nesting dolls or Matryoshka dolls”, which consist of a series of wooden doll-figures that can be pulled apart, each revealing a smaller version within the whole, central to peripheral and vice-versa. The diversity of the figures, in shape and/or size might be symbolised concepts, within which to describe and interpret how various analyses are similar, but different in each paradigm, each revealing health care practitioners’ experiences in different ways. The very concepts of self and self-in-community/country/world/universe forms part of this metaphor as they are interrelated levels, which function simultaneously as wholes and parts of wholes within the synergistic system.

Therefore, ontologically, the research was concerned with health care practitioners’ daily existences within the health care system. Epistemologically, it was concerned with the processing of these health care practitioner’s perceptions, experiences and knowledge. Methodologically, it involved interpretation of interactions with health care practitioners’ experiences by collecting data, and technologically, responses to five qualitative open-ended questions were used to describe participant experiences; analyse the meaning of these experiences; and use these experiences to explicate meaningful discourses, themes and narratives and the synthesis of these.

3.9 Research strategy

The qualitative, general phenomenological orientation approach and strategy of the present study included suspension of personal assumptions; the conceptualisation of the topic; planning the methodology as a whole; defining the rationale; collecting the data; and the process of data analysis.

The researcher’s original promoter, himself a health care practitioner, helped her to devise the ideas/topics for her previous 2011 as well as the present study. Both these studies were undertaken to explore and reveal ordinary/everyday health care practitioner’s experiences of the South African health care system as there appeared to be a gap in the research pertaining to this sector of health care. Essentially, the idea also included gathering data which could be used to inform policy-makers about suggestions for improvement to health care from the health care practitioners themselves.
Using self-report open-ended questions versus face-to-face interviews was a consideration during the planning phase of the present study. Self-report open-ended questions were considered favourable to avoid participants giving socially desirable answers. Participants were aware that permission was granted for the research to be conducted by the KwaZulu-Natal Department of Health, and if the researcher employed face-to-face interviews some participants may have resisted voicing their opinions and/or complaints if they thought that an interview might be used for government purposes and/or was gathered via a covert government- or other representative. Thus, allowing participants to reveal their experiences through their written responses in their own time and privacy (confidentially and openly), was considered important in that their experiences, perceptions, feelings and opinions would be obtained directly from them, thus preventing bias.

In order to systematically deepen and thicken the analysis of health care practitioners’ experiences/responses and because the sample was limited, the researcher decided to use a multiple methods and triangulated approach to obtain results in the study as per the descriptive, social construction and interpretive paradigms (superficial to deep) in a holistic context to provide richer findings and to improve the reliability and trustworthiness of the data. Often, methodologically, all researchers want to do is to reduce complexity of data into statistics to better understand the phenomenon (Terre Blanche et al., 2006, p. 242), this was however not the case in the present study. Because the researcher was unsure of what the variables in the study would turn out to be, she embarked on a more inductive, open-ended exploration method instead. This method of research has now been accepted in medical research and most social science perspectives (Terre Blanche et al., 2006, pp. 272-273) and was deemed a “demand driven” tool for exploring the context within which health care practitioners worked. By their involvement in the present study, health care practitioners would be able to feel that research was connecting their opinions with policy-making authorities and, as such, it was hoped that they would feel like valuable agents of change. The South African Government, by all accounts, is aware of the problems in the health care system, but seems, often, to be perceived to be unaware of some of the causes. In some other parts of the world, for example China, evidence gathered from demand-driven research through responding to people’s needs, allowed its
government to justify revised resource allocation in their health services (WHO, 2012).

Therefore, this type of research provided a vehicle for health care practitioners to feel valued within the health care system, creating more awareness of the part that government should or needs to play in collaboration with them as important catalysts for change “on the ground” in order to learn from them and grow health care policies/systems that are meaningful. Finding solutions to problems through their dynamics, as reflected in their working environments in health care, provides an opportunity for government to include health care practitioner’s suggestions in future policy frameworks via consultation.

3.10 Sampling and sampling frame

The present study employed a non-probability, convenience, purposive sample, complemented by snowballing techniques, where necessary.

Purposive convenience sampling enabled and facilitated the researcher’s use of judgement to select cases that would best enable and/or facilitate the responses to the research questions and meet the objectives of the study. Purposive sampling is therefore most suitable when working with smaller samples as it enables the researcher to select cases that are particularly informative (Saunders, Lewis, & Thornhill, 2009, p. 237).

The sample used in the present study was therefore considered adequate to answer the research questions. While these types of smaller qualitative samples may be deemed a methodological limitation in terms of social desirability, the advantage of this type of exploratory research study was that it is evaluative by nature and any limitations could be addressed through further and larger studies across the entire country, by using larger samples in future studies.

The sample consisted of 30 (N = 30) adult registered health care practitioners from the public and private sectors, currently working in health care systems in the uThungulu District of KwaZulu-Natal. Participants were sampled from local hospitals, clinics and private practices over an eight-week period between May and June 2013. Completed questionnaires were collected from participants during the second stage of the study, i.e. in the month after the eight-week period, July
2013. A total of 12 responses from the 15 public sector sample and 14 from the 15 private sector sample were returned. The sample was equally divided between these two sectors (15 from each) as health care in South Africa is strictly divided into these two categories. The private sector is perceived to meet the expectations of world-standards, whilst the public sector experiences major limitations in terms of high patient numbers and public demand. This situation is also a reflection of the past socio-political system of apartheid in South Africa and the deficits it created through separate development of different population groups (Apartheid is described in more detail in section 1.4.2.2 in chapter 1). These historical factors inevitably affect health care practitioners working in the public and private environments differently.

The selection of participants did not depend on whether they would still be working in these sectors in time to come, as practitioners may leave the area due to many possibilities such as internships, community service obligations, further specialisation, training, post changes, resignations, relocations, transfers, emigration, and so forth, as these form part of the realistic or actual and transient milieu of health care practitioners in South Africa. Age, race and gender were also not considered as selection criteria, as there is a limited pool of health care practitioners in the area. However, for basic descriptive purposes, these biographical statistics were made available in the descriptive paradigm (level 1).

Inclusion criteria for all participants were their qualification as health care practitioners and, as such, their assumed registration with the health statutory bodies of their respective professions. An attempt was made to access more junior health care practitioners in the health care system in order to obtain results that reflected a more “grass-roots” or “bottom-up” rather than a “top-down” approach/perspective as it was felt that those participants might have had the closest contact with the community, thus being reflective of an apparent lack of research in that area of health care.

The spectrum of health care practitioners who took part included nurses, medical practitioners, psychologists, occupational therapists, dieticians, physiotherapists and radiographers. All participants from the public sector were employed as salaried government health care practitioners and those from the private sector
were either salary-employed or self-employed (owned private practices). The sample was considered appropriate to satisfy the saturation criteria needed for the important and central investigation of the participants’ experiences.

Participants were selected for their willingness to participate, their proximity to the researcher’s current home and workplace, and/or their enthusiasm for articulating their experiences through exploring and describing these. All participants were simply involved in their normal everyday working activities as would be professionally expected of them.

In order to recruit participants the researcher, over an eight-week period (May to June 2013), visited numerous departments, spoke to some heads of department, who happened to be there at the time, contacted health care practitioners, those who were available and/or who had previously had conversations with the researcher about their experiences in the health care system, clinics and private practices, as well as word-of-mouth referrals. All participants made themselves available during their meal-intervals, specified times or after-hours, either personally or telephonically, in order to familiarise themselves with the research requirements and details of participation as well as to return the data.

Data were collected, at a time and place convenient to participants, with the cut-off date set for the end of June 2013. Participants either returned their responses in sealed and numbered envelopes, which were assigned to them or the researcher collected the data when participants called to say that it was ready.

The sample selected for this study was felt to have “filled a gap” in health care research in South Africa in terms of its description of the everyday health care practitioners’ experiences. In this undertaking, the vested interest of the researcher cannot be overlooked, due to her previous professional experience in the public and private health care delivery service over the years. As such, the researcher reflexively became “a part of “the participants, through her own experiences as well as during conversations undertaken with others over the years, with regard to issues such as service delivery, psychological stressors and views and beliefs, which were experienced as part of everyday life in those settings. This researcher involvement therefore provided an important part of the
motivation for the 2011 and present studies and, as such, is interventionist in its approach, with the researcher fully “emerged” in the research process at all levels.

3.11 Open-ended self-report questionnaire

The self-report open-ended questionnaire was considered the best manner through which to gather the desired rich data pertaining to participants’ experiences of the current health care system. This questionnaire afforded participants the freedom to formulate their own responses in their own time, rather than restricting them to a list of pre-coded categories (Clark, 1999). Furthermore, the questionnaire had the potential to illicit responses that would vary in length, ranging from many pages to simple sentences. Therefore, this approach to data collection sought to support health care practitioners’ underlying individual needs in relation to the extent to which they decided to elaborate in their responses (Terre Blanche et al., 2006, p. 486). Because the researcher had no prior knowledge of possible responses, the open-ended questions were left entirely to the participants to interpret and answer (Payne & Payne, 2004). Thus, participants were not influenced in any way, which they could have been if, for instance, face-to-face interviews were conducted. Interviews could have resulted in participants being suspicious that the researcher represented a health establishment or organisation, and this in turn may have prompted them to provide socially desirable answers.

Open-ended questionnaires are therefore good vehicles for descriptive or explanatory research, allowing for the analysis of participant attitudes and opinions to be identified with “variability in different phenomena”, enabling relationships between variables to be explored, in particular, cause-and-effect relationships in the analysis (Saunders, Lewis, & Thornhill, 2009, p. 362). The open-ended questions were deemed to be appropriate in this study as the best way to obtain data as health care practitioners interact with each other daily and, as such, also speak and listen to each other, which, in turn, constructs meaning.

The open ended questionnaire was compiled by the researcher and each of the five questions was designed to elicit information about various aspects related to the health care delivery system and formulated with a view to gathering rich and
diverse data from various categories of health care practitioners ‘experiences in the political, social and personal community landscapes in which they worked and lived at that time. It was anticipated/hoped that the health care practitioners in the sample would not find the questionnaire challenging, but rather view it as a suitable outlet for their experiential, subjective expressions in the privacy of their own settings, instead of, for instance, in a face-to-face interview scenario that could possibly have elicited skewed/biased responses and/or other distractions.

Open-ended self-report questionnaires were chosen in order to allow participants to formulate their responses themselves (Huysamen, 1994), rather than being restricted to choosing from a list of pre-coded categories (Clarke, 1999). Leaving the answers entirely to the participants was considered best, because the researcher either had little prior knowledge of possible responses, or felt that responses that were more detailed could add depth to the study (Payne & Payne, 2004).

**Conceptualisation of the five open-ended questions**

The five open-ended questions were conceptualised to reveal different aspects of experiences relative to the health care system and how health care practitioners perceived/described them.

**Question 1: How are you experiencing the current health care system?**

It was anticipated that this question would elicit the thickest responses to health care practitioners’ lived experiences and therefore, it was left “open” without any specific clues or pointers. It was presumed that participants could “freely associate “their responses and project or interpret them accordingly. In the researcher’s previous 2011 study, which only had one question, “How are you experiencing the current health care system?” rich narratives were received in the responses. It was thus decided to use a similar question in this study, for similar and comparative/reflective reasons.
Question 2: What are your views about the proposed changes within the health care system?

Question 2 was geared towards understanding the scope of participants’ knowledge of the legislation being tabled and implemented with particular interest in eliciting information and gauging their knowledge/exposure to the NHI and their interpretation thereof. It was envisaged that insights and ideas gained from health care practitioners could result in helpful recommendations which could be passed on to policy-makers and other interested parties and stakeholders in the health care industry.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

It was anticipated that ideas and recommendations for positive change would emerge from this question, which could potentially provide stakeholders with solutions for problems relating to overall service delivery in the current health care dispensation, and which (it was hoped) would be more “needs-driven”. Therefore, health care practitioners, as the valuable human resources essential for effective medical service delivery, were the people, who were deemed “qualified “to make suggestions for changes to the health care delivery system and its stakeholders (i.e. other health care practitioners, patients and relevant health care structures).

Question 4: Do you have any experience in your field outside of South to Africa? If you do, please discuss your experience.

Question 4 was formulated with the intention of enabling to provide participants to provide further/expanded responses with a view to understanding the degree to which they were exposed to having worked outside of South Africa and how many of them were from the public and private health care sectors and what those international experiences meant to them personally and professionally. Because health care practitioners migrate, responses were considered valuable to ascertain the value (or not) of migration.
Question 5: Would you consider leaving South Africa and, if so, why?

South Africa has faced the impact of professionals emigrating otherwise known as the “brain drain” (brain drain is discussed in more detail in section 2.13.1 of chapter 2) of its health care practitioners (Pillay & Kramers, 2003) on a large scale, for some years. Because of this, the question was framed with a view to finding possible reasons for the consideration to emigrate as well as possible solutions to the causes of them emigrating, which may make the South African health care system more desirable; thereby stemming the exodus of valuable human resources. Much government and tax-payers’ money is spent annually on educating health care practitioners, only to see them absorbed into other countries which benefit from their expertise instead. Although this is considered a problem for countries worldwide, the African continent is especially affected and this question sought to elicit experiences and/or expressions thereto.

In summary, questions one and four provided material which allowed the researcher to explore the lived-world experience of health care practitioners. Furthermore, questions two and three dealt with ideas, which participants might have had regarding health care delivery. Although question five may have appeared to be an add-on question, it was included in order to elicit any indications of whether participants’ responses to the first four questions might have influenced their decision to leave or stay in South Africa. In that sense, it was deemed to tie in with the underpinning of key questions with regard to the research, which was essentially exploratory in nature and aimed at achieving a more detailed understanding of the health care system and the current skills shortages the country is facing in the health care sector, with particular reference to the “brain drain.”

3.12 Data analysis involving three paradigms and/or levels of description, explication and interpretation of participants’ experiences

Data were analysed and explicated for prevailing narratives, themes and discourses that emerged, as per the descriptive, social constructionist and interpretive paradigms respectively. Gaining different levels of insight into the phenomena and through searching progressively and recursively for recurring
themes, discourses, narratives, experiences, feelings, reflections and abstractions, these methods of analysis added to the holistic approach that was envisaged for the present study. Each paradigm essentially thickened and deepened the analysis and explication, providing different emphases (e.g. the descriptive paradigm simply “describes” the data as is; the social constructionist paradigm searches for social meanings that the data may hold; and the interpretive paradigm seeks to illicit deeper meanings from data), which became apparent in the extraction of meanings as they revealed themselves. In other words, as the researcher progressed through the process of analysis from the descriptive to the social constructionist and then to the interpretive paradigms, the data was analysed keeping different underlying goals in mind. Careful attention was paid to recurring descriptions, themes/narratives and feelings as the explication progressed at different levels and “depths”, using the metaphor of the “Russian doll concept” within which to understand the dynamics of the settings in which participants found themselves.

Extracts from participants’ transcripts were included verbatim, where applicable, but all identifying information was deleted/disguised (use of xxxx) in order to protect and ensure anonymity. Minimal changes were made to the extracts to make them readable/understandable, but these were insignificant and were not intended to alter the original meanings. Some sentences were altered, lengthened, or shortened in order to exclude extraneous information, with the use of punctuation marks, i.e. … and xxxx

3.12.1 Description, interpretation and explication of data

As mentioned above, data were analysed at three levels:

1. Descriptive level: experiential responses revealed in concrete terms and their clusters were arranged into main themes, categories and issues. Descriptive statistics were obtained to establish trustworthiness.

2. Social constructionist level: to amplify the narratives, discourses, textual patterns in the words and sentences, reflecting what participants repeatedly said about their social truths within the health care delivery system.
3. Interpretive level: explication of participant’s in-depth experiences and their underlying feelings.

The inclusion of the three paradigms meant that all the data became a part of the study’s general phenomenological orientation, which was essential and central to its design and allowed different levels and depths of participants’ experiences to emerge within a community psychological context (Terre Blanch, Kelly, & Painter, 2006). Each level therefore had a unique character (as described above) (Morse, 1994) and these levels complemented each other with regard to the central concern of the thesis, which was described as interventionist in attempting to offer some (albeit minimal and incomplete) solutions to problems in relation to the current South African health care delivery system and its health care practitioners. In that sense, within its context and structure, the orientation and methods provided “transformative” value to the study (Edwards, 2001, p. 6) and the best and most appropriate/unique way to honour and reflect the experiences of the health care practitioners.

Particular attention was paid to the context of knowledge construction throughout the process of analysis, reflecting the aim of using multiple levels of description and explication to ensure that quality, rigour, reflexivity and trustworthiness were enhanced. It was considered that the uniqueness of analysis techniques added different textures and deepened insights into the dynamics and meanings of the participants’ lived experiences and, as such, were also considered to be triangulated. Meanings were enhanced and understood more holistically, and thus stayed as true to participant experiences as possible with each paradigm complementing the other. As major units of meaning were extracted and expanded upon, and sub-narratives/themes identified as they emerged from those, meaning was derived on numerous levels.

3.12.1.1 Descriptive paradigm (first level of analysis)

Following suspension of all personal assumptions, especially with regard to prior work experience in the health care system, it was considered appropriate in the analysis and explication process to “sift through the diamond-bearing material, and not miss the diamonds”, thus using this first level paradigm as a “coarse sieve”. As the research was intentionally interventionist and undertaken with research
questions in mind, in order to further suspend personal bias and improve objectivity, the use of statistics/mechanical analysis was incorporated. From her own experiences, the researcher had also formed personal impressions of the issues inherent within health care and wanted to bracket out and temporarily suspend her own ideas and biases through the assistance and employment of independent statisticians/analysts and quantitative statistics. The subsequent analyses (Mann-Whitney Test and NVivo Qualitative Analysis), as a first step in the description, were followed by the second level of social constructionist, and third level of interpretive analysis.

Therefore, the descriptive paradigm (statistics and description) was essentially considered to be more “superficial”, but no less important, while simultaneously promoting and providing validity, reliability and trustworthiness in the study. In devising the descriptive framework, the main features/issues relating to the research were identified and predicted, such as whether there might be relationships between the themes in the five open-ended questions which were used to collect the data (Saunders, 2009). These reflections inductively directed the descriptive analysis process and thereafter holistically informed the social constructionist and interpretive paradigms, which were each metaphorically “nested” within the other.

The descriptive paradigm, or first level of analysis, which described, revealed and summarised participants’ experiences, was enhanced by the use of descriptive statistics techniques, improve and Nvivo Qualitative Analysis. This paradigm therefore highlighted specific details relating to health care practitioners’ experiences and established the “how” and “why” of their responses as a first step towards understanding the phenomena being studied (Collins, Du Plooy, Grobbelaar, Puttergill, Terre Blanche, Van Eeden, Van Rensburg, & Wigston, 2000, p. 95). According to Saunders et al. (2009, p. 445), “descriptive statistics enable you to describe (and compare) variables numerically”, thus providing enough flexibility during the first part of the analysis of the study. This was undertaken with as much reflection as possible and prudently applied. The general strategy was to essentially organise the data in a way that would resonate with the readers, who could then form their own judgements (Elliott & Timulak, 2005, p.
Descriptive statistics:

a) Mann-Whitney Test (Mann, 1947)

A statistician, Dr H. Moolman, assisted the researcher in analysing the descriptive data, using the Mann-Whitney Test (non-parametric equivalent of the independent samples t-test), one of the most popular statistical techniques, used because of its suitability to the practical application of the study. The Mann-Whitney is a test that is reasonably easy to use and understand, and it produces results that can be easily interpreted (Maree, 2012). It is a non-parametric test that can be used when two independent groups need to be compared, based on a single variable, namely the non-parametric equivalent of the t-test for independent groups. It is useful to apply the Mann-Whitney test rather than the t-test, when the samples from the populations are small (less than 30) and it cannot be assumed that the study variable is normally distributed in the population (Maree, 2012, p. 233).

After the Mann-Whitney test was applied, summaries condensed the data into fewer words with meanings, findings and main issues/themes summarised from the context. Key points and observations were made, then combined into one document (Saunders, 2009) and synthesised. Based upon descriptive data, the Mann-Whitney test simply ranks the derived, existing, descriptive data into categories such as private-public, male-female, older-younger and so forth.

b) NVivo Qualitative Analysis

NVivo is a specialised qualitative data analysis software program (www.qsrinternational.com), which has the capability of organising and enabling in-depth analysis of rich and/or voluminous data sets.

The NVivo analysis was performed by Dr Pinadai Sithole from the Centre for Development, Research and Evaluation (CeDRE) International Africa, after an in-depth consultation and brief of what the requirements and strategy of the research entailed. In devising the NVivo qualitative data analysis, the researcher reflexively suggested or discussed some information in telephonic or “Skype” discussions
with the chief analyst, which included (amongst others) the use of summaries of identifying information, “unpacking” and amplifying narratives and discourses or themes (manifest and latent meanings) that emerged from the initial reflection on the manual and statistical narratives/discourses/themes. It is acknowledged that this type of reflexivity can influence the results of an analysis tool such as NVivo. The discussions around the use of the program did, however, include the brief, which was to allow the program to identify themes through its own coding system and apply those appropriately as per the program and as seen fit to do by the specialists in this program.

Data were analysed from participants’ responses to the five open-ended self-report questions, which were captured in their raw state (without any initial summarisation) in a specially developed Microsoft Word data-capturing template and thereafter imported into the NVivo application. Once capturing and formatting was completed, the data sets were analysed by question after which themes, discourses and patterns were established across all responses.

**Rationale for choice of descriptive statistics, Mann-Whitney Test and NVivo Qualitative Analysis**

Carrying out research electronically through programs such as the Mann-Whitney Test and NVivo Qualitative Analysis Program had the advantages of reducing the human error factor significantly. Through entering certain key words and phrases that elicited some of the results as well as providing for an alternative technique to strengthen the analysis, being a “coarse sieve” or first level of analysis.

However, the pitfalls of electronic methods of analysis and searches were also obvious if one considers that, for instance, the terms “NHI” or “service delivery” could involve the “existence of multiple synonyms leading to partial retrieval of information”. Therefore, these methods could also have the inherent potential to yield less reliable results than doing a manual search, where all the nuances of the interpretation and reflexivity are more applicable and appropriate.

Most importantly, perhaps, validity was enhanced electronically, taking the pro’s and con’s into consideration, with the assurance that all examples of a particular usage are, in fact, found in the end, which may have been missed through the
exclusive use of manual searches and techniques, no matter the levels of scrutiny (Welsh, 2002).

By introducing mixed-method analyses, it was envisaged that a more thorough description, interpretation and analysis of health care practitioners' experiences would ensue.

3.12.1.2 Social constructionist paradigm (second level of analysis)

The social constructionist paradigm, second level of analysis, described, explored and explicated the factors, which impacted on participants in their socially-constructed realities and provided added contextual layers to the analysis. It provided for the amplification of the language and textual patterns used in the words and sentences, reflecting what the social worlds of the health care practitioners repeatedly revealed about their social truths within the health care delivery system. The process therefore essentially involved identifying and amplifying those narratives and social/textual patterns in the participants’ own words and sentences, allowing the researcher also to reflect on what was said repeatedly about their lives and the worlds in which they found themselves. In such a way, the participants’ social truths were being identified and explored through the details that they themselves provided in their responses and then reflexively used also by the researcher.

Thus, on the social constructionist level, health care practitioners’ experiences were investigated as meaningful human activity rather than simply being evaluated as mind and behaviour, asocial and ahistorical phenomena (as on the descriptive level); experiences were also not explicating as deeply and as in-depth as in the interpretive paradigm. Each stage therefore, just like the “Russian-dolls” metaphor, revealed itself in different synergistic nuances and/or levels of analysis and explication.

The social constructionist analysis entailed taking a “discursive turn” by assuming that the meanings the participants expressed originated in socially-shared constructions and were, as a result, the bona fide objects of a community psychological investigation. This line of reasoning has started making an impact on South African psychology (see, for example, the special edition of the SAJP,
although it remains unaccepted in some circles, being renounced as relativist and subjective (Durrheim, 1997). Explications at the social constructionist level nevertheless aimed to explore how participants experienced underlying representations, signs, political images, meanings, individual and group experiences, and derived meanings from these experiences, as well as revealing how these understandings were derived and how they fed into larger narratives/discourses. It revealed the extent to which their experiences, thoughts and feelings were coming out of their social contexts rather than at individual (“I”) levels of their lives (Terre Blanche et al., 2006).

### 3.12.1.3 Interpretive paradigm (third level of analysis)

The interpretive or third level, described, interpreted and explicated the experiences and meanings, which were revealed from the textual realities of participants, providing a deeper intuitive or “pre-verbal” interpretation of participants “realities”.

The interpretive paradigm was incorporated in order to obtain deeper, thicker and more personal levels of participants’ experiences in the health care setting by identifying concrete terms and their clusters (Henning, Van Rensburg, & Smit, 2004) through their personal perspectives, inner worlds at an often intuitive “pre-verbal” level, which provided fresh ontological perspectives. The five open-ended questions, by their design, also facilitated interpretive explication, since health care practitioners interact empathically with each other on a daily basis in their normal, natural work settings and tend to know things by simply being able to speak, listen and look (Terre Blanche et al., 2006).

Remaining true to interpretive principles, the researcher adopted an empathic understanding of the phenomena, staying as close as possible to the data during the refinement process as the explication processes evolved. Knowing also that interpretivism requires the researcher to be the “instrument” and, as such, take the participant’s subjective experiences seriously, this study sought to harness and extend “the power of ordinary language and expression”. It attempted to further thicken, deepen and understand the social world in which the health care practitioners that were selected, lived and worked (Terre Blanche et al., 2006, pp.
273-274) as individuals within a health care system, while remaining aware of the researchers’ role in the interpretation because of her previous interactions that took place within health care settings. For example, work experience, the interaction with participants prior to and during the study and the inevitable subconscious process at play in any human activity requiring interpretation, meant that data were thus interactively interpreted to obtain those in-depth experiences and feelings in order to reconstruct the intended original meanings in the responses (Niewenhuis, 2015), albeit through the relatively more subjective and explorative basis.

Because the meanings that participants sustained and generated in their everyday working lives also involved interacting with the community, being their colleagues, patients, management and so forth, within the larger system of their work or living environments. In other words, a more value-laden research was explored, offering an alternative to the dominant positivist approach of analysis, and specifically using self-report open-ended questionnaires for this purpose (Ratele, Duncan, Hook, Mkhize, Kiguwa, & Collins, 2004, pp. 7-14). This paradigm sought to deepen and place the real-life events and phenomena of the health care practitioners’ experiences into some type of organised perspective (Terre Blanche et al., 2006, p. 321) ontologically and subjectively, and subsequently being understood as occurring within the larger realm of the health care system and not separate from it. Hence, one cannot separate them (the social actors, the health care practitioners themselves) from the “social phenomena” (management, hospital, community, home, and so forth) of their lives, as they recursively affect each other – with their individual subjective perceptions being created from the social phenomena and their responses to those, the consequent reactions (Saunders, Lewis, & Thornhill, 2009, p. 110).

3.12.2 Reflection on the use of the three paradigms/levels of interpretation

One of the central concerns of the present study was to ensure that the description, interpretation and explications of the data presented a true representation of health care practitioners’ experiences. For this specific reason, a lot of emphasis was placed on progressive deepening of the data through the three research paradigms to provide a “tapestry” of interpretations of the rich
narratives and to give participants “a voice”, through which to reconstruct their reality. “Telling it like it is” often provides only a partial representation of the meanings, actions and events, without giving sufficient understanding of the same. Although Davies (1999, p. 194) argued that descriptions, being close to original raw data, still remain selective in that they stay close to the original data obtained, it remains questionable, whether the premise that materials “speak for themselves” holds true. That is why a researcher often needs to interpret these by providing the context for the “voices” to be heard and understood. Thus, the need for reflection in interpreting the data would provoke some abstraction by transforming the responses and gaining inferences for them in order to build an analytic framework (Collins et al., 2000).

3.13 Ensuring the quality of the study

Care was taken to reduce investigator bias in the analysis and explication of data (Mack et al., 2005) through the suspension and bracketing out of bias, which the researcher may have had in respect of previous work experience in the health care delivery system. In addition, the quality of the study was ensured through the use of multiple methods of analysis with a triangulation of research paradigms, for example, the quantitative component of the Mann-Whitney Test and NVivo Qualitative Analysis in the descriptive paradigm followed by social constructionist and interpretive paradigms analysed and explicated by the researcher. Thus, these paradigms collectively expanded, thickened and deepened the data with the strengths of one form of analysis and explication compensating for the weakness of others and providing a holistic context to the research, ensuring its quality. These considerations ensured that the overall reliability, validity and trustworthiness of the findings were increased.

3.14 Ethical considerations

Participation in the study was voluntary with the option to decline or discontinue participation, with no untoward consequences. Written informed consent was obtained and all participants verbally communicated their willingness to partake in the study. No participants indicated the need for an interpreter. The risks of participation were minimal in this study. No major psychological or physical stressors were anticipated and there was no direct material benefit received by
Participants, other than the potential for their views to be made available via the publication of this study and to relevant bodies who required feedback.

Attempts to keep health care practitioners’ identities confidential were made through removing identifying information in the transcripts as far as was possible without compromising the integrity of responses. Taking into account the results of the researcher’s previous 2011 study, which explored the experiences of medical practitioners in the health care delivery system, it was anticipated that some participants in the present study might express negative or controversial opinions in their responses in the current research as well. Therefore, the study sought to prevent the possibility of this research resulting in damaged relationships within the health care practitioners’ workplaces or even possible victimisation in the workplace due to information being used against them in some way. By ensuring that information gathered from the participants was treated confidentially, this would be circumvented. The data and findings were presented in the best possible way in order to keep the identities of participants concealed, unless their identities and express views had been made publicly, for example, to the media or in any publications.

It was intended that through the ethical representation of the participants’ experiences, opinions, feelings and views, a platform for these valuable stakeholders in the health care delivery system was created, which may impact on potential future policy and therefore the South African population as a whole. In that sense, ethical means were used by the researcher and the health care practitioners in this study, to promote the interests of better health care for all and ultimately, human rights and social justice.

3.15 Write-up and dissemination

In line with the WHO’s proposals for all countries to be consumers as well as producers of research (WHO, 2013), the write-up and dissemination of the present study was done with the potential for the results to be used by various stakeholders and beneficiaries such as health care policy-makers, hospitals, government departments, academic institutions and individuals. Feedback will be made available to the KwaZulu-Natal Health Department, Ngwelezana Hospital
and participants whose contact details remained valid. This research will be published by the University of Zululand and, as such, will be available on the internet for interested parties.

In order to fulfil the academic requirements for this PhD at the University of Zululand, a journal article was submitted for review and publication in a peer-reviewed journal and presentations at international and national congresses were undertaken for consumption by the conference’s audience, academic community, other interested parties and stakeholders in the health care environment. It is hoped that the dissemination of this work will cascade into future research in this area of study.

3.16 Conclusion

In this chapter, the research methodology was described in detail with the purpose of the research design being the optimisation of responses to the research questions. This was achieved through a qualitative enquiry, general phenomenological orientation and through use of mixed methods, triangulation, three research paradigms (descriptive, social constructionist, and interpretive), within a community psychological and health care context.
Chapter 4
Findings and discussion

“There is no part of the world of coast, continents, oceans, seas, straits, capes and inlands, which is not under the sway of a reigning wind, the sovereign of its typical weather. The wind rules the aspects of the sky and the action of the sea. But no wind rules unchallenged his realm of land and water.”


4.1 Introduction

A qualitative, general phenomenological orientation was considered the most appropriate way to adequately fulfil the intention of providing a more holistic analysis, explication and discussion of participant responses and was considered unique to this study.

This chapter presents findings and data from participants’ experiences by presenting resultant emerging experiential narratives and discourses according to the descriptive, social constructionist and interpretive paradigms. These paradigms exist on a continuum from superficial to deep and may be conceptualised as three interrelated levels (as per a “Russian Doll” metaphor), where each structure is imbedded in the other, forming a whole or part of the whole.

Findings are presented relative to responses to the five self-report open-ended questions, which were:

1. How are you experiencing the current health care system?
2. What are your views about the proposed changes within the health care system?
3. What suggestions do you have to improve the health care delivery system in South Africa?
4. Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.
5. Would you consider leaving South Africa, and if so, why?

The findings and discussion are presented in sequence, according to the three
paradigms:

a) Descriptive;

b) Social constructionist; and

c) Interpretive.

Original excerpts from the transcriptions are included to support the findings that were noted.

4.2 Descriptive paradigm (level 1 of analysis)

Analysis at this level aimed to:

- construct a profile of the public and private health care practitioners who took part in the present study.

- compare the views of public and private health care practitioners with regard to their experiences in the current health care system in the uThungulu District, South Africa.

- Obtain suggestions for possible changes for the health care system, and get participants ideas of how to improve the health care system.

- learn from the experiences of health care practitioners that have overseas work experience.

- To determine whether and under what circumstances health care practitioners would consider leaving South Africa.

Responses to Question 1: How are you experiencing the current health care system?

Experiences of health care practitioners in both the public and private sectors indicate that each sector has its own problems. All health care practitioners experienced anger, disillusionment, loss of faith and scepticism about the overall state of health care in South Africa. Two major aspects, which emerged from the experiences of both sectors, were the relatively poor quality of nursing and the need for efficient systems and procedures to be put in place for the provision of a
better functioning health care delivery service across all specialties and
departments. Inter- and intra-professional irritations and divisions were expressed
in both sectors pertaining to working in a multi-disciplinary team environment.
Many felt that the situation was not going to change in the foreseeable future as
hierarchical structures in the health system perpetuated the lack of cohesion,
which would be ideal for effective health care service delivery. For example,
medical practitioners were deemed to be “favoured” and, as a result, they also
considered themselves more important. Nurse/medical practitioner relationships
were most obviously not harmonious by many accounts.

It emerged strongly from the private sector participants that their experiences
revealed a more sustained focus on care, customer satisfaction, keeping staff
motivated to work, financial issues, medical aid interaction and the importance of
primary health care. A few private sector practitioners provided their overviews
and opinions of the basic differences between the public and private health care
sectors. The private sector was experienced by some as unregulated in terms of
over-servicing of patients. For others, especially nurses, the difficulties
experienced in treating/caring for patients and having to explain to them that their
medical aid funds were depleted was concerning and distressing. Fears about
government legislation (and medical aid pressures) and their futures in health care
in South Africa were expressed with some private sector practitioners deciding to
keep their options open to emigrate if the situation became untenable. Inadequate
consultation was a major frustration, in terms of mutual dialogues for policy
changes. On the whole, private practitioners reported feeling overall reasonably
happy with their working environments, despite the extreme stress they often
experienced, coupled with the responsibility of managing their own finances and/or
practices.

Public sector practitioners were also, to a large extent, suffering from chronic
psychological symptoms, related experiences of overwork, tiredness, loss of
motivation and other problems. This sector experienced relatively more anger and
frustration than did the private sector, due largely to a very stressful work
environment for health care practitioners and overcrowded or inadequate
conditions for patients. These were compounded by poor and/or inefficient
management structures, limited resources, too many patients for too few human resources, fears about personal and patient safety and the future of health care in such an environment. Other stressors were factors such as staff shortages caused by health care practitioners leaving to work in the private sector, or resignations/early retirement hastened on by stress, that put those colleagues left behind under further pressure and more work, whilst being underpaid. Health care service delivery was made more difficult due to low staff morale (feeling unappreciated), lack of empathy from many health care practitioners, a tendency to work as little as possible, not enough pressure from supervisors and/or management to maintain standards, poor support and inadequate consultation.

**Key experiences/narratives of public and private health care practitioners, from most prevalent to least prevalent are described:**

All health care practitioners experienced anger and frustration with particular reference to:

1. Understaffing resulting in poor service delivery (14 participants)
2. Lack of personal development (7 participants)
3. Insufficient equipment (6 participants)
4. Negative attitudes of senior staff towards subordinates and patients (5 participants)
5. Health care facilities being overcrowded (5 participants)
6. Limited teamwork resulting in poor inter- and intra-departmental communication (5 participants)
7. Lack of accountability (4 participants)
8. Poor remuneration (4 participants)
9. Expensive health care services (3 participants)
10. Poor resource planning and distribution (2 participants)
11. Irregular supply of basic utilities such as water, electricity as well as the often experienced dysfunctional sewerage system and poor ventilation (2 participants)
12. Politics in procurement practices (1 participant)

13. Lack of staff capacity/procurement development (1 participant)

14. Unsafe workplace environment (1 participant).

Expressions of frustration and anger were ascribed to “disconnected” reporting structures, which resulted in faith being lost in management structures, with the only options available being to protest or “toyi-toyi” as a last resort.

“The reporting channels are not satisfactory, as a radiographer, one has to report to a medical manager, who knows very little about the department, and why is it that when all has failed within the institution, no one on ground level has powers to go to district or province or national without “toyi-toyi” (industrial action).” Public radiographer

The older health professionals expressed that these days, young people were not motivated to work and sometimes the work they did was inadequate.

“The other problem lies with the younger generation, who are a generation of instant gratification with expectations of high monetary rewards – the caring professions are never really going to suit that requirement. I really feel there are so few now, who see it as a ‘calling’ rather than a ‘job.’” Private nurse

The issue of remuneration, support, training and morale with respect to health care was emotively expressed by participants, particularly in the public sector, who felt that the morale of health care practitioners was low and also constantly dwindling.

“If the wages can be reviewed – better wages can motivate workers to do their best in delivering quality services. If they can provide one with accommodation to stay with our families, this can even reduce the absenteeism rate hence people will be staying with their loved ones, because sometimes or in most cases we live far from our families – and if the DOH. (Department of Health) can provide us with that, it can be better.” Public nurse

Participants felt that providing further studying options for health care practitioners would strengthen the skills capacity, leading to long-term resourcing of the health care system.
“Treat all employees equally, support them all in order to bring about effective teamwork. Government to please offer courses, seminars, workshops for all disciplines, not just nursing and doctors… I would definitely consider to broaden my knowledge and experience in other countries, also to seek for greener pastures abroad.” Public physiotherapist

“The training of doctors is substandard, and the governing bodies are aware of this, but allowing it due to political pressure to provide warm bodies on the ground, irrespective of quality of training and subsequent care provided.” Private medical practitioner

“We are being neglected as workers, we are not being given enough chances to upgrade ourselves, if you are in the rank you just stay there for couple of years and yet it takes time to be given a chance to go and study” Public Nurse

All health care practitioners in the study expressed anger and frustration with the current system in terms of institutional arrangements, logistics support and work relationships. In addition, bureaucracy, politics, high patient-medical practitioner/nurse and other ratios, shortage of human resources and equipment were some of the issues raised.

“I find public health care extremely frustrating and often infuriating, lack of integrity and accountability, I find my boss and colleagues around the hospital looking very busy, but actually getting no work done. Look as busy as possible and get away with as much as possible – forget about the patient. It is challenging to take pride in my own work since I am so embarrassed to be part of a very broken system.” Public medical practitioner

“There are no working tools – you are always wanted (expected) to improvise and it causes emotional and physical exhaustion. Patients were critically ill, while there is no adequate equipment, e.g. mask, gloves, to protect ourselves from those who are affected by TB diseases.” Public nurse

“Politics between professions, professionals and regions also impairs the service delivery to the patient. I see one to two patients a day, while the xxxx (therapist) in the hospital down the road has a six-month waiting list. I am here – available to help – but fear of the hospital politics suppresses the service I could offer clients waiting at the other hospital” Public therapist
Positive and/or peak experiences were expressed with regard to feelings of patriotism and altruism, for example, helping those in need, loving their country and enjoying the challenges of new technology.

“I love helping people who cannot help themselves. I love helping them realise their occupations and engaging in them daily. People are very appreciative for the help that they get. I find my job very rewarding.” Public therapist

“I would never leave South Africa. This is my soil, my home, my beloved country. I am passionate about the people I serve and the work I do.” Public medical practitioner

Nurses, particularly in the public service, described the challenges of staff shortages, poor remuneration, scarce resources, intra- and inter-professional mistrust, long working hours, not being involved in decision-making processes, neglect and resultant emotional and physical exhaustion leading to apathy, resignations and/or early retirement.

Private sector nurses described being happier overall, but described a lack of adequate training, staff shortages, being unable to care adequately for patients, whose medical aids had become depleted and lack of compassion and work ethic towards patients.

“The shortage of staff; that is a great challenge. Instead of eight nurses, there are one or two, that also causes a health practitioner to take early retirement or resign. There are no working tools – you are always wanted to improvise and it causes emotional and physical exhaustion. In comparison to all the (other) public servants, health is paying far less. At the end of the day, no one comes to say thank you to you – instead, they look for mistakes you have done. If you are not okay/not feeling well, no one trusts you. The type of hours worked does not give your family access to you.” Public nurse

“We are getting less pay and the work is too much. We are being neglected as workers.” Public nurse

“Patients are critically ill, while there is no adequate equipment e.g. masks, gloves, to protect us from those who are affected by TB, diseases, etc. Shortage of staff leads to working unpaid overtime. As a result, we end up
with no interest to do your work properly due to tiredness.” Public nurse

“I am happy to be working in the private sector….seen many changes, mostly for the better. Changes need to focus on the importance of quality nursing care and customer satisfaction, getting staff back to the bedside.” Private nurse

“Nurses consider nursing as a pay cheque and have no compassion for their patients. Many of them cannot take a message or carry out a simple instruction.” Private nurse

Health care practitioners’ experiences in both the public and the private sector, regarding the possible reasons behind the malfunctioning of the public health care sector, were primarily concerned about decisions made by the Department of Health. Further compounding the public sector problems was the spiralling effect government decisions have on the public health care problems. They also expressed the view that people with insufficient knowledge, experience and skills were appointed to senior positions and that promotions were not based on merit, but on political and family/friends and connections. Corruption was believed to be rife. Equipment tenders were similarly given to people with political and family/friends connections and not to those who could provide the best service. This resulted in mismanagement of resources, poor supply lines for equipment, and sub-standard equipment being supplied. Communication between management and the staff “on the ground” was poor or non-existent.

The following scenario illustrates this effect:

A health care facility has insufficient quantity and poor quality of equipment. As a result, the staff cannot treat all the patients and even fail to treat those who do receive treatment properly. Consequently, the facility becomes overcrowded with more and more patients needing treatment. The lack of proper equipment frustrates the staff. Matters are made worse by the fact that there are no proper channels available for making complaints about the situation and having it rectified. A culture of “the less work done, the less the frustration” starts developing among the staff and mediocrity becomes the norm. Management fails to deal with the equipment problem, to properly supervise such staff and get them
back to work. In order to get work and pay conditions improved, the unions become involved and health care services are further disrupted. The few staff members, who still care about their work and keep trying their best, become overworked and leave the public sector for work where their skills are more appreciated and wages/remunerations are better.

“The effect of the sequence of events described above was that the public health care facilities were unable to provide proper health care to patients and the situation is expected to get worse and worse as time goes by. Everybody (staff and patients) at the health care facilities were unhappy about the situation, but could do nothing to change it until the root-causes of the problems are rectified.” Private sector medical practitioner

Detailed summaries of public and private health care practitioner experiences

Public sector experiences

1. Problems with facilities and equipment

1.1 Poor facilities

1.2 Equipment defective, malfunctioning, substandard, insufficient e.g. air conditioners, scales, blood pressure machines, gloves, masks

1.3 Equipment supply tenders given to friends, not handled professionally.

1.4 Insufficient resources e.g. human and material.

2. Management

2.1 Poor management, resource allocation and responsibility.

2.2 Unproductive staff and/or lack of accountability.

2.3 No proper supervision of staff.

2.4 Poor communication and/or unsatisfactory reporting channels from management and district level upwards. Management is out of touch with what is happening “on the ground”.

2.5 Corruption and/or mismanagement of funds.
3. Problems with Government and unions

3.1 Politics interferes with the health care delivery system.

3.2 Autocratic type of Department of Health leadership is not good for health care.

4. Staffing attitude

4.1 Understaffed, overworked, underpaid and/or demotivated staff.

4.2 Medical practitioners do private work and neglect public hospital work.

4.3 Staff are not given financial help to upgrade knowledge; insufficient training.

4.4 Staff are only interested in their pay cheque and have little or no compassion for their patients.

5. Services lacking or not functioning properly

5.1 No standardisation, protocols and/or teamwork, forces poor practices onto patients.

5.2 Medical facilities in rural areas are insufficient and difficult for patients to access.

5.3 Certain services are not functioning properly, e.g. ambulances, transport of medication.

5.4 No transport for elderly rural patients who often cannot fetch medication or attend consultations.

5.5 Clinics are not functioning well and there is often not enough or no water, electricity and defective sewerage systems cause further problems.

6. Problems patients face

6.1 Overcrowding in facilities and lack of space.

6.2 Patients have no freedom of choice.
7. Special problems that health care staff face

7.1 Abused by the patients.

7.2 Feel unsafe in the work environment

8. Cultural awareness

8.1 Try to provide same-language health care practitioners, especially in rural areas.

9. Positives

9.1 Like helping people in need, love their country.

9.2 Challenging with new technology.

Private sector experiences

1. Finances and viability

1.1 Private practice less viable for work outside of private hospitals.

1.2 Private health care is expensive and the costs are increasing.

1.3 Private health sector is under financial pressure.

1.4 Difficult to plan financial future due to influence of the government and economy.

1.5 Rates charged are not standard for all areas of residence and practice.

1.6 Private sector is not regulated. Over-charging and non-essential services do occur.

1.7 Private health care is run as businesses and therefore financial issues can become more important than the patients.

2. Medical aid issues

2.1 Medical aids delays in giving authorisation, making payment, and/or limitations in payments for health services.

2.2 Difficult to explain medical aid issues to sick people, e.g. when funds unavailable.
3. Perceptions

3.1 Perception that only medical practitioners are involved, consulted and/or considered in health care structures.

4. Primary health care clinics

4.1 Primary health care clinics should be made efficient to deal with all basic health care services. This will relieve some of the pressure on public and private hospitals and health care service delivery.

5. Positives

5.1 Private health care is generally good and of a high standard.

5.2 Most are happy to work in the private health care sector.

5.3 Patients have freedom of choice if they have medical aids and can afford their own costs.

Virtually all the comments made by public sector participants were concerned with the poor state of the public sector health care and possible reasons behind this state of affairs. The private sector comments were largely concerned with financial issues, health insurance and comments about the disparities between public health care and private. All practitioners expressed anger and frustration with the current state of health care delivery in the country, which impacted on them personally, the patients, on the community and on society and especially the health care related “fallout” of those in terms of health care delivery to everyone in the country.

Responses to Question 2: What are your views about the proposed changes within the health care system?

The largest number of both public and private health care practitioners expressed the view that proposed changes would worsen the already poor health care system and that it would never work. They furthermore expressed that they felt the public service did not have the infrastructure to support the proposed initiatives yet they hoped that any changes would provide better access to health care for
especially the poor. Across both sectors, some practitioners expressed that they felt unsure of the impact that any changes would have on them personally and/or their positions/practices. The intentions behind the NHI appeared to be well received in terms of their motives, although practitioners felt that the changes would take time and may be over-optimistic.

The anger and frustration, which most practitioners expressed in various forms throughout this study, was evident also in some expressions of contempt, particularly in the public sector. In particular, nurses reported being already overworked and would be under more stress if the present conditions did not improve. Warnings that psychological factors, such as stress, burnout, apathy, anger and frustration were important factors when considering what it meant to be part of a healthy workforce. Factors that could negatively influence health care and lead to further human resource losses were expressed.

In general, regarding the NHI, participants from both the public and private sectors expressed negative sentiments, cynicism, some reservations and hopes for better health care for all. They felt that their limited knowledge and/or interest in the proposed changes within the health care system was partially as a result of apathy or insufficient consultation and education from government.

“Very ambitious, and although morally defendable, it is totally unattainable and unrealistic in terms of the financial implications to our country. The implementation and management thereof also currently seem beyond the government's capabilities.” Private therapist

“How can they even think of NHI, when other hospitals don’t even have urine “dipstix” or gloves or BP cuff, which are like the basic things??? Are they crazy? (Laughing). Public medical practitioner

“At this juncture, it’s not easy to tell/say because the proposed NHI has not gone under operation and one cannot always trust what our government says. Today, they’ll say this, and tomorrow it’s another.” Private radiographer

“The way it has been communicated has caused some confusion.” Private nurse

“Health care is a human right.” Private therapist
“I feel quite unprepared to answer the above question, partly due to a lack of information from government and partly due to my own ignorance and laziness to find out more details regarding the proposed plans.” Public medical practitioner

“Another concern I have, is my future financial security. Unfortunately, I haven’t the information to comment properly….but I worry that my future income might be controlled and governed by the government policy influencing how much health care costs. This is an extremely selfish view to hold…but I would be lying if I said it wasn’t a major concern for me. Income potential did play a role in my career choice and now that is being threatened.” Public medical practitioner

“I think they are having good policies, but the problem is with its implementation. They propose changes, but without consulting the workers, so it’s bad.” Public nurse

Summary of numbers of public and private health care practitioners’ views and experiences regarding proposed changes within the health care system (NHI), most represented by profession:

1. It will never work and will worsen the already bad current situation (3 radiographers, 2 nurses, 2 medical practitioners, 1 therapist)

2. The public sector does not have the infrastructure to support any new initiatives (3 nurses, 2 therapists, 1 medical practitioner, 1 radiographer)

3. The poor would have better access to health care (2 nurses, 2 therapists 1 medical practitioner, 1 radiographer)

4. Unsure of the impact of the changes to the system (4 therapists, 1 nurse, 1 radiographer, 1 medical practitioner)

5. Extra stress would be placed on already overworked nurses (1 nurse)

6. Any changes would take time, although the motive behind changes is good (1 radiographer, 1 medical practitioner, 1 nurse)

All practitioners expressed views about the changes to the health care system. In
particular, one nurse expressed the view that nurses, who were already overworked, would be placed under further stress. Other health care practitioners did not express the same views in relation to nurses and the stressors they experienced, feeling that nurses lacked proper work-ethic and had a lack of adequate skills. This may indicate some negative inter-professional opinions and dynamics/discourses in relation to the nurses, who felt that they were bearing much of the work-burden.

Summary of public and private health care practitioners’ experiences, main themes and sub themes, narratives and discourses about proposed changes to the health care system:

1. Communication of changes
   1.1 Details of the changes are not well understood.
   1.2 Lack of information about the system from the government; making it difficult to express an informed opinion.

2. Advantageous to the South African Government, not to the patients
   2.1 The system will be dysfunctional and serve the government, not the people.
   2.2 Another ploy by government to get more money through taxes.
   2.3 Effort by government to control health care costs.
   2.4 Government use changes to their political advantage (political “bargaining chip”) and do not really care whether it benefits the patients.

3. Wrong focus
   3.1 Rather optimise resource allocation and minimise wasteful expenditure.
   3.2 Should rather plan ahead and set training and staff targets.
   3.3 Rather have basic equipment available before introducing changes.
4. Implementation issues and problems

4.1 The health care system might be overloaded.

4.2 Doubtful whether managers can carry out the proposed changes.

4.3 Nothing will change soon and policies will never work.

4.4 Changes can only be implemented with better infrastructure, more motivated staff and less staff shortages.

5. Forced to pay for something you never use

5.1 Patients who use private health care facilities would/may not want to use new public health care system, but will be forced to pay for it via taxes.

6. Positives

6.1 Better access to health care for poor.

6.2 Medical aid would not depend on having a job.

7. Implementation of proposed changes to the health care system

7.1 For the population size and disease burden, the proposed changes are ambitious, totally unattainable. The country does not have the infrastructure and it is therefore unrealistic. The implementation and management thereof are beyond the government’s capabilities.

7.2 Will worsen an already poor situation; none of the real problems in the public sector are likely to be addressed.

7.3 Will fail due to inefficiency (not easy to offer by the state) and inequality.

7.4 Training staff and extra stress on existing staff.

7.5 No incentives provided for health care practitioners to do a good job.

7.6 Will still have to implement the changes with the same staff and facilities; need more than this to make changes work.
Staff that can do the work cannot be found.  

Unfair financial burden on too few taxpayers.  

Too few will have to pay for the many with too many needs.  

Will be very expensive to the taxpayers.  

Real problems, rather, need to be addressed.  

Better policing of supply chains and measures of performance of health care practitioners in terms of patient outcomes.  

Simpler, cost-effective, and efficiently run national health system.  

Government should first manage their own many public hospitals properly.  

Slow changes with gradual involvement of the private sector.  

Communication of changes was inadequate.  

Changes not well communicated. Health care professionals need to be better educated about the NHI and motivated about its implementation.  

Better simpler solution.  

Rather send the patients to private health care providers; and then negotiate lower fees for service.  

**8. Positives**  

Ambitious and morally defendable.  

Motive is good – government wants to bring health care services to those who need it.  

**Responses to Question 3: What suggestions do you have to improve the health care delivery system in South Africa?**  

Health care practitioners from both the public and private sectors provided suggestions and ideas about improving the health care sector. Suggestions were
constructive and profuse, indicating high or advanced levels of social responsibility and personal responsibility with regard to what the necessary factors to support themselves as professionals were and the implications for society. This included social responsibilities to patients and the community with respect to the accountability of institutions and policies/laws, which govern the health care environment, rights and access to services. Responses indicated that health care practitioners were enthusiastic about the present study’s potential to serve as a platform to improve health care delivery for all stakeholders in health and for its provision of an opportunity to “be heard”.

Suggestions by number of participants, of ways to improve the health care delivery system:

1. More awareness campaigns being needed to promote disease prevention. (17 participants).
2. Instituting or strengthening continuous training of health care practitioners. (16 participants)
3. Improve health care services at “grassroots” levels. (15 participants)
4. Using indigenous languages/vernacular when providing health care services, especially in the rural areas. (13 participants)
5. Improving supplies at health care facilities such as: equipment, linen, install fans, windows, air conditioning, gloves, stethoscopes, blood-pressure machines, and security. (9 participants)
6. Improving the referral system between primary, secondary and tertiary hospitals. (8 participants)
7. Increasing hospitals and clinics, especially in rural areas. (7 participants)
8. Providing incentives for staff and better salaries, especially for the public sector. (6 participants)
9. Increasing the numbers of health care practitioners, especially to cover the rural areas. (6 participants)
10. Teamwork and communication needed to improve the health care delivery system. (5 participants)
11. Improving the health care bidding procedure. (5 participants)
12. Improving resource planning and efficiency in the utilisation of the
resources. (4 participants)

13. Computerising filing systems to improve management of patients’ records/information. (3 participants)

14. Employees needing to improve their attitude towards work and their patients. (3 participants)

15. Reviewing service charges to make health care services affordable. (3 participants)

16. Abandoning sliding scale marking systems for the exams taken. (1 participant)

17. Doing away with hospital health, e.g. life care insurances. (1 participant)

Summary of main suggestions to improve the health care delivery system, divided into the public and private sectors respectively. (These will be further expanded on in the recommendations in Chapter 5):

Public sector

1. Better salaries, working conditions, incentives to perform well, multi-disciplinary teamwork, motivation.

2. Better management of patients, leave time, resources, accountability and communication channels.

3. Quality of and management of required equipment and the procurement thereof.

4. Services to patients need to improve overall including the delivery of medication and transport to and from rural areas.

5. Referral systems need to improve between hospitals and clinics.

6. Staff need more financial assistance to study further, day-care centres for their families and accommodation (especially nurses).

Private sector

1. Use money more efficiently and integrate the public and private sectors better.
2. Politically independent and efficient management to address corruption and nepotism with accountability and transparency in the public sector. This would allow the health system to be more effective.

3. Decentralise the buying and ordering of equipment.

4. Put measures in place to monitor and prescribe staff performance and attitudes. Better mentorship would improve morale and motivation to perform better, take pride in their work and be enthusiastic. Failure to perform should have disciplinary consequences.

5. Overhaul how health care practitioners are trained by reinstating nursing colleges. Prevent the lowering of academic standards and ethics and increase awareness/training for HIV/AIDS and other diseases. Ensure adequate staff intake in all health care facilities.

6. Introduce effective hygiene protocols to ensure better standards.

7. Primary health care clinics must be better funded, maintained and accessible to all citizens.

8. Patient care needs to improve in areas such as growth monitoring and effective immunisation. Prevention is better than cure.

9. Procure special skills from outside the public sector by making it financially more attractive for medical practitioners to do sessional work in an effectively integrated public/private health service. Relax the registration process for foreign medical practitioners to bolster human resources and work on a rotational basis.

Responses to question 3 provided varied and valuable responses for measures to improve the current health care delivery system. It is vitally important to engage in meaningful and useful processes of consultation and effective communication with health care practitioners in both the public and private sectors in the interests of truly evaluating and implementing measures and means towards achieving a good, equitable health care delivery system in South Africa. The consensus regarding education and consultation, especially from the public sector participants, was that the government was not as in-touch with health care practitioners as they deemed it ought to be. Many felt that low morale, frustrations and lack of opportunities were being ignored at the peril of any stakeholders who have the health care of the country at heart. It was hoped that the responses to
this question be utilised in future policy considerations as a valuable information system from the health care practitioners themselves, at grass-roots levels, who are the “heart” of the health care system and have their “fingers on the pulse”.

Responses to Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Less than a quarter of private sector health care practitioners had overseas work experience. Of those, three were nurses, two medical practitioners and one a dietician. Countries that were part of participants’ work experiences included: the United Kingdom, i.e. England, Scotland, Wales (3 responses), the United States of America (1) and Saudi Arabia (1). Conferences/courses: Zimbabwe (1).

None of the public sector participants had gained any experience in their fields outside of South Africa, although some expressed the wish to do so and would consider even leaving the country under certain conditions.

Participants described mixed personal, financial and social/cultural experiences with regard to overseas work experience, as follows:

“While all human endeavours have defects, the systems in both countries worked well and both health care workers and patients were by and large satisfied with the situation.” Private medical practitioner

“Every system, where medical practitioners are underpaid or over-regulated is deemed to be a jail.” Private medical practitioner

“I was fortunate to spend two weeks in….. and found the National Health System not much better than our health department, with patients treated in general as sausages in a machine.” Private nurse

“I have not worked outside South Africa, but I do know people who have and I don’t think that the ‘grass is greener on the other side’, unless it is all about the money.” Private nurse

“I was supposed to be there for two years. I was back in South Africa after three and a half months. The people there are rude and very self-centred. The isolation I experienced was the worst. The big difference in culture was also a
Summary of private health care practitioners’ experiences abroad:

1. Health care systems in the UK and the US work well; by and large health care workers and patients are satisfied.
2. There is good governance in the UK and US with patient-driven health care systems.
3. The UK National Health System (NHS) is “overburdened and abused by the public.” Several types of illnesses are caused by poor lifestyle, e.g. smoking, drugs.
4. Isolation and cultural differences overseas, e.g. Saudi Arabia.
5. UK NHS is not much better than the South African Department of Health.
6. Work in Scotland and Wales provided good and rich experience.
7. Medical practitioners must be paid proper salaries (no flat or low salaries), or else the system will fail.
8. Efficient systems stimulate remuneration of medical practitioners.
9. South African health practitioners performed as well as their overseas counterparts in courses offered at universities in the UK.
10. Challenging working conditions outside of South Africa (Saudi Arabia).
11. People in Saudi Arabia are rude and self-centred. Their socio-cultural values, norms and practices are quite different from South Africa and can lead to feelings of social isolation. Those difficulties made the participant return to South Africa after only 3 1/2 months instead of the planned two years.
12. Any pre-conceived ideas about the NHS in the UK being better than, or more efficient/effective than the South African system/ Department of Health turned out not to be the case in the end.

Work experiences overseas were not always that “rosy” for some health care practitioners who faced different successes and challenges in different cultural and health care contexts. Some experiences were deemed to be valuable in terms of better remuneration and efficiency in other health care systems. Although mixed experiences were described, responses indicate that health care practitioners
were willing to face the challenges of leaving the country, which is a trend all over the world. In South Africa, it unfortunately means leaving the continent that has an enormous burden of disease for countries that are wealthier and can afford to pay for foreign expertise. Social, moral and ethical questions inevitably also arise from the policies which govern such migration. On the other hand, health care practitioners may consider it immoral to restrict their freedom of choice and movement in the interests of a better quality of life for them and their families – or at least the chance to explore those options. Restricting health worker movement around the world may have the unfortunate consequence of discouraging young people from embarking on pursuing a career in health care. Careful consideration needs to be given to finding adequate solutions to these issues in the interests of local and global health. Steps, such as relaxing registration for foreign health care practitioners, rotating health care practitioners on a “locum” basis and training more health care practitioners to stabilise the human resource shortage, are some of the possible solutions to staff shortages.

Responses to Question 5: Would you consider leaving South Africa and if so, why?

Close to 60% of public and private health care practitioners indicated that they would consider leaving South Africa. Most of those (nine) were from the public sector and six were from the private sector. The remainder of the practitioners indicated that they would not consider emigrating, with most (seven) being from the public sector and the remaining four from the private sector. By far the largest age-group considering emigration was the 31-40 years’ age group (eight females and five males), followed by the 41-50 years’ age group of five females and two males. Of interest is that females were in the majority, which may indicate their concerns about their families’ future well-being, a trend that is seen quite often in the media and social commentary. These may tie in with fears about the future and their increased sensitivity and responsibility as women to these issues, whether overtly expressed or not. Females tend to predominate in the nursing profession, which may also be a reason for the higher number of female responses.

Participants described personal, social, financial and political reasons for
considering emigration. Fears about personal safety, political instability and “collapse” of the country’s key structures, wanting to experience what the world had to offer, both financially and personally, as well as anger about not being respected as a professional health care practitioner in this country were described as reasons to consider the prospect of emigration. Some participants indicated that the reasons they would not consider emigration were factors such as their advanced age, fear of a worse quality of life, patriotism and altruism.

“At this stage and at the age of nearly 50 I would not consider leaving South Africa.” Private radiographer

“Yes. I would like to live in a country, where my opinion as a health care professional counts and is respected.” Private dietician

“No, I would never leave South Africa. This is my soil, my home, my beloved country. I am passionate about the people I serve and the work I do.” Public medical practitioner

“Society is becoming unstable and the have-nots will not suffer in silence forever. Crime is out of control and government is getting worse day by day.” Public medical practitioner.

“This country has a shortage of health care practitioners and if we start leaving, it is going to get worse.” Public medical practitioner.

“If I feel that I am not able to pursue postgraduate studies and therefore unable to specialise, I will not hesitate to emigrate to further my studies abroad, if I feel that I am being unfairly discriminated against or if the country lacks the resources and places to allow me to specialise. As it stands, I will not continue in the medical field, if it means I remain a general practitioner.” Public medical practitioner

“I may leave South Africa for a short period (temporary basis) to grow personally, travel, perhaps grow financially, and broaden my field of experience. After that, I will return to South Africa – home. I also feel a responsibility to give back to my community. I understand the South African context – I am an African at heart.” Public therapist
Summary of reasons for health care practitioners to consider leaving South Africa and emigrate:

1. If there was economic and political collapse, e.g. like Zimbabwe, with society becoming unstable.
2. Leave on a temporary basis for work reasons, e.g. conduct short courses in neighbouring countries like Zimbabwe.
3. To experience something different and try new challenges.
4. Feeling there is no future for next generations.
5. Explore opportunities for personal or financial growth because of better remuneration.
6. To travel, learn about and experience different cultures and broaden their knowledge and/or expertise, which is limited in South Africa, i.e. to gain international experience.
7. Simply to travel to other countries.
8. Meet new people and learn from their experiences.
11. Good governance and democracy in the workplace (health care system) in other countries.
12. Economic and political stability elsewhere.
14. Ability to earn a decent living in the health care sector is severely threatened by unattainable and unrealistic government health care policies.
15. There may be more political stability, better remuneration and also shorter working hours.
16. To live in a country, where health care professionals' opinions are respected.

Summary of reasons for health care practitioners not to consider leaving South Africa or emigrate:

1. Patriotism and the love of the country and the people.
2. Facing challenges in a foreign country is difficult and one should not
accept that things will never change in South Africa.

3. Family commitments make it hard to leave, even though the remuneration overseas may be better.

4. Leaving would make the health care system worse at a time when health care professionals are most needed.

5. Due to advanced age, it might not be feasible to emigrate.

6. If the family emigrates, medical care becomes problematic and living standards also tend to drop.

Descriptive findings were presented and discussed as the first level or “coarse sieve” in the analysis/explication process. The use of quantitative statistics formed part of and added to the overall description and holistic value in the general phenomenological orientation of this study and was deemed to be a useful tool to improve the reliability, validity and trustworthiness of the results as a whole. The descriptive analysis offered a valuable additional paradigm, which would serve to reduce the possibility of investigator bias in the analysis, due to the researcher being a health care professional.

Major narratives, discourses, themes, sub-themes and summaries evolved from the rich descriptions provided by participants and were used to support the explication process. The descriptive paradigm was thus used as the first level (coarse sieve) of describing the experiences of public and private health care practitioners at the experiential level. From this departure point, the second level emerged, which was the social constructionist paradigm, in the next step of refining and deepening the analysis/explication.

4.3 Social constructionist paradigm (level 2 of analysis)

Social narratives, themes and discourses were described and interpreted in a social constructionist paradigm as a second level of analysis. Health care practitioners communicate with each other on a day-to-day basis and develop jointly constructed views of their work context, which, in turn, become the basis for shared assumptions relating to their realities. The researcher thus similarly became emerged in the social milieu of the participants ‘worlds as their experiences revealed meanings and social relatedness through careful reflection.
and with conscious awareness of attempting to suspend and bracket out all bias. This research paradigm was considered essentially complementary to the study as a whole, adding to the holistic interpretation of the data.

4.3.1 Medical practitioner – Patient relationships

Medical practitioners, particularly in public health care facilities, were said to often display a lack of empathy, responsibility and accountability towards their patients, for example, when health care practitioners perform procedures on patients without adequate supervision to do those procedures, when they do not care properly for patients due to large and unmanageable patient numbers and do not follow up on patients.

“Doctors do not communicate with the patients at all and make no effort to see that the patient can access treatment once leaving hospital.” Private therapist

“Having only been working for less than three months, I’ve already had a very mixed experience at the hospital. Having said that, overwhelmingly I feel my experience has left a bitter taste in the mouth. To sum up what I have witnessed at xxxx hospital; it seems to be a matter of avoiding responsibility as much as possible, whenever possible. The less work you have to do, the fewer patients you accept, the better. To get a department to accept a patient from you in casualty can be an uphill battle, that ultimately means patients lie in casualty for hours on end (over 24 hours in my experience) before being taken to a ward. I, as the junior doctor get driven to near rage.” Public medical practitioner

“… lack of supervision means that doctors can act essentially unchecked. Patients have no ‘power’ to act against their health care provider, as they would in the case of private practice. This opens the door to patients being treated poorly; at least in a manner that we would not want to be treated if we were in the patient’s shoes.” Public medical practitioner

Social, ethical and policy procedural deficits appeared to exist, especially in the public sector, which had negative implications for the manner in which patients and medical practitioners interacted and related to each other. For mutual respect to exist, medical practitioners should be held accountable and responsible for not only the procedures they do, but also for the professional way in which they
conduct themselves. Supervisors need to assure that quality control measures are put in place and monitored in order to keep the standards of professionalism at an acceptable level. Patients and medical practitioners probably lose hope in a system that is not functioning optimally.”

4.3.2 Medical practitioner – Nurse “power relationships”

Medical practitioners complained about and expressed contempt regarding the nurses’ poor work ethic and, in turn, nurses complained about medical practitioners behaving in a “superior” manner and being supported by health care hierarchies. Nurses felt that they were not allowed to interact with medical practitioners as part of a valuable, professional, multi-disciplinary team. Negative relationships appeared to be more prolific in the public sector.

“Unfortunately, I feel that we are in a situation still, where there are hierarchies rather than inter-disciplinary teams. For instance, doctors are not recognising the worth of expertise of other health care professionals, such as nurses.” Nurse

“Doctors do not respect or value the opinions of other health care professionals, especially nursing staff. There is no such thing as a multi-disciplinary team in the private sector.” Therapist

“Not to forget the difficulties encountered with our nursing counterparts. It is a nightmare working with most of them, constantly dragging their feet, as if they are doing you a favour, lack of ability, whatsoever. Constantly on tea, lunch breaks. I have none of the above, so quick to remind you of their job description. Can someone send me mine, please!” Medical practitioner

Team-building and multi-disciplinary team interaction can only happen, when supervisors and management structures introduce procedural measures to uphold and encourage cohesion amongst the different professions, who need to work together to optimise their own work experiences and the experiences of the patients.

Ethics and morality are often not an upward spiral, rather they tend to degenerate in the absence of the will to do the right thing and fight for what is right.
4.3.3 Medical practitioner – Other power relationships

Health care practitioners experienced medical practitioners being considered “more important” in the health care hierarchy and that patients’ perceptions were that anyone they consulted was called “doctor”. Feelings of anger, frustration and perceptions of inferiority in the workplace appeared to translate into covert resentment towards medical practitioners, creating a rift in those relationships, which should be mutually beneficial, but instead were considered mutually exclusive. Medical practitioners were perceived to be disrupting team efforts or any team spirit, causing other health care practitioners to defend themselves by externalising their emotions in unhealthy ways.

“Each profession within the health care system is treated differently, financially and otherwise, hence, no team spirit. A doctor is a doctor and always right, cannot be told by a nurse or xxxx (other health care practitioner), for example.” Radiographer

“Honestly – as we are saying – but in a way the doctors are still dominating the health care system. Society doesn’t understand other disciplines can help. Team practices don’t exist in private, maybe in government – don’t know. Each person is doing his own thing. We need a body – to comply and work as a team. If we can – length of time in hospital can be reduced. Therapist

“Management say all cases to be discussed with consultants before being accepted to our hospital … but you would find patients booked directly to us and doctors have an attitude that they cannot be told by an xxxx (health care practitioner) what is to be discussed with a consultant and what is not to be discussed.” Radiographer

“We need to change that perception. You cannot convince them. Even the nurses call me ‘doctor’ outside the hospital, it’s their thinking. Even if the community thinks that the ‘doctors’ are ‘the’ ones. Even if you tell them you’re an xxxx (health care practitioner) – they insist you are a ‘doctor’ … Doctors are still dominating the health care system. Society doesn’t understand other disciplines can also help … whoever provides health service is a ‘doctor’. The Department of Health only considers doctors. I read in the paper that even the dentists think they are out of the system.” Therapist
“Referrals to other health care professionals are not based on ‘who can do the job best’, but rather given to friends.” Dietician

“Doctors must be in the wards consulting, not running lucrative private practices.” Dietician

Resentment about the perceived higher status of medical practitioners by other health care practitioners has created a negative recursive feedback loop, which inevitably affects patients as well. Extensive education and efforts to address the hierarchical imbalances needs to be considered to promote unity and fair representation in the public’s perceptions of who is treating them and what status they have. Mutual respect and co-operation between professions is essential for an effective and efficient workforce. The expressed mistrust towards medical practitioners, who are delivering "sub-standard" care whilst working in private practices, needs to be investigated in order to ascertain whether there are reasonable grounds to suspect that this is the case. Feelings of powerlessness and resentment created dialogues which ultimately impact the entire health care system.

4.3.4 You pretend to manage, I will pretend to work

Considerable anger, resentment, contempt and frustration was expressed, particularly with regard to the public health care system, concerning management structures not being “in-touch” with what was happening “on the ground” where health care practitioners faced stressful patient demands with limited resources (human and material). This, and perceptions that the health care system as a whole had become very disjointed and out of touch with reality, were due partially to inadequate channels of communication between health care practitioners themselves and between them and management. Working conditions contrasted sharply with the private health care system, which was perceived to be working well by most standards, although stressors did exist as part of the reality of health care practitioners’ daily lives.

“I find my boss and colleagues around the hospital looking very busy, but actually getting no work done. Look as busy as possible and get away with as much as possible – forget about the patient. It is challenging to take pride in my own work, since I am so embarrassed to be part of a very broken system.”
Therapist

“Top management should spend x number of hours a month working at ‘grass roots’ level ‘front-line’ with patients to stay in contact with what is really happening (less cupcakes and tea!).” Therapist

“I feel negative about the changes presently, simply because people (managers) are not being pro-active regarding brainstorming and carrying out proposed changes.” Therapist

“The reporting channels are not satisfactory … one has to report to a medical manager who knows very little about the department and why it is, that when all has failed, no-one on ‘ground level’ has powers to go to district or province or national without ‘toyi-toyi’ (industrial action).” Radiographer

“… there is never enough money to buy equipment, even a chair for someone to rest during lunch, whereas in the management offices they sit on rotating chairs.” Radiographer

“Supervisors need to play a more active role in overseeing the quality of care provided … the lack of supervision and recourse in the case of malpractice means that doctors can act essentially unchecked. Hospital management needs to open channels to allow those involved in poor practice to be disciplined.” Medical practitioner

“Shortage of staff leads to working unpaid overtime. As a result, we end up with no interest to do our work properly due to tiredness.” Nurse

“Performance of health care workers should be measured in patient outcome, and not in hours spent at work, as typical civil servant pen-pushers are evaluated. Failure to perform professional duties should be reported to professional bodies (HPCSA), etc.) rather than be managed by clueless human resources personnel interpreting Civil Service Law.” Medical practitioner

“The only time I will get to interact with my employer is when I do something wrong.” Medical practitioner

“Attitude amongst ourselves as professionals makes it even more difficult to perform our duties.” Medical practitioner
“... in the state sector, a trend of mediocrity seems the norm, where it is almost discouraged to extend yourself.” Nurse

Accountability of managers to health care practitioners and vice versa needs to improve to boost overall public sector service delivery, accountability, responsibility and morale. The negative feelings towards and perception of management and government structures were endemic. It will require a lot of effort from all health care stakeholders to change these perceptions and experiences especially when managers were perceived to be “working in luxury” and “pretending to work”. Anger, frustration and resentment is bound to build up, especially if health care practitioners feel powerless to change their circumstances. These and other frustrations might inevitably lead to anger being expressed in harmful ways, for example, misdirected at the patients, each other and filtering through into all aspects of their lives, often also resulting in leaving the professions altogether. If “top” structures are not seen to be upholding high standards, the workforce will follow, with negative consequences. If a system is functioning well, then both health care practitioners and management support each other and a culture of caring is created with open-dialogues to address any issues. When staff feel valued, they tend to stay in their jobs longer and are more committed. Workplace unhappiness is often a precursor to general unhappiness in one’s life in all spheres, as the effect “ripples” from work to home.

4.3.5 Hero-saviour roles

There appeared to be hero-saviour dynamics, especially with regard to private health care practitioners’ sentiments related to wanting to “help” the essentially “helpless” and/or often the “unappreciative” public sector and especially nurses. This impression could potentially serve to cement an “us-versus-them” dynamic within the public/private system and maintain a less than constructive relationship through “helpful” criticism and the expectation that this criticism would be well received.

“Although I am working within the private sector, I have a lot to do with the state (public) health as I am involved in training … of health care professionals … Despite their reasonably good salaries, state nurses will never pay for themselves to be up-skilled – in fact, they expect all expenses covered,
complain about the food at the courses, and expect to be given the time back if it is on a weekend … The other main problem is that unfortunately, there is a mentality within these nurses that it is only worth improving yourself or learning more skills, if it is for a financial reward. The other problem lies with the younger generation, who are a generation of instant gratification with expectations of high monetary rewards. The caring professions are never really going to suit that requirement. I really feel there are so few now who see it as a ‘calling’ rather than a ‘job’.” Nurse

“I would prefer not to work in the private sector, but I am forced to in South Africa, as my experience outside of South Africa, as well as my teaching experience, is not recognised – if I go to the public sector, I would have to accept an entry-level position.” Nurse

“People from the public sector usually have the attitude of ‘I don’t care’ … and it’s not mine. With almost all of them, responsibility lies with the superiors only, which impacts on service delivery. However, in the private sector, everyone is responsible and accountable, which is a key factor to a good service delivery.” Radiographer

The imbalance of “us versus them” needs meaningful dialogue, ideally facilitated by team-building workshops. Perceptions are socially constructed realities which reflect health care practitioners’ intuitively looking, listening and seeing. The perception of staff being less disciplined, less motivated and more unionised appeared to be more associated with the public sector. This was expressed by both public and private respondents. New narratives will need to be constructed to assist in healing the apparent imbalances which appear to emphasise the belief that the private sector is more favourable than the public health care environment.

4.3.6 Disempowerment dynamics

Public health care practitioners felt more “helpless”, “powerless”, neglected and angry, displaying features consistent with low self-esteem and/or low self-efficacy when compared to private sector practitioners.

“My personal feeling is that the worst thing ‘apartheid’ did was disempower people so they do not feel they have the right/power to self-care, to take some responsibility for their own health within a support system made of their
“We are being neglected as workers. We are not being given enough chances to upgrade ourselves. If you are in the ‘rank’, you just stay there for a couple of years and yet it takes time to be given a chance to go and study.” Nurse

“I personally do not feel appreciated. We as nurses, the government does not support us financially if we want to do courses to uplift our academic knowledge.” Nurse

“We always have to pay for our own courses (short).” Nurse

“I feel overburdened, unappreciated for the efforts I make. The only time I will get to interact with the employer is when I do something wrong. Very demoralising for a young professional like myself.” Medical practitioner

“I see 1-2 patients a day, while the xxxx (health care professional) in the hospital down the road has a 6-month waiting list. I am here – available to help – but fear of the hospital politics suppresses the service I could offer clients waiting at the other hospital.” Therapist

“As a result, we end up with disinterest to do your work properly due to tiredness.” Nurse

“Not to mention the difficulties with our nursing counterparts. It’s a nightmare working with them, constantly dragging their feet, as if they are doing you a favour … Constantly on tea, lunch breaks … So quick to remind you of their job description. Can someone send me mine, please!!” Medical practitioner

A possible “dysthymic-type syndrome” related to chronic stressors in the workplace featured alongside negative coping styles such as “learned helplessness”, i.e. perceptions of being unable or powerless to change the outcomes of their poor working situations (Peterson, Maier, & Seligman 1993). Tiredness, irritability, negativity and anhedonia suggestive of chronic stress and burnout were also evident. Historically, some of these behaviours and symptoms might have been acquired by members of previously disadvantaged groups in South African society (whether gender-based or socio-political) prior to 1994 and during the apartheid government-era, when disenfranchised and oppressed populations were prevented from exercising self-determination due to historical
dynamics of those times. In terms of these dynamics, women experienced culturally sanctioned oppression, whether due to religious dogma, political factors, or both, or patriarchy, all of which may have contributed to the creation of a “learned-helpless” response in the face of seemingly insurmountable stressors. In that sense, some practitioners tended to “give-up” rather than address their adverse situations for a more favourable outcome. Historical and past circumstances perpetuating, as psychological sequelae, may result in health care practitioners resorting to covert forms of aggression such as “acting-out”, being passive/aggressive, pretending to work, pretending to manage and so forth. These behaviours essentially create a negative feedback loop that affects the entire public health care sector. Literature suggested that despite being “liberated” since 1994, previously disadvantaged South African health care practitioners still faced hardships in their psychological, economic, cultural and political environments with perpetuation of different levels of suffering still remaining (Prilleltensky, & Gonick, 1996). In the sense that every person on earth is part of a community, oppression co-exists and is co-determined.

When one describes a people as oppressed, one most often considers an oppression that is economic and political in character. However, recent liberation movements, the black liberation movement and the women’s movement in particular, brought to light forms of oppression that are not immediately economic or political. It is possible to be oppressed in ways that do not involve deprivation, legal inequality or economic exploitation; one can be oppressed psychologically, the “psychic alienation” of which Fanon spoke. To be psychologically oppressed is to be weighed down in one’s mind; it is to have a harsh dominion exercised over one’s self-esteem. The psychologically oppressed become their own oppressors; they come to exercise dominion over their own self-esteem. Differently put, psychological oppression can be regarded as the “internalisation of intimations of inferiority (Prilleltensky, & Gonick, 1996).

4.3.7 Projecting/Externalising/Intellectualising

Health care practitioners, from a psychoanalytic perspective, appeared to exhibit “blame-shifting” behaviour, thereby externalising unpleasant feelings they had of, for instance, anxiety and attributing them to others (Freud, 1992).
“The reporting channels are not satisfactory … one has to report to the medical manager, who knows very little about the department and why is it that when all has failed within the institution, no-one on ground level has powers to go to district or province or national without ‘toy-toy’ing’ (industrial action)’?” Radiographer

“There are no working tools – you are always wanted to improvise and it causes emotional and physical exhaustion … health is paying for less … no one comes to say thank you – instead they look for mistakes you have done. If you are not feeling well, no-one trusts you.” Nurse

“I personally think the patients’ rights are just over-rated. They swear at us, do not give us respect as professionals, they come to us sick as hell, you do your part and see the need to admit; after the hard work, they decide to sign RHT (Refuse Hospital Treatment).” Medical practitioner

The health care system was perceived by some participants as uncaring, chaotic, uncontrolled, unsatisfactory and inconsistent, resulting in health care practitioners feeling justified in projecting their frustrations and anger towards the system, which they felt helpless to change, essentially resorting to externalising their inner frustrations in order to cope; or intellectualising their anger and becoming detached/under-involved. Some participants appeared to empathise with their patients’ suffering (Freud, 1992), identifying with their abuses such as the poor treatment by the system, as well as bullying by health care colleagues – suggestive of a system that is systemically abusive. The negative environment for both health care practitioner and patient caused anger and contempt towards the system as a whole. By denying and defending themselves from their own unpleasant impulses, such as anger, rudeness, greed and so forth, it is possible that some health care practitioners might have, instead, accused the system of those “vices” (Freud, 1992). For others, anger resulted in a loss of self-confidence. These conflict-laden relationships were often filled with drama (over-involvement) and appeared to be destructive with regard to shifting the blame, feeling persecuted or, in fact, reversing the roles and “becoming the persecutor”.

In summary, social constructionist findings presented health care practitioners’ experiences from a social/community perspective. They are a valuable barometer
of the state of the current health care system and, as such, are as important as other facets that make up the health care system as a whole. Because participants are socially situated in their work environments, their interactions with others also inevitably shape that environment. The subjective meanings which they attributed to their lives in those social settings eventually become social facts, with the groups constructing knowledge for each other by creating their own “culture” within other cultures, similar to the “Russian doll” metaphor. Whatever meanings the health care practitioners gave to their social environments would therefore influence and be influenced by the context in which they found themselves – their shared experiences and individual psychological make-up also inevitably affecting those. There are many “truths” in a socially constructed world. Health care practitioners construct their own personal realities in their communities according to their own understanding and these understandings create shared assumptions about reality.

4.4 Interpretive paradigm (level 3 of analysis)

A deductive discussion format was used to interpret health care practitioners’ responses, which were read and re-read and themes found, which, in turn, formed the sub-headings under the broad themes. For each of these cases, the themes and sub-themes are discussed and substantiated with excerpts of participant responses.

Twelve broad themes emerged at the third level of describing and reflecting on the experiences of the participants. This stage may essentially be conceptualised as interpreting the “I-Self” or “pre-verbal” level of their experiences.

It is, however, acknowledged that any interpretation of results at this level may have represented only one version, the researcher’s, of description and that interpretations done by others might have produced different themes and therefore different results. It was, nevertheless, the express intention in this explication to avoid misrepresenting health care practitioners’ responses, despite knowing that, methodologically, interpretation involves self-reflection, personal filters and possible expectations or pre-conceived ideas. In this sense, it is accepted that the interpretation at this level is subjective, no matter what the intention was to avoid
it, even though every effort was made to do so, bearing in mind that the study was conducted by a registered health care professional who was also a part of the system described. To what extent this may have had an influence on the interpretation, however much it was the intention to avoid such bias, is difficult to judge. Recursive reflection and critical thought was employed sincerely and judiciously to avoid these pitfalls in attempting to remain faithful to the participants ‘original experiences and intentions.

4.4.1 Emerging themes from the five open-ended questions

Emerging themes from the 5 open-ended questions are presented in the following twelve sections and with particular reference to:

4.4.1.1 Anger

Anger is often a result of frustration that cannot be controlled. It is a state of physical and emotional arousal of varying degrees and results in actions and/or reactions that are sometimes beneficial if they are agents for positive change. They may often be destructive and recursive, leading to further cycles of anger and/or frustration in the absence of healthier learned responses or coping mechanisms, such as discerning what can be changed, what is out of one’s control or what may or may not happen in the future (Kassinove, & Tafrate, 2002).

Health care practitioners, at times, became angry and often displaced their anger (blaming others, giving up, mocking the system, feeling neglected and so forth) as a way of coping and their coping style (Berger, 2005) may include examples such as accusing others of “dragging their feet”, “protect us, don’t prosecute us”, “can someone give me my job description” and “just thinking about it gives me a headache”. Anger was experienced by participants, particularly in relation to the perceived “systemic ills” pertaining to the health care delivery system and how it affected their lives (and their patients’ lives), playing-out in feelings of and experiences related to contempt, neglect, exclusion, mismanagement, misappropriation, nepotism, lack of team-work, loss of faith in the system, apathy, poor ethics, and overall low morale. It emerged that, in general and in particular, health care practitioner’s anger was vented at the government, the local institutional hierarchies, at colleagues, as well as towards themselves with
projected and introjected angers, inevitably also affecting their overall health and mental well-being within the system as a whole.

Some health care practitioners engaged with the experiences they felt and expressed them strongly and, in some cases, this may have been a subconscious attempt to offload their discomfort, thereby defending themselves by rather using projected outrage. Anger may sometimes be expressed psychodynamically as a temporary projection of guilt, shame or vulnerability that could be interpreted as a consequence of frustration and the uncomfortable sequelae of feelings of stress and anxiety. Some participants might have reflexively or subconsciously introjected certain views without thinking them through, adopting them unanalysed or "digesting" them as part of their own personalities and expressing them in behaviours and as expressions of anger. These defences may often have been adopted without affecting their moral values and/or integrity, for example, being angry despite doing the right thing (Freud, 1992).

Some health care practitioners often chose to opt-out and rather “disengage” by suppressing how they felt, choosing rather to deal with what they could and postponing their feelings “for later” in order to cope; or intellectualising the anger for the same reason. In some instances, humour or contempt were expressed to ease stress, frustration and anxiety and to vent feelings in a more socially acceptable manner. Chronic stressors caused many health care practitioners to become either over-involved or under-involved and finding it difficult to remain balanced and objective – sequelae of chronic stress (Freud, 1992).

Although there are blurred nuances in the interpretation of anger and frustration, they are discussed separately. This was done in order to reveal the subtleties and to highlight the incongruence participants seemed to feel concerning their expectations of and failures of the health care system, and what they were actually experiencing through their expression of feelings, but in different ways.

The nuances and subtleties of anger are broken down into the following sub-themes and with particular reference to the following:
a) Contempt

Health care practitioners expressed contempt with regards to management of resources, lack of work ethic, managers being out of touch with staff, government taxation laws, overspending by politicians’ including the presidents' perceived lavish lifestyle while others were suffering, misgivings about the NHS, inadequate redress for unprofessional behaviours. Complaints were felt to "fall on deaf ears". Contempt covered a wide variety of social injustice issues as well as personal opinions about the state of health care and proposed changes. The following excerpts illustrate participant’s contempt:

“How can they even think of NHI, when other hospitals don’t even have urine ‘dipstix’ (urine testing kits) or gloves or BP (blood pressure) cuffs, which are like basic things? Are they crazy? (Laugh out loud). And I personally won’t be happy about the fact that I will be paying medical aid for someone who is too lazy to wake up and get a job; at least look for one! As it is, we are paying too much tax for all sorts of grants and RDP (Redistribution and Development Programme) houses and not to mention our President's lavish lifestyle!”

Medical practitioner

“Top management should spend x number of hours a month working at grass roots level/front line with patients to stay in contact with what is really happening (less cupcakes and tea!).” Therapist

“As noble as the proposed (NHI) changes sound; I think I would rather die than be treated in Public health care myself.” Therapist

“Performance of health care workers should be measured in patient outcome, and not in hours spent at work, as typical civil servant pen-pushers are evaluated. Failure to perform professional duties should be reported to professional bodies (HPCSA), etc. rather than be managed by clueless human resources personnel interpreting civil service law.” Medical practitioner

b) Poor communication

Poor communication was also a point which caused some participants to feel angry. Some health care practitioners felt that the procurement process for nurses needed to be reviewed, as many were perceived to have inadequate language
skills and/or communication skills. Furthermore, poor communication between health care practitioners due to "lax" or inadequate referral letters/telephone calls was perceived to be problematic and a source of anger at times. Communication was also felt to be lacking with regards to the time it took for grievances to be addressed by superiors. The following excerpts illustrate participant’s anger towards situations where poor communication was experienced:

   Many of them (nurses) cannot take a message or carry out a simple instruction." Nurse

   “I hate receiving referrals with no clear instructions/expectations.” Therapist

   “They must respond immediately to our grievances as staff.” Nurse

   c) Mismanagement

Mismanagement was a further factor which seemed to cause anger amongst health care practitioners. Practitioners felt angry that citizen's taxes were not spent prudently and that there was a perception of mismanagement and misappropriation of those funds. This resulted in patients being underserviced and suffering as a result. Although there is enough money in the budget to buy top of the range equipment (e.g. CAT scanner), it wasn't working properly. The following excerpts illustrate some situations where mismanagement caused participants to feel angry:

   “In the public hospitals, you will find that they do not have human resources, material and even financing. I personally think that this may be due to mismanagement of funds and equipment, too. You will find that they have the top of the range equipment, but it is not in working condition.” Radiographer

   “Mismanagement of funds allocated to public hospitals is often mishandled both internally and externally, and services often suffer, which results in a breakdown of medical care to the patients.” Radiographer

   “In my opinion, there isn’t a shortage of money in the health sector, but rather poor resource allocation and mismanagement.” Medical practitioner
d) Corruption

Health care practitioners felt angry about the levels of corruption in the public sector and the over-emphasis on financial gain in the private sector. The following excerpts illustrate this:

“… given the levels of corruption (in the state sector) and poor governance, the situation is not going to change in the foreseeable future.” Medical practitioner

“Private sectors seem to want to worry more about profits and in the public sectors corruption is rife!” Radiographer

“Address rampant corruption, mismanagement and misappropriation of funds.” Therapist

e) Insufficient remuneration

Insufficient remuneration and negative expectations for future reimbursement was also experienced as a source of anger. Some health care practitioners felt that they would consider emigration if the situation did not improve, or that they may be "forced" to leave. Others felt that their love for the people of South Africa outweighed their financial wishes, despite feeling angry about it. Overseas countries were perceived to be paying higher salaries and offering better remuneration. This is illustrated in the following excerpts:

“Give the workers money, not peanuts. Change the working hours.” Nurse

“Private doctors are likely to be triply under-remunerated by the National Health Insurance!” Medical practitioner

“If I do leave, it would be for financial reasons. Let’s face it, there is no money in this field … but I love my people.” Medical practitioner

“I have friends, who are xxxx (health care practitioners) in other countries and we are not singing the same tune financially.” Radiographer

f) National Health Insurance (NHI)

Health care practitioners felt angry about extra taxes which the government would
impose on the working class in order to be able to finance the NHI, especially when they were already highly taxed. The high rate of unemployment and/or perceived laziness of ordinary people to "try and get a job", meant that they were often conveniently supported by social grants, which the tax-payer had to foot-the-bill for. Thus, the proposed NHI was a “sore” point for some of the participants, as can be seen from the following:

“The NHI as I understand it, is a way to get more money for the health care by, in simple terms, adding another tax to those who, can afford it … perhaps we should have optimised resource allocation and minimised wasteful expenditure before wanting more money.” Medical practitioner

“And personally, I won’t be happy about the fact that I will be paying medical aid for someone who is too lazy to wake up and get a job; at least look for one! As it is, we are paying too much tax for all sorts of grants and RDP (Redistribution and Development Programme) houses and not to mention our President’s lavish lifestyle!” Medical practitioner

g) Lack of team work

Anger was expressed in relation to the divisions between different health care professions, due to their perceived status. Medical practitioners were perceived to have a higher status and patients were not educated to know the difference. Management was felt to be "disjointed", with some of the managers doing their duties as expected while others tried to exploit the system for personal gain. Thus, these divisions and a lack of team work aroused feelings of anger for some participants, for example:

“Team practices don’t exist in private, maybe in government – don’t know. Each person is doing his own thing. We need a body – to comply and work as a team. If we can – length of time in hospital can be reduced. Even if the community thinks that the doctors are ‘the’ ones. Even if you tell them you are an xxxx (health care practitioner) – they insist you are a ‘doctor’. We need to change that perception. You cannot convince them: ‘if you are not a doctor, then why am I here?’ Even the nurses call me ‘doctor’ outside the hospital; it’s their thinking. Whoever provides health service, is a ‘doctor’.” Therapist

“Unfortunately, there will always have to be audits of such managed care
programmes, as there will be those who are motivated and make it work well and then those who are in it for their own enrichment and will do the minimum care possible.” Nurse

h) Politics

Anger was expressed about the current government's propensity to blame the previous government for social injustices, including perpetuation of race-related divisions and issues in society. Politics appears to be an integral part of the health care sector and is perceived negatively by health care practitioners who feel that health care should be "above" political agendas. This can be seen in the following excerpts:

“So far, in government, honestly, sometimes people say ‘the previous government’, but I don’t know the previous government. I can only see what’s happening now. They are not doing what I think they are doing. They say – the other government was in power in democracy for nineteen years –and still no difference. It’s not about black and white. We need to get beyond that. Slowly the ANC is losing voters. Our children don’t see the facts. They will vote differently. The problem for the ANC will be the Youth League; they don’t see the colour divide anymore.” Therapist

“Leave politics out. ‘Free’ health care is usually a pre-electoral bargaining chip for the voting masses!” Therapist

i) Insufficient consultation with the workforce

Health care practitioners were angry about being “devalued” and not consulted regarding health care policies and procedures. They felt excluded, disadvantaged and often neglected. The following excerpts illustrate these feelings of anger:

“I would like to live in a country, where my opinion as a health care professional counts and is respected.” Dietician

“We are not being involved in decision-making and there is a shortage of staff/personnel; we are overworked and yet we are expected to deliver quality nursing care, but there are insufficient resources. We always improvise.” Nurse
j) Lack of productivity

Anger was expressed about managers who "pretended" to have patients' best interests at heart. Many patients travelled long distances to get help at hospitals and clinics only to be turned away, often due to maladministration and lack of supervision and accountability. Managers/supervisors' attitudes towards their responsibilities made it hard for the hard working younger health care practitioners, who were trying to provide the best care, to provide the best care and service. The younger health care practitioners expressed their feelings as follows:

"I find my boss and colleagues around the hospital looking very busy, but actually getting no work done. Look as busy as possible and get away with as much as possible – forget about the patient. It is challenging to take pride in my own work since I am so embarrassed to be part of a very broken system."
Therapist

"I feel that the main problem within our health care system is the inefficiencies in management and low productivity and corruption rather than funding."
Therapist

k) Negligence

Health care practitioners in the public sector felt that doctors, in particular, were often negligent and that patients suffered as a result. Inefficiencies in service procurement were felt to be dragging the whole health service down. Comparisons were made to the perceived efficiency of the private health care sector, which made the public sector seem dismal by comparison. This is seen in the following excerpt:

"The government do have hospitals, a lot of them; why don't they first manage them properly because when you look at it closely, public hospitals do have and provide a lot of services. It's just that there is a lot of negligence. Is this not going to drag the whole of South African's health care down? They are failing the public hospitals. How will they make sure that the private hospitals don't go through the same problems? Private people have worked so hard to put their services to the standards they are at. I think they should just come
with a new strategy – this matter is too sensitive.” Radiographer

I) Lack of efficiency and responsibility

Participants expressed anger that health care practitioners and other hospital workers (such as cleaners) are not held accountable for their failure to uphold good health care standards, nor do many of them adhere to the principles they were taught. Equipment in public hospitals and clinics was not efficiently procured, essential machinery was often broken and of poor quality. These factors are evident in the following excerpts:

“There needs to be a bigger focus on efficiency and responsibility. One example that illustrates my view is this: I have witnessed cleaners mopping the floor, using sterile gloves because no regular gloves were easily available. Sterile gloves are easily twenty times (as a conservative guess) more expensive than non-sterile, regular latex examination gloves. I’ve also experienced an entire weekend in casualty without paper towels to dry one's hands. The inability of doctors and nurses to properly clean their hands goes against one of the first principles of being a doctor: first, do no harm. The cost of treating a patient for a hospital-acquired infection far exceeds that of a roll of paper towels; not to mention the human cost of a patient dying.” Medical practitioner

“There is new equipment that is bought. They do not stay for long because they are cheap stuff, it breaks easily ... Give the good quality equipment that does not break easily.” Nurse

m) Governing bodies

Medical practitioners were perceived to be inadequately trained due to pressure on the government to produce a certain quota to fill posts. As a result, they were paid to do a poor job which they weren't well enough trained to do and the patients suffered. One participant voiced his opinion as follows:

“The training of doctors are sub-standard, and the governing bodies are aware of this, but allowing it due to political pressure to provide warm bodies on the ground, irrespective of the quality of training and subsequent care provided.” Medical practitioner
n) Job descriptions

Poor management and training of staff with regards to what is expected of them in a professional medical environment and in terms of "job description" was felt to be seriously lacking in the public health care sector. Two participants expressed their anger towards this lack of clearly defined roles as follows:

“… medical personnel need to be motivated, educated! On their 'job purpose', nurses need to be more dedicated, responsible, caring and enjoy doing their jobs.” Radiographer

“Not to forget the difficulties encountered with our nursing counterparts. It is a nightmare working with most of them, constantly dragging their feet, as if they are doing you a favour, lack of ability whatsoever. Constantly on tea, lunch breaks. I have none of the above. So quick to remind you of their job description. Can someone send me mine, please!” Medical practitioner

o) Lack of supervision

Anger was expressed, especially in the public sector, about lack of supervision. For example, a community service health care practitioner felt that there was no continuity from one practitioner to the next if someone left. When there were supervisors, many were perceived as being disinterested in maintaining high standards of efficiency in their departments. This therapist expressed their opinion as follows:

“Next year, a new therapist will come and our work will not be carried over because there is no one to supervise.” Therapist

“There is a trend to work as little as possible, if there is no pressure from management or supervisors.” Medical practitioner

p) Funds

Anger was experienced about the unfair allocation and mismanagement of funds in the public health care sector. Managers, were perceived to be selfish about their own needs instead of doing the job they were being paid to do and having a professional attitude about it. Health care practitioners complained about not
having chairs to sit on, to rest, while managers had "rotating chairs" in their offices. This anger towards mismanagement was expressed as follows:

“Mismanagement of funds allocated to public hospitals is often mishandled both internally and externally and services often suffer, which results in a breakdown of medical care to the patients.” Radiographer

“…there is never enough money to buy equipment, even a chair for someone to rest during lunch, whereas in the management offices, they sit on rotating chairs.” Radiographer

q) Fraud

Health care practitioners were angry about how fraud impacted on health care service delivery. This is evident from the following excerpts:

“The management at the top there, they must sit and think for themselves. There is too much fraud happening there, that hinders good quality health care.” Radiographer

“Private sector is not regulated in any way, resulting in patients being overcharged, staying in hospital for longer periods than is needed, being consulted to by many health care providers, which is not necessary.” Dietician

“Around there is still fraud cases reported over media, etc.” Nurse

r) Compassion and empathy

Some of the participants felt angry about the lack of compassion and empathy that some of their colleagues showed towards patients. This can be seen in the following excerpt:

“The nurses consider nursing as a pay cheque and have no compassion for their patients.” Nurse

“Big problem is ...lack of empathy from many health care practitioners.” Medical practitioner
s) Unsatisfactory reporting channels

Health care practitioners felt that their requests and concerns for adequate staffing and other needs was not addressed or grasped, in part because managers were either ill-informed, were disinterested and out of touch, did not have sufficient authority to act, or used their positions to thwart those proposals. Their dissatisfaction and anger was expressed as follows:

“The reporting channels are not satisfactory, as a radiographer, one has to report to a medical manager, who knows very little about the department and why is it that, when all has failed within the institution, no-one on ground level has powers to go to district or province or national without ‘toyi-toyi’ing’ (Industrial Action)?” Radiographer

“But I don’t see this happening because again, one proposes on the number of staff needed for the department, you get crushed by those in management, when they have no idea what’s happening on the ground.” Radiographer

t) Rage

Extreme anger, expressed as rage, was experienced in stressful situations when medical practitioners were unable to perform their duties properly (such as admit critically ill patients) due to bureaucracy, inefficiency and/or lack of morals and ethics of hospital staff and colleagues. Patients were turned away, who would otherwise have been admitted to the wards. The following excerpts illustrate this rage:

“Having only been working for less than three months, I’ve already had a very mixed experience at the hospital. Having said that, overwhelmingly, I feel my experience has left a bitter taste in the mouth. To sum up what I have witnessed at xxxx hospital; it seems to be a matter of avoiding responsibility as much as possible, whenever possible. The less work you have to do, the fewer patients you accept, the better. To get a department to accept a patient from you in casualty can be an uphill battle that ultimately means patients lie in casualty for hours on end (over 24 hours in my experience) before being taken to a ward. I, as the junior doctor get driven to near rage.” Medical practitioner
u) Nepotism and theft

There is a perception that jobs and promotions are given to family and friends. This, coupled with tenders which are deemed to have been unfairly awarded, poor accounting practices, and centralised buying was a source of anger for health care practitioners. If there was no prospect of promotion, many would stop trying their best, as it would go unnoticed anyway. Accountability/criminal prosecution was deemed a fitting punishment for such behaviour, if someone was caught doing it. This is expressed as follows:

“The state care should be improved by adequate policing of supply chains, so that the theft of equipment is stopped. This starts with the tender system and the corrupt provision of tenders: not to qualified individuals, but to politically connected ‘friends’ and ‘family’ of politicians. Ordering and buying of equipment should be decentralised and become the responsibility of the individual units delivering the service: failure to comply with first world accounting practices in this process should lead to loss of jobs and criminal prosecution.” Medical practitioner

“Promotions to higher positions should be given on merit and not to friends and family.” Nurse

v) Mistrust

Lack of trust in the integrity/capability of government to deliver good quality health services, inadequate or non-existent hospital security services to protect patients and health care practitioners created anger and feelings of mistrust. Participants did not trust the government's motives regarding training of medical practitioners, because they felt that at present substandard training was the norm, simply to supply volumes of health care practitioners instead of high quality, efficient and well-trained, for example, medical practitioners. Furthermore, incidents of violence have been occurring in public hospitals and clinics which are also reported in mainstream media. A lot of work will need to be done to restore faith and trust in the medical system once more. This can be seen from the following:

“Now, how would we trust, if we are scared of being stopped outside the gate, or raped inside the premises?” Medical practitioner
“The training of doctors are sub-standard, and the governing bodies are aware of this, but allowing it due to political pressure to provide warm bodies on the ground irrespective of quality of training and subsequent care provided.”
Medical practitioner

“At this juncture, it’s not easy to tell or say because the proposed NHI has not gone under operation and one cannot always trust what our government says. Today, they’ll say this, and tomorrow it’s the other.” Radiographer

“I am very sceptical about the implementation (of the NHI) and how it is all going to function and cannot see it happening for a long time to come.” Nurse

As apparent in the above experiential descriptions, anger manifested itself in health care practitioners’ lives in different ways and in varying degrees/intensities. Responses suggested that participants experienced negative psychological states when their needs were not met and expectations were not reached within the health care environments they were in. Some experienced extreme anger/rage while others expressed dissatisfaction about a variety of issues affecting them, possibly also in the hope that their contributions would result in change or simply that they had been "heard" and considered important in the long-term vision of this study. This view was expressed during the data collection stage of this research.

4.4.1.2 Frustration

Whereas anger reflected an outpouring of strong emotions (usually resulting from frustration, for example, frustration-aggression hypothesis, which postulates that frustration leads to aggression), participants expressed their frustrations through voicing their experiences, in particular, where they felt that their goals and/or expectations were thwarted. “The single most potent means of inciting human beings to aggression is frustration” (Sadock & Sadock, 2007, p. 150). John Dollard’s frustration-aggression hypothesis proposes that frustration almost always leads to aggression (whether overt or covert) and that aggressive behaviour is always an indication of frustration (Dollard et al., 1939; Reber, 2001). Reber (2001) and Sadock and Sadock (2007) suggest a revised version of this hypothesis: Frustration appears to increase aggression when the level of frustration is intense. If frustration is perceived as deserved or legitimate, rather than arbitrary or illegitimate, the frustration is likely to facilitate aggression.
Frustration is often a psychological response to feelings of being opposed and/or blocked, resulting in a sense of having a loss of control over the future and/or personal goals. If it is managed, it does not become destructive or lead to anger and destruction (Berger, 2005). Good and open communication channels may assist in facilitating the release of negative psychological states and provide a managed approach to dealing with frustrations. Most public sector participants experienced these channels of communication to be poor or non-existent or not responding adequately to their needs.

Some participants experienced difficulties and frustrations concerning the realisation of their pre-conceived ideas or expectations of the health system and were critical of the health care structures and how they thought they should function. These feelings were sometimes expressed as being rather more vulnerable or having helpless experiences, in which health care practitioners felt most aggrieved at not achieving desired outcomes, but had not resorted to full-blown anger. They felt particularly aggrieved about expectations for health care regarding poor human resources, lack of basic equipment, better performance of their duties, ethical maladies, management issues, working together (or lack of it), fears and anxieties about their lives and futures.

Some health care practitioner’s experienced internal frustration from not having their real or imagined deficiencies met, for example, their lack of self-confidence, external locus of control, personal goals that opposed each other, helplessness and so forth. Others experienced frustrations related to external factors (outside of the self), which blocked, irritated and got in the way of their perceived goals and/or needs. These were, in some instances, people such as managers, departments, government and individuals they had to deal with, and were often related to perceptions of “wasting time” or being frustrated by long patient waiting lines, job descriptions, wages, lacking, broken or faulty equipment, which were in “others’ hands” (Berger, 2005).

Although some frustrations appeared unavoidable, health care practitioners coped in different ways and dealt with their frustrations differently. Some chose to be rather more altruistic (mature defence against goals that are not met), others being more optimistic and seeking to find solutions despite their frustrations, whilst
others became angry, frustrated, upset, dispirited and apathetic instead. Overwork and stress were factors that appeared to contribute to health care practitioners’ frustrations, which inevitably negatively affected their frame of mind (Berger, 2005) and their physical health.

Frustrations were experienced and reflected with particular reference to the following:

**a) Understaffing**

Health care practitioners felt frustrated about being inadequately staffed. They felt that this could be addressed through adequate remuneration of staff and sufficient people being trained in institutions which supply the health care sector. This can be seen in the following excerpts:

“I think the first would be to acquire more medical staff. This could be by adjusting their packages or match the ones offered by private sector so that there would be less people leaving the public sector because of better pay.” Radiographer

“Department of Education and Health need to make sure that there’s a great number of medical professionals that are produced annually so that all the institutions have enough staff.” Radiographer

“Most departments in the health care system run with insufficient staff and surely you will get tired and frustrated, staff faces it all the time, and bad service.” Radiographer

**b) Lack of basic resources**

Lack of resources, medication, staff, and transport for patients was a source of frustration for health care practitioners. These frustrations are strongly expressed in the following excerpts:

“Lack of the most basic resources frustrates the hell out of me!” Medical practitioner

“The government must make sure that things like medication and equipment are sent to the institutions in time, so that service delivery is not impacted.”
Radiographer

“At times, it can be frustrating, especially when you don’t have the resources to service the patients. Short-staffing is also a problem. Currently, I am the only active therapist at our hospital. I have an HOD (Head of Department), but she has different responsibilities. Transport is also a problem – patients have to travel far distances to get therapeutic intervention. They also cannot afford to have continuous therapy and therefore it is a challenge to rehabilitate them to a point of optimal functionality. Addressing one’s concerns is also another problem, as no one wants to take responsibility to hear my view and suggestions on how I think the department can be better facilitated. Overall communication is a problem.” Therapist

c) Emigration

Frustration from working in a sub-optimal health care system led to some health care practitioners considering leaving their professions or the country. One participant voiced this consideration as follows:

“… if my ability to earn a decent living in the health care sector is severely threatened by unattainable and unrealistic Government Health Care Policies, then I will look for alternatives.” Therapist

d) Economic and political instability

Health care practitioners were frustrated about health care within a politically and economically unstable country and felt that the quality of nursing was poor.

“Economic and political stability elsewhere. Better remuneration for shorter working hours. Better quality of nurses.” Medical practitioner

e) Discrimination

The selection and procurement process for further studies or specialisation were not adequate or clearly defined, and in some cases might be discriminatory. This led to health care practitioners feeling disillusioned, frustrated and questioning whether they would stay in the medical field at all. These frustrations were expressed as follows:
“... if I feel that I am unfairly not able to pursue postgraduate studies and therefore unable to specialise, I will not hesitate to emigrate to further my studies abroad if I feel that I am being unfairly discriminated against or if the country lacks the resources and places to allow me to specialise. As it stands, I will not continue in the medical field if it means I remain a general practitioner.” Medical practitioner

f) Lack of team spirit

Not working as a team, being respected as an equal multi-disciplinary team member, or being fairly remunerated was experienced as frustrating to health care practitioners who know that team practices enhance an efficient and happy workforce. These frustrations can be seen in the following:

“Each profession within the health care system is treated differently, financially and otherwise, hence no team spirit.” Radiographer

“It's going to be one-sided, not multi-disciplinary.” Therapist

“Doctors do not respect or value the opinions of other health care professionals, especially nursing staff. There is no such thing as a multi-disciplinary team in the private sector.” Dietician

g) Poor attitude

It is difficult for health care practitioners to work in a health care system where staff attitudes are poor, which inevitably affect morale and patient care. Bad attitudes have an insidious way of creeping into the "culture" of any organisation and make it very frustrating for those who are trying their best to be professional. These views towards poor attitudes were expressed as follows:

“Attitude amongst ourselves as professionals makes it even more difficult to perform out duties.” Medical practitioner

“Attitudes towards work need to change.” Radiographer
h) Lack of recognition

Medical practitioners, who continue to work in the stressful and frustrating environments of the public health care sector are often over-looked and not recognised for their dedication or altruism, leading to resentment and frustration, which can be seen in the following excerpts:

“Government medical institutions are often not recognised for the part they play. Some very dedicated and experienced doctors and medical staff stay in these institutions, working under very trying conditions, often causing frustrations …” Radiographer

i) Poor economic climate

Frustrations about inadequate medical aid funding, affordability of private health care for the ordinary person, the poor economy, and loss of human resources from the public health care sector, made it difficult for health care practitioners to earn a good living in a stressed economy. This is seen in the following:

“Being in the private sector, it’s not always affordable for patients to attend xxxx therapy treatment. Most medical aids have very limited cover for xxxx therapy, it becomes a luxury rather than a necessity in our current economic situation. Private practices in more wealthy areas (e.g. Johannesburg) can charge much higher rates. Our area’s population is made up largely of ‘blue collar’ workers with not much spare cash at the end of the month.” Therapist

“The private sector is under pressure financially due to the general downturn of the economy, as well as the influx of people abandoning the sinking state sector: more people have to share in a dwindling funder’s pool.” Medical practitioner

j) Poor Health care budget/lack of funds

Similar to the lack of resources, health care practitioners also expressed their frustration relating to the fact that they did not have adequate staffing for their departments. They also felt sceptical/mistrustful about the “reasons” which were given for these poor resource allocations. This is evident from the following:

“I am not sure what happens to budget for human resources because there is
always no budget to advertise posts for more staff. Most departments in the health care system run with insufficient staff and surely you will get tired and frustrated, staff faces it all the time, and bad service.” Radiographer

“It will still take time; always complain of not enough funds.” Nurse

**k) Poor conditions in clinics**

Basic services in the public health care sector, such as water, electricity and sewerage were often non-existent or inadequate which made it difficult for health care practitioners to exercise care for their patients or have conditions for good hygiene and service delivery. Some of these challenges are evident from the following excerpts:

“Clinics are a huge challenge … there is always no water, no electricity, or sewerage is not functioning well.” Radiographer

**l) Dying patients**

Health care practitioners were frustrated that too many patients were dying in the public health care sector due to inadequate service delivery, lack of supervision and poor hygiene standards. Junior staff were essentially "unchecked" and allowed free-reign instead of being properly guided by good supervisors. This serious frustration can be seen in the following:

“Some patients die because they can’t afford to come and fetch their medication.” Therapist

“People are dying because the most basic equipment is not available.” Therapist

“The cost of treating a patient for a hospital-acquired infection far exceeds that of a roll of paper towels; not to mention the human cost of a patient dying. The same aspect of our health sector that allows us junior doctors to gain brilliant practical experience, the lack of supervision and recourse in the case of malpractice, means that doctors can act essentially unchecked. Patients have no ‘power’ to act against their health care provider, as they would in the case of private practice. This opens the door to patients being treated poorly; at least in a manner that we would not want to be treated if we were in the
Health care practitioners often felt that their future goals were thwarted because of unsatisfactory or untenable situations either in their close environment or in the country in general. These frustrations created resistance, upset and annoyance because they felt unable to achieve their imagined outcomes and those of the patients they served. Their frustrations could increase if solutions are not found to address their needs adequately and through thorough consultation. Frustrations, particularly related to public respondents feeling underpaid in comparison to their private counterparts; providing poor service to patients due to lack of medication, equipment and facilities in clinics and hospitals; not having their concerns addressed adequately; poor overall communication with their views not being heard; considerations to emigrate due to poor salary outlook and political/economic instability in the country; lack of opportunities to specialise; lack of respect and co-operation between different professionals; poor work attitudes; lack of recognition for professional experience and a general lack of trust towards the government being transparent regarding funding.

4.4.1.3 Overwork and stress

Overwork and stress were experienced by some health care practitioners with particular reference to lack of support, psychological symptoms such as burnout, demotivation, pressure and having to work in a system that was experiencing a huge burden of disease under difficult circumstances. These experiences became apparent in all spheres of the health care system (public and private), but were particularly evident in the public sector. Resentment about insufficient salaries and resultant apathy, added to those stressors. Some health care practitioners ‘experiences were relayed in a manner that attempted to raise or highlight personal and work problems, some had a hope of finding solutions, whilst others were rather more avoidant, preferring to cope with what they could and “looking the other way” by defending themselves against the unpleasant feelings they experienced.

Overwork and stress were expressed in the following ways with reference to:
a) Pressure

Health care practitioners felt that they were placed under a lot of pressure due to high patient demand, large burden of disease, long hours and understaffing. These pressures are evident in the following excerpts:

“Private health care is usually quite stressful … there are usually no fixed hours for the doctor … pressure to accommodate all patients … Private health care is a business with all the associated financial, procurement, staff, administrative, tax, etc. demands and stress.” Medical practitioner

“The shortage of staff within the public sector is also caused by professionals leaving the state to the private sector for many reasons. This also puts a lot of pressure on the few guys left behind, as they have to work extra hard, while they are being under-paid.” Radiographer

“I only started working in the health care system last year and already the workload is exceedingly high. The HPCSA states that I should manage 25 patients or less as an xxxx (young medical practitioner), however I manage as many as 45 patients every day because we do not have enough staff.” Medical practitioner

b) Over-burden

Over-burden was experienced by health care practitioners as a result of inefficient booking and management of patients by administrators in the public health care sector. To add to this, there appears to be the perception that interaction with superiors only happens when someone has done "something wrong". This leads to anticipatory stress when interacting with those higher up in the hierarchy, causing negative psychological states. The following excerpts illustrate these feelings of over-burden:

“Attending to large numbers of patients at out-patient departments, ranging from non-functional booking systems, patients having rights to be seen anytime of the day with minor ailments, which could be dealt with at primary health care level. Poorly resourced “PHO” (Primary Health Organisation) services, patients having hope in those services.” Medical practitioner
“I feel overburdened, unappreciated for the efforts I make. The only time I get to interact with my employer is when I do something wrong. Very demoralising for a young professional like myself.” Medical practitioner

c) Burnout

Health care practitioners often displayed symptoms typical of burnout, due to work stress. Chronic fatigue, from working long hours, coupled with a poor self-esteem, their current situation and the future were perceived as being negative overall, particularly in the public health care sector. These burnout symptoms are evident in the following excerpts:

“…it is difficult if not impossible, to do any long-term planning in one’s life, both professionally and privately, if your income is dependent on either of the systems. The uncertainty and the looming threat of loss of income or employment eats away at the quality of life and peace of mind of health care workers, contributing to burnout and related psychological harms.” Medical practitioner

“Shortage of staff; leads to working unpaid overtime. As a result we end up with no interest to do your work properly due to tiredness.” Nurse

d) Lack of recognition

Health care practitioners did not feel recognised for working in difficult circumstances and trying conditions and often also felt under-remunerated. Those who wanted to work in the public sector could not get their private sector work experience recognised in order to get better public sector salaries. This resulted in highly qualified staff working in departments that they were not specialised to work in, causing frustration. Participants voiced their feelings towards this lack of recognition as follows:

“Government medical institutions are often not recognised for the part they play. Some very dedicated and experienced doctors and medical staff stay in these institutions working under very trying conditions...” Radiographer

“Medical practitioners, who are motivated to help people and who want to work in the public sector are struggling to have their private sector experience...”
recognised, and so are being offered sub-optimal salary packages.” Dietician

e) Stressful everyday environment

Care-giver/compassion fatigue and stress was experienced by health care practitioners from their everyday work environment. Across the board, they also felt overworked and underpaid. The following excerpts give us a glimpse into the health care practitioner’s everyday circumstances:

“The current system provides poor care to patients and a very stressful environment for caregivers in which we function.” Medical practitioner

“Currently all health care workers are unhappy. They are overworked and underpaid both in public and private sectors.” Radiographer

“Very frustrating! Medical aids often delay, obfuscate, deny vital services for the very patients that pay their bills, to the detriment of patients. Doctors are compelled to wait for pre-authorisation (from a distant clerk) for a procedure (pre-authorisation is not a guarantee of payment!).” Medical practitioner

f) Apathy and disengagement

Apathy and disengagement was experienced by health care practitioners resulting from working in stressful environments and often as a defence mechanism to cope with those stressors.

“Just mixed feelings. I do not want to bother myself. I will get a headache when I think how they plan to do it (NHS).” Therapist

“I think like everything else with our government, they continue to shift from one non-functional system to another. With short-term solutions, no sustainability at all. I have no desire to be part of it because it serves them (men in suits) not the people on the ground.” Medical practitioner

“… Just another way of accumulating debt, while paying us peanuts and failing to retain us.” Medical practitioner

“Instead of eight nurses, there is one or two. That also causes a health practitioner to take the early retirement or resign.” Nurse
g) Systemic burdens

The burdens facing the health care system, such as a lack of equipment, overcrowding in public hospitals and clinics and insufficient staff to deal with those, was experienced by health care practitioners as stressful. On top of that, many felt that staff were inadequately trained to provide adequate treatment for patients. These systemic burdens become evident from the following:

“The system is overcrowded. People are dying because the most basic equipment is not available. I do not believe we are poor or understaffed. If everyone did their bit, I believe more people will receive satisfactory health care.” Therapist

“There is also a lack of training for us as new health practitioners and this is due to high workload.” Medical practitioner

h) Inadequate remuneration

Health care practitioners across the board felt that they were inadequately remunerated, causing additional stress. Because of the staff shortages, many felt that they were over-extended for the remuneration they received, and thus sought alternative employment known as "locum" work. This is seen in the following:

“… in general, doctors are overworked and underpaid.” Medical practitioner

“Due to shortage of staff, one finds overworked public sector workers ‘locuming’ in private hospitals.” Radiographer

i) Negativity towards the NHI

Health care practitioners anticipated that the NHI would further add to their individual stress as well as stress on the public health care sector. Already feeling the burdens which the system has, there was a perception that many middle class citizens would use public health care facilities because of the new NHI. Health care practitioners expressed their worries about the NHI as follows:

“I do not like the possibility that the middle-class currently using private care will turn to public facilities, thereby creating a further overload.” Therapist
“I feel it (the NHI) is going to place extra stress on nurses that are already over-worked.” Nurse

j) Internship and Community Service

Junior health care practitioners felt over-worked and overburdened because they felt that they worked harder than senior staff who also often abdicated their responsibilities to them and/or did not take their supervisory responsibilities seriously. These negative concerns relating to interns and community service practitioners can be seen in the following:

“Interns and community service (especially doctors) work like slaves, while more ‘permanent’ State employees abdicate as much work responsibility as possible. I do not believe we are poor or understaffed. If everyone did their bit, I believe more people will receive satisfactory health care.” Therapist

“They only use community service staff (most of the time in our district) for xxxx (health care profession), we have one permanent therapist for the entire district … Next year, a new therapist will come and our work will not be carried over because there is no one to supervise.” Therapist

k) Inadequate legislation

Health care practitioners, overburdened by patient numbers, felt that protocols were either not in place or not adhered to, leading to stressful working conditions. They felt that revised legislation, policies and procedures would go a long way towards streamlining their working conditions and easing their workloads. Creating a national standard for all health care workers was one way, it was felt, for the health care system to improve on service delivery. The following excerpts illustrate some of the legislative lapses:

“I only started working in the health care system last year and already the workload is exceedingly high. The HPCSA states that I should manage 25 patients or less as an intern, however I manage as many as 45 patients every day because we do not have enough staff. There is also a lack of teaching for us as new health practitioners, and this is due to high workload. Because one intern sees more than 40 patients a day instead of 25, this compromises the quality of care given to each patient. The current health care system is not
meeting the needs of patients.” Medical practitioner

“There doesn’t appear to be a national standard of health care across the board as one would be made to believe. Not only is there inequality between private and public health sectors, but it would seem, within the public sector itself.” Medical practitioner

“… why is it that when all has failed within the institution, no-one on ground level has powers to go to district or province or national without ‘toyi-toyi’ing’ (Industrial Action)?” Radiographer

Overwork and stress had a negative impact on some participants' overall quality of life such as their happiness and health which is likely to have adverse consequences for organisations such as hospitals and clinics in the public and private health care sectors. National standards for good quality service and performance with regards to patient-load, effective communication channels, human resource allocation and multi-disciplinary team practices may go a long way to ensuring that health care practitioners are able to perform their duties. Effective management that is seen to be involved at grass-roots levels, would likely have a positive effect on morale and staff cohesion.

4.4.1.4 Bullying

Bullying was experienced by participants, in particular, where they were exposed to unwanted negative situations which caused negative psychological states and which took on different forms. These appeared to be associated with negative outcomes which were detrimental either to the victim or simply being an observer or being repeatedly exposed to bullying behaviour (Hoel & Einarsen, 1999). Bullying was presented and discussed separately from frustration and anger. The distinction was made, based on experiences that participants reported, which appeared to be rather more intentionally aggressive (overt) and involved a power-imbalance that appeared to be recurring.

Bullying was experienced by participants with particular reference to:

a) Health care practitioners bullying their patients

Health care practitioners often see many patients and have long working hours,
which may lead to frustrations. Chronic stress and exhaustion often leads to burnout and health care practitioners might treat their patients badly from becoming cold, persecutory and/or detached. The following excerpt illustrates a situation where health care practitioners bully their patients:

“The … junior doctors can act essentially unchecked. Patients have no ‘power’ to act against their health care provider as they would in the case of private practice. This opens the door to patients being treated poorly; at least in a manner that we would not want to be treated if we were in the patient’s shoes.” Medical practitioner

b) Health care practitioners being bullied by patients

Health care practitioners in the public health care sector felt that patients bullied them at times. Examples are: when patients swore at them, refused treatment, or lashed out at them, often violently. This can be seen in the following excerpt:

“I personally think the patient’s rights are just overrated. They swear at us, do not give us respect as professionals, they come to us sick as hell, and you do your part and see the need to admit; after the hard work, then they decide to sign RHT (Refuse Hospital Treatment form). The following day (if they are lucky), the relative brings the very same patient and you have to start afresh. And how safe are we? No one seems to be addressing the issue … we are being stabbed, raped and murdered in the premises. Are you really telling us that we should respect the very same people whom we feel threatened by?” Medical practitioner

“Protect us and not prosecute us. We love our patients and we try our best with what is available to give them the best service. We would not do anything on purpose to harm them.” Medical practitioner

c) Institutionalised bullying

Keeping quiet for fear of being bullied by superiors/authority, was experienced in the following way by public health care practitioners in particular:

“I find it hard to believe that the patient comes first in what we do, e.g. all mothers are forced to breastfeed, even if they are HIV positive, despite research indicating the harmful effects of mother to child transfer, and
psychology states that mothers should not be forced to breastfeed. Apparently, it is a money-saving political decision. I hate receiving referrals with no clear instructions or expectations. Nevertheless, I try to assist the patient, where they are and empathise with their experience of bullying in the hospital system. It’s as if patients are saying ‘get in, get help, get out – don’t make waves or else you will never be helped’.” Therapist

Bullying was experienced on three different working levels, the participant being bullied, patients being bullied and institutional bullying. The three features appeared to be consistent with bullying behaviour, although in different contexts. Some participants experienced extreme anger while others identified with the victims whilst feeling powerless to effect a change. Hoel and Einarson (1999) suggest that, where there are risk factors and individual vulnerabilities, these are often played down by organisations. It would be more beneficial if hospital and clinic managers focused on effectively addressing the work environment and carrying out thorough investigations, preferably by impartial investigators. It would also be helpful if policies for addressing bullying were adequately managed in order to circumvent and formally manage these negative incidents.

4.4.1.5 Confusion/poor understanding

Participants also reported experiencing confusion with particular reference to the way, in which the NHI Scheme had been conveyed to them, for example, lack of information and/or clarity. Others had not “done their homework” and learned about it for themselves, whilst some were perplexed about how the NHI would work in the present health care delivery system. Some participants expressed feelings of apathy, which were also consistent with negative psychological states such as hopelessness, stress, anxiety, depression and burnout.

Their confusion related to the following:

a) NHI (National Health Insurance)

Most health care practitioners were confused about the details and implementation of the NHI. There appeared to be scant information available and/or it was poorly understood. This is seen from the following excerpts:
“The way it (NHI) has been communicated has caused some confusion.”
Nurse

“I do not understand how the NHI is going to work. It is very difficult to comment on it now.” Therapist

“I feel quite unprepared to answer the above question, partly due to a lack of information from government and partly due to my own ignorance and laziness to find out more details regarding the proposed plans.” Medical practitioner

Poor communication appeared to lead to confusion in the work place and may cause a general atmosphere which is not friendly, rendering health care practitioners less efficient and effective in doing their work. The government and hospital management would benefit from greater efforts to effectively get health care workers to participate in proposed health care policy changes.

4.4.1.6 Needs

People are motivated to achieve certain needs which, if they are satisfied, lead to self-actualisation. However, some health care practitioners expressed frustrations in having their needs met and often felt thwarted by factors which Maslow called "preconditions for the basic need satisfactions" (Maslow 1943). These include

freedom to speak, freedom to do what one wishes, so long as no harm is done to others, freedom to express oneself, freedom to investigate and seek for information, freedom to defend oneself, justice, fairness, honesty, and orderliness in the group (Maslow 1943, p. 384).

Needs were expressed with reference to:

a) Need for more money

Health care practitioners felt under-remunerated for the work they did. This was apparent across all the professions. The need for more money was expressed in the following excerpts:

“If I do leave, it would be for financial reasons. Let's face it, there is no money in this field … but I love my people.” Medical practitioner
“Too few will have to pay for the many with too many needs and this will kill the goose that lays the golden egg.” Therapist

“Pay us more money for stretching ourselves.” Medical practitioner

“Please and I mean please, provide incentives for us if you really want to keep us.” Medical practitioner

b) Need for better facilities

Better facilities for patients and staff were needed, especially in respect of maintaining family units/structures, which are considered important for their social well-being. Participants voiced their need for better facilities as follows:

“If the Department can arrange for day-care centres inside institutions as staff members are in trouble finding nannies, this will help the workers to perform their duties with pleasure, knowing that their kids are safe.” Nurse

“If they can provide us with accommodation to stay with our families, this can even reduce the absenteeism rate, hence people will be staying with their loved ones, because sometimes or in most cases we live far from our families – and if the Department of Health can provide with that, it can be better.” Nurse

c) Need for financial support

Assistance with funds for further educations was a need expressed by health care practitioners, especially nurses. One nurse had the following to say in this regard:

“We as nurses, the government does not support us financially, if we want to do courses to uplift our academic knowledge. We always have to pay for our own courses (short).” Nurse

d) Patients’ needs

Patient needs were perceived as not being adequately met, more particularly the cost of day-to-day medical needs was rising and placing patients under more financial pressure. This can be seen from the following:

“The current health care system is not meeting the needs of patients.” Medical
practitioner

“Patients are having to pay more and more for their day-to-day medical needs.” Therapist

e) Need for better education and training

Health care practitioners felt that education was lacking in three areas: patient education, health care practitioner education and community education. Health care practitioners’ suggestions on how to meet this need for better education are expressed as follows:

“The biggest problem that needs to be addressed, in my opinion, is education. Educate people on birth control. Parents must be accountable and responsible for their children. Children should all be educated in basic hygiene and how to look after themselves in schools.” Nurse

“We are not being given enough chances to upgrade ourselves. If you are in the rank you just stay there for a couple of years and yet it takes time to be given a chance to go and study.” Nurse

“The Department of Health must make some means to educate our communities about different diseases, so that they know the signs and symptoms and how to deal with those who are already affected in our community.” Nurse

“The country must also train more specialists to run regional hospitals. Teaching for junior health care practitioners is crucial.” Medical practitioner

f) Need for more responsibility and better governance

Health care practitioners expressed the need for better governance and responsibility with reference to the following areas of concern:

“The obvious area of the health sector that needs improvement is responsibility. The same aspect of our health sector that allows us junior doctors to gain brilliant practical experience, the lack of supervision, and recourse in the case of malpractice, means that doctors can act essentially unchecked. Patients have no ‘power’ to act against their health care provider, as they would in the case of private practice. This opens the door to patients
be treated poorly; at least in a manner that we would not want to be treated if we were in the patient's shoes. Supervisors need to play a more active role in overseeing the quality of care provided. Hospital management needs to open channels to allow those involved in poor practice to be disciplined.” Medical practitioner

“More awareness campaigns, promoting disease prevention.” Medical practitioner

**g) Needs for better human resources**

Needs concerning adequate staffing and better human resources were expressed as follows:

“The state needs to employ better calibre nurses, more doctors.” Medical practitioner

“Focus on the needs of the nurses, equipment, linen, support system training.” Nurse

“Change the working hours.” Nurse

Meeting health care practitioners work place needs will result in a happier and more fulfilled staff.

**4.4.1.7 Integrity**

Integrity was considered to be important individually as well as in terms of participants' professions and also towards patients. Remembering why health care professionals chose their “noble” professions in the first place, their integrity essentially meant behaving honourably, morally, righteously, sincerely, being trustworthy and maintaining high principles, amongst others.

Health care practitioners expressed the need for stronger principled individuals, leaders and managers who would uphold the territorial integrity of the entire health care system, be accountable, transparent and responsible. These factors would inevitably cascade into the whole health system, creating higher standards across all health sectors/facilities in the country. The health system was experienced as lacking in cohesion, not unified, divided and having internal tensions. Integrity was
reflected in responses with particular reference to:

a) Personal qualities

Personal qualities such as caring and a sense of responsibility were considered important by health care practitioners, but were often felt to be lacking. This can be seen in the following:

“They need to remember, why they chose the profession. They are there to help the sick to get better, so they need to care for them. If they care for them, they will care for the equipment too because health equipment plays a role in helping with patients’ diagnosis. The staff must have it at heart that they are here for the patients all the time.” Radiographer

“People from the public sector usually have the attitude of ‘I don’t care’ … and ‘it’s not mine’. With almost all of them, responsibility lies with the superiors only, which impacts on service delivery. However, in the private sector everyone is responsible and accountable, which is a key factor to a good service delivery.” Radiographer

“People need to search their hearts once again; this may help a lot.” Radiographer

b) Systemic ills/shameful conduct

Participants felt that the integrity of some health care practitioners could be called into question. The following excerpts illustrate this:

“The inability of doctors and nurses to properly clean their hands goes against one of the first principles of being a doctor: “first do no harm.” Medical practitioner

“The same aspect of our health sector that allows us junior doctors to gain brilliant practical experience, the lack of supervision and recourse in the case of malpractice, means that doctors can act essentially unchecked. Patients have no “power” to act against their health care provider as they would in the case of private practice. This opens the door to patients be treated poorly; at least in a manner that we would not want to be treated if we were in the patient’s shoes. Supervisors need to play a more active role in overseeing the
quality of care provided. Hospital management needs to open channels to allow those involved in poor practice to be disciplined.” Medical practitioner

c) Broken collective

Administrative integrity was considered essential for maintaining a good health care system. These administrative shortfalls are expressed in the following excerpts:

“Big problem is low efficiency of the public health care institutions, poor management, and lack of empathy from many health care practitioners. There is a trend to work as little as possible, if there is no pressure from management or supervisors.” Medical practitioner

“The state sector is virtually non-functional with health care workers unable to deliver care due to lack of personnel and equipment. Working in that environment is soul destroying and given the levels of corruption and poor governance, the situation is not going to change in the foreseeable future…The private sector is also under serious attack from the present government: the ruling rich is seeking new venues to tax (directly and indirectly) to fund their excesses, and private medicine will be the new milking cow.” Medical practitioner

Health care practitioners’ needs included their expressed personal needs as well as needs for material items such as equipment, pharmaceuticals and salaries. Education needs were felt to be important with respect to educating the public about health related issues as well as health care practitioners’ needs for further education and training. The needs of under-serviced patients were of concern to most participants, reflective of community and social needs for health care. Insufficient or low income, not considered adequate to support themselves and their families, in an environment with growing patient demands, a high burden of disease and the resultant stretched services amidst staff shortages, were seen as major problems. Particularly in the public sector, many practitioners did not feel appreciated, felt unheard, worked in poorly resourced environments and had fears for the well-being of themselves (personal safety), their children (inadequate facilities) and families who had inadequate/insufficient access to them (particularly among the nursing staff).
Integrity, good moral and ethical principles were considered by participants to be important in good relationships of value, such as with other health care practitioners, patients and health care stakeholders. These reciprocal values were often expressed to be lacking in the health care environment and it might therefore be important for leaders in those fields to concentrate efforts to build integrity into the health care plan and to monitor health care workers’ adherence to those values. These include arriving at work on time, responsible record keeping, communicating difficulties, focusing on work performance, responsible behaviour, solution-focused problem solving, discipline and optimising reporting processes. Integrity, transparency and honesty might similarly be achieved through careful mentoring and monitoring in the health care workers’ environments.

4.4.1.8 Faithfulness or lack of faithfulness to the calling

It is often said or believed that healers, which include health care practitioners, have a “calling” or deep desire and responsibility to devote themselves to helping others through service, care and selfless devotion (Raatikainen, 1997).

Certainly, some participants expressed their absolute willingness to help in this way, despite being in a health care system where some of their experiences clearly pointed out that this was, in fact, no longer so and where many were perceived to be in the professions for monetary reward and that the “calling” no longer existed as it did before.

Some participants wished to exercise their calling, but were working in circumstances that they felt were preventing them from doing so, or making it very difficult. These two poles are presented as follows:

a) Faithfulness to the calling

Across the board, health care practitioners wished to remain faithful to their calling, despite the limitations of the health care system. This is evident from the following:

“We are sometimes stopped for caring for our patients properly, due to depletion of medical aid.” Nurse
“A nurse cannot give quality nursing care, if she has no clean linen to put on the patient's bed.” Nurse

“Politics between professions/professionals/regions also impairs the service delivery to the patient. I see one to two patients a day, while the xxxx (therapist) in the hospital down the road has a 6-month waiting list. I am here – available to help – but fear of the hospital politics suppresses the service I could offer clients waiting at the other hospital.” Therapist

“I do not want to leave South Africa. At the same stage, maybe to get experience. I am a hard worker. xxxx is a hard profession. I make the means to tell others and make a difference.” Therapist

b) Lack of faithfulness to the calling

While on the other hand some health care practitioners also felt that there was a lack of faithfulness to the calling in both the public and private sectors. They provided the following reasons to support this view:

“… Private medical institutions are run as businesses and therefore do not accommodate or always have empathy for those who cannot afford the fees. Some private doctors and medical staff, of whom the majority are extremely well educated in their fields, forget why they entered their professions and see status and financial rewards instead of the patient's needs first.” Nurse

“Despite their reasonably good salaries, state nurses will never pay for themselves to be up-skilled – in fact, they expect all expenses covered, complain about the food at the courses, and expect to be given the time back if it is on a weekend. The other main problem is that unfortunately, there is a mentality within these nurses that is only worth improving yourself or learning more skills, if it is for a financial reward. The other problem lies with the younger generation, who are a generation of instant gratification with expectations of high monetary rewards. The caring professions are never really going to suit that requirement. I really feel there are so few now who see it as a ‘calling’ rather than a ‘job’.” Nurse

“The nurses consider nursing as a pay cheque and have no compassion for their patients. Many of them cannot take a message or carry out a simple instruction.” Nurse
“Private sector seems to want to worry more about profits and in the public sector corruption is rife!” Radiographer

“They need to remember why they chose the profession. They are there to help the sick to get better, so they need to care for them.” Radiographer

“The inability of doctors and nurses to properly clean their hands goes against one of the first principles of being a doctor: “first, do no harm.” Medical practitioner

While some respondents indicated their devotion to serving people, aligning themselves with the high values of their professions (Raatikainen, 1997), others were felt to be neglecting their professional duties and ethics and seeking monetary gain instead, especially the younger generation. Monetary gain was also reflected in the perception that private health care is run strictly on monetary values and that patients and staff are prevented from carrying out their moral, ethical and professional duties. Corruption, particularly in the public sector, was perceived as being somewhat systemic. Some participants felt that health standards of medical staff had dropped with adverse effects for sick patients. The concept of care, one of the highest values, which should be at the heart of any health care professional’s practice, was often felt to be lacking.

4.4.1.9 Neglect

Neglect is defined as paying no or little attention to; disregard; to be remiss in the care of, to omit through indifference or carelessness (Dictionary.com)

The psycho-dynamics of neglect in South Africa, in particular, might metaphorically transcribe or allude to the role that health care practitioners saw themselves in, for example, within a “family”, with the government as “parent” in control and themselves as the “child”, possibly without power. These dynamics might possibly also relate and be pertinent to previously disadvantaged members of society who are widely believed to have suffered chronic or protracted forms of abuse by the socio/political apartheid system and continued to do so in the current system, essentially “trapping” the individual into a psychodynamic state that was not easy to resolve and which might still not have the circumstances that might be conducive towards personal or psychic growth (Smith, Lobban, &
A type of “secondary traumatisation” dynamic might emerge, where, the new democratic government is also seen to have failed or abandoned its workers causing psychological wounding (Kaminer & Eagle, 2010).

Psychodynamically, feelings of neglect and powerlessness may eventually also result in a reversal of power-dynamics, such as where the “victim” may become the perpetrator (Smith, 2004), for example, in despotic managerial and/or governmental practices or persecutory attitudes towards others. A rather more persecutory dynamic might exist in which the individual is expected to do good work despite feeling neglected and being unable to change that, other than to express those dynamics through reflecting them outwards, as well as inwards, in ways which include passive-aggressive behaviour, depression, anxiety, displaced anger, sublimation, reaction formation, intellectualisation, dark humour and detachment among many others (Freud 1992).

Participants expressed their feelings relating to neglect as follows:

“We are being neglected as workers. We are not being given enough chances to upgrade ourselves. If you are in the rank, you just stay there for a couple of years and yet, it takes time to be given a chance to go and study.” Nurse

“They propose changes but without consulting the workers, so it’s bad. We are always being neglected but we are expected to do good.” Nurse

“Not to forget the difficulties encountered with our nursing counterparts. It is a nightmare working with most of them, constantly dragging their feet, as if they are doing you a favour, lack of ability whatsoever. Constantly on tea, lunch breaks. I have none of the above. So quick to remind you of their job description. Can someone send me mine, please!” Medical practitioner

Neglect was experienced by health care practitioners with particular reference to a lack of training opportunities, little promotion in rank, not being consulted with regard to proposed changes to the health care delivery system, poor feedback for a job well done, insufficient wages, essentially “being forgotten”/neglected by the authorities or superiors, such as management/government/bosses who had prescribed their job descriptions in the first place and the use of defence mechanisms to cope with those.
4.4.1.10 Hopelessness

Hopelessness was experienced by health care practitioners, most especially in the public sector, with particular reference to feeling “disconnected” or unable, or prevented from being able to make a difference to the health care delivery service in the country, or not being able to work or perform optimally, a desired safety need not being met, feeling unappreciated, demotivated and having a negative future outlook.

Hopelessness is a psychological state seen in depression and dysthymia (Snow, Lascher, & Mottur-Pilson, 2000) and can be a symptom of burnout and/or overwork. Hopelessness can be expressed as part of low self-esteem or a lack of self-confidence (Pompili, Innamorati, Narciso, Kotzalidis, Dominici, Talamo, & Tatarelli, 2009) and part of feeling overwhelmed and unable to adequately cope (especially if circumstances are chronic or pervasive), which may also be indicative of the frustrations and angers that health care practitioners expressed, sometimes overtly and often covertly. Together, they reflect chronic and negative psychological states, which may often also be misinterpreted at “face-value” as purely contempt, emotional outbursts, acting out, wishing to “escape” and being persecutory.

Health care practitioners’ needs, such as safety needs, feelings of “belonging” and love should be considered essential components for good health, which would then be reflected in the work environment. Being egoically/psychologically stronger means being able to cope with stressors which results in better resilience in the face of increased psychological burdens. The extent to which basic needs are not fulfilled also inevitably are reflected in areas such as low self-esteem, low self-efficacy and other psychological states that are not conducive to optimal living (Maslow, 1943). In this sense, the bio-psycho-social worlds of health care practitioners and their effectiveness as people and as workers, is crucial.

Feelings of hopelessness were experienced with particular reference to:
a) Feeling unwanted/unwelcome/unsafe

Some of the health care practitioners felt that the future was uncertain, as reflected in one participant’s response:

“If there were to be a political and economic collapse as seen in a country like Zimbabwe, I feel I would have no choice but to leave. I would be unwilling to live in a country, where my vote holds no weight, the Constitution is ignored, and on the whole, I feel unwelcome and unwanted. I will prioritise my and my family’s safety and security over the needs of patients and the country as a whole.” Medical practitioner

b) Doom and Gloom

The future for health care practitioners and patients in the country was perceived to be hopeless by some health care practitioners. The following excerpts illustrate this:

“The changes are doomed to worsen a poor situation as none of the real problems are addressed…” Medical practitioner

“If the outlook for the health care workers appear gloomy, the present and future of patients are worse.” Medical practitioner

c) Lack of care

Lack of hope for the future of quality care in the health care sector was expressed as follows:

“On top of paying for NHI, I will still be obliged to pay for medical aid, as I feel quite confident that the public sector will be unable to provide a level and quality of care I would view as acceptable to me and my family.” Medical practitioner

“Good chance the whole system will implode.” Therapist

“I really would not like to leave. However, there is no future for the next generations to come.” Radiographer
d) Lack of appreciation

Not feeling appreciated led to feelings of hopelessness for some health care practitioners. This is evident from the following:

“I personally do not feel appreciated.” Therapist

“The shortage of staff … causes a health practitioner to take the early retirement or resign. There are no working tools – you are always wanted to improvise and it causes emotional and physical exhaustion … At the end of the day, no one comes to say thank you to you – instead they look for mistakes you have done. If you are not okay, i.e. not feeling well, no one trusts you. The type of hours worked does not give your family access to you.” Nurse

e) Demotivation

Health care practitioners working in stressful circumstances became demotivated and negative. The following excerpts illustrate this:

“Working in that (public sector) environment is soul destroying.” Medical practitioner

“Medical staff are overworked, demotivated, and do not provide the service required of them.” Radiographer

Neglect was experienced by participants as, amongst others, the loss of feeling “looked after” by the employer, being ignored, failing to communicate, lack of equipment, not enough praise, and lack of adequate training. Through this study, participants expressed their willingness to communicate these issues, possibly in the hope that their experiences would be reported and heard.

4.4.1.11 Fear, worry and concern

Fear, worry, and concern were experienced by health care practitioners regarding their wish to be able to provide adequately for their families and future needs, their uncertainty about new and proposed government policies for the public and private health care sectors (the NHI), ideological concerns and their fears for their personal health because of unsafe working environments. Lack of safety
equipment, masks, gloves, security measures, diseases they are exposed to without adequate protection, the crime rate and fears about their future earning potential were expressed. The instability of society in general (politics) was also experienced as a worry or concern especially for female participants who were worried for their families and male participants expressing safety concerns and concerns relating to their earning ability.

Fears, worries, and concerns were experienced with particular reference to:

a) Ability to earn money in future

Fears, worries and concerns about how the proposed NHI and legislations will impact on the finances of health care practitioners were expressed as follows:

“Another concern I have, is my future financial security … I worry that my future income might be controlled and governed by government policy, influencing how much health care costs. This is an extremely selfish view to hold (as are many of mine), but I would be lying if I said it wasn’t a major concern for me. Income potential did play a role in my career choice and now that is being threatened.” Medical practitioner

“I believe everyone has a right to good health care. The motive behind the NHI is good because they say they want to bring service to those who need it the most, but my concern is what will this do to the private sector?” Radiographer

b) Personal health and safety

Health care practitioners worked in conditions which did not protect their own health, as reflected in the following excerpts:

“I am experiencing difficulties in the workplace. Patients are critically ill, while there is no adequate equipment, e.g. masks, gloves to protect ourselves from those, who are affected by TB diseases, etc.” Nurse

“It feels like a risk to one’s health working in over-crowded wards; poor ventilation, lack of privacy, one-on-one interaction with a patient. Cheap gloves that tear, while examining patients. No number 5 masks as promised.” Medical practitioner
c) Crime

Crime in South Africa has become a concern for health care practitioners and was expressed as follows:

“Yes, it’s quite scary to be an elderly person in this country.” Nurse

“Society is becoming unstable and the have-nots will not suffer in silence forever. Crime is out of control and government is getting worse day by day.” Medical practitioner

“Who takes patients who are ill at night? … No ambulances in certain areas – like because of crime, hijacking … Problems with service.” Therapist

d) Earning capacity

Fears, worries and concerns about the state of the economy and its effect on earning capacity was also expressed by health care practitioners, this can be seen in the following:

“The slice of the health care cake is getting smaller and smaller for service providers that work outside the private hospitals. Medical aids are allocating more and more of the funds to private hospitalisation, as the costs there just keep rising … this is making it increasingly difficult to have a financially viable private practice.” Therapist

e) Occupational safety

A safe working environment for health care practitioners and a safe environment for patients were considered essential, although currently this was not always the case, especially in public health care facilities.

“The working place must be in good condition, e.g. air conditioner, safety.” Nurse

f) Ideology

Ideological concerns were expressed, with reference to the following excerpt:

“I feel positive about the future of South Africa in general, so long as the
Health care practitioners expressed fear, worry and concern about their individual and collective work experiences. These experiences often had the effect of increasing participants’ levels of stress, particularly if they felt threatened physically or if future events seemed to be out of their control. Through thorough consultation with health care practitioners, these fears could be addressed or allayed which would result in a feeling of having control over their environment to some extent, leading to a more satisfying work experience overall, despite the relatively normal challenges which most people deal with every day. Fears, worries and concerns often gave rise to psychological factors such as anxiety and other chronic and pervasive stressors, especially prevalent in the public sector. These dynamics are features suggestive of a “dysthymic syndrome“, similar to those experienced by medical practitioners in the Stoyanov (2011) study.

4.4.1.12 Positivity/looking on the bright side

Despite the negative factors mentioned above, it was very refreshing to note that some health care practitioners were optimistic about their plans to grow and evolve personally as health care professionals. In both sectors, some expressed that they were generally satisfied with their lives and work environments in terms of technology, working in the private sector, feelings of patriotism and expressed a positive forecast for the country as a whole. Remaining in South Africa to assist with rectifying and supporting the health care system was expressed as being important to them, reflecting altruism, patriotism and social conscience. Some participants wished to leave the country for a short period to expand their personal and professional experiences in other countries before returning “home” to South Africa. Others would assess the political situation and keep their options open, if necessary, and then leave.

Some participants appeared to be more resilient despite their difficult working circumstances (particularly in the public sector), reflecting a coping style attributed to individuals who had adequate psychological resources at their disposal, the extent of which varied individually, whilst others had poorer coping styles reflective of chronic unresolved stress and poor coping mechanisms for facing those challenges.
Positivity and “looking on the bright side of life” was experienced by participants with particular reference to:

a) Job satisfaction

Many health care practitioners, despite facing challenges in the work place, experienced job satisfaction. Examples are as follows:

“It gives me complete satisfaction that the government has reduced the number of pills taken by the people suffering from AIDS.” Nurse

“I find the health care system very nice, challenging every day with new technology and practicing that may need a lot of in-service educating, that can help to standardise your daily knowledge.” Nurse

“I am happy to be working in the private sector. I have worked for xxxx (health care facility) for xxxx years and have seen many changes, mostly for the better.” Nurse

“... I really enjoy my job. I love helping people, who cannot help themselves. I love helping them realise their occupations and engaging in them daily. People are very appreciative for the help that they get. I find my job very rewarding.” Therapist

b) Patriotism

Some health care practitioners were patriotic and positive about South Africa. The following excerpts illustrate this patriotism:

“No, I would never leave South Africa. This is my soil, my home, my beloved country. I am passionate about the people I serve and the work I do.” Medical practitioner

“No, I don’t want to leave South Africa. We live in a beautiful, diverse country, good people and wonderful landscapes and climate. We need to make this country united and use our resources to the maximum. We need democracy. Less politics, good politicians, strong private sector, better education, and a better health care system!” Medical practitioner
c) Altruism

Some health care practitioners pledged their selfless concern for others above their own needs. This altruism is seen in the following excerpts:

“It’s important for me to see South Africa changing in the health care system, to make a better country – and not just to run overseas.” Therapist

“This country has a shortage of health care practitioners and if we start leaving, it is going to get worse.” Medical practitioner

“I may leave South Africa for a short period (temporary basis) to grow personally, travel, perhaps grow financially, and broaden my field of experience. After that, I will return to South Africa – home. I also feel a responsibility to give back to my community. I understand the South African context – I am an African at heart.” Therapist

“You know, at the end of the day, we have to put something on our tables, but it’s not about the money, it’s about making a change to others. It’s important to me to see a child sit still, able to hold a pen, able to make a circle, able to make the A of the alphabet. I go home happy that I’ve made a difference.” Therapist

d) Personal growth

Some health care practitioners also wished to travel and learn about other countries and cultures to better themselves and add to their life experiences. This striving towards personal growth can be seen in the following excerpts:

“Yes, I would leave South Africa for another country … for work. I am still a young professional and would love to travel around the world, while I still can. It is always a good thing to explore new ventures, try new challenges, meet new faces and people, and also learn their culture. If given an opportunity to work in another country, I would seize the moment, but it would have to be a country that is on a better class/level than Republic of South Africa, e.g. Europe, North America. This would be a great opportunity for me to gain international experience and would be a test for me in the market and my career. Another advantage of going and travelling to different places is to learn more about a certain place and their culture besides the way they do things in
their working areas.” Radiographer

“I may leave South Africa for a short period (temporary basis) to grow personally, travel, perhaps grow financially and broaden my field of experience.” Therapist

e) Collective positivity/suggestions for change

Bringing about positive change requires a positive mind-set and optimistic outlook on life. Some health care practitioners felt that this type of thinking was essential for positive results in health care. This is evident from the following excerpts:

“Negativity breeds negativity and I feel that if we can put out a positive vibe, much can be achieved.” Nurse

“People should be encouraged to strive to improve themselves, financially, health-wise and education.” Nurse

While some health care practitioners appeared to be more positive and happier than others, many experienced strong reactions to negative circumstances in the health care environment. Stakeholders in health care might need to introduce novel ways to encourage greater positivity through training methods which may encourage positive relationships. Support programs, recognition awards and ways of finding greater meaning might collectively spread through any working environment, influencing the health care system positively to the benefit all stakeholders.

The above interpretive findings revealed health care practitioners’ subjective experiences of their worlds as they revealed themselves to the researcher during the explication of the narratives. The in-depth, inter-subjective meanings which “spoke to” or became evident to the researcher through the shared construction of what the participants’ social realities entailed, provided the inferences and abstractions which were made in the interpretation process. The “sense-making” process acknowledges that there is no “correct” or “incorrect” interpretation while at the same time accepting that ascribing meaning through repeated reflection of responses revealed inter-dependent parts of the “whole” – the enquirer; interlocked into an interactive process with the enquired-into.
4.5 Conclusion

In this chapter, health care practitioners’ experiences, experiential data and resultant emerging narrative, discourses and themes, were explicated and analysed using three research paradigms: descriptive, social constructionist and interpretive. In so doing, it was possible to neither claim that one method was superior to the other, but that they all had advantages that contributed towards understanding or merging the experiences/“voices” of the participants through the methods/techniques of explication at different levels.

Key findings in the overall analysis, revealed:

1. Public and private sector health care practitioners were overall unhappy with the state of health care delivery in the country, whether pertaining particularly to the public sector, the private sector or both. Health care practitioners from both sectors expressed reservations with regard to the future of health care services, which the NHI proposed to implement. The proposed changes and legislation tabled by the government and the extent, to which the health care practitioners felt that they were or were not “on board“ was expressed in terms of feeling that they were not informed well enough about policy changes, or had been too lax to find out more and were also not consulted. Lack of motivation, overwork, government’s perceived failure to communicate effectively through relevant structures at its disposal in a more “inclusive“ way were feelings evident throughout the study. The feasibility of the NHI was questioned across the board. Health care practitioners who are the very people who would have to support the NHI changes and provide the workforce to service them, did not feel engaged with respect to feeling “heard”, included, consulted and considered.

2. Nurses and some other health care practitioners who were not hospital doctors, often felt that the medical system (government, managers) favoured medical practitioners in all spheres of health care, creating the perception that they were “more important“ and therefore valued more in terms of their opinions and authority. Examples were referrals only being
allowed to come from medical practitioners (medical practitioners not accepting referrals from, for example, radiographers) and reporting structures engineered in favour of medical practitioners. These were considered to be unfair and undermined other professionals and their opinions, essentially also thwarting their rights in terms of their scopes of practice.

3. Sub-standard or a lack of morals and ethics was perceived to be a problem overall.

4. Poor treatment and care of patients, lack of compassion, seeing their work as a pay-check and general lack of dedication were evident and particularly attributed to nurses. Inter- and intra-professional and/or departmental complaints related to issues concerned with values, attitudes towards each other and across designations and multi-disciplinary teams, which many felt did not exist as they should. Medical practitioners complained particularly about nurses’ attitudes, lack of adequate training and a general loss of values that were expected from them as health care professionals. Intra- and inter-professional complaints and conflicts between nurses and medical practitioners were evident, with nurses complaining that medical practitioners considered themselves superior and, in turn, medical practitioners experiencing the nurses as “lazy” or incompetent with not enough training and attention to their moral and ethical duties towards patients. Nurses in both sectors felt that they were particularly understaffed.

5. Public sector participants expressed general unhappiness, most particularly in respect of lack of resources or materials, over-crowding, inefficiency, managerial insufficiencies and inefficiencies/lack of capabilities, lack of supervision, overwork/stress, bullying, confusion/poor understanding, lack of integrity, loss of moral and ethical attitudes, feeling neglected as workers, hopelessness, and fear/worry/concern. Nurses, in particular, often felt neglected, excluded, overlooked and expected to “always do good” with very little reward or recognition. Some positive sentiments were experienced, particularly in respect of health care practitioners feeling patriotic and “making a difference” in the lives of patients, especially the
poor. Altruism such as putting the needs of the country before their own was experienced by some. However, emigration was a real consideration, with varied reasons such as worries about crime, wanting extra work experience, better wages and other opportunities.

6. Private sector health care practitioners, although stressed, were overall happier with their work experiences and working environments. Fears and worries were experienced with regard to government involvement in changes to the private sector, which led to some participants considering their options to emigrate, if necessary, as their livelihoods may be negatively affected. They also made comments about the poor state of public health care service delivery.

7. A unique problem for nurses was their difficulty to exercise their professional duties of care when they needed to explain to patients whose medical aids had run out, that they would no longer be treated.

8. Stress can be debilitating, affecting work and personal lives. Psychological factors, which negatively affected health care practitioners, especially in the public sector, led to sub-optimal functioning with irritability and irrationality often being a result. Chronic and pervasive stressors often also lead to burnout and other negative psychological states. Overall, private sector participants tended to express less emotion-laden experiences in relation to their working lives and were more business focused.

9. Themes from the researcher’s previous study relating to a stressful working environment were also evident in this study, although the designs of the study differed. Although no tests for stress, anxiety and depression were conducted in the present study, chronic symptoms related to stress, anxiety, hopelessness, emotional discomfort, anger, and so forth, were once again evident, but in a broader selection of health care professions and professionals who were found to be similarly affected especially, once again, in the public sector. These negative psychological states often led to statements which are reflective of low self-esteem and demoralisation. Low self-efficacy and external locus of control was particularly prevalent in
nurses in the public sector. Abdicating responsibility and not caring for patients may be interpreted as expressions of demoralisation in some instances.

10. Human resource shortages, communication with and by management and/or government structures were felt to be inadequate and inefficient or ineffective in addressing the root causes of the staff shortages. Not engaging adequately with health care practitioners and communicating effectively through proper consultation processes led to demoralisation in general. Plans to address this situation would, no doubt, prove helpful not only materially but psychologically, if health care practitioners are to be educated, upskilled and retained.

11. Even though many participants expressed patriotism, optimism and moral fortitude in often heart-felt responses, there appeared to be a material and psychological limit to the extent to which prevailing circumstances could be tolerated, which may lead to early retirement, resignation, abandoning their professions altogether or considering emigration.

Although a small sample of health care practitioners in a district in KwaZulu-Natal were the focus of this study, it is evident that they face work-related and psychological pressure from working in the province with the second highest population. The resultant existing burden of disease (especially relating to the rates of HIV and TB), and participants’ exposure to them, provided rich and valuable experiences from which all health care stakeholders could learn. Being a rural area with hospitals and clinics away from city infrastructures, ineffective services will inevitably impact the population negatively, cascading to the most vulnerable people in society such as the elderly, the very young and the poor. The logistical difficulties and deficits patients face, such as lack of transport, erratic supply of medication and abnormally long waiting queues at the hospitals and clinics has revealed moral and ethical issues confronting not only the health care practitioners, but the government as well. Factors such as social justice and human rights, in terms of access to health care, quality of services rendered and adequate human resources to service the public remain pertinent. Health care practitioners’ experiences were predominantly expressed with a mixture of anger.
about the health system deficits and empathy for the patients in need of health services. This reality was often reflected as incongruent emotional/psychological states, which were difficult to reconcile. Effective and sustainable measures to address these problems are urgently needed for more effective and efficient administration of health care in the area, such as addressing staff shortages, lack of resources in the hospitals/clinics and logistics relating to transport shortages. Clearly, there is still a long journey ahead, to rectify an ongoing inequitable and fragmented health system. Despite current policies and NHI proposals, it remains challenging for health care practitioners to put people first and adhere to the moral and ethical principle of “first, do no harm” when they feel that they are working in a health system which is perceived to be unsupportive or has limitations in terms of human resources, policies and health care structures.

Since the announcement of the White Paper on Transforming Public Service Delivery in 1997, much still needs to be achieved to prevent the possible “re-traumatisation” of South African society after the previous apartheid history, which fractured the population at all levels, not least health care. Because health care practitioners have specific knowledge of the health care system, their voices need to be heard through thorough engagement and consultation. Their professional experience and qualities should be a part of policy development going forward. Solutions to problems will inevitably flow from engagement with key stakeholders, the health care practitioners themselves and especially those with “grass-roots” levels of experience. These, together with solutions proposed by other stakeholders in health care, will be of value for holistic and inclusive health outcomes at many levels, from personal to inter-personal, community and country consciousness. The generosity of participants in this study in terms of the time they took to relay their experiences should not be overlooked as, without those, the purpose of this work would be lost. Their concerns about health care in the broader interest of better health care and social justice have been valuable.

Historically discriminating practices in the country, by all accounts, appear to have been perpetuated and can be considered to be part of the reason for the negative psychological states experienced by the participants in this study in terms of health care in the country. The research may have provided an outlet for these
experiences and emotional expressions, which have also proved to be a humbling journey for the researcher and hopefully a meaningful journey for the participants. Holistically, the five open-ended questions adequately revealed rich narratives and themes, which spoke about human needs, human rights, and laws governing the world, the country, the professions and what it means to be a healer in the current multi-cultural health care system in South Africa. It may be cautiously safe to say that health care in other areas of South Africa are similarly affected and thus these findings are transferable; larger studies would provide more information and add to this literature.

**Final conclusion**

With health being a human right, one may illuminate those rights against the South African Constitution and ask the question as to whether those rights are currently upheld. But probably most importantly, South Africa has to “care for the carers”. By opening a dialogue in this study, in which the hopes, fears and concerns of health care practitioners’ experiences have been raised and solutions proposed to address the problems, these “conversations” need to reach the ears of those who need to hear them (i.e. government, management and policy makers).

At this point, it is useful to think of the qualitative research study as a rich tapestry. The software was the loom that facilitated the weaving together of the tapestry, but the loom cannot determine the final picture of the tapestry. It can, though, through its advanced technology, speed up the process of producing the tapestry and it may also limit the weavers’ errors but, for the weavers to succeed in making the tapestry, they need to have an overview of what they are trying to produce. It is very possible, and quite legitimate, that different researchers would weave different tapestries from the same available material, depending on the questions asked of the data. However, they would have to agree on the material they have to begin with. Software programs can be used to explore systematically this basic material, creating broad agreement amongst researchers about what is being dealt with. Hence, the quality, rigour and trustworthiness of the research are enhanced (Welsh, 2002, p. 4) through the use of multiple methods of enquiry.
Chapter 5
Conclusions, limitations and recommendations

“We are like islands in the sea, separate on the surface, but connected in the deep.”
William James

5.1 Conclusion

5.1.1 Achieved outcome of the aims and objectives of the study

The aims and objectives of the present study were achieved with particular reference to:

- Capturing and explicating health care practitioners’ experiences of the current health care delivery system in the uThungulu District.

- Participants were enthusiastic about their participation in this study and felt that their contributions were valuable. In this respect, the research was successful and meaningful not only for the participants, but also for the researcher, who became part of the process and who gained insights that were not normally accessible in everyday life. This study provoked further questions that could be addressed in further studies and, as such, this research once again provided “food for thought” with regard to new research in broader populations of health care practitioners, both locally and the wider region/country.

- A deeper understanding of specific questions relating to the current health care environment, particularly with reference to the NHI, views on emigration, international experiences and recommendations was achieved through participant responses that were lengthy and well thought-out in most cases. From these, valuable statistics, recommendations and other information could be disseminated for the greater good of the South African health care system, with particular focus on the KwaZulu-Natal region.

- The study has the potential to reach all stakeholders in the health care sectors (public and private), making it available for consideration in future
policy reforms and the effective transformation of the South African health system.

- The recommendations that participants made in their roles as advocators for health care were reflected by their trust in the research process, their willingness to participate and their sense of responsibility. It was also reflected in their assistance towards achieving the goals for themselves, the community, and the overall good of the health system through personal expressions and by putting forth recommendations that could be valuable for consideration in policy development.

- Participants ‘experiences were analysed and sequentially/reflexively amplified to extract maximum understanding and meaning through the use of three research paradigms: the descriptive, social constructionist and interpretive paradigms. These processes revealed a substantial amount of narratives/discourses, which could be interpreted and used as a catalyst to reach target audiences such as relevant health care stakeholders, comprising national and provincial government, hospital administrators, local communities and individuals. Although not all health care practitioners’ experiences were alike, participants collectively provided experiences from the public and private health care sectors, which together, provided the basis for understanding the health care system they worked in, the dynamics they experienced, and which provided the information used in recommendations for improvements to all spheres of the current health care system.

- The current socio-political climate in South Africa and changes being made in legislation, such as the roll-out of the relatively new NHI, contributed significantly to the mood of health care practitioners. Although there were participants, who felt altruistic about helping people in need and who did not want to “desert” the country, leaving the health system weakened; the overriding anger, frustration and negativity within the health care sectors, particularly the public health care sector, took centre-stage with the emergence of multi-factorial issues. These issues included the huge burden of disease, under-staffing, poor management, insufficient
resources (and cheap resources that break down), services not working properly (ambulances, clinics, equipment), lack of accountability, corruption, low morale, uncertainty about the future and various expressions of anger about the health care delivery system as a whole overwhelmingly dominated the analysis.

- The study inevitably also had an effect on the personal transformation of the researcher, whose insight into the research topic was considerably broadened and expanded. With this new knowledge, there also emanated a deep sense of humility and gratitude to participants in all the spheres connected with this study, referring to the participants themselves, university promotors, external examiners, administrative staff and provincial governmental bodies who granted permission for this research, ethics and other committees, as well as individuals, editors and advisors. All of them were holistically, synchronistically and collectively involved in assisting with the outcome of this study. The journey undertaken in the community has left the traveller forever changed in a positive way.

5.1.2 Theoretical underpinnings and their relevance to the study

a) Bronfenbrenner’s ecological systems theory

It was stated at the beginning of the study that Bronfenbrenner’s (2005) bioecological systems theory and Maslow’s hierarchy of needs were relevant to health care practitioners’ experiences of the health care system in the uThungulu District. Bronfenbrenner’s 1979 ecological systems theory and his later (2004) bioecological systems theory emphasised, as its central premise, the development of the self in the context of the everyday environment within which health care practitioners live and work. These bi-directional influences are in line with an evolving systems theory. This focuses on the role that integrative and interdisciplinary processes have on health care practitioners’ development as individuals who, due to the nature of their work, need these processes in order to work with others.

Participants’ experiences revealed that the socio-emotional levels of functioning that they were exposed to at work also impacted upon all areas of their lives, for
example, family and socio-political factors influenced one another in recursive feedback loops reflective of their level of “relatedness” or “disconnection”, or over-or-under involvement.

These valuable insights and information also correlate with current rhetoric and media reports concerning the health care system in South Africa, illuminating the importance of social and/or political dissent as everyday realities affecting all areas of the participants’ lives. Stressors such as work-overload, a “disconnection” between health care stakeholders (i.e. health care practitioners, patients, management structures and government policy) emerged as affecting the “ecological system”. Psychological factors such as anger, frustration, anxiety and feelings of hopelessness might have led to the development of coping “defences” when working under extreme pressure, for example, intellectualised anger and/or displaced anger. These factors revealed that participants were even angrier, more frustrated, anxious and often exhausted rather than suffering from depression. It is also possible that many of them were suffering from “burnout”, but considering that these factors were not tested in the present study, their clinical picture was not measured in terms of Western medical diagnostic criteria. It was also difficult to gauge to what extent proximal processes, such as traditional healers/healing, affected African participants, although customs such as those witnessed by the researcher (e.g. the “umthandazi” or faith healers) might have influenced the daily existence of the health care practitioners, although this was not expressed in their responses. Therefore, it is assumed that diverse cultural beliefs were accepted as part of the ecological system, in which participants worked and lived and was incorporated into their “landscapes” and expressed at different levels.

The diversity of participants did, however, to some extent, reflect their general world-views and cultural origins (individual versus collective, Western vs African) and were expressed in the need to treat patients in their own languages in order to foster better cultural understanding in the best interests of health.

Common factors across all cultures in this study concerned the collective frustrations, joys and hopes for health care. In this regard, health care practitioners were united in expressing their experiences as was evident in the number who participated in the study. Their communal wish and willingness to be a part of the
research was reflected in the extent to which they provided the rich data that were gathered.

In conclusion, health care practitioners’ responses reflected how they were affected by:

- **The Microsystem**: Health care practitioners as individuals with their personal and immediate family needs, the hospital, clinics, ethics, spiritual affiliations, management and neighbourhoods.

- **Mesosystem**: The extent to which health care practitioner’s family, their peers, workplace and neighbourhood affected each other.

- **Exosystem**: How health care practitioners lives were affected by the current economic system, political system, education system, government system, and religious/ethical/spiritual systems.

- **Macrosystem**: Health care practitioners overarching beliefs, values, and how these affected their lives within the system.

- **Chronosystem**: How health care practitioners integrated their lives into the total dimension of time.

**b) Maslow’s hierarchy of needs and health care practitioners**

Health care practitioners’ experiences reflected the often suboptimal environments in which they worked and lived. As such, when viewing these environments in terms of Maslow’s hierarchy of needs it can be deduced that health practitioners who work in these environments would more than likely find it difficult to self-actualise. Although it was not considered possible to be totally self-actualised, some participants felt fulfilled, altruistic and patriotic, which indicated various levels of “peak experiences“.

However, nurses, in particular, experienced features of “learned helplessness” and low self-esteem from their perceptions that their lives were not under their control and they believed that it was the government that was responsible to change the quality of their lives. Many felt neglected, unappreciated, hopeless and angry
about, amongst other aspects, their unfulfilled need for housing and safety of their children in terms of crèche facilities, better transport and even seating facilities at work. It is entirely possible that discriminating practices, such as those seen in South Africa’s historical past, may have led to the development of certain psychological/affective states.

Health care practitioners, whose basic needs were met, especially in their early years, and who had the characteristics required to self-actualise, developed greater resilience. They were overall happier, optimistic and better able to cope with adversity due to a healthier ego-structure, behaviours and characteristics, which would move them towards self-actualisation, despite the stressful environment in which they worked. All health care practitioners, whether in the public or private sector, experienced their working environments as stressful to varying degrees and had different ways of dealing with these stressors.

Despite some basic needs not being met, some health care practitioners still experienced higher-order needs such as a sense of love and belongingness, i.e. to the country and its people, for example. This corresponds with the observations in McLeod (2014) that Maslow’s hierarchy of needs is often not observed in some cases (for instance impoverished cultures in India), where it appears that some individuals, although living without basic needs, still appear to experience higher-order needs. Maslow’s Theory, which focuses on happy individuals and their development towards self-actualisation, can be viewed as a positive approach to health care practitioners’ experiences in that it does not focus on pathology as such, but rather on the development of a more “whole” person. This “hierarchy of needs” can then be applied within the health care system as a whole, in a symbolic metaphor for transformation with patterns that might predict its self-actualisation through motivational factors such as are found in the terms “physiological”, “safety”, “belongingness”, “love”, “esteem”, “self-actualisation” and “self-transcendence”. Understanding these highest aspirations, the collective striving toward health (bio-psycho-social) provides for an ideal identity and autonomy through “striving upward”, which appears to be a universal tendency common to all human beings.

Maslow’s holistic approach, contending that learning is affected by physical,
emotional, social, as well as intellectual attributes of an individual rather than reducing behaviour to a response in the environment, if applied in the health care environment, could mean that, before the cognitive needs of health care practitioners can be met, their physiological/basic needs must be fulfilled. For example, an exhausted health care practitioner will find it taxing to focus. Similarly, the practitioner also needs to feel physically and emotionally safe in the work environment, respected and valued in a supportive environment both at work and at home. Practitioners need to feel that they and their families are safe and taken care of. If these needs are met, health care practitioners will be able to progress, work and reach their full potential. Conversely, health care practitioners with low self-esteem are unlikely to progress optimally until their self-esteem is strengthened. The implications for health care practitioners and stakeholders in health care would seem obvious in this regard and these should be addressed in order to optimise the health care delivery system as a whole, by knowing what people’s experiences are as part of the human race.

In conclusion, and to summarise:

- “Safety “needs are not only physical needs, they are also needs such as social, work, economic and psychological security. Being safe and secure would make health care practitioners happier and more confident to face life’s trials and tribulations.

- Meeting needs such as love, belongingness and relationships in their communities as well as feeling inter-connected mean that health care practitioners would experience less psychological symptoms such as depression, dysthymia or burnout. Health care practitioners who feel respected/esteemed and recognised for their worth would be able to perform better and experience generosity and personal growth.

- Health care practitioners want to fulfil their potential and feel that they may become more than what they are, in the pursuit of self-actualisation. They would be less self-centred, more humorous/relaxed, independent thinkers, kinder and have a sense of gratitude about their lives and have a deep connection to other human beings as central to their lives if their lower
order needs were fulfilled. This would allow them to raise their consciousness above any limits such as culture, colour or creed.

- Personal growth would take place if health care practitioners felt an overall sense of enthusiasm, when making transitions to higher order needs. Examples of growth being thwarted might be that health care practitioners may become more defensive, and at times irrational, as they are not coming from a strong space within but rather one of weakness.

Thus, Maslow’s “hierarchy” should be viewed as a series of stages that are “nested” within each other, rather than exclusive and specific “steps” (from lowest to highest) in the pyramid. This would suggest a health care environment in which health care practitioner’s growth could take place in a rather more organic, fluid and holistic way with peak experiences along the way and a general sense of well-being. Although many participants were struggling to achieve higher levels of self-actualisation, some participants did express feelings and motivations or “peak experiences “such as altruism and patriotism.

Maslow did not believe that all mental illness/psychological factors are caused by physiological factors, but rather by the loss of what it means to be fully human and as being an integral part of human nature. In respect to health care practitioners, their anxieties or other negative feelings were possibly more of origin disorder with loss of the meaning of their lives and doubts about their goals, loss of self-worth, courage or hope and despair about the future with no current possibility for love or joy.

That social, political and familial factors play a very important part in the formation of psychopathologies has implications for health care practitioners, as it provides a solution for certain psychological states that might be reversed in an optimal environment. This is especially hopeful for those whose lives and/or futures appeared hopeless in the current study. Instead, healers need focus, compassion and good intention, which may be achieved if ethical governance within the health care sector is perceived to protect and enshrine the rights in the Constitution.
5.2 Limitations

The limitations of the present study are discussed with particular reference to:

- The study was conducted in the uThungulu District, KwaZulu-Natal, South Africa. Therefore, it might not have reflected the dynamics of the “experiences” of health care practitioners in other districts, provinces, or the country as a whole. Therefore, it is debatable whether results can be transferred to the whole country.

- The study did not include all the possible clinics and health care facilities in the district and therefore findings cannot be transferred to the whole uThungulu District.

- The sample size was purposive and limited and therefore results cannot be transferred to all health care practitioners in the uThungulu District, the province or the country.

- Written responses to open-ended questions were the sole source of data in the present study. Therefore, if a participant’s response seemed vague or unclear the researcher was not able to ask follow-up questions as would have been the case if face-to-face interviews were used.

Although this study had limitations, the results were considered trustworthy, valid, and reliable, using multiple methods of analysis (triangulation), which included: descriptive, social constructionist and interpretive levels of analysis which build upon one another in ever-increasing depths of explication, providing a holistic structure and thorough analysis. The sample size was considered to be adequate for the purposes of this study and was reflected in the trustworthiness, validity and reliability of the results.

5.3 Recommendations/Policy implications

Based on the findings in this study, the following recommendations for improvements to the health care delivery system in South Africa are made with particular reference to:

1. Recommendations for public and private health care practitioners and
management structures – the advocators of good quality health care and service delivery in the uThungulu District;

2. Recommendations from the participants themselves, to various stakeholders in the health care environment;

3. Recommendations for future research;

4. Mnemonic “SIPHIWE” developed for this study with recommendations for further/future development.

5.3.1 Recommendations for public and private health care practitioners and management structures – The advocators of good quality health care delivery services in the uThungulu District

Recommendations taken from participants’ experiences are similar to those found in a Harrison (2009) overview of the South African health care system. These have been incorporated and expanded and include the following:

A. Service delivery:

• Processes for improving quality of care: the current inefficiencies may be of a rather endemic nature and would require a wide-ranging, multi-disciplinary approach that could include monitoring, programme-based monitoring and quality improvement. This would include on-going monitoring of the quality of equipment, management and care.

• Allow health care/hospital managers and senior staff to focus on attaining quality health care service delivery by greater separation of management and political responsibilities. Greater emphasis needs to be placed on maintaining universal standards for good quality of health care which is seen to be independent and non-politically motivated.

• Accountability for performance, by management with a clear responsibility brief. Regular audits to ensure that quality of leadership is effective. Interactive leadership from local, to regional and national level which encourages and empowers assertive managers to meet health care challenges.
• Greater efficiency and accuracy of information systems, thus allowing management information in decision-making to become more effective.

• Regular maintenance and care of equipment and effective procurement of resources.

• Tracking expenditure in relation to service performance through better financial management. Measures to hold management accountable and ensure transparency.

• Effective use of time in meetings and close monitoring of efficient time-management through planning-ahead with clear briefs.

• Strategies to reduce paperwork and data collection through efficient systems, thus allowing for better time-use of health care professionals. These would reduce waiting times for patients and result in greater efficiency and service delivery.

• Punctuality commitments. Effective measures to increase awareness of social responsibility and commitment to working-hours.

• Audits to ensure that safety standards for health care practitioners and patients are met. These standards include personal security, effective/adequate equipment and health care training programmes.

b. Improving health care practitioners’ morale:

• Implement local and national campaigns which award and recognise health care practitioners and affirm their value.

• Provide regular feed-back programmes/channels through which interactive communication can take place via leaders/managers to target health care practitioners’ needs. This will promote understanding health care workers’ “obstacles” in the work place, through consultation and effective reporting channels.

• Encouraging uThungulu district management teams to increase interaction and support with staff at “grass-roots” levels as opposed to
interacting on national and provincial or “top-down“ levels. Effective
inter-hospital/clinic communication through interactive leadership to
support the community and increase awareness and establish joint
priorities.

- Trimming and condensing of annual business plans and simplification of
  paperwork, including datasets and programme reports.
- Re-assess ineffective methods of auditing, training, staff-procurement.
- Better support to health care personnel, beyond occasional training.
  This could include programmes for incentivising further studies and staff
development.
- Inter-disciplinary awareness training with regular multi-disciplinary team
  events to encourage cohesion/respect.

Noting the above, where emphasis is placed on areas where health care
practitioners ‘morale and health care services could be improved, it is important to
remember that that there are indeed hospitals and clinics across the country that
render high quality services despite their resource restraints and deficits. The
common denominator in these facilities of excellence is motivated staff and strong
leadership. Therefore, it is essential that clinic managers and hospital senior staff
receive the type of training that middle and senior managers receive. Only when
health care practitioners have a real sense of personal fulfilment and mission will
their morale improve and this will only happen if local provincial and national
managers/senior staff instil a clear plan of action and vision which health care
practitioners can aspire to.

c. Uphold the “Batho Pele” (“People First”) principles and the Constitution:

The eight “Batho Pele” principles, consultation, service standards, access,
courtesy, information, openness and transparency, redress and value for money
(KZN DOH, 2001) have their roots in a number of policy and legislative
frameworks that are in line with the Constitution of the Republic of South Africa of
1996 (as amended) Section 32 of the Constitution. This enshrines the rights of its
citizens to protection of, amongst others, prescribed service packages with a view to placing citizens (and therefore patients) at the centre of service delivery and compelling public departments (national and provincial) to align their services accordingly especially in under-serviced areas. In the same vein, if the needs of citizens change, then information needs to be updated to reflect those needs. In transforming health care service delivery, legislation provides for progressive increases in patients’ access to health care services, also promoting good governance and efficient administration.

Patients’ rights to be consulted, receive procedurally fair administration, rights of redress, value for money, accountability and prudent use of public funds effectively compels health care practitioners to be essentially service-oriented, commit themselves to being transparent in everything they do in the interests of their patients and in upholding the laws of the country. This is a stark departure from the previous dispensations, which excluded the majority of South Africans from adequate and equitable health care services. This prevented them from actively participating in government machinery for a “better life for all”, which the new democracy in South Africa sought to enshrine after 1994.

A common purpose is needed in both the public and private health care environments, individually and collectively, with the vision to improve standards of health care for all, which is people-driven and people-centred and underscored by quality, equity, being timeous and upholding strong ethical codes for fostering partnerships with others (NWDS, 2015).

Although the eight principles were originally directed at all public servants, they are nevertheless applicable to all health care practitioners which include: all management structures, private health care practitioners and managers working in private health care institutions. The eight principles are:

1. Consultation

Patients (as citizens) should be consulted about the level and quality of the health care services they receive. Wherever possible, they should be given a choice about the services that are offered (KZN DOH, 2001). This type of proactive consultation and interaction, with important feedback systems in place to inform
management, allows for avenues to be created, in which changes can be made to the health care system, the feedback-loop providing the dialogue-link, which is much needed between health care practitioners, patients and management, adopting a more holistic or “people-centred” approach and ethic (ETU, n.d.). The evolution of health care is dependent on active, purposive consultation. Without it, a devolution of the health care system will occur.

2. Service Standards

Patients “should be told what level and quality of public services they will receive so that they are aware of what to expect” (KZN DOH, 2001). This indicates the clear need for more concrete guidelines for service delivery and to which health care practitioners and management will be held accountable. This may include feedback providing explanations and/or apologies for standards that are not upheld (ETU, n.d.). Procedures and guidelines for disciplining health care practitioners who do not uphold service standards need to be introduced in order to maintain a high level of accountability.

3. Access

All patients should have “equal access to the services, to which they are entitled” (KZN DOH, 2001). This is especially applicable to marginalised and/or challenged patients such as the disabled, illiterate, hearing and visually impaired, and rural populations who have poor access to health care facilities in general. Therefore, it is imperative that health care practitioners become advocates for the achievement of these objectives (ETU, n.d.). In order to become part of a solution-focused health care system, health care practitioners, who are the cornerstone of the health care system, need to be consulted by policy-makers.

4. Courtesy

Patients “should be treated with courtesy and consideration” (KZN DOH, 2001). As such, health care practitioners should ensure that they do not become obstacles in the process of patients’ rights to access quality health care by being impolite, unhelpful or disrespectful (ETU, n.d.), remembering that their attitude could make a huge difference in terms of the experience of their patients at the health care
facilities at which they work.

5. Information

Patients should be given full, accurate information about the public health care services they are entitled to receive (KZN DOH, 2001). This would also apply to private health care as patients have a right to be informed. Health care practitioners, by being helpful to patients, who need to be referred elsewhere or need re-direction, can circumvent the time spent in often endless queues by taking the extra time to explain and make their instructions clear in a friendly and professional manner (ETU, n.d.). Health care practitioners need guidelines/training, which are applicable to their local clinics and/or hospitals, in order to inform patients about their health care options.

6. Openness and transparency

Patients should be told how “departments are run, how much they cost and who is in charge” (KZN DOH, 2001). This “open-book” approach (ETU, n.d.) goes a long way towards providing patients with the information they need to access health care when they often do not have that information and/or do not know it existed at all, for example, social grants, specialised services and so forth. Therefore, education is imperative as part of everyday practice and towards a better health care system for all.

7. Redress

If the promised standard of service is not delivered [patients] should be offered an apology, a full explanation and a speedy and effective remedy; and when the complaints are made, citizens should receive a sympathetic, positive response (KZN DOH, 2001).

This could mean that the matter is referred to or discussed with seniors, supervisors, managers, and so forth, to find a solution. If patients are still not satisfied, they have the right to take legal action by way of a review from a court of law and/or impartial tribunal (ETU, n.d.). Health care practitioners need to be accountable for their acts and omissions.
8. Value for Money

Health care services “should be provided economically and efficiently in order to give [patients] the best possible value for money” (KZN DOH, 2001) and those services should include the duty upon health care practitioners to report any wastage and/or compromise to those services and the delivery thereof (ETU, n.d.).

In addition to the original eight “Batho Pele” principles, health care institutions and, in turn, health care practitioners, should also be encumbered with the following principles, which can be considered as additions to the original eight and, as such, are numbered accordingly. All of these call for a holistic approach for their implementation and visible proof that each principle is being carried out for the greater good and/or sum total of all the principles together and enhancing their effect:

9. Encouraging innovation and rewarding excellence

Innovation can be new ways of providing better service, cutting costs, improving conditions, streamlining and generally making changes, which tie in with the spirit of “Batho Pele”. It is also about rewarding the staff who “go the extra mile” (KZN DOH, 2001).

10. Customer impact

Impact means looking at the benefits that are provided for patients both internal and external; it is how the previous nine principles link together to show an improved overall service delivery and patient satisfaction. It is also about making sure that all patients are aware of and exercising their rights in terms of the “Batho Pele” principles (KZN DOH, 2001).

11. Leadership and Strategic Direction

Good leadership is one of the most critical ingredients for successful organisations. Organisations that do well in serving their customers can demonstrate that they have leaders who lead by example, set the vision and ensure that the strategy for achieving the vision is owned by all and properly deployed throughout the organisation. They take an active role in the
organisation’s success (KZN DOH, 2001).

For leadership to be effective, all systems (local, regional and national) need to collaborate to find new and innovative ways to meet the complex challenges which the district and country faces.

5.3.2 Recommendations from the participants themselves to various stakeholders

Responses to Question 3 of the open-ended self-report questionnaire, “What suggestions do you have to improve the health care delivery system in South Africa?” provided the recommendations that are presented in two sections: those made by public service health care practitioners and those made by private health care practitioners. These recommendations may apply individually to either sector or to the health care sector as a whole.

A) Public sector health care practitioners’ recommendations:

1. Implement better pay, better working conditions, and incentives to perform well, and promote teamwork. This can be done by:

   a) Giving more credit and recognition where it is due and more incentives for staff to perform their duties well. Encourage and praise staff who do their duties well rather than simply calling them in to discuss their “faults” or omissions.

   b) Implementing better pay and working conditions. Provide compensation for after-hours work, as some practitioners are working extra hard to compensate for a lack of staff. Often staff work without gloves, masks and other equipment which puts them at risk.

   c) Motivating staff to realise the importance of their jobs. Low morale and low self-esteem leads to a demoralised work force. Lack of multi-disciplinary team practices and lack of respect between professionals has negative psychological effects.

   d) Having open discussions and offering workable solutions. Staff feel “cut-off” from and out of touch with management, who are also perceived to have a
luxurious lifestyle (“cupcakes and tea”, “new chairs”) at the expense of health care practitioners and patients’ well-being.

2. Promote better management practices, this can be done by implementing:

   a) Better communication channels to manage patients. Patients need to be distributed equally/fairly between clinics/hospitals to lessen waiting lists, particularly in the public sector. Patient education with regards to hospital benefits (medical aid) needs to be communicated via education programmes and not left to nurses. Nurses, in particular, find that they are unable to care adequately for patients whose benefits have “run out”.

   b) Providing clear guidelines for the management of leave time. Coming to work late, long tea breaks, leaving early, and so forth, must be deducted from annual leave. Working overtime could be added to annual leave.

   c) Better resource allocation and management to circumvent lack of working equipment and human resources.

   d) Involving management more at “grass-roots” level and less “cupcakes and tea”.

   e) Putting more focus on efficiency, accountability and responsibility.

   f) Implementing good communication with staff concerning their grievances. Swifter responses in order to circumvent anger, frustration and low morale.

3. Improve quality and management of equipment. This can be done by:

   a) Acquiring better equipment. Broken or “cheap” equipment results in poor patient care. Effective management of purchasing of equipment, such as bidding procedure and delivery process. Procurement processes need to result in visible improvements.

   b) b) Ensuring no shortages of equipment. Adequate equipment, such as air-conditioning, blood pressure machines, scales, gloves, masks, paper towels are essential for effective service delivery.
4. Offering better quality services to patients. This can be done by:

a) Promoting greater awareness, and running campaigns that prevent diseases. “Prevention is better than cure”, for example, TB and diabetes prevention programmes. Special campaigns to educate parents about basic hygiene for their children and immunisation programmes.

b) Offering better organisation of medication delivery to patients, for example, drop medication at clinics and provide transport for pensioners in rural areas to pick up their medication.

c) Taking steps to prevent overcrowding of health care facilities.

d) Providing more facilities and personnel, such as hospitals, clinics, ambulances and staff.

e) Encouraging health care practitioners in rural areas to communicate in languages understood by patients and use interpreters when necessary.

5. Making referrals and upholding standards. This can be done by:

a) Improving referral systems between the primary, secondary and tertiary hospitals and clinics.

b) Reviewing standards and protocols. Some are old and out-dated and need to be audited.

6. Offering Fringe benefits for staff. These could include:

a) Financial help for health care practitioners who want to upgrade their knowledge and skills.

b) Better facilities for families of health care practitioners, for example, day care centres for the staff’s small children and accommodation near the hospital.

c) More training and education of health care practitioners, for example, courses and workshops.
d) Facilities to look after health practitioner’s safety. Provide security officers in wards, clinics and hospitals.

b) Private sector health care practitioners’ recommendations

1. Attain more of and make more efficient use of resources. This can be done by:

   a) Involving more private health care practitioners in the public service.

   b) Using money more efficiently. Money is squandered, which could be put to better use.

2. Appointing efficient and politically independent management. This can be promoted by:

   a) Appointing competent managers in public hospitals and giving them more disciplinary powers.

   b) Addressing rampant mismanagement, corruption and misappropriation of funds.

   c) Insisting the health care system becomes effective, well planned and managed.

   d) Insisting that managers take steps to prevent fraud and corruption. Effective transformation emanates from effective leadership.

   e) Creating strong, politically independent management structures for public hospitals.

   f) Putting structures in place to ensure that funds that are allocated for projects and hospitals are spent wisely and audited.

   g) Giving promotions to higher positions or ranks on merit and not to family, friends and those who are (politically) well connected. Audit applications and encourage/ensure transparency.

   h) Making sure that public sector staff with specialised skills are used where
they are most needed. Specialised staff should not be allocated to departments which do not require those skill-sets.

i) Implementing a Managed Care System especially for the management of chronic diseases.

3. Reorganise procurement of equipment. This can be done by:

a) Decentralising the ordering and buying of equipment. Allow local management to take responsibility for ensuring the procurement/saturation of equipment.

4. Pay attention to performance and attitude of staff. This can be promoted by:

a) Measuring health care practitioners’ performance in patient outcomes and not in hours spent at work.

b) Reporting failure to perform professional duties to professional bodies. Disciplining staff who fail to perform, for example, by making deductions from salaries, suspension or dismissal in extreme cases.

c) Encouraging Health care practitioners to have the interests of their patients at heart at all times, such as taking pride in their work and being accountable for their actions.

d) Instilling Enthusiasm for work in health care practitioners. Staff should be motivated to perform their duties well.

e) Providing better supervision and mentorship in the public sector.

f) Regulating staff performance to ensure good service delivery.

5. Overhauling the education and training of health care practitioners. Suggestions to do this include:

a) Training of medical practitioners should revert to a six-year course. Students should master anatomy and physiology before they confront pathology and treatment.
b) Maintain high academic standards, for example, no adjustment of marks to achieve a particular target percentage pass.

c) Hospital-associated nursing colleges should be reinstated. Improve the training of nurses.

d) Health care practitioners should receive more training in ethics and management.

e) Produce a greater number of medical professionals annually so that all institutions have enough staff, but without lowering academic standards.

f) Workshops should include important specialised topics such as HIV/AIDS, TB, diabetes and nursing care.

6. Implementing strict standards of cleanliness. Staff should:

a) Provide clean linen and have clean equipment. Patients' psychological and physical well-being in the clinics and wards is essential for their recovery. Poor standards negatively affect health care practitioners' morale.

7. Involving communities at grass roots level in health care. Suggestions to achieve this include:

a) Making parents more responsible and accountable for their children.

b) Teaching all children basic hygiene.

c) Teaching people to take responsibility for their own health. Run campaigns and introduce programmes in the community.

d) Teaching career and basic health care guidance in schools.

8. Clinics

a) Primary health care clinics should be available and accessible to all.

b) Allocate more funds for primary health care and utilise those funds wisely.

c) Better care at clinics for patients. Improve the conditions at clinics, such as
water, sewage and electricity.

9. Better Patient care

a) “Prevention is better than cure”. Run effective programmes to prevent diseases.

b) Growth monitoring, promotion and immunisation must be done more effectively.

10. Making use of skills and help from outside the public sector. This can be done by:

a) Partially integrating the public and private sectors.

b) Making conditions more attractive for private medical practitioners to work sessions in public hospitals.

c) Relaxing the registration process for well-qualified foreign medical practitioners. This will relieve the human resource scarcity.

d) Establishing joint ventures with powerful overseas medical institutions and create local branches.

e) Bringing foreign specialists into the public sector on a rotational basis.

5.4 “Siphiwe” Recommendations for further development

Recommendations for a future health care framework was developed for this study and are briefly presented with the hope that they will be expanded and more fully developed into an official outlined document, aimed at achieving a transformative health care programme, using the mnemonic “SIPHIWE”, a Zulu name, the meaning of which is “we have been given” (Zulu names).

The name chosen is as a dedication to the life and work of Professor H.S.B. Ngcobo, a health care professional himself, who inspired this research and the previous study. He lived and worked in the uThungulu District and is remembered by everyone who knew him for his tireless efforts to promote the improvement of health care standards and working conditions of health care practitioners, both
locally and in the country as a whole. Whilst championing the rights of health care practitioners in the health care system in general, he never lost sight of the patients and the systems that were essential for the services they received. As a previous nurse and clinical psychologist, past professor at Zululand University and President of the Psychological Association of South Africa (PSYSSA) amongst others, he remained “faithful to the calling” until the very end of his life. Although his presence is sadly missed, honouring him, through using his name in these recommendations, seems right and befitting of such an honourable man.

5.4.1 The Mnemonic: “Siphiwe”

“SIPHIWE” S = Strategise

Health care practitioners need to strategise with all stakeholders to ensure a better life for patients, as well as optimal working conditions for themselves. This may involve meetings, workshops, circulars and constant feedback loops between themselves, their patients and management structures, who will then be mandated to take their suggestions further, such as to decision-making bodies in both the public and private health care sectors. Their inclusivity is in line with the mission of the KwaZulu-Natal Department of Health’s mission: “To develop a sustainable, coordinated, integrated and comprehensive health system at all levels” (KZN DOH, 2013), which upholds the constitutional rights through a strategic framework for practical purposes (Naidoo, 2013).

I = Itemise

Hard copies of items that are essential for health care practitioners’ day-to-day professional practices in their relevant departments, clinics and/or other workplaces need to be concretely established and accepted as such by management in the spirit of “open communication, transparency and consultation” (KZN DOH, 2013). These need to be established through frequent input from health care practitioners who interact with patients on a daily basis and need to be adjusted when necessary.

P = Plan

Once strategies are in place and itemised, plans need to be made regarding their
circulation to all stakeholders of expectations, implementation strategies and accountability. These items should be introduced and made available, visible, and accessible in the interests of a common vision for “optimal health status for all persons in KwaZulu-Natal” (KZN DOH, 2013).

**H = Hardcopy**

Hard copies of the plans must be drawn up with a view to adherence to the principles of “commitment to performance, innovation and change through being courageous about learning from others based on trust and which, in turn, is built on truth, integrity and reconciliation” (KZN DOH, 2013). These hard copies should be made available to all health care practitioners, who should acknowledge receipt thereof, and be held accountable for their effective implementation.

**I = Implement**

Implementation would take place through good governance principles and should not be interfered with, undermined or defeated by anyone, who does not have the South African Constitution at heart and the intention to uphold its authority (Sebola, 2014). Effective implementation should take place according to the African Union Draft Charter, which provides administrative principles and values for public administrators. These principles can be adapted/adopted for both public and private health care practitioners with particular reference to “political neutrality, professionalism, effective policy implementation, fair working conditions, respect for ethical principles, and a fight against corruption and satisfaction of users’ needs” (Sebola, 2014, p. 999).

Therefore, implementation needs to be adopted according to the best interests and needs of health care practitioners and the citizens/patients that they serve and by whom and through whom laws are made and amended in South Africa according to the current climate of public participation. If the plans and strategies are conformed with, and values are adhered to by individuals of integrity, trust in the system will be achieved (Sebola, 2014, pp. 1002-1003).

**W = Work ethic**

In order for public and private health care practitioners to work and function in a
professionally acceptable environment, work ethic cannot be over-emphasised. The values, beliefs and norms of professionals as a collective, management bodies, provincial authorities, within the societies in which they live and work for the good of the “whole”, is often undermined by reports of “disregard for human dignity, under-use of health care services, over-use of services, avoidable errors, and large variations in standards of services. Therefore, for health care practitioners to be productive and enhance the health and lives of their patients, a high level of work ethic is essential (Naidoo, 2013) and should be continually evaluated.

**E = Evaluate**

Outcomes should be evaluated or audited and feedback provided so that learning can take place with changes made accordingly on an ongoing basis. One method that has been extensively described in the presentation by Pillay (2013) (which is beyond the scope of this study) and which could be a useful tool for evaluation in both the public and private health care sectors, is the Balanced Score Card method (Naidoo, 2013). This is a transformational tool by design; it measures quality improvement in terms of patients, human resources, systems/processes and finance. Being outcome-led, this method evaluates clinical standards, public responses, responses to areas of need by professional bodies and management guidelines for good governance. These evaluations will take place ranging from an individual level (health care practitioners and patients) up to higher levels including Provincial Advisory Boards; they require significant organisational, personal commitment, commitment to upholding procedures and practices as well as effective teamwork from all involved (Naidoo, 2013).

### 5.5 Recommendations for future research

This study concentrated on a selection of professional health care practitioner participants from health care facilities in the uThungulu District, KwaZulu-Natal, with particular emphasis on describing, analysing, exposing and interpreting their experiences in the current health care delivery system in South Africa. As such, the research was limited but valuable in terms of being one of the first studies to focus on a broad spectrum of health care practitioners’ experiences from a
“bottom-down” or “grass-roots” level and was undertaken with a view to finding solutions to problems in health care service delivery.

a) Future research could expand the experiences of health care practitioners in whole provinces or in selected health care facilities countrywide, which would compound the information contained in this study and provide further experiential and evidence-based data that could be valuable for all stakeholders in the health care delivery system in the country.

b) Comparisons from data obtained from further studies could determine, where pockets of excellence exist and be used to identify areas and/or facilities that need attention and where solutions need to be found in the interests of promoting better health care environments for all who work in them and patients who attend them.

c) Expansion of the SIPHIWE recommendations into a manual for distribution to all health care practitioners and/or stakeholders in the South African health care delivery system.
Final personal statement

“Out of my experience, such as it is (and it is limited enough), one fixed conclusion dogmatically emerges, and that is this, that we with our lives are like islands in the sea, or like trees in the forest.
The maple and the pine may whisper to each other with their leaves …
But the trees also commingle their roots in the darkness underground, and the islands also hang together through the ocean’s bottom.
Just so there is a continuum of cosmic consciousness, against which our individuality builds but accidental fences, and into which our several minds plunge as into a mother-sea or reservoir.”
William James, 1909.

This study emerged as an extension of my previous research in 2011. Upon reflection, it would be an omission if I did not, at the end of the current study in 2016, consider the effect it had on me.

The process of this study (formulating the research idea, coming to grips with the research technicalities, methodology and application) contributed to my own personal “psycho-spiritual" development through the mutually informative and integrative experience of the research. The use of self-report open-ended questionnaires employed an alternate way of "listening" that evolved into different layers of phenomenological interpretation, which emerged as the process unfolded and the health care practitioners’ experiences grew louder and louder in my consciousness and/or subconscious. In that sense, Maslow and Bronfenbrenner’s theories became an integral part of my own transpersonal experience alongside those that may have occurred with the health care practitioners and the application of their minds/emotions/senses/consciousness during the process of analysing their responses.

As a result, there remains in me a sense of unity with the participants and a consciousness of holism, rather than the concept of dualism that the researcher-and-participant relationship provokes superficially.

Collecting the data in this study did not embark from the usual linear, rational method employed more routinely to gauge information in the health care sector and, which, I believe, culminated in the presentation of information conveyed synergistically as it developed between each stage of the process and analysis.
Both the present as well as the 2011 study have collectively humbled and enriched me personally to share my own experience and, especially, the present study has had an effect on me that has left me even more grateful as I conclude this chapter, with deep gratitude, appreciation and admiration for each and every participant, with whom I feel I now share a personal bond. The research was essentially a dynamic process at the outset, in which I was involved both from an insider’s perspective (although indirect and incomplete) and actively involved in the interpretation of health care practitioners’ perspectives, which was thus inevitably complicated by my own perceptions and experience as an “outsider looking in”. By entering into the health care practitioners’ personal worlds through “an insider’s” (Smith & Osborn, 2003, p. 53) perspective, it was nevertheless accepted that the process was never fully complete or direct.

“Thus, a two-stage interpretation process, or a double hermeneutic, was involved, in which the participants were trying to make sense of their world; and the researcher (by ‘taking their side’) was also trying to make sense of their world”, yet also asking critical questions such as “What was the person trying to achieve here? Was there something leaking out that was not intended? Did the researcher have a sense of something going on that maybe the participants themselves were less aware of?” (Smith & Osborn, 2003, p. 53).

In conclusion, the intention of the present study was to analyse, describe, interpret and explicate health care practitioners’ lived experiences of the South African health care delivery system. The study was approached with the positive vision of fully capturing all aspects of their responses through the interpretations, as well as including symbolic interactionism (Smith & Osborn, 2003, p. 53), reflecting how their social and personal worlds were constructed within their contexts (Smith & Osborn, 2003). Most importantly, health care practitioners made their own recommendations to address problems that surfaced. The researcher remains faithful to every aspect of this work, in every way.
Final conclusion

“It is not what your ship will NOT do that you want to know to get on terms of successful partnership with her; it is, rather that you ought to have a precise knowledge of what she will do for you when called upon to put forth what is in her by a sympathetic touch.”


It seems relevant to conclude that the field of health care does not need more cynics. Instead, it is imperative that all stakeholders need to be pragmatic in finding solutions to health care problems, to find a way of speaking to one another respectfully with a view to finding solutions to problems, which inevitably affect services as a whole and individuals, to achieve better outcomes. It would not be helpful or healthy to ignore health care practitioners’ experiences if progress is to be made. By exposing practitioner’s feelings, attitudes, hopes, fears and opinions, bridges have been built that will strengthen health care not only locally, but also generally and are in line with certain universal goals, such as the need for good health, a sense of belonging, good governance, responsibility, accountability and ethics. These common needs and/or goals exist across all professional disciplines, countries, cultures, health systems, and people in general, affecting the whole system recursively. Health care recipients, meaning patients, also long to be part of an efficient system just as much as health care practitioners do, both wishing to receive mutual benefit from a supportive environment, where they are respected, nurtured, loved and rewarded.

The collective community in South African society and the world should not lose faith in striving to make the health care systems better for all. Just as much one should not lose oneself by only measuring outcomes with endless statistics, workshops and roadshows, when instead, greater effort needs to be made to listen carefully to the voices of the ordinary people/individuals, which is as relevant today as it was in generations past. Having faith in the individual and collective ability to inform important stakeholders and decision-makers, who have health care policies in South Africa at heart, should be central to any planning that would influence such an important sector of society as the health care sector. Striving for positive change through all of the above takes openness, resilience, hope,
courage and fortitude; just as it has done in the histories of transformation in South Africa and indeed the world.
References

“Of all the living creatures upon land and sea, it is ships alone that cannot be taken in by barren pretences, that will not put up with bad art from their masters.”
Joseph Conrad


Council of Health Service Accreditation for Southern Africa, see COHSASA.


Addendums

“I must go down to the seas again, for the call of the running tide
Is a wild call and a clear call that may not be denied:
And all I ask is a windy day, with the white clouds flying,
And the flung spray and the blown spume, and the seagulls crying.”

John Masefield

Addendum A: Participant information required and five self-report, open-ended questions

Participant information required and outline of questions for your responses.

Age:
Gender:
Occupation:
Designation/position
Home language:
Religion:
Nationality:
Public or private sector:

Question 1: How are you experiencing the current health care system?

Question 2: What are your views about the proposed changes within the health care system?

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Question 5: Would you consider leaving South Africa and if so, why?
Dear health care practitioner

South Africa is at a critical point in the debate about the future of health care in the occupation-specific dispensation.

By assisting with the information required on the following pages, you will make a significant and valuable contribution to understanding how health care practitioners actually experience the health care delivery system.

The title of this PhD is:

South African health care practitioners’ experiences of the current health care delivery system in uThungulu District

By highlighting the experiences, opinions and feelings of health care practitioners in the various sectors of the health care community, another platform for debate will have been opened that could assist all stakeholders in formulating a system beneficial to all South Africans. Personal and social solutions also inevitably arise from such experiences.

The intention in this PhD is to document, describe, explicate, analyse, and expose health care practitioners’ experiences of the current health care delivery system and proposed changes with the aim of finding solutions to envisaged problems.
Addendum C: Informed Consent

Consent form

I, (full name)……………………………………………………………………………………………………………………………

agree to take part in a research study entitled: South African health care practitioners’ experiences of the current health care delivery system in uThungulu district.

I declare that:

• I have read/had read to me, the information and consent form and that it is written in a language with which I am fluent and comfortable.

• I have had a chance to ask questions and all my questions have been adequately answered.

• I understand that participation in this study is voluntary and I have not been forced to take part.

• I understand that information gathered from the study will remain confidential and anonymous.

• I may choose to withdraw from the study at any time and I will not be penalised or prejudiced in any way.

• I understand that no potential risks exist for me if I participate in this study.

• I understand that the information gathered in the study will be published; however, none of the presented information will be linked to me directly.

• I understand that I will be required to complete a short questionnaire.

Signed at: (place) .................................................. on: (date) ........................................ 2013

...........................................................................................................

Signature of participant
Addendum D: Ethical clearance certificate

UNIVERSITY OF ZULULAND
Website: http://www.unizala.ac.za
Private Bag X1001
KwaUlangezwa 3880
Tel: 035 902 6465
Fax: 035 902 6222
Email: kuzoa@unizala.ac.za

UNIVERSITY RESEARCH ETHICS COMMITTEE
(Reg No: UZREC 171110-30)

ETHICAL CLEARANCE CERTIFICATE

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<tr>
<td>Project Title</td>
<td>South Africa health care practitioner's experiences of the current health care delivery system in Uthungulu District</td>
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<tr>
<td>Principal Researcher/Investigator</td>
<td>JE Stoyanov</td>
</tr>
<tr>
<td>Supervisor and Co-supervisor</td>
<td>Prof. HS B Ngcobo</td>
</tr>
<tr>
<td>Department</td>
<td>Psychology</td>
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<tr>
<td>Nature of Project</td>
<td>Honours/4th Year</td>
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The University of Zululand’s Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project proposal and the documents listed on page 2 of this Certificate. Special conditions, if any, are also listed on page 2.

The Researcher may therefore commence with the research as from the date of this Certificate, using the reference number indicated above, but may not conduct any data collection using research instruments that are yet to be approved.

Please note that the UZREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the documents that were presented to the UZREC
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UZREC in the prescribe format, where applicable, annually and at the end of the project, in respect of ethical compliance.
The table below indicates which documents the UZREC considered in granting this Certificate and which documents, if any, still require ethical clearance. (Please note that this is not a closed list and should new instruments be developed, these may also require approval.)

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**Special conditions:** Documents marked "To be submitted" must be presented for ethical clearance before any data collection can commence.

The UZREC retains the right to

- Withdraw or amend this Certificate if
  
  - Any unethical principles or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in this Certificate have not been adhered to

- Request access to any information or data at any time during the course or after completion of the project

The UZREC wishes the researcher well in conducting the research.

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**Professor Rob Midgley**  
Deputy Vice-Chancellor, Research and Innovation  
Chairperson: University Research Ethics Committee  
08 March 2013

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**PROF. JR MIDGLEY**  
DEPUTY VICE-CHANCELLOR  
RESEARCH & INNOVATION  
- 8 MAR 2013

UNIVERSITY OF ZULULAND  
PRIVATE BAG X1001  
KWADLANGEZWA, 3886
Addendum E: Department of Health, Province of KwaZulu-Natal. Permission to conduct research

Health Research & Knowledge Management sub-component
10-103 Natalia Building, 330 Langalibalele Street
Private Bag X9051
Pietermaritzburg
3200
Tel: 033 – 3533169
Fax: 033 – 3543752
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference: HRKM 043/13
Enquiries: Mr X Xaba
Tel: 033 – 355 2805

Dear Ms JE Stoyanov,

Subject: Approval of a Research Proposal

1. The research proposal titled ‘South African health care practitioners’ experiences of the current health-care delivery system in U’Thungulu District’ was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby approved for research to be undertaken at Ngwalizana Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Keba on 033-355 2805.

Yours Sincerely,

Dr E Lutge
Chairperson, Health Research Committee
Date: 18/06/2013

uMnyango Wezempilo Departament van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope
Addendum F: Ngwelezana Hospital. Permission to conduct research

Dear Mrs Stoyanov,

RE: PERMISSION TO CONDUCT RESEARCH AT NGWELEZANA HOSPITAL

I have pleasure in informing you that permission has been granted to you by the Institution to conduct research on “South Africa Health-Care Practitioners Experiences of the Current Care Disorganisation.”

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. The research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The Institution will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Institution.

Sincerely,

Dr TT Khanyile
Chief Executive Officer
Chairperson Ethics Committee
Ngwelezana Hospital

Umnyango Wiesempla, Departement van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope
Addendum G: Transcripts: Public and private health care practitioner responses

A) Public health care practitioner responses

Pub 1 (Medical practitioner)

Question 1: How are you experiencing the current health care system?

Well, it’s challenging to work in the public sector in so many ways.

1. It feels like a risk to one's health working in over-crowded wards; poor ventilation, lack of privacy, one-on-one interaction with a patient. Cheap gloves that tear, while examining patients. No number 5 masks as promised.

2. Attending to large numbers of patients at outpatients departments, ranging from non-functional booking systems, patients having rights to be seen anytime of the day with minor ailments, which could be dealt with at primary health care level. Poorly resourced “PHO” (Primary Health Organisation) services, patients having hope in those services.

3. I feel overburdened, unappreciated for the efforts I make. The only time I will get to interact with the employer is when I do something wrong. Very demoralising for a young professional like myself.

4. Not to forget the difficulties encountered with our nursing counterparts. It is a nightmare working with most of them, constantly dragging their feet, as if they are doing you a favour, lack of ability whatsoever. Constantly on tea, lunch breaks. I have none of the above. So quick to remind you of their job description. Can someone send me mine, please!

Question 2: What are your views about the proposed changes within the health care system?

1. Give more credit and recognition where it is due.

2. Pay us more money for stretching ourselves.

3. Improve our working environment; install fans, windows, or even air conditioning in our wards.

4. Conduct workshops for the public health care staff; boost their confidence in handling patients and managing appropriately, especially minor ailments. Give more resources to them, medication and equipment.

5. Improve on the quality of equipment, supplies, gloves, stethoscopes, blood pressure machines. Stop supplying bathroom scales to weigh patients in hospital. It’s unreliable.


Question 3: What suggestions do you have to improve the health care delivery system in
South Africa?

None

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No.

Question 5: Would you consider leaving South Africa and if so, why?

No, I would never leave South Africa. This is my soil, my home, my beloved country. I am passionate about the people I serve and the work I do.

Thank you!!

Pub 3 (Medical practitioner)

Question 1: How are you experiencing the current health care system?

Having only been working for less than three months, I’ve already had a very mixed experience at the hospital. Having said that, overwhelmingly I feel my experience has left a bitter taste in the mouth. To sum up what I have witnessed at xxxx hospital; it seems to be a matter of avoiding responsibility as much as possible, whenever possible. The less work you have to do the fewer patients you accept, the better. To get a department to accept a patient from you in casualty can be an uphill battle that ultimately means patients lie in casualty for hours on end (over 24 hours in my experience) before being taken to a ward. I, as the junior doctor get driven to near rage.

Having trained in xxxx (different province), I had the opportunity to see how a relatively properly functioning government health sector should work, where we in the KZN (KwaZulu-Natal) department fall short. Numerous very ill patients that I have seen have been sent home on medication rather than admitted, as would be the case in the xxxx (province). This is due to a horrible lack of beds and “resources” here. There doesn’t appear to be a national standard of health care across the board as one would be made to believe. Not only is there inequality between the public and private health sectors, but it would seem, within the public sector itself.

Question 2: What are your views about the proposed changes within the health care system?

I feel quite unprepared to answer the above question, partly due to a lack of information from government and partly due to my own ignorance and laziness to find out more details regarding the proposed plans.

From the little I have read on the subject of the NHI since getting this questionnaire, I can say that on paper at least it sounds like a good idea. Having said that, and as I will discuss in the following question, however, I feel they are not identifying many of the other issues facing our health sector. NHI, as I understand it, is a way to get more money for the health care by, in simple terms adding another tax to those who can afford it.
As I alluded to in the following answer, perhaps we should have optimised resource allocation and minimised wasteful expenditure before wanting more money.

Then comes the question of paying for something that in all likelihood I will never use. On top of paying for NHI, I will still be obliged to pay for medical aid, as I feel quite confident that the public sector will be unable to provide a level and quality of care I would view as acceptable to me and my family. So, from the view of the “middle class”, the NHI gives me very little to get excited about, but merely another monthly cost.

Another concern I have, is my future financial security. Unfortunately, I haven’t the information to comment properly, but as someone who most likely saw himself working in the private sector in future, I worry that my future income might be controlled and governed by government policy influencing how much health care costs. This is an extremely selfish view to hold (as are many of mine), but I would be lying if I said it wasn’t a major concern for me. Income potential did play a role in my career choice and now that is being threatened.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

In my opinion, there isn’t a shortage of money in the health sector, but rather poor resource allocation and mismanagement. There needs to be a bigger focus on efficiency and responsibility. One example that illustrates my view is this: I have witnessed cleaners mopping the floor, using sterile gloves because no regular gloves were easily available. Sterile gloves are easily twenty times (as a conservative guess) more expensive than non-sterile, regular latex examination gloves. I’ve also experienced an entire weekend in casualty without paper towel to dry one’s hands. The inability of doctors and nurses to properly clean their hands goes against one of the first principles of being a doctor: “first do no harm.” The cost of treating a patient for a hospital-acquired infection far exceeds that of a roll of paper towels; not to mention the human cost of a patient dying.

The second obvious area of the health sector that needs improvement is responsibility. The same aspect of our health sector that allows us junior doctors to gain brilliant practical experience, the lack of supervision and recourse in the case of malpractice, means that doctors can act essentially unchecked. Patients have no “power” to act against their health care provider as they would in the case of private practice. This opens the door to patients to be treated poorly; at least in a manner that we would not want to be treated, if we were in the patient’s shoes. Supervisors need to play a more active role in overseeing the quality of care provided. Hospital management needs to open channels to allow those involved in poor practice to be disciplined.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Not applicable

Question 5: Would you consider leaving South Africa and if so, why?
Ideally, I would like to stay in South Africa and have no current plans to leave. There are, however, two situations that I feel would cause me to want to emigrate.

Firstly, is the general state of the country, its economy and political landscape. If there were to be a political and economic collapse as seen in a country like Zimbabwe, I feel I would have no choice, but to leave. I would be unwilling to live in a country where my vote holds no weight, the constitution is ignored, and on the whole I feel unwelcome and unwanted. I will prioritise my and my family’s safety and security over the needs of patients and the country as a whole.

The second situation is, if I feel that I am unfairly not able to pursue postgraduate studies and therefore unable to specialise, I will not hesitate to emigrate to further my studies abroad if I feel that I am being unfairly discriminated against or if the country lacks the resources and places to allow me to specialise. As it stands, I will not continue in the medical field, if it means I remain a general practitioner.

**Pub 5 (Therapist)**

**Question 1: How are you experiencing the current health care system?**

I find public health care extremely frustrating and often infuriating.

1. Lack of integrity and accountability

I find my boss and colleagues around the hospital looking very busy, but actually getting no work done. Look as busy as possible and get away with as much as possible – forget about the patient. It is challenging to take pride in my own work since I am so embarrassed to be part of a very broken system.

2. Bullying the patient

I find it hard to believe that the patient comes first in what we do, e.g. all mothers are forced to breastfeed even if they are HIV positive, despite research indicating the harmful effects of mother to child transfer and psychology states that mothers should not be forced to breastfeed. Apparently, it is a money-saving political decision. I hate receiving referrals with no clear instructions/expectations. Nevertheless, I try to assist the patient where they are and empathise with their experience of bullying in the hospital system. It’s as if patients are saying, “get in, get help, get out – don’t make waves, or else you will never be helped.”

3. Poor distribution of resources

The system is overcrowded. People are dying because the most basic equipment is not available. Interns and community service (especially doctors) work like slaves, while more “permanent” state employees abdicate as much work responsibility as possible. I do not believe we are poor or understaffed. If everyone did their bit, I believe more people will receive satisfactory health care. Politics between professions/professionals/regions also impairs the service delivery to the patient. I see one to two patients a day, while the xxxx (health care professional) in the hospital down the road has a 6-month waiting list. I am
here - available to help – but fear of the hospital politics suppresses the service I could offer clients waiting at the other hospital.

Question 2: What are your views about the proposed changes within the health care system?

I know very little about it. I think we discussed it once or twice in group support during Internship.

I like the idea that the poor will have better access to health care and that hopefully, public and private will share the workload. I do not like the possibility that the middle class currently using private care will turn to public facilities thereby creating a further overload.

As noble as the proposed changes sound, I think I would rather die than be treated in public health care myself.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

1. If you are late or leave early or take longer lunch, the time should be deducted from your annual leave. If you work overtime (i.e. 10 minutes) you can add it to annual leave.

2. Computerised filing system for patients so that all professions can link to the online database to see readable notes from previous entries. It also eliminates files getting lost.

3. Limit professionals (public and private) per area to spread resources across the country including rural areas.

4. Appoint translators/interpreters.

5. Top management should spend x number of hours a month working at grass roots level/front line with patients to stay in contact with what is really happening (less cupcakes and tea!).

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

I may leave South Africa for a short period (temporary basis) to grow personally, travel, perhaps grow financially, and broaden my field of experience.

After that, I will return to South Africa – home. I also feel a responsibility to give back to my community. I understand the South African context – I am an African at heart.

Pub 6 (Therapist)

Question 1: How are you experiencing the current health care system?
At times, it can be frustrating, especially when you don’t have the resources to service the patients. Short staffing is also a problem. Currently, I am the only active xxxx (health care professional) at our hospital. I have an HOD (Head of Department), but she has different responsibilities. Transport is also a problem – patients have to travel far distances to get therapeutic intervention. They also cannot afford to have continuous xxxx (treatment) and therefore it is a challenge to rehabilitate them to a point of optimal functionality. Addressing one’s concerns is also another problem as no one wants to take responsibility to hear my view and suggestions on how I think the department can be better facilitated. Overall communication is a problem.

While I have mentioned many of the bad aspects, some of the good aspects are that I really enjoy my job. I love helping people who cannot help themselves. I love helping them realise their occupations and engaging in them daily. People are very appreciative for the help that they get. I find my job very rewarding.

They only use community service staff (most of the time in our district) for xxxx (health care profession). We have one permanent xxxx (health care profession) for the entire district. To date, all its allied community services are coming together to build our knowledge and learn from each other/or formulate groups ( xxxx ). Next year, a new xxxx (health care professional) will come and our work will not be carried over because there is no one to supervise.

Question 2: What are your views about the proposed changes within the health care system?

I am still a new xxxx (health care professional) and therefore I do not know much about the new changes. I feel negative about the changes presently, simply because people (managers) are not being pro-active regarding brainstorming and carrying out proposed changes.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

1. As an xxxx (health care profession) ( xxxx team ), we should have a day, where we visit the clinic and bring our service closer to the people who need it.

2. Doctors who visit clinics, Allied’s (Allied Health Care workers) who visit clinics, or deliverymen, could drop medication at the clinics for the patients who receive medication monthly, to collect. They would then not need to come to the hospital. Some patients die because they can’t afford to come and fetch their medication.

3. I know that at some hospitals they have a service where pensioners and patients who really cannot afford to pay for medication, are picked up at the clinics and brought to the main hospital. Our hospital should make this service available.

4. Have a better referral system between the primary, secondary and tertiary hospitals. Most people/patients only know to go to their main hospital. They are turned away because they need to be referred by their clinic. People need to be
informed.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

Despite the challenges, I love helping people who are unable to help themselves. I feel that the hospital that I work in has many diagnoses that I wouldn’t see anywhere else in the world. Every day is a challenge. I have my good days and my bad days. I am an advocate, so I have fought for better resources and better equipment. Most people accept what they have, which is a problem, because then things will never change.

**Pub 7 (Nurse)**

Question 1: How are you experiencing the current health care system?

I find the health care system very nice, challenging every day with new technology and practice that may need a lot of in-service educating that can help to standardise your daily knowledge.

1. The shortage of staff; that is a great challenge. Instead of eight xxxx (health care professionals), there is one or two that also causes a health practitioner to take the early retirement or resign.
2. There are no working tools – you are always wanted to improvise and it causes emotional and physical exhaustion.
3. (Compared) To all the public servants, health is paying far less. At the end of the day, no one comes to say thank you to you – instead, they look for mistakes you have done.
4. If you are not okay, i.e. not feeling well, no one trusts you.
5. The type of hours worked does not give your family access to you.

Question 2: What are your views about the proposed changes within the health care system?

1. It will still take time; always complain of enough funds.
2. The Health Department still uses autocracy type of leading.
3. Why can’t they copy from overseas countries, where they use rotation, with the equipment around you?
4. There is new equipment that is bought. They do not stay longer because they are cheap stuff, it breaks easily.
5. Around there is still fraud cases reported over media, etc.

Question 3: What suggestions do you have to improve the health care delivery system in
South Africa?

1. I may employ enough staff
2. Give the good quality equipment that does not break easily.
3. Give the workers money, not peanuts.
4. Allocate more money for health.
5. Change the working hours.
6. Try and review working standards and protocols. Network with other countries, e.g. internationally.
7. Use the system of ratio according to the stamina they can afford.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

I can be very much grateful so as to have something different.

Pub 8 (Nurse)

Question 1: How are you experiencing the current health care system?

We are not being involved in decision-making and there is a shortage of staff/personnel; we are overworked and yet, we are expected to deliver quality nursing care, but there are insufficient resources. We always improvise.

We are getting less pay and the work is too much. We are being neglected as workers.

We are not being given enough chances to upgrade ourselves. If you are in the rank, you just stay there for a couple of years and yet, it takes time to be given a chance to go and study.

Question 2: What are your views about the proposed changes within the health care system?

I think they are having good policies, but the problem is with its implementation.

They propose changes, but without consulting the workers, so it’s bad. We are always being neglected, but we are expected to ‘do good’.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

If the department can arrange for day-care centres inside institutions as staff members are in trouble finding nannies. This will help the xxxx (health care professionals) to perform their duties with pleasure knowing that their kids are safe.

If the wages can be reviewed – better wages can motivate workers to do their best in
delivering quality services.

If they can provide with accommodation to stay with our families, this can even reduce the absenteeism rate, hence people will be staying with their loved ones, because sometimes or in most cases we live far from our families – and if the Department of Health can provide with that, it can be better.

Employ more staff to cover this shortage that we are facing.

Upgrade workers – give of them enough chances to go and study either part time or full time.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

I will at some stage, to find some greener pastures as other countries are paying more than we are paid. We are getting peanuts here.

Pub 9 (Nurse)

Question 1: How are you experiencing the current health care system?

I am experiencing difficulties in workplace.

Patients are critically ill, while there is no adequate equipment, e.g. mask, gloves to protect ourselves to those who are affected by TB, diseases, etc.

Shortage of staff; leads to working unpaid overtime.

As a result we end up no interest to do your work properly due to tiredness.

Question 2: What are your views about the proposed changes within the health care system?

I am feeling positive to those changes, because patients will receive a high standard of care.

Also, people will have an access to medical aid no matter whether they are working or not.

It gives me complete satisfaction that the government has reduced the number of pills taken by the people suffering from AIDS.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

They must increase the staff in a working place.

They must respond immediately to our grievances as staff. They must make a working place well equipped.

The working place must be in good condition, e.g. air conditioner, safety.
The proper training must be provided to staff; by organising workshops. To increase number of doctors (medical practitioners) in hospitals.

People must not stand in long queues to get help or assistance in health care system.

Department of Health must make some means to educate our communities about different diseases, so that they know the signs and symptoms and how to deal with those who are already affected in our community.

The government should build more clinics and hospitals in our community.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

I do not have any experience outside South Africa in the same field.

Question 5: Would you consider leaving South Africa and if so, why?

No, I will not consider leaving South Africa.

Pub 10 (Radiographer)

Question 1: How are you experiencing the current health care system?

As somebody who works in a tertiary institution, where we have at least 18 hospitals that refer to us, I would say the referring system in our district is a mess.

Management would say all cases to be discussed with consultants before accepted to our hospital for special examinations xxxx (type of examination), but you would find patients booked directly to us and doctors have an attitude that they cannot be told by a xxxx (health care professional) what is to be discussed with a consultant and what is not to be discussed.

I am not sure what happens to budget for human resources because there is always no budget to advertise posts for more staff. Most departments in the health care system run with insufficient staff and surely you will get tired and frustrated staff faces all the time and bad service.

The reporting channels are not satisfactory, as a xxxx (health care professional), one has to report to the medical manager, who knows very little about the department and why is it that when all has failed within the institution, no-one on ground level has powers to go to district or province or national without “toyi-toyi’ing” (industrial action).

Still on budget, there is never enough money to buy equipment, even a chair for someone to rest during lunch, whereas in the management offices they sit on rotating chairs.

Clinics are a huge challenge in our current health care system. Not enough, if there is, there is always no water, no electricity or sewerage is not functioning well.

Each profession within the health care system is treated differently, financially and otherwise, hence no team spirit. A doctor is a doctor and always right, cannot be told by a xxxx or xxxx (health care professions), for example.
Question 2: What are your views about the proposed changes within the health care system?

I take it we talking the NHI?.

My opinion is it will never work, they will introduce it by force just like everything else in this country, but it will not work. You must see the state of our public hospitals as we speak.

This is just amongst the National Health System Routine (10-point plan) for 2010-2014.

Improved Human Resource Planning Development and Management, i.e. specify staff shortages and training targets for the next 5 years. But I don’t see this happening because again, one proposes on the number of staff needed for the department, you get crushed by those management, when they have no idea what’s happening on the ground.

Maybe there is the good in what is happening or what they (health care system) is trying to do “accelerating implementation of the HIV and AIDS strategic plan and other communicable diseases.” They are trying, but still a long way to go.

Other point I do not even want to touch on because 2014 will come and go without changes.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

A common vision, they will to co-operate and the need for team spirit should be our focus. An agreement to disagree and add value by open discussion and offer workable solutions.

Elevating our health care delivery and improve the quality of life for our people by working together.

Address challenges of the planning for South African Health Systems. We need change of mind-set – plan for the NHI.

New approaches to overcome current weaknesses in workforce planning. We still need more Clinics, population is going up every day.

Increase the number of ambulances.

Change the whole bidding procedure, which takes forever to even buy something small but essential for service delivery.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

No

But the only reason to stay is my family, especially my xxxx year old xxxx (child), without them I would be on the next plane out of this country.
I have friends who are xxxx (health care professionals) in other countries and we are not singing the same tune financially.

**Pub 11 (Radiographer)**

Question 1: How are you experiencing the current health care system?

Currently, I would say we have a very poor health care system, this applies to both the public and private sectors. There is a shortage of qualified, experienced medical staff, e.g. specialists, doctors and professional nurses, etc."

Medical staff are overworked, demotivated and do not provide the service required of them.

Rural areas have insufficient medical facilities and it is difficult for the ordinary working class to access good health facilities and care, even with medical aid and in private hospitals. Due to shortage of staff, one finds overworked public sector workers “locum’ing” in private hospitals.

Question 2: What are your views about the proposed changes within the health care system?

I do not think this will work, until changes are made. Infrastructure needs improvement, medical personnel needs to be motivated, educated!! On their “job purpose” – nurses need to be more dedicated, responsible, caring and enjoy doing their jobs.

Same applies to auxiliary health workers.

The shortage of qualified personnel is also a critical issue. These issues must be addressed before implementing changes.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Training, continuous training and training!!! And educating!!! Motivation is also very important.

Medical personnel need to realise the importance of their jobs. The roles they play in providing health care.

**ATTITUDES TOWARDS WORK NEED TO CHANGE.**

Motivated, happy workers will solve and improve health care in South Africa.

Currently ALL HEALTH WORKERS are unhappy. They are overworked and underpaid both in public and private sectors.

Private sectors seem to want to worry more about profits and in the public sectors corruption is rife!

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No
Question 5: Would you consider leaving South Africa and if so, why?

No, I really would not like to leave. However, there is no future for the next generations to come.

Pub 12 (Therapist)

Question 1: How are you experiencing the current health care system?

I personally do not feel appreciated. We as xxxx (health care professionals), the government does not support us financially, if we want to do courses to uplift our academic knowledge.

We always have to pay for our own courses (short).

We have shortage of human resources and equipment as therapists. It is very frustrating. I also feel we are not getting paid enough as xxxx (health care professionals).

Question 2: What are your views about the proposed changes within the health care system?

I do not understand how the NHI is going to work. It is very difficult to comment on it now.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Treat all employees equally, support them all in order to bring about effective teamwork.

Government to please offer courses, seminars, workshops for all disciplines not just nurses and doctors.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

I would definitely consider broadening my knowledge and experience in other countries. Also to seek for greener pastures abroad.

Pub 13 (Medical practitioner)

Question 1: How are you experiencing the current health care system?

Workload is currently bearable, but in general doctors are overworked and UNDERPAID.

Attitude amongst ourselves as professionals makes it even more difficult to perform out duties.

Lack of the most basic resources frustrates the hell out of me!!

I personally think the patient's rights are just OVER-RATED. They swear at us, do not give respect as professionals, they come to us sick as hell, and you do your part and see
the need to admit; after the hard work, then they decide to sign RHT (Refuse Hospital Treatment) form. The following day (if they are lucky), the relative brings the very same patient and you have to start afresh.

And how safe are we? No one seems to be addressing the issue.....we are being stabbed, raped and murdered IN THE PREMISES.

Are you really telling us that we should respect the very same people whom we feel threatened by????

I think two years of Internship and one year of community service is good. It has allowed adequate exposure to almost all the fields, maybe in some rotations, e.g. anaesthesia, increased to at least two months and not one.

Question 2: What are your views about the proposed changes within the health care system?

How can they even think of NHI, when other hospitals don’t even have urine “dipstix” (urine testing kits) or gloves or BP (blood pressure) cuffs, which are like basic things??? Are they crazy?? (Laugh out loud).

And I personally won’t be happy about the fact that I will be paying medical aid for someone who is too lazy to wake up and get a job; at least look for one!!! As it is, we are paying too much tax for all sorts of grants and RDP (Redistribution and Development Program) houses and not to mention our President’s lavish lifestyle!!!

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Posts must be unfrozen.

Please and I mean PLEASE provide incentives for us if you really want to keep us.

PROTECT US AND NOT PROSECUTE US. We love our patients and we try our best with what is available to give them the best service. We would not do anything on purpose to harm them.

Now how would we trust, if we are scared of being stopped outside the gate, or raped inside the premises????????

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

If I do leave, it would be for financial reasons. Let’s face it, there is no money in this field……but I love my people.

Pub 15 (Medical practitioner)

Question 1: How are you experiencing the current health care system?
I only started working in the health care system last year and already the workload is exceedingly high. The HPCSA states that I should manage 25 patients or less as an Intern, however, I manage as many as 45 patients every day because we do not have enough staff.

There is also a lack of teaching for us as new health practitioners, and this is due to high workload.

Because one intern sees more than 40 patients a day instead of 25, this compromises the quality of care given to each patient.

The current health care system is not meeting the needs of patients.

Question 2: What are your views about the proposed changes within the health care system?

I feel that a change would bring a difference. Given the current health care system, which is not serving us well, I would like a change to take place.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

More regional hospitals are needed.

The country must also train more specialists to run these regional hospitals. Teaching for junior health care practitioners is crucial.

Resources are needed within the existing hospitals.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

I have only worked in South Africa.

Question 5: Would you consider leaving South Africa and if so, why?

I think I will stay within the country.

This country has a shortage of health care practitioners and if we start leaving, it is going to get worse.

Private health care practitioner responses

Pvt 1 (Therapist)

Question 1: How are you experiencing the current health care system?

The slice of the health care cake is getting smaller and smaller for service providers that work outside the private hospitals.

Medical aids are allocating more and more of the funds to private hospitalisation, as the costs there just keep rising.

Patients are having to pay more and more for their day-to-day medical needs and this is
making it increasingly difficult to have a financially viable private practice.

Currently, the health care system does, however, generally service the people that belong to it and can keep affording to belong to it, fairly well. But is expensive and therefore fairly exclusive.

Question 2: What are your views about the proposed changes within the health care system?

Very ambitious and although morally defendable, it is totally unattainable and unrealistic in terms of the financial implications to our country.

The implementation and management thereof also currently seem beyond the government’s capabilities.

Too few will have to pay for the many with too many needs and this will kill the goose that lays the golden egg.

Good chance the whole system will implode.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Use the money already available through the health care budget more effectively. Address rampant corruption, mismanagement, and misappropriation of funds.

This alone will make a huge difference to millions of South African that deserve a half-decent health care system, which is attainable if the system becomes far more effective and well planned and managed.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Unfortunately not.

Question 5: Would you consider leaving South Africa and if so, why?

Yes, if my ability to earn a decent living in the health care sector is severely threatened by unattainable and unrealistic government health care policies, then I will look for alternatives.

Not, however, my first choice by a long way.

**Pvt 3 (Medical practitioner)**

Question 1: How are you experiencing the current health care system?

The current system provides poor care to patients and a very stressful environment for caregivers, in which we function.

The private sector is under pressure financially due to the general downward turn of the economy as well as the influx of people abandoning the sinking state sector: more people have to share in a dwindling funder’s pool. The sector is also under a serious attack from the present government: the ruling rich, seeking new venues to tax (directly and indirectly)
to fund their excesses, and private medicine will be the new milking cow.

The state sector is virtually non-functional with health care workers unable to deliver care due to lack of personnel and equipment. Working in that environment is soul destroying and given the levels of corruption and poor governance, the situation is not going to change in the foreseeable future.

Given the above, it is difficult if not impossible, to do any long-term planning in one’s life, both professionally and privately, if your income is dependent on either of the systems. The uncertainty and the looming threat of loss of income or employment eats away at the quality of life and peace of mind of health care workers, contributing to burnout and related psychological harms.

If the outlook for health care workers appears gloomy, the present and future of patients are worse. In the state they receive poor care if any care is given, and outcomes in studies. Looking at all markers of quality care in South Africa are low and declining. In private practice, there are pockets of excellent care, but standards vary enormously from place to place. In my own experience as a specialist, the quality of referrals from primary care physicians are generally very poor, indicating that many treatable illnesses are simply not found and referred, and other insignificant problems are over-serviced. The training of doctors is sub-standard, and the governing bodies are aware of this, but are allowing it due to political pressure to provide warm bodies on the ground, irrespective of quality of training and subsequent care provided.

Question 2: What are your views about the proposed changes within the health care system?

The changes are doomed to worsen a poor situation, as none of the real problems are addressed.

The state (government) care should be improved by adequate policing of supply chains, so that the theft of equipment is stopped. This starts with the tender system and the corrupt provision of tenders: not to qualified individuals, but to politically connected “friends” and “family” politicians. Ordering and buying of equipment should be decentralised and become the responsibility of the individual units delivering the service: failure to comply with first-world accounting practices in this process should lead to loss of jobs and criminal prosecution.

Performance of health care workers should be measured in patient outcome, and not in hours spent at work, as typical civil servant pen-pushers are evaluated. Failure to perform professional duties should be reported to professional bodies (Health Profession’s Council of South Africa (HPCSA), etc. rather than be managed by clueless human resources personnel interpreting Civil Service Law.

Once delivery of equipment to state facilities is as efficient as in private practice, and state (public) health care workers are giving care to their patients on a level that satisfies the
professional supervising bodies, the need for change should be re-assessed. If state facilities are run efficiently, it may be apparent that the nature of the need for the NHI may be significantly less than anticipated at present. A much simpler and less expensive NHI can then be rolled out on a community based level, rather than the destruction of the whole present system. If needed, such a community based NHI can then be expanded in time (as experience, skill and funding grows) to incorporate other levels of care provision. Such expansion can occur based on the template of existing state/private ventures. At present, those ventures are failing not because of inadequate skill or service provided by private health care, but because of poor or non-existent government funding.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Training of doctors should revert back to the six-year course and the module structure abandoned. Students should master anatomy and physiology before they confront pathology and treatment. No exam should be marked according to a sliding scale to manipulate the number of candidates passing: if 100% fail, they fail. The number of doctors qualifying should never reduce the quality of doctors qualifying.

All hospital associated nursing colleges should be reinstated and out of hospital training policed very very strictly.

Refer to question 2 for other suggestions.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Worked in xxxx (country) and xxxx (country).

While all human endeavours have defects, the systems in both countries worked well and both health care workers and patients were by and large satisfied with the situation.

Question 5: Would you consider leaving South Africa and if so, why?

Yes.

Society is becoming unstable and the have-nots will not suffer in silence forever. Crime is out of control and government is getting worse day by day.

Pvt 4 (Medical practitioner)

Question 1: How are you experiencing the current health care system?

VERY FRUSTRATING!

There is a multi-pronged attack by private health care funders and the state on private health care practitioners!

Medical aids often delay, obfuscate, deny vital services for the very patients that pay their bills, to the detriment of patients.

Doctors are compelled to wait for pre-authorisation (from a distant clerk) for a procedure
(pre-authorisation is not a guarantee of payment!).

Question 2: What are your views about the proposed changes within the health care system?

Not sustainable for our size of economy, our disease burden or our population size. The state needs to employ better calibre nurses, more doctors (private doctors are likely to be TRIPLY under-remunerated by the NHI!).

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Leave politics out (“FREE” HEALTH CARE is usually a pre-electoral bargaining chip for the voting masses!).

Set up a few public/private ventures with intensive management; actuarial foresight and accounting skills. Leave clinical skills to the clinicians.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Yes

Locum in xxxx (country).

The NHS is OVERBURDENED. It is abused by the public.

Numerous clinical sequelae of poor lifestyle have imposed this on the state, e.g. smoking, emphysema, cancer

Intra-venous drug use: Hepatitis B and C, Human Immune Virus (HIV)

Usually delay in obtaining basic investigations, e.g. outpatient ultra-sound has 3 to 4 week waiting period!

Question 5: Would you consider leaving South Africa and if so, why?


Pvt 5 (Nurse)

Question 1: How are you experiencing the current health care system?

The nurses consider nursing as a pay cheque and have no compassion for their patients. Many of them cannot take a message or carry out a simple instruction.

Question 2: What are your views about the proposed changes within the health care system?

I cannot see it working as the health care system is in trouble, as it is. Where are they going to find nurses to work?

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?
To have better trained, more caring nurses and to have the medical procurement services more pro-active.

To do away with hospital health, e.g. life care insurances (not medical aids).

Doctors not to over-service patients.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

Yes, it is quite scary to be an elderly person in this country.

**Pvt 6 (Nurse)**

Question 1: How are you experiencing the current health care system?

I am happy to be working in the private sector.

I have worked for xxxx (private health care facility) for plus/minus xxxx(more than ten) years and have seen many changes, mostly for the better.

Changes need to focus on the importance of quality nursing care and customer satisfaction, getting staff back to the bedside.

Dealing with medical aids can be difficult at times; explaining limits and co-payments to sick people takes some getting used to.

I have not been to a public sector hospital for some time, but am also hearing about a shift in focus and quality, etc.

Question 2: What are your views about the proposed changes within the health care system?

The way it has been communicated has caused some confusion.

I am still not really sure how this will impact on me as a xxxx (health care professional) or as a xxxx (designation) in a private hospital working close to patients.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Focus on the needs of the xxxx (health care practitioners), equipment, linen, support system training.

A xxxx (health care practitioner) cannot give quality nursing care if she has no clean linen to put on the patient’s bed.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

I have not worked outside South Africa, but I do know people, who have and I don’t think that the “grass is greener on the other side”, unless it is all about money.
Question 5: Would you consider leaving South Africa and if so, why?

No, not at this stage.

**Pvt 7 (Therapist)**

Question 1: How are you experiencing the current health care system?

Being in private sector, it’s not always affordable for patients to attend a xxxx (health care practitioner) treatment. Most medical aids have very limited cover for (health care profession).

Xxxx (health care profession) becomes a luxury rather than a necessity in our current economic situation.

Private practices in more wealthy areas (e.g. Johannesburg) can charge much higher rates. Our area’s population is made up largely of “blue collar” workers with not much spare cash at the end of the month.

Question 2: What are your views about the proposed changes within the health care system?

I feel that the main problem within our health care system is the inefficiencies in management and low productivity and corruption rather than funding.

There are, however, huge inequalities that do need to be addressed.

I see inefficiency and inequality being the main two areas that need to be addressed.

I hope that it does provide better health care for the majority of South Africans. This is only possible through improved management and general efficiency and productivity.

Health care is a human right.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

All health care professionals need more training in management and ethics.

Health care professionals need to be educated better about the NHI. They need to be motivated about its implementation.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

At this stage, no. We live in a beautiful, diverse country.

**Pvt 8 (Radiographer)**

Question 1: How are you experiencing the current health care system?

There is a lot one can talk about concerning the health care system, but I feel the most
important areas to look at are as follows:

1. Shortage of staff
2. Work overload
3. Poor service delivery
4. Poor access to health care

The health care services are provided by both the public sector (state) and the private sector (private companies). The state provides about 75% to the South African population, whilst the private sector provides about 25% in terms of health care services. The service from the state is very basic (primary) and in most cases provides for the highly disadvantaged socio-economic group (low-class level). On the other side, the private sector caters of the middle-class and high-class group and their health services are highly rated.

The shortage of staff within the public sector is also caused by professionals leaving the state to the private sector for many reasons.

This also puts a lot of pressure on the few guys left behind, as they have to work extra hard, while they are being under-paid.

People from the public sector usually have the attitude of “I DON’T CARE”….and it’s not mine. With almost all of them, responsibility lies with the superiors only, which impacts on service delivery.

However, in the private sector, everyone is responsible and accountable, which is a key factor to a good service delivery.

Question 2: What are your views about the proposed changes within the health care system?

At this juncture, it’s not easy to tell/ say because the proposed NHI has not gone under operation and one cannot always trust what our government says. Today, they’ll say this, and tomorrow it’s the other.

What the NHI promised, or what it will try to do, is to try and do away with the “good service” offered to only those individuals with medical aids and make it available to everyone. This does not look like an easy task to be done because these services from NHI will still be offered by the state, I believe.

This will not stop people from going to private sectors because they can afford to do so.

Competition between the state and private sectors will still go on, thus we will still have medical professionals leaving the public sector to join the private sector.

However, should the NHI achieve its proposed objectives, it would be great.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?
I think the first would be to acquire more medical staff. This could be by adjusting their packages or match the ones offered by the private sector so that there would be less people leaving the public sector because of better pay.

The government must make sure that things like medication and equipment are sent to the institutions on time, so that service delivery is not impacted.

Department of Education and Health need to make sure that there’s a great number of medical professionals that are produced annually so that all the institutions have enough staff.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No, not at the moment.

Question 5: Would you consider leaving South Africa and if so, why?

Yes, I would leave South Africa for another country…..for work.

I am still a young professional and would love to travel around the world, while I still can. It is always a good thing to explore new ventures, try new challenges, meet new faces and people, and also learn their culture.

If given an opportunity to and work in another country, I would seize the moment, but it would have to be a country that is on a better class/level than Republic of South Africa, e.g. Europe, North America. This would be a great opportunity for me to gain international experience and would be a test for me in the market and my career.

Another advantage of going and travelling different places is to learn more about a certain place and their culture besides the way they do things in their working areas.

Pvt 9 (Radiographer)

Question 1: How are you experiencing the current health care system?

The current health care system is divided into two:

- Private (for middle- to high class); and
- Public (for low-class citizens, who are the majority of the very sick).

Private hospitals are quite expensive. Only working people with lots of money can afford it or the ones with medical aids. These people can choose any choice provider operating in the private sector that is not extended to the public or to the rest of the population.

A larger part of financial and human resources for health is located in the private health, which is available to the minority. Medical aids are the major contributors and this is where the financing comes from.

In the public hospitals, you will find that they do not have human resources, material and even financing. I personally think that this may be due to mismanagement of funds and equipment too. You will find that they have the TOP OF THE RANGE equipment, but it is
not in working condition.

A large number of very sick patients do go to public hospitals and sometimes find no help.

Question 2: What are your views about the proposed changes within the health care system?

I believe everyone has a right to good health care. The motive behind the NHI is good because they say they want to bring service to those who need it the most, but my concern is what will this do to the private sector.

The government do have hospitals, a lot of them; why don’t they first manage them properly because when you look at it closely, public hospitals do have and provide a lot of services. It’s just that there is a lot of negligence.

Is this not going to drag the whole of South African’s health care down? They are failing the public hospitals. How will they make sure that the private don’t go through the same problem?

Private people have worked so hard to put their services to the standard they are at. I think they should just come with a new strategy – this matter is too sensitive.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

I think it all starts with the person who is a health care worker. They need to remember why they chose the profession. They are there to help the sick to get better, so they need to care for them. If they care for them, they will care for the equipment too because health equipment plays a role in helping with patient’s diagnosis.

The staff must have it at heart that they are here for the patients all the time.

The management at the top there, they mustn’t sit and think for themselves. There is too much fraud happening there that hinders good quality health care.

People need to search their hearts once again; this may help a lot.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

N/A.

Question 5: Would you consider leaving South Africa and if so, why?

N/A

Pvt 10 (Radiographer)

Question 1: How are you experiencing the current health care system?

The current health care system can be divided into two. Those who can afford to belong to the medical aids or who can pay their own bills privately and therefore have freedom of choice; and those who are at the mercy of the state and get their medical care from public hospitals and clinics and have no choice often of where and by whom they are attended
Private medical health care in South Africa, in my opinion, is rated highly. We have excellent medical practitioners and facilities. Medical aids and medical costs have increased rapidly over the past decade and although patients belong to and pay high premiums for private medical care, private medical institutions are run as businesses and therefore do not accommodate or always have empathy for those who cannot afford the fees. Some private doctors and medical staff, of whom the majority are extremely well educated in their fields, forget why they entered their professions and see status and financial rewards instead of the patient’s needs first.

Government medical institutions are often not recognised for the part they play. Some very dedicated and experienced medical practitioners and medical staff stay in these institutions, working under very trying conditions, often causing frustrations and this results in them leaving either to join the private health care or emigrating to other countries, resulting in a huge loss and wide gap being left. Government then has to offer over-inflated salaries to lure medical staff back into their institutions.

Mismanagement of funds allocated to public hospitals is often mishandled both internally and externally and services often suffer, which results in a breakdown of medical care to the patients. The role of the primary health care clinics plays a vital role in helping hospitals. They alleviate the problems of over-working and allow patients to be treated close to their homes.

Question 2: What are your views about the proposed changes within the health care system?

I think the proposed changes within the health care systems is really benefitting the patients dependent on state health care. They will have access to improved facilities and medical staff expertise.

I am very sceptical about the implementation and how it is all going to function and cannot see it happening for a long time to come.

Financially, I believe it will be very taxing on all parties. Private patients, who are on private medical aids at present will be reluctant to resign from their present medical aids. Affordability for the middle class, who will be forced to contribute to the proposed scheme, will end up being very expensive. Private patients will no doubt oppose the proposed system at first, being fearful that they will not receive care that is at the present level.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

The biggest problem that needs to be addressed, in my opinion, is education. Educate people on birth control. Parents must be accountable and responsible for their children. Children should all be educated in basic hygiene and how to look after themselves in schools.

Primary Health Care Clinics should be accessible and available to all. Some Primary
Health Care Clinics are brilliant, while others are sub-standard. Measures should be put in place to monitor these facilities and rectify, where problem areas are.

Medical staff in public hospitals should be encouraged to take pride in their professions and be accountable for their actions. A salary at the end of the month should not be their main priority.

Ongoing training and enthusiasm should be instilled in staff by their seniors. Medical staff must be constantly reminded, why they are working in the medical fields and work as a team to give the patient the best possible diagnosis, care, and treatment.

Structures must be put in place to ensure that funds allocated for projects and hospitals are spent wisely. Promotions to higher positions should be given on merit and not to friends and family.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No

Question 5: Would you consider leaving South Africa and if so, why?

At this stage and at the age of nearly xxxx, I would not consider leaving South Africa.

I would however, encourage my children to at least experience life in another country before deciding to live in South Africa for the rest of their lives.

If my children emigrated and medical care, which I am accustomed to today, plus the affordability becomes problematic and standards drop, I would consider leaving South Africa.

Pvt 12 (Nurse)

Question 1: How are you experiencing the current health care system?

We are sometimes stopped for caring for our patients properly, due to depletion of Medical Aid.

Understaffing and lack of experience by some xxxx (health care practitioners) is also a big problem.

Proper training is a huge problem.

Question 2: What are your views about the proposed changes within the health care system?

I feel it is going to place extra stress on xxxx (health care practitioners) that are already over-worked.

The lack of properly trained staff is going to be a huge problem.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?
1. Proper training
2. Better salaries
3. More staff that are trained
4. To put better motivations out, for staff to perform

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Yes, I went to xxxx (country). I was supposed to be there for xxx years. I was back in South Africa after xxx months. The people there are rude and very self-centred. The isolation I experienced was the worst. The big difference in culture was also a huge barrier. I will never go back.

Question 5: Would you consider leaving South Africa and if so, why?

No!! Never again.

Pvt 13 (Nurse)

Question 1: How are you experiencing the current health care system?

Although I am working within the private sector I have a lot to do with the state (public sector) health as I am involved in training on xxxx (specialty health care practitioner training) to health care professionals.

Unfortunately, I feel that we are in a situation still, where there are hierarchies rather than inter-disciplinary teams. For instance, doctors are not recognising the worth of expertise of other health care professionals, such as nurses.

The people who interact the most with the patients are xxxx (health care profession) and by up-skilling them, a lot of time can be saved. The other main problem is that unfortunately there is a mentality within these xxxx (health care practitioners) that is only worth improving yourself or learning more skills, if it is for a financial reward.

The other problem lies with the younger generation, who are a generation of instant gratification with expectations of high monetary rewards. The caring professions are never really going to suit that requirement. I really feel there are so few now who see it as a “calling” rather than a “job.”

I am a member of the xxxx (specialist health care professional) Educators Society of xxxx (Country), with the portfolio of xxxx. We are trying to get our training programme for xxxx (specialty) to xxxx (health care practitioners), especially those running clinics. But the state does not pay, so unless it is sponsored, it’s not happening. Despite their reasonably good salaries, state xxxx (health care practitioner) will never pay for themselves to be up-skilled – in fact, they expect all expenses covered, complain about the food at the courses and expect to be given the time back, if it is on a weekend.

Question 2: What are your views about the proposed changes within the health care
I have some concerns about the changes within the health care system. My personal feeling is that it will reduce the overall health care in the country, as there will be no incentive for anyone to “go the extra mile.”

If managed care programmes can be instituted and managed competently, I think we may have a chance of good health care (see Question 3).

Currently, good health care is in a few isolated pockets within the state system, mainly driven by a few motivated individuals.

Unfortunately, even in xxxx (country) where they had some great systems, these pockets often became overwhelmed by the general trend of mediocrity.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

I am fortunate to be working within the framework of a managed care system, which, if done correctly, offers excellent care to patients. If this idea could be used across the health care system especially for chronic disease management, I think there could be excellent outcomes for patients and big savings financially.

My personal feeling is that the worst thing “apartheid” did was disempower people so they do not feel they have the right/power to self-care, to take some responsibility for their own health within a support system made of their inter-disciplinary health team.

Unfortunately, there will always have to be audits of such managed care programmes, as there will be those who are motivated and make it work well and then those who are in it for their own enrichment and will do the minimum care possible.

One of my main requests of the state sector is, to allow a person who specialises in a certain condition, e.g. xxxx (speciality profession) to remain working in that field rather than being shunted around, e.g. a xxx (health care practitioner) from chronic diseases clinic changed to night duty in a surgical ward, where her extra training and specialisation would be lost.

xxxx management is not recognised as a specialisation in South Africa, equivalent to theatre or Intensive Care Unit (ICU) training, within xxxx (health care profession). When you consider the xxxx (chronic disease) epidemic, where more people die in South Africa today from complications of xxxx (chronic disease) than of HIV/AIDS, the HPCSA (Health Professions Council of South Africa) should be more proactive.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

I was fortunate to spend two weeks in xxxx in xxxx (specialisation and country) and found the national health system not much better than our Health Department, with patients treated in general as “sausages in a machine.”
I have also recently completed a post graduate diploma in xxxx (professional training) through xxxx (country) university in xxxx (country), where we interacted daily with xxxx (health care professionals) across the world dealing with xxxx (specialty). I am proud to say, we held our own; in fact, all three South African xxxx (health care professionals) completed the course with distinction, showing that in the Republic of South Africa, we do have the skilled personnel with the knowledge, but that it is not recognised and encouraged, especially within the state sector.

As a top xxxx (specialist health care practitioner) and educator in South Africa, I have been fortunate to attend many conferences, courses and meetings internationally and it has been my experience that in the private sector, we can hold our own, but in the state sector a trend of mediocrity seems the norm, where it is almost discouraged to extend yourself.

Question 5: Would you consider leaving South Africa and if so, why?

I really would never leave South Africa. I may move from South Africa, but only to go to possibly xxxx country, where I have recently run a four-day xxxx (specialist health care practitioner) course and it was so motivating to see what people can and want to do with so little.

I feel positive about the future of South Africa in general, so long as the “communist” way of thinking isn’t allowed to prevail.

People should be encouraged to strive to improve THEMSELVES, financially, health-wise and education.

Negativity breeds negativity and I feel that if we can put out a positive vibe, much can be achieved.

Pvt 14 (Therapist)

Question 1: How are you experiencing the current health care system?

Honestly – as we are saying – but in a way the doctors are still dominating the health care system, society doesn’t understand other disciplines can help.

Team practices don’t exist in private, maybe in government – don’t know. Each person is doing his own thing.

We need a body – to comply and work as a team.

If we can – length of time in hospital can be reduced.

Even if the community thinks that the doctors are THE ones. Even if you tell them you are an xxxx (health care practitioner) – they insist you are a doctor. We need to change that perception. You cannot convince them: “if you are not a doctor, then why am I here!” Even the nurses call me “doctor” outside the hospital; it’s their thinking. Whoever provides health service, is a “DOCTOR.”

Question 2: What are your views about the proposed changes within the health care
system?

In this one, I am not sure because I am an xxxx (health care practitioner). I read in the paper that even the dentists think they are out of the system.

The Department of Health only considers doctors.

It’s going to be one-sided, not multi-disciplinary – most likely for doctors, maybe psychologists? Dentists think they are excluded.

It’s not researched when it comes to multi-disciplinary work.

Still going to see a shortage of not achieving/reaching all the people as some of the community members did not have medical illness – it may be a thing.

Some have limitations, needing xxxx (health care profession discipline). So, if the system does not recognise the other disciplines, there will definitely be a shortage of other disciplines reaching the community.

I would not say the South African community has been prepared for the system, i.e. medical aids.

The long queues and waiting lists – how much more, when people have Medical Aids. How is it going to happen – honestly, not well planned and researched. Because even at xxxx (public) hospital you have to wait days for a bed.

There is a shortage of private hospitals as well because clinics are not well prepared for everything. It’s only Mon-Friday.

There was a clinic – a private day hospital for minor surgeries – one to two day stay. Because of demand, they changed it to a private hospital, i.e. Margate and Shelley Beach.

Will the government clinics be well equipped? It’s Mon-Fri. It should take patients 24 hours to be serviced. It’s not happening.

Who takes patients who are ill at night? xxxx (public hospital) is already full. No ambulances in certain areas – like because of crime, hijacking. Problems with service.

The system still benefits people with medical aid to go straight to xxxx (private hospital). What happens to the people in rural areas? Even if they have medical aids, where can they go if no one has beds?

The hospital (private) on xxxx (name of motor highway) is private. Dr xxxx (name omitted) from xxxx (place) has a number of surgeries in the area.

People from Pongola, Mbazwane – come here.

I don’t take locals in on Saturdays.

They must improve the public hospital.

Just mixed feelings. I do not want to bother myself. I will get a headache when I think how they plan to do it.
Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

Improve clinics.
Improve hospitals (government), e.g. xxxx (government hospital in uThungulu District).
Allow extension of beds, etc. to private hospitals, e.g. xxxx (private hospital in uThungulu District).
They talk about shortage of xxxx (health care practitioners) – what about xxxx (health care practitioners)?
There is no need for a doctor – the patient can see a “?????” and be better.
They must invest in all the health care professionals, e.g. bursaries to all disciplines. I am not sure if they still do it.
When I was in public service, I used to go to the schools and tell them about xxxx (health care profession) and other therapists.
Promotion of CAREER GUIDANCE is NB. Those in high school are our future health care professionals.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

I have not worked outside South Africa.
I have seen children from xxxx (neighbouring country) for assessment. They used to ask me to book them in a "bed & breakfast" and come here. They go back the following day.
Other than that, no foreign experience.

Question 5: Would you consider leaving South Africa and if so, why?

I do not want to leave South Africa. At the same stage, maybe to get experience. I am a hard worker and I “do not do xxxx (health care profession) here. xxxx (health care profession) is a hard profession. I make the means to tell others and make a difference.
It’s important for me to see South Africa changing in the health care system, to make a better country – and not just to run overseas.
You know, at the end of the day we have to put something on our tables, but it’s not about the money, it’s about making a change to others. It’s important to me to see a child sit still, able to hold a pen, able to make a circle, able to make the "a" of the alphabet. I go home happy that I’ve made a difference. If the government supports us, that will make the difference. So far, in government, honestly, sometimes people say “the previous government”, but I don’t know the previous government. I can only see what’s happening now. They are not doing what I think they are doing. They say – the other government was in power in democracy for 19 years –and still no difference.
It’s not about black and white. We need to get beyond that. Slowly, the ANC is losing
voters. Our children don’t see the facts. They will vote differently. The problem for the ANC will be the Youth League; they don’t see the colour divide anymore.

**Pvt 15 (Dietician)**

**Question 1:** How are you experiencing the current health care system?

I feel the public sector is under-resourced resulting in patients getting poor service.

Private sector is not regulated in any way, resulting in patients being over-charged, staying in hospital for longer periods than is needed, being consulted to by many health care providers, which is not necessary.

Xxxx (health care professionals), who are motivated to help people and who want to work in the public sector are struggling to have their private sector experience recognised and so are being offered sub-optimal salary packages.

Doctors do not respect or value the opinions of other health care professionals, especially nursing staff. There is no such “thing” as a multi-disciplinary team in the private sector.

Xxxx (health care professional) do not communicate with the patients at all and make no effort to see that the patient can access treatment once leaving hospital.

Referrals to other health care professionals are not based on “who can do the job best”, but rather given to friends.

**Question 2:** What are your views about the proposed changes within the health care system?

Theoretically, it is a good idea; however, practically, the public sector does not have the infrastructure in place to support such a move.

**Question 3:** What suggestions do you have to improve the health care delivery system in South Africa?

Offer staff better incentives to go back to the public sector.

Improve care at “grass-roots” level. Care at the clinics must be better by implementing a multi-disciplinary approach.

Better supervision and mentorship in the public sector.

Setting up to “prevent” rather than cure, e.g. annual review services for diabetic and cardiac patients.

Growth monitoring and promotion and immunisation must be done more effectively – take it to the communities at times when people are available.

Performance of staff must be regulated better, i.e. doctors must be in the wards consulting, not running lucrative private practices.

**Question 4:** Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.
Yes.

xxxx (country) – xx years
xxxx (health care profession) in specialist xxxx (type of medical disorder unit)
xxxx (country) – xx years general ward work
xxxx (medical condition) annual review service non-enteral xxxx (type of therapeutic intervention)
xxxx (health care profession) at xxxx (type of medical practice)

Question 5: Would you consider leaving South Africa and if so, why?

Yes.
I would like to live in a country, where my opinion as a health care professional counts and is respected.
I believe in other countries, there are more opportunities for professional development.
I would prefer not to work in the private sector, but I am forced to, in South Africa, as my experience outside South Africa as well as my teaching experience is not recognised – if I go to the public sector, I would have to accept an entry level position.

Pvt 16 (Medical practitioner)

Question 1: How are you experiencing the current health care system?

There is a big division in the health care systems. Private: relatively well organised.
There is demand and also competition, which drives the level of service up.
Private health care is usually quite stressful, because of the expected level of service.
There are usually no fixed hours for the doctor.
There is pressure to accommodate all patients, who need your services.
Private health care is a business, with all the associated financial, procurement, staff, administrative, tax, etc. demands and stress.

Public: Too many patients, lots of pathology with very limited resources.
Burden of HIV and opportunistic infections, low level of medical knowledge and care for the population.
Big problem is low efficiency of the public health care institutions, poor management, and lack of empathy from many health care practitioners.
There is a trend to work as little as possible, if there is no pressure from management or supervisors.

Question 2: What are your views about the proposed changes within the health care system?

Ideal solution would be difficult as there are lots of sick people, not enough budget from
the government and high unemployment.

A way forward would be slow and gradual involvement of the private sector and privatisation of some public hospitals.

The only principle that can work is that xxxx (health care professionals) receive a corresponding fee for service.

The government will probably pay less to send the patients to private health care providers and pay a fee for service. Some of the public hospitals cost huge amounts of money to run and have low efficiency. I have tried with some calculations and do believe that this scheme can work.

Government should also allow incentives for good specialists to either see private patients in public hospitals or do limited private practice. At the moment, public hospitals have no real incentives to attract good specialists.

Furthermore, public hospitals are getting too politicised and unionised.

The new health care system should try and expand the private sector and involve more private practitioners in the public care.

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

1. Integrate partially public and private sectors by relaxing the rules and regulations.
2. Negotiate service at lower fees for public patients in private facilities.
3. Make attractive conditions for private (health care profession) to work sessions in public hospitals.
4. Create strong politically independent management of public hospitals.
5. Appoint competent managers in public hospitals and give them more disciplinary power.
6. Allocate more funds for primary health care and utilise the funds wisely.
7. Relax the registration process for well-qualified foreign xxxx (health care practitioners).
8. Establish joint ventures with powerful overseas medical institutions and create local branches.
9. Bring foreign specialists into the public sector on a rotational basis.

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Yes, I do. Every system, where xxxx (health care professionals) are under paid or over regulated is deemed to be a jail.

The xxxx (health care profession) fraternity is in demand all over the world and good
Specialists are sought after.

Systems that are efficient have a way to stimulate the remuneration of xxxx (health care professional). Fee for service is one of them. Good hourly-based payment is another.

The efficiency of systems where xxxx (health care professionals) are paid a flat or low salary, is doomed to failure.

Question 5: Would you consider leaving South Africa and if so, why?

No, I don’t. We live in a beautiful country, good people and wonderful landscapes and climate. We need to make this country united and use our resources to the maximum.

We need democracy. Less politics, good politicians, strong private sector, better education, and a better health care system!
Addendum H: “Batho Pele” Principles

“Batho Pele” is based on the following principles (KZN DOH, 2001):

a) Consultation: Citizens should be consulted about the level and quality of the public services they receive, and wherever possible, should be given a choice about the services that are offered.

b) Service standards: Citizens should be told what level and quality of public services they would receive so that they are aware of what to expect.

c) Access: All citizens should have equal access to the services to which they are entitled.

d) Courtesy: Citizens should be treated with courtesy and consideration.

e) Information: Citizens should be given full, accurate information about the public services they are entitled to receive.

f) Openness and transparency: Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.

g) Redress: If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation, and a speedy and effective remedy; and when the complaints are made, citizens should receive a sympathetic, positive response.

h) Value for money: Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

i) Encouraging innovation and rewarding excellence: Innovation can be new ways of providing better service, cutting costs, improving conditions, streamlining, and generally making changes that tie in with the spirit of “Batho Pele.” It is also about rewarding the staff who ‘go the extra mile’ in making it all happen.

j) Customer impact: Impact means looking at the benefits we have provided for our customers both internal and external – it is how the nine principles link together to show how we have improved our overall service delivery and customer satisfaction.

k) It is also about making sure that all our customers are aware of and exercising their rights in terms of the “Batho Pele” principles.

l) Leadership and strategic direction: Good leadership is one of the most critical ingredients for successful organisations. Organisations that do well in serving their customers can demonstrate that they have leaders who lead by example, who set the vision, and ensure that the strategy for achieving the vision is owned by all and properly deployed throughout the organisation. They take an active role in the organisation’s success (KZN DOH, 2001).
Addendum I: National Patients’ Rights Charter

1 Introduction

1.1 For many decades, the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services.

1.2 To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa, 1996 (Act No. 109 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and, therefore, proclaims this PATIENTS’ RIGHTS CHARTER as a common standard for achieving the realisation of this right.

1.3 Equally, practitioners should adhere to the stipulations of this charter as it relates to them.

2 Patient’s rights

2.1 Healthy and safe environment

Everyone has a right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological degradation, or infection.

2.2 Participation in decision making

Every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision-making on matters affecting one’s own health.

2.3 Access to health care

Everyone has the right to access to health care services that include:

- a. Receiving timely emergency care at any health care facility that is open, regardless of one’s ability to pay;
- b. Treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- c. Provision for special needs in the case of new-born infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV, or AIDS patients;
- d. Counselling without discrimination, coercion, or violence on matters such as reproductive health, cancer, or HIV/AIDS;
- e. Palliative care that is affordable and effective in cases of incurable or terminal
f. A positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance;

g. Health information that includes information on the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

2.4 Knowledge of one’s health insurance/medical aid scheme

A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to challenge, where necessary, the decision of such health insurance or medical aid scheme relating to the member.

2.5 Choice of health services

Everyone has a right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.

2.6 Treated by a named health care provider

Everyone has a right to know the person that is providing health care and, therefore, must be attended to by only clearly identified health care providers.

2.7 Confidentiality and privacy

Information concerning one’s health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order of court.

2.8 Informed consent

Everyone has a right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and risks associated therewith, and the costs involved.

2.9 Refusal of treatment

A person may refuse treatment and such refusal shall be verbal or in writing, provided that such refusal does not endanger the health of others.

2.10 A second opinion

Everyone has the right on request to be referred for a second opinion to a health provider of one’s choice.

2.11 Continuity of care

No one shall be abandoned by a health care professional who or a health facility which initially took responsibility for one’s health without appropriate referral or hand-over.
2.12 Complaints about health services

Everyone has the right to complain about health care services, to have such complaints investigated, and to receive a full response on such investigation.

3 Responsibilities of the patient

Every patient or client has the following responsibilities:

3.1 To take care of his or her own health.
3.2 To care for and protect the environment.
3.3 To respect the rights of other patients and health care providers.
3.4 To utilise the health care system properly and not to abuse it.
Chapter one:
Fundamental Principles

1.1 Opening Declaration

The Parties to this Health Charter earnestly and sincerely desire to facilitate and effect transformation of the health sector in the following key areas:

1. Access to health services
2. Equity in health services
3. Quality of health services

They acknowledge that it is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals for each of these areas. They further acknowledge the urgent need to effect transformation of the national health system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa.

Therefore the parties - Recognising:

1. That there is a legacy of apartheid in terms of which access to and distribution of health care and ownership of health care establishments was grossly inequitable and disadvantaged the vast majority of South Africans on the basis of their race, gender and economic status;
2. That there is an urgent and compelling need to effect transformation throughout the South African health sector in order to remedy the wrongs of the past;
3. That the government of the Republic of South Africa is mandated in section 7(2) of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights;
4. That the Government of the Republic of South Africa is mandated in section 27 of the Constitution to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of access to health care services, including reproductive health care, sufficient food and water, and social security, including appropriate social assistance, where people are unable to support themselves and their dependants;
5. That the rights in the Bill of Rights may be limited only in terms of section 36 of the Constitution;
6. Generally, that the powers and functions, roles and responsibilities of the national, provincial and local spheres of government and of the legislature, the executive and the
judiciary are as set out in the Constitution and that such powers and functions, roles and responsibilities may not lawfully be fettered or restricted by any other law, agreement or transaction;

7. That the government in 2004 passed the National Health Act No 61 of 2003 into law, which is intended inter alia to remedy the inequities of the past in the distribution of health care and to create a national health system that is patient-centred and for the good of all;

8. That it is the Constitutional role and function of the National Government of the Republic of South Africa to exercise executive authority by –

   (a) implementing national legislation;
   (b) developing and implementing national policy;
   (c) co-ordinating the functions of state departments and administrations;
   (d) preparing and initiating legislation;
   (e) performing any other executive functions provided for in the Constitution or in national legislation;

9. That the national, provincial and municipal spheres of government have the power and the duty to deliver health services to the people of the Republic of South Africa;

10. That within the context of paragraphs 1 to 6 of this Preamble, when read together with the Constitution and the laws made by the Government of the Republic of South Africa, the private health sector has an important and meaningful role to play in:

   (a) working with the Government of the Republic of South Africa in a spirit of constructive, mutual co-operation and respect in order to fulfil the government’s constitutional mandates;
   (b) contributing to the health and well-being of the people of South Africa through the provision of products and services in accordance with internationally recognised or legally prescribed norms and standards, as the case may be, with the object of promoting, maintaining, preserving or restoring human health and well-being;
   (c) ensuring that while it makes sufficient profits from its business activities to remain financially sustainable in the long term, the products and services it delivers provide value for money to consumers;
   (d) conducting its business in a manner that it is ethical, honest, and fair and that satisfies the needs of consumers of health products and services,
   (e) ensuring the safety of consumers and the adequate protection of both people and the environment in the use of products and services that may be dangerous to health or life;
   (f) respecting and observing the right of consumers to information and to be protected against dishonest or misleading advertising and labelling;
(g) accepting and respecting the power of consumers to choose from a range of products and services offered at competitive prices with the assurance of externally recognised and accepted standards of quality;

(h) recognising the right of consumers to fair compensation for misrepresentations by providers of goods and services, for the failure of goods and services to adequately address the health needs of consumers and the failure to comply with externally recognised and accepted standards of safety, quality and efficacy;

(i) ensuring that the rights of patients reflected in the Patient Charter as published by the National Department of Health are observed;

(j) upholding the rights of providers of health care products and services to human dignity, a safe working environment that is not detrimental to their well-being and to psychological and bodily integrity;

And noting the need:

1. for the public and private health sectors to constructively engage in dialogue and discussion on health matters;

2. for the interests and views of the private sector to be taken into consideration by the Government when introducing legislative and other reform;

3. for the rational and equitable distribution of health services in the Republic of South Africa;

4. to achieve the most effective, economic and efficient utilisation of resources within the health sector, including human resources, so as to adequately address the health needs of the greatest possible number of people in South Africa;

5. to establish a rational and consistent framework for public-private initiatives within the South African health sector within the parameters set by the Public Finance Management Act No 1 of 1999 and the regulations thereto. In this regard the Parties acknowledge that PPIs (Public Private Initiatives) –

   (a) must be developed in accordance with a clear framework that allows for a thorough investigation of the case for each PPI, a sound and cost effective implementation and sufficient public reporting mechanisms;

   (b) must contribute to the overall sustainability of the national health system;

   (c) must contribute to promoting equity of access to primary care;

   (d) must contribute to promoting equity of access to affordable health care and strengthened public hospital care;

   (e) must contribute to promoting equity in financing of health services;

Agree
1. to create for South Africa a health system that is coherent, efficient, cost effective and quality driven and which optimises the utilisation of public and private sector resources within the health system for the benefit of the entire population;

2. for the public and private sectors to work together in a relationship of mutual cooperation, trust and respect in order to improve the scope, accessibility and quality of care at all levels of the health system;

3. to the undertakings and commitments reflected in this Charter with regard to each of the four areas of transformation;

4. to uphold and give effect to the principles and the spirit of this Charter in the course of their activities as stakeholders within the South African Health Sector; and

5. that the weighing of various factors shall be in terms of a Balanced Scorecard that incorporates all of the areas of transformation outlined in this Charter.

1.2 Definitions and interpretation

In this Charter, except where the context clearly indicates a contrary intention, the following words and phrases have the meaning ascribed to them below:

“Access” means having the capacity and means to obtain and use an affordable package of health care services in South Africa in manner that is equitable;

“Affirmative” means targeted procurement of commercial goods procurement or and services from persons disadvantaged by preferential, unfair discrimination on the basis of race, gender, procurement “disability”, or similar grounds

“BEE Act” means the Broad-Based Black Economic Empowerment Act No 53 of 2003;

“Black people” has the meaning ascribed to it in the BEE Act and

“Black person” has a corresponding meaning;

“Broad-based black means the economic empowerment of all economic empowerment” black people including women, workers, youth, people with disabilities and people living in rural areas through diverse but integrated socio-economic strategies that include, but are not limited to-

(a) increasing the number of black people that manage, own and control enterprises and productive assets;

(b) facilitating ownership and management of enterprises and productive assets by communities, workers, cooperatives and other collective enterprises;

(c) human resource and skills development;

(d) achieving equitable representation in all occupational categories and levels in the workforce;

(e) preferential procurement; and

(f) investment in enterprises that are owned or managed by black people; (definition
from BEE Act No 53 of 2003);

“Charter” means the Charter for the South African health sector;

“Coherent” means rationally co-ordinated and unified;

“Company” means a legal entity registered in accordance with the laws of the Republic of South Africa for the purpose of conducting business;

“Control” means the right or the ability to direct or otherwise control the majority of the votes attaching to the shareholders’ issued shares, the right or ability to appoint or remove directors holding a majority of voting rights at meetings of the board of directors, as well as the right to control the management of the enterprise;

“Cost-effective” means a ratio between cost and efficacy with regard to expenditure such that within any given circumstance, optimum and demonstrable benefit is derived through the most efficient utilisation of the resources required to create that benefit;

“Direct ownership” means ownership of an equity interest together with control over voting rights attaching to that equity interest;

“Discrimination” means discrimination as defined in the Promotion of Equality and Prevention of Unfair Discrimination Act (2000);

“Efficient” means the utilisation of limited inputs or resources in order to obtain or achieve a specific output or outcome in such a manner as to ensure the attainment or achievement of that output or outcome at optimal level;

“Employment Equity” has the meaning ascribed to it in the Employment Equity Act (Act No 55 of 1998);

“Enterprise Development” means investment in, and/or development of and/or joint ventures with black owned or black empowered enterprises and SMMEs, with real economic benefit flowing to the recipient enterprise allowing it to be set up and run on a sustainable basis;

“Equity” means the fair and rational distribution of an affordable package of quality health care services to the entire population of South Africa, irrespective of patients’ ability to pay for such services and irrespective of their race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth; and ‘equitable’ has a corresponding meaning;

“Executive management” means those managers who have a significant leadership role in the enterprises, have control over day-to-day operations, have decision-making powers and report directly to the Chief Executive Officer and/or equivalent or the board of directors;

“GDP” means Gross Domestic Product, i.e. the market value of all final goods and services being produced within the borders of a country;

“HDI” means a South African citizen-
(1) who, due to the apartheid policy that had been in place, had no franchise in national elections prior to the introduction of the Constitution of the Republic of South Africa, 1983 (Act 110 of 1983) or the Constitution of the Republic of South Africa, 1993 (Act 200 of 1993) (‘the Interim Constitution’); and/or

(2) who is a female; and/or

(3) who has a disability; Provided that a person who obtained South African citizenship on or after the coming to effect of the Interim Constitution, is deemed not to be an HDI; (2001 Regulations to the Preferential Procurement Policy Framework Act No 5 of 2000;

“Health care personnel” means health care providers and health workers as defined in the National Health Act No 61 of 2003;

“Health sector” means natural persons and other entities involved in the provision or funding of health services in one or more of its aspects to people in South Africa;

“Health services” means health services as defined in the National Health Act No 61 of 2003;

“National health system” means the system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services;

“Junior Management” means the level of management below middle management and includes academically qualified workers who possess technical knowledge and experience in their chosen field;

“Middle Management” means the level of management below senior management and includes people who possess a high level of professional knowledge and experience in their chosen field;

“NGO” means an organisation that is independent from government and its policies, which is generally, a non-profit organisation that obtains a significant proportion of its funding by way of donations from private sources and includes a non-profit organisation as defined in the Non-profit Organisations Act No 71 of 1997;

“Parties” means the parties to this Charter;

“PPI” means a Public Private Interaction in terms of which one or more persons or entities involved in health care within the public sector interact with one or more persons or entities involved in health care within the private sector or the NGO sector, with the object of achieving a mutual benefit or goal and includes, but is not limited to a PPP; PPIs include: public financing of health services provided by the private and/ or NGO sectors; private financing of publicly provided health services; innovative healthcare delivery models and business models for health practices; delivery models aimed at skill retention and effective distribution and utilisation of skills; use of public assets for the provision of health services by the private sector; use of private assets for the provision of health
services by the public sector;

“PPP” means Public Private Partnership as defined in Regulation 16 of the Treasury Regulations issued in terms of section 76 of the Public Finance Management Act, 1999 (Act 1 of 1999);

“PPPF Act” means the Preferential Procurement Policy Framework Act No 5 of 2000;

“Private sector” means persons and entities who are not within the “public sector” and includes NGOs;

“Procurement” means procedures and expenditure, including capital expenditure, for the purpose of acquiring goods and/or services and which, in the case of the public sector, are governed by legislation;

“Public sector” means government departments, organs of state and institutions exercising a public power or performing a public function in terms of legislation;

“Quality” in relation to health care means input of such a nature and applied in such a manner as to ensure optimum results within the available resources and the circumstances of each case, taking into account the constitutional rights of the patient, including the rights to life, human dignity, freedom and security of the person, bodily and psychological integrity, freedom of religion, belief and opinion and privacy;

“Senior Management” means people who plan, direct and co-ordinate the activities of a business/organisation and who have the authority to hire, discipline and dismiss employees;

“SETA” means a sector education and training authority established in terms of section 9 (1) of the Skills Development Act 97 of 1998;

“Skills Development” means the process of enhancing individuals’ specialised capabilities in order to provide them with career advancement opportunities;

“SMME” means a small, medium or micro enterprise as defined in the National Small Business Act 102 of 1996;

“Sustainability” means having a reasonable prospect of continued, successful existence in the present and the foreseeable future with regard to those critical success factors that define and affect the viability of a particular enterprise over time;

Chapter Two:

Challenges

2.1 Access

2.1.1 Access to health care is a complex issue of constitutional significance. There are significant numbers of people in South Africa who do not have adequate access to health services due to geographical, financial, physical, communication, sociological (such as unfair discrimination and stigmatisation) and other barriers.
2.1.2 The general challenges to improved access for all are to identify specifically such barriers as and where they occur in communities throughout South Africa and to implement interventions that are explicitly designed to overcome them with due regard to the –

a. relevant health policy and the need for access to policy makers;
b. range of health services required;
c. nature and type of health services required;
d. necessary human and other resources and infrastructure;
e. need for communication and information concerning health services;
f. other relevant factors specific to the particular community.

2.1.3 A specific challenge with regard to information in the context of access to health services is to make available:

a. information relating to health and health services options to all patients, providers and employers in order to promote informed decision-making;
b. information designed to address the particular needs of vulnerable groups, including people living in rural and under-serviced areas, and the illiterate;
c. information relating to the purchase of health insurance products (i.e. value for money, richness of benefits); and

d. information relating to quality of care (i.e. appropriateness, necessity, cost-effectiveness).

Improved “access” requires improved efficiency, since increases in efficiency should lead to increased access. The sustainability of the national health system is dependent upon its efficient use, management and generation of resources, including financial, human, technological, scientific, clinical, managerial, infra-structural and resources in the area of materials and equipment and research and development. Inefficiency in the national health system threatens its sustainability since it leads to maldistribution of resources, and negates or undermines policies and procedures designed to give effect to the distribution, allocation or utilisation of resources. Policies and procedures should be developed with an awareness of the need for sustainability of the national health system and with a view to the elimination of inefficiencies within the system that could arise, for instance from wasteful duplication of resources, under-utilisation of resources and cost ineffective application of resources.

2.1.4 Human Resources

(a) The Parties to this Charter hereby acknowledge that human resources are critical to adequate access to health services. Access to health services training is essential for the attainment of the Charter objectives. There is a need to ensure that historically disadvantaged individuals in particular have access to training institutions or other
institutions, for purposes of obtaining academic, or other training in all aspects of health services.

(b) There are currently shortages of health care personnel in a number of different areas. These include specialised nursing, general medical practice, specialised medical practice, clinical technology, pharmacy, radiology and pathology. If the skills necessary to ensure access to a basic minimum package of care and services are not maintained throughout the National Health system, then access is not achievable.

(c) There is no common baseline of information involving certain key parameters with regard to human resources. A baseline is a fundamental step necessary to establish targets with regard to human resources within this Charter. There is currently inadequate benchmarking of salaries and conditions of service within the health professions or with regard to health care personnel generally.

(d) There are different salary ranges in the public and private health sectors, which create significant disparities in human resources and incentive structures.

(f) A further challenge is to eliminate harassment from workplaces since it undermines access to health services by consumers and affects the availability of human resources to perform those services.

2.1.5 Financing

(a) Access to medical schemes is diminishing in real terms. Medical schemes provide financing for almost 7 million people, but over the years, membership figures have declined as a percentage of the general population. This is due in part to major increases in non-health expenditure by medical schemes on items such as administration and brokers’ fees.

(b) Given that health care expenditure in South Africa was approximately R107 billion in 2003/4, equivalent to 8.7% of GDP in that year, and that this compares favourably with many other countries in terms of percentage of GDP, there is a strong basis for arguing that the key challenge facing the National Health system is not necessarily one of inadequate resources, but inequitable and inefficient application of resources. Inequitable application of resources results in inadequate access for many. In 2003/4, medical schemes spent approximately R8 800 per beneficiary, while in the public sector, the figure was approximately R1 050 for persons who were not members of medical schemes.

(c) There are geographical inequities in the provision of health care financing, which is skewed towards the urban and private sector. This clearly affects access in the rural and public sector. The challenge is to find a way of providing health services at a low cost to what are perceived by health care financers as high risk areas such as townships, rural areas and poor provinces. Whilst health service providers are interested in meeting the needs in these areas, they are discouraged by the fact that it is difficult to find appropriately structured funding solutions.

(d) These are challenges which the parties to this Charter will address by means of the
strategies and targets set out in a Chapter three.

2.2 Equity

2.2.1 Equity in health care involves ensuring equal access to equal care for equal need in a situation, in which resources are efficiently utilised in a fair manner. The challenge is to develop a minimum defined basic package of health services, without detracting from the principle of buy-ups and other mechanisms of funding levels of care that are higher than the basic minimum.

2.2.2 The basic package of care must reflect the minimum acceptable standard of health services to be made available as the health care safety net for all. This will not preclude the purchase or provision of larger baskets of health services by persons who can afford to do so.

2.2.3 There is a small minority of South Africans (between 15 and 20% of the population), who have a high degree of access to health services and a large majority (between 75 and 80% of the population), who have limited access to health services. According to the latest figures, the state spends some R33.2 billion on health care for 38 million people, while the private sector spends some R43 billion servicing 7 million people.

2.2.4 Health outcomes and life expectancy for the poor and medium-income groups are generally worse than those for high-income groups due to inequity in health services. The services to which the minority has access are far superior in terms of quality and quantity, to those to which the majority has access.

2.2.5 The general challenges with regard to equity in health services are –

a. The lack of availability of a minimum defined basic package of health services to which everyone can have access, irrespective of their ability to pay;

b. Discrepancies in the quality of health services across different groupings within the socio-economic spectrum;

c. To eliminate stigmatisation of persons by the broader community, health personnel and health establishments on the basis of health conditions, reproductive decisions or treatment choices;

d. To eliminate unfair discrimination on the basis of sex, sexual orientation, gender, disability, health status, race, culture, religious beliefs and other prohibited grounds, from within health establishments, the health professions, health services and the broader communities they serve. Unfair discrimination consists of acts or omissions, policies, laws, rules, practices, conditions or situations which directly or indirectly impose burdens, obligations or disadvantage on, or withhold benefits, opportunities or advantages from persons on one or more legally prohibited grounds;

2.2.6 Human Resources

(a) The Parties acknowledge that the availability of human resources is central to the
question of equity in health services between the public and the private sectors, between rural and urban communities and between historically disadvantaged individuals and those not historically disadvantaged. For this reason, appropriate numbers of suitably qualified and trained health care personnel must be assured throughout the National Health system. This is presently not the case.

(b) Harassment also impacts on equity in the National Health system since it is unwanted conduct, which is persistent or serious and demeans, humiliates or creates a hostile or intimidating environment or is calculated to induce submission by actual or threatened adverse consequences. Harassment is related to sex, gender or sexual orientation or a person's membership or presumed membership of a group identified by one or more of the prohibited grounds or a characteristic associated with such group.

2.2.7 Financing

(a) The most significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each.

(b) The financing of health care in South Africa currently contributes to the inequity between the public and private health sectors. Slightly more than 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the National, Provincial and Local Departments of Health), while 62% flows via private intermediaries. Medical schemes are the single largest financing intermediary, accounting for nearly 47% of all healthcare expenditure followed by the Provincial Departments of Health at 33% and households (in terms of out-of-pocket payments directly to health care providers) at 14% of all health care expenditure. The National and Local Government Health Departments and direct expenditure by firms account for less than 6%. In relation to the original sources of finance, the vast majority of funds flowing through public sector financing intermediaries are funded through nationally collected general tax and other revenues. From the provider perspective, about 39% of all health care expenditure occurs on public sector providers and 61% on private sector providers. This is inequitable, when one considers the number of persons treated by private sector providers as opposed to public sector providers.

(c) A further challenge in the area of health financing in the public sector is the inequitable distribution of health care resources between provinces. There are considerable differences between provinces in public sector expenditure per person. The challenge is how to gradually reduce disparities so that South Africans are not disadvantaged in their access to health services purely as a result of their place of residence without unduly infringing on provincial autonomy with regard to budgetary allocations.

(d) In the private sector, membership of medical schemes has become increasingly unaffordable, thus widening the gap between the high-income group and the middle-income group in terms of equitable access to health care. Medical scheme membership
has decreased in absolute terms and has declined as a percentage of the population. This is due in part to rapid increases in expenditure on private hospitals in the late 1990s and early 2000s. Another area of rapid increase in expenditure by medical schemes is non-health items such as scheme administration fees (R4.5 billion in 2003), managed care initiatives (R1.1 billion) and brokers’ fees (which increased 64% from R354 million in 2002 to R581 million in 2003).

(e) The challenge is to control the rapid spiral of medical scheme contributions and expenditure. It is significant that direct out-of-pocket payments, the most regressive form of health financing, account for almost a quarter of private health care financing. The majority of such expenditure is by medical scheme members (for instance for co-payments and services not covered by the scheme). These are challenges that the parties to this Charter will address, using the methods and strategies set out in Chapter three.

2.3 Quality

2.3.1 To achieve quality in health services, the best health outcomes must be secured with regard to the available resources. The issue of quality of health services is inextricably connected to issues of both access and equity. Access to health services of unacceptable quality is not access. Access by some categories of people to health services of inferior quality to those accessible by others creates inequity.

2.3.2 General challenges in the area of quality in health services include –

   a. Failure within the National Health System to focus on the patient in terms of their social and clinical needs, health service options and health service choices;
   b. Failure to measure health outcomes;
   c. The absence of a caring ethos within the health professions;
   d. Poor or inadequate quality assurance and quality measurement programs in health establishments;
   e. Inefficient or ineffective utilisation of health services in order to achieve improved quality;
   f. Inadequate feedback by mechanisms such as patient complaint systems into the planning and implementation of health services.

2.3.3 Measurement of quality in health services on an ongoing basis is critical to promote and maintain the delivery tracking, publication and feedback processes to ensure awareness of health outcomes in relation to quality of services.

2.3.4 Human Resources

   (a) Specifically in the area of human resources, the parties to this Charter hereby acknowledge that quality in health services is heavily dependent upon the availability and work ethic of health care personnel.
   (b) They concede that for a number of years, there have been concerns about
the attitudes of health care personnel towards patients and the fact that the health care system needs to become patient-centred. A lack of respect for the human dignity and freedom of patients on the part of some health care personnel continues to be an obstacle to the achievement of quality in health services.

(c) The parties further acknowledge that quality is also affected by the skills shortages in the health sector. The resultant psychological, and physical work pressures upon those who work in such fields, leads to a downward spiral of diminished availability of such personnel within the National Health system as a whole. In some instances, failure on the part of employers, in some instances, to implement adequate employment equity programmes, to actively develop historically disadvantaged individuals and ensure the transformation of employment practices at all levels within health establishments further contributes to lack of motivation amongst human resources.

2.3.5 Financing

(a) One of the challenges with regard to quality in particular is that low cost options should not be perceived as, or become, low quality options. The quality of health services that are offered by low-cost options must be the same as that offered by other options. The absence of low cost solutions is largely due to the cost of providing health care on the supply side with high concentrations of services and vertical integration. In the private sector, this is evidenced by limited growth.

(b) Linked to the high costs are the current business practices and pricing models in the provider market.

(c) A further challenge is that it is difficult for new entrants to get into the hospital services market by small, medium and micro enterprises. This is due to the concentration of suppliers in the hospital sector and financing requirements for such services. Improved price competition would have the effect of forcing prices downwards, leading to lower cost at acceptable levels of quality.

(d) In order to ensure its sustainability, the National Health system must be able to produce and reproduce all the resources needed to deliver quality, affordable health services in the medium to long term. The sustainability of the National Health system is dependent upon its efficient use, management and generation of resources, including financial, human, technological, scientific, clinical, managerial, infrastructural resources in the area of materials, equipment, and research and development.

(e) Inefficiency in the National Health system threatens its sustainability since it leads to maldistribution of resources, and negates or undermines policies and procedures designed to give effect to the distribution, allocation or utilisation of resources. Policies and procedures should be developed with an awareness of the need for sustainability of the National Health system and with a view to the elimination of inefficiencies within the system that could arise, for instance, from
wasteful duplication of resources, under-utilisation of resources and cost ineffective application of resources.

2.4 Broad Based Black Economic Empowerment

2.4.1 The Parties to this Charter acknowledge that transformation is a process that involves a comprehensive change in the status quo, the manner in which the National Health system is structured and operates. It includes profound changes in the levels of ownership, concentration and representation of black persons across the value chain within the health sector. Therefore, the outcomes of any transformation process should reflect a redressing of the imbalances created by apartheid policies and other discriminatory laws and practices of the past. Therefore, the principles of Broad Based Black Economic Empowerment are applicable to all those firms and/or individuals that conduct business or economic activity in the health sector, whether for profit or otherwise.

2.4.2 Equity in ownership refers to a state of affairs, in which black people are fairly and proportionately represented in all areas of, and at all levels within, business in the health sector. This is to be achieved by a process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain in the sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans.

2.4.3 With regard to procurement, joint ventures, enterprise development and control, and other business activities, in the context of Broad Based Black Economic Empowerment, it is necessary to be aware there are different varieties of BEE ventures.

a. Black companies, i.e. companies that are more than 50% owned and controlled by black people;

b. Black empowered companies, i.e. companies that are more than 25% owned by black people and where substantial participation in control is vested in black people;

c. Black influenced companies, i.e. companies that are between 5 and 25% owned by black people and with participation in control by black people;

d. Black women-empowered enterprise, i.e. companies that are more than 30% owned by black women, and where substantial participation in control is vested in black women;

e. Indirect ownership is, where an empowerment shareholder represents a broad base of members such as employees (to the extent that the options have actually been exercised), collectives and/or communities, or where the benefits support a target group, for example black women, people living with disabilities and
the youth. Shares are held directly and indirectly through, for example, non-profit organisations, trusts and pension funds. At the same time, directors and management of the groups should predominantly comprise black people;

2.4.4 A key challenge in the context of broad based BEE is to ensure that it is implemented in all of the following areas –

a. Direct (BEE shareholding) and indirect ownership (employee or trust/community shareholding schemes);

b. Management and control (by black people);

c. Procurement (from BEE companies for example, Affirmative Procurement or Preferential Procurement);

d. Enterprise development;

e. Investment in joint ventures with BEE companies (in sustainable Department of Health or other accredited BEE programmes involving, for instance, PPIs insofar as such programmes are proven to lead to, or contribute to broad-based BEE within the National Health system);

f. Employment equity and skills development; e.g. Corporate social investment.

2.4.5 A further major challenge in the context of BEE within the health sector is the lack of a common vision. Despite many players in the industry pledging allegiance to making the National Health system robust and sustainable, overall health outcomes thus far do not give an indication that all are focusing on the same goal. The debate of quality versus profits still dominates discussions of transformation in many instances. It is therefore necessary to create a platform for the sharing of a common vision. Once there is a common vision, impact indicators and measurable outcomes can be identified to evaluate the levels of participation of the parties in working towards and contributing to the common vision.

2.4.6 There are a number of general challenges to BEE. These include the following –

a. Whether equity should simply be transferred to those who were previously excluded or should they be obliged to acquire it in the same way as non-historically disadvantaged individuals. If so, how could this be adequately financed, given the significant inequities that still exist?

b. How should transformation in this area be monitored?

c. Empowerment is necessary in real terms, which enable black people to take up positions, opportunities and interests that were previously denied them. For instance, a few years back, ownership of pharmacies was opened to non-pharmacists, but it did not lead to any noticeable increase in ownership of pharmacies by black people.
d. Ownership of enterprises by health professionals raises some serious professional and ethical challenges. It is important that there are sufficient safeguards to ensure that with the rise in equity ownership by health professionals, the challenges of unethical conduct and business practices based on perverse incentives are addressed.

e. A process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain is required in the health sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans.

2.4.7 Human Resources

(a) This challenge is a challenge shared with institutions of higher learning. How far these institutions transform and whom they produce for this country is directly linked to the speed, with which the health sector can be transformed. Even though the skills development levy and affirmative action legislation are in place, there is little evidence to suggest that the health sector has made significant progress in addressing this issue.

(b) Transformation of management echelons relates more to affirmative action legislation (Employment Equity Act No 55 of 1998). Despite the many years that this Act has been in place there is still paucity of representation at senior management level in the private sector. Not many black people have been promoted to management level. Lack of movement in this area is said to have led to a lot of job-hopping. The challenge is to ensure that genuine transformation takes place at this level.

(c) It is important that the process of transforming the workplace covers the total value chain. In identifying the appropriate levels, at which changes must take place, the following broad categories are identified:

(i) Executive Management – this includes the board of directors, members of the Executive Committee (Exco) and persons earning more than R600 000 p.a.

(ii) Senior/Middle Management – includes persons who report to members of Exco and any person earning between R400 000 and R599 999 p.a.

(iii) Junior Management – includes supervisors and heads of section and any person who earns between R200 000 and R399 999 p.a.

(iv) Professional and skilled workers – includes persons who are not in management and are employed because they have special knowledge or
particular skill.

(d) The question of the quality and orientation of leadership of company boards is a major issue of concern. The presence of black people in the local or even international boards of multinational companies does not necessarily guarantee the implementation of BEE and the other principles of this Charter. The challenge is how to empower black people who sit in corporate governance provisions so that they are in a position to be able to influence or drive the implementation of the initiatives envisaged in the Charter.

2.4.8 Financing

(a) Health care financing faces the challenge of geographical inequities in the provision of health care in South Africa, particularly looking at high and low density areas, rural and urban, and making specific interventions to foster a more equitable approach. Currently, health care financing is skewed to the urban and private sector.

(b) There is very little development financing in the health sector. What financing is available is primarily finance to facilitate provision of health care services at the same returns that would be charged in the ordinary course of financing businesses. Often, the cost of finance is so high that it is considered prohibitive. Investments in the health sector by Development Finance Institutions compete with other investments in their portfolio. Without development financing, the cost of entry for black persons and black businesses in the health sector prevents the achievement of the objectives of this Charter.

(c) Low cost service providers are still heavily dependent on the finance provided at costs that are not sensitive to the special health care need for low cost solutions. Townships, rural areas and poor provinces are considered very risky, and as a result, battle to attract appropriately structured funding solutions. Sometimes, finance takes too long to be made available and people become discouraged. This kills the spirit of entrepreneurship. While there is a lot of talk around the need for low cost health care services, financially there is very little that is being done to address such a need.

(d) There is very little BEE in the health care sector, except for a few recent transactions at equity level. The sector remains largely untransformed and the involvement of BEE is made more difficult by the concentration in the supply side and the funding side of the private sector.

(e) The absence of low-cost solutions is largely due to the high cost of providing health care on the supply side, with high concentration of services and vertical integration. This can be seen by the limited growth in the private sector. Linked to the high costs are the current business practices and pricing models in the provider market.
Chapter Three:

Solutions and resolutions

3.1 Access

The parties hereby resolve and commit to move towards a coherent, unified health system, offering financial protection for all the population in accessing a nationally affordable package of health care at the time of need and to improve access to health care services by –

3.1.1 Investigating the feasibility of the creation of a category of independent practitioners, who will be contracted to the state in order to improve access to health care at the primary level;

3.1.2 Strengthening working relations between independent private practitioners and public services in the provision of primary health care;

3.1.3 Appropriately increasing the range of health services available to under-serviced communities. The parties commit to tailoring solutions, which meet the needs of the particular community concerned;

3.1.4 The provision of information designed to address the particular needs of vulnerable groups, including people living in rural and under-serviced areas and the illiterate;

3.1.5 Entering into public private initiatives in order to more efficiently utilise the available resources, reduce inequities and improve access to both provision and financing of health services for the benefit of all;

3.1.6 Not refusing anyone emergency medical treatment, irrespective of whether or not they are able to pay;

3.1.7 Providing or sponsoring health profession education, training and development which includes -

(a) Formal health training and education;

(b) Continuing Professional Development education, sponsored programmes and events in relevant categories of health care personnel;

(c) Management & Leadership programme provision or sponsorship;

3.1.8 Establishing a Health Sector Education Trust by contributing to provide financial support to students, who wish to study in the health field.

3.1.9 Using existing funding mechanisms, such as the skills development levy, to more efficiently and effectively provide financial support to students, who wish to study in the health field.

3.1.10 Embarking upon a sector marketing campaign and a career education campaign to introduce pupils and students to the careers and work opportunities within the national health system.
3.1.11 Exploring ways of marketing the health professions to attract home qualified South Africans.

3.1.12 Developing indicators within 6 months of the finalisation of the Charter to measure improved/increased access, in order to track the extent of progress made, and evaluate the sustainability and quality of such access.

3.2 Equity

The parties hereby resolve and commit to improving equity in health services by –

3.2.1 Developing a minimum defined basic package of care that is available to all patients in both the public and the private sectors regardless of the ability to pay;

3.2.2 The elimination of inefficiencies from health service delivery;

3.2.3 Implementing a policy of zero tolerance of unfair discrimination by health care personnel, which will be communicated to all health care personnel employed by them together with the nature of the disciplinary steps that will be taken;

3.2.4 To develop and implement a human capital programme that fairly plans for and meets the human resources requirements of South Africa over the next 15 years. Such programme will address the demographics and diversity of the people being trained and developed in the National Health system;

3.2.5 Support existing initiatives to increase the number of black people and young women matriculating in higher grade science, mathematics and computer science;

3.2.6 Setting annual targets for recruiting, training and retention of health care personnel;

3.2.7 Setting out milestone leadership programmes with curricula that meet the needs of the health organisations;

3.2.8 Eliminating harassment from workplaces through a policy of zero tolerance that is effectively and continuously communicated to staff and patients alike;

3.2.9 With regard to particular health service needs, considering, whether a PPI would be an appropriate and feasible means, by which the required improvements to access, equity, quality and efficiency within the National Health system can be achieved;

3.2.10 Developing a code of practice on the ethical recruitment of health professionals;

3.2.11 Putting in place programmes that result in the broader representation of black persons in the workplace. It is the target at all levels in the chain that by 2010, the workplace will be 60% black across the value chain and will comprise 50% women. Further, it is the target that by 2014 the workplace will be 70% black across the value chain and shall comprise 60% women.

3.3 Quality. The parties hereby resolve to improve quality in health services by –

3.3.1 Conducting regular and sustained training programmes for health care personnel on the rights of patients and the Batho Pele principles;
3.3.2 Implementing comprehensive Employee Assistance Programmes to support and assist the health care personnel employed by them;

3.3.3 Committing to the development of low-cost health service and financing options that are accessible to middle- and low-income groups and that assure value for money in terms of health outcomes;

3.3.4 The implementation of benchmarked quality assurance programmes that include a quality monitoring system and the measurement of health outcomes;

3.3.5 The consideration of complaints by users of the national health system and the creation of mechanisms, whereby such complaints are used to inform the planning and delivery of health services so as to be able to continually improve the quality of health care.

3.4 Broad Based Black Economic Empowerment

The Parties commit themselves to the transformation objective of equity in ownership and more particularly, Broad Based Black Economic Empowerment, employing the strategies outlined in terms of section 11 of the BEE Act and this Charter.

3.4.1 Each of the firms or businesses in the healthcare sector shall be at least 26% owned and/or controlled by black people. This process should commence immediately.

3.4.2 Further, by 2010, at least each of the firms or businesses in the healthcare sector shall be 35% owned and/or controlled by black people.

3.4.3 Equity ownership by black people shall increase to 51% by 2014.

3.4.4 Regulations will be developed under the National Health Act that facilitate Broad-Based Black Economic Empowerment. Procurement policies and processes that are favourable to firms owned or controlled by black people will be implemented. The stakeholders in the healthcare sector also commit to supporting government on these initiatives. In this regard the following areas should be noted for special focus:

- a. Hospitality services and general procurement;
- b. Pharmaceutical products and medicines;
- c. Medical equipment;
- d. Professional services;
- e. IT systems;
- f. Distribution and wholesaling services.

3.4.5 At least 60% of all procurement shall be from black-owned firms or black persons by 2010. By 2014, this should increase to 80%.

3.4.6 The private sector commits to expenditure of a fixed proportion of their annual income on social responsibility projects, which include new and existing projects, providing funding and resources for new and existing community development projects.
3.4.7 Development finance must be derived from three sources, partially from DFIs, particularly where the risk profile excludes other sources, with the majority sourced from mainstream financial institutions and vendors themselves.

3.4.8 Development Financing must be used –

   (a) to fund small black-owned businesses, either entering into or wishing to expand their operations in the health sector. It is essential that existing risk and return profiles are modified with the financing over a longer duration;

   (b) to finance PPIs and other initiatives to promote the objectives of this Charter.

3.4.9 There must be a concerted team effort from both the public and private sector to approach parastatal funding institutions to come up with ways of funding BEE transactions in the health sector as it is not affordable for current banking institutions to fund such transactions (PMG, 2009).

The 30 articles are set out hereunder:

Article 1.
- All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.
- Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.
- Everyone has the right to life, liberty and security of person.

Article 4.
- No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5.
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6.
- Everyone has the right to recognition everywhere as a person before the law.

Article 7.
- All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8.
- Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9.
- No one shall be subjected to arbitrary arrest, detention or exile.

Article 10.
• Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

**Article 11.**

• Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

• No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

**Article 12.**

• No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

**Article 13.**

• Everyone has the right to freedom of movement and residence within the borders of each state.

• Everyone has the right to leave any country, including his own, and to return to his country.

**Article 14.**

• Everyone has the right to seek and to enjoy in other countries asylum from persecution.

• This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

**Article 15.**

• Everyone has the right to a nationality.

• No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

**Article 16.**

• Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

• Marriage shall be entered into only with the free and full consent of the intending spouses.
• The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.
• Everyone has the right to own property alone as well as in association with others.
• No one shall be arbitrarily deprived of his property.

Article 18.
• Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19.
• Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.
• Everyone has the right to freedom of peaceful assembly and association.
• No one may be compelled to belong to an association.

Article 21.
• Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
• Everyone has the right of equal access to public service in his country.
• The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections, which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.
• Everyone, as a member of society, has the right to social security and is entitled to realisation, through national effort and international co-operation and in accordance with the organisation and resources of each state, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.
• Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
• Everyone, without any discrimination, has the right to equal pay for equal work.
Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

Everyone has the right to form and to join trade unions for the protection of his interests.

**Article 24.**

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

**Article 25.**

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

**Article 26.**

Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

Parents have a prior right to choose the kind of education that shall be given to their children.

**Article 27.**

Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

**Article 28.**

Everyone is entitled to a social and international order, in which the rights and freedoms set forth in this Declaration can be fully realised.
Article 29.

- Everyone has duties to the community, in which alone the free and full development of his personality is possible.

- In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

- These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

- Nothing in this Declaration may be interpreted as implying for any state, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.
Addendum L: Economic and human resource losses in South Africa and 9 Sub-Saharan African countries

Table 4
Statistics on Health Status and Human Resources in Nine Sub-Saharan Countries Included in Analysis

<table>
<thead>
<tr>
<th>Country</th>
<th>HIV prevalence (%) in 15-49 year olds, 2007</th>
<th>Estimated No of people* with HIV</th>
<th>Year of available data on medical school costs</th>
<th>No of medical schools</th>
<th>Medical practitioners per 10000 population</th>
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<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Zambia</td>
<td>14.3</td>
<td>1 100 000</td>
<td>2009</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>15.3</td>
<td>1 300 000</td>
<td>2009</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Mills et al., 2011, p. 8)

*Adults and children.


Primary school education

Table 5
Expenditure on Primary and Secondary Schools in Nine Sub-Saharan African Countries, Using the Most Recent Year for which Data were Available

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditure per student</th>
<th>Cost per student</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary school</td>
<td>Secondary school</td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>12.6</td>
<td>9.0</td>
<td>934.0</td>
<td>2008</td>
</tr>
<tr>
<td>Kenya</td>
<td>22.5</td>
<td>22.2</td>
<td>1573.0</td>
<td>2008</td>
</tr>
<tr>
<td>Malawi</td>
<td>10.2</td>
<td>21.6</td>
<td>794.0</td>
<td>2008</td>
</tr>
<tr>
<td>Nigeria</td>
<td>28.3</td>
<td>56.6</td>
<td>2203.0</td>
<td>2008</td>
</tr>
<tr>
<td>South Africa</td>
<td>13.7</td>
<td>18.0</td>
<td>10278.0</td>
<td>2008</td>
</tr>
<tr>
<td>Tanzania</td>
<td>22.9</td>
<td>NA</td>
<td>1400.0</td>
<td>2008</td>
</tr>
<tr>
<td>Uganda</td>
<td>7.3</td>
<td>21.2</td>
<td>1217.0</td>
<td>2008</td>
</tr>
<tr>
<td>Zambia</td>
<td>5.5</td>
<td>7.8</td>
<td>1430.0</td>
<td>2008</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>14.0</td>
<td>21.0</td>
<td>500.0</td>
<td>2008</td>
</tr>
</tbody>
</table>

(Source: Mills et al., 2011, p. 9)

GDP=gross domestic product; NA=not available.

*As percentage of GDP per capita.
Medical school expenditure

Table 6
Expenditure on Medical Schools in Nine Sub-Saharan African Countries Included in Analysis

<table>
<thead>
<tr>
<th>Country</th>
<th>Government subsidised cost (local currency)</th>
<th>Expenditure rate to % (July 2011)</th>
<th>Total cost of medical school ($)</th>
<th>Total cost of primary and secondary school ($)</th>
<th>Total education cost per student ($) (Government funded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>485 927</td>
<td>1 Ethiopian birr=0.06</td>
<td>28 620</td>
<td>1278</td>
<td>29 898</td>
</tr>
<tr>
<td>Kenya</td>
<td>2 652 500</td>
<td>1 shilling=0.012</td>
<td>32 225</td>
<td>4228</td>
<td>36 453</td>
</tr>
<tr>
<td>Malawi</td>
<td>4 969 161</td>
<td>1 kwacha=0.0066</td>
<td>32 952</td>
<td>1334</td>
<td>34 286</td>
</tr>
<tr>
<td>Nigeria</td>
<td>3 860 100</td>
<td>1 Nigerian naira=0.0066</td>
<td>25 188</td>
<td>11 222</td>
<td>36 410</td>
</tr>
<tr>
<td>South Africa</td>
<td>280 364 79</td>
<td>1 rand=0.13</td>
<td>40 383</td>
<td>18 315</td>
<td>58 698</td>
</tr>
<tr>
<td>Tanzania</td>
<td>37 335 000</td>
<td>1 shilling=0.00073</td>
<td>23 511</td>
<td>3745</td>
<td>27 256</td>
</tr>
<tr>
<td>Uganda</td>
<td>49 155 400</td>
<td>1 shilling=0.00048</td>
<td>18 870</td>
<td>2170</td>
<td>21 040</td>
</tr>
<tr>
<td>Zambia</td>
<td>127 073 700</td>
<td>1 kwacha=0.0002</td>
<td>26 529</td>
<td>1220</td>
<td>27 749</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>37 500</td>
<td>$1=1</td>
<td>37 500</td>
<td>1120</td>
<td>38 620</td>
</tr>
</tbody>
</table>

(Source: Mills et al., 2011, p. 10)

Lost investment from medical practitioners emigrating

Table 7
Estimated Lost Investment from Training Medical Practitioners in Nine High Prevalence HIV Countries who are Currently Practising in Canada, the United States, the United Kingdom, or Australia

<table>
<thead>
<tr>
<th>Source country</th>
<th>Average savings interest rate (%)</th>
<th>Destination country</th>
<th>No of source country doctors in destination countries (95% CI)</th>
<th>Estimated lost investment for source countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>1.80</td>
<td>Canada</td>
<td>567 (526 to 608)</td>
<td>43 752</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td>43 883</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td></td>
<td>37 883</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td>40 589</td>
</tr>
<tr>
<td>Kenya</td>
<td>1.81</td>
<td>Canada</td>
<td>328 (293 to 363)</td>
<td>53 461</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td>53 623</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td></td>
<td>46 253</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td>49 577</td>
</tr>
<tr>
<td>Malawi</td>
<td>2.75</td>
<td>Canada</td>
<td>41 (2 to 53)</td>
<td>61 926</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td>62 412</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td></td>
<td>49 722</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td>55 415</td>
</tr>
<tr>
<td>Nigeria</td>
<td>4.75</td>
<td>Canada</td>
<td>7106 (7059 to 7156)</td>
<td>104 362</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td>107 001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td></td>
<td>71 757</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td>87 354</td>
</tr>
<tr>
<td>South</td>
<td>4.27</td>
<td>Canada</td>
<td>10 822 (10 644 to 10 999)</td>
<td>150 273</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td>153 327</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td></td>
<td>107 178</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td>127 669</td>
</tr>
</tbody>
</table>
### Sensitivity estimation of lost investment

**Table 8**  
*Sensitivity Analysis of Estimated Lost Investment using Variations on Time Working in Destination Countries, Interest Rates, and Cost of Education*

<table>
<thead>
<tr>
<th>Source country</th>
<th>Assuming later emigration and attendance at Compounding over full length of career and using deposit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>24.63</td>
</tr>
<tr>
<td>Kenya</td>
<td>16.75</td>
</tr>
<tr>
<td>Malawi</td>
<td>2.16</td>
</tr>
<tr>
<td>Nigeria</td>
<td>674.26</td>
</tr>
<tr>
<td>South Africa</td>
<td>1412.70</td>
</tr>
<tr>
<td>Tanzania</td>
<td>3.49</td>
</tr>
<tr>
<td>Uganda</td>
<td>13.61</td>
</tr>
<tr>
<td>Zambia</td>
<td>12.14</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>5.1*</td>
</tr>
</tbody>
</table>

(Source: Mills et al., 2011, p. 12)
Figure 9. Sub-Saharan African countries with HIV prevalence of the same or more than 5% in adults aged 15-49 or more than one million of the population with HIV (n=17)
(Source: Mills et al., 2011, p. 13)

Figure 10. Loss of medical practitioners to destination countries, compared with burden of HIV in nine African source countries. Size of each bubble represents ratio of estimated compounded lost investment over gross domestic product, and y-axis corresponds to ratio of doctors working in target countries and doctors currently working domestically
(Source: Mills et al., 2011, p. 13)
Addendum M: Policy and legislative framework for TB and HIV in health care workers in South Africa

Table 9
Policy and Legislative Framework for TB and HIV in Health Care Workers in South Africa

<table>
<thead>
<tr>
<th>Policy</th>
<th>Scope</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO TREAT guideline (2010)</td>
<td>Policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB</td>
<td>WHO</td>
</tr>
<tr>
<td>WHO policy on TB infection control on health care facilities, congregate settings and households (2009)</td>
<td>Proposes a set of measures to promote TB infection control at national and facility levels, which include on-site surveillance of TB disease among health care workers</td>
<td>WHO</td>
</tr>
<tr>
<td>South African Labour Statutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Health and Safety Act (Act 85 of 1993)</td>
<td>Provides for a healthy and safe working environment</td>
<td>*DoL</td>
</tr>
<tr>
<td>Regulations for Hazardous Biological Agents (HBA) (2001)</td>
<td>- Mandates regular risk assessment every 2 years and specifies that records need to be kept for 40 years&lt;br&gt;- Requires the provision of information and training to employees on potential risks of HBA and risk reduction</td>
<td>DoL</td>
</tr>
<tr>
<td>Labour Relations Act (Act 66 of 1995)</td>
<td>- Prevents discrimination and unfair dismissal of workers afflicted with occupational disease or injury&lt;br&gt;- Allows for workplace accommodation</td>
<td>DoL</td>
</tr>
<tr>
<td>Code of Good Practice on key aspects of HIV/AIDS and employment</td>
<td>Provides for:&lt;br&gt;- Establishment of a workplace HIV policy and programme&lt;br&gt;- Elimination of discrimination</td>
<td>DoL</td>
</tr>
<tr>
<td>Compensation for Occupational Injuries and Diseases Act</td>
<td>Recognises and mandates the reporting of occupational diseases to the Department of Labour</td>
<td>DoL</td>
</tr>
<tr>
<td>Circular Instruction Regarding Compensation For Pulmonary Tuberculosis In Health</td>
<td>- Mandates the reporting of occupational pulmonary TB and advises on reporting TB and compensation for disability caused in health care workers</td>
<td>DoL</td>
</tr>
<tr>
<td>South African DOH Policy</td>
<td></td>
<td>**DoH</td>
</tr>
<tr>
<td>National Core Standards for Health Establishments in SA (2011)</td>
<td>- Develop a common definition of quality care, a benchmark and certification for compliance for all health establishments in SA&lt;br&gt;- Staff are protected from workplace hazards through effective occupational health and safety systems (responsibilities under Occupational Health and Safety Act; active health and safety committees; medical surveillance based on risk assessment in place; measures in place to minimise occupational</td>
<td>**DoH</td>
</tr>
</tbody>
</table>
All categories of health care personnel have an increased risk of TB when compared to the general population. In addition to reducing their exposure, specific measures that target health care personnel are required:

- Informing health care personnel of the signs and symptoms of TB and encouraging early recognition of symptoms and presentation for sputum tests
- Ensuring that all health care personnel with signs and symptoms are evaluated as “high-risk TB suspects” and have 2 sputum specimens sent for evaluation (a spot specimen for smear and an early morning specimen for smear and culture and drug susceptibility testing)
- Providing voluntary counselling and testing (VCT) and encouraging health care personnel to know their HIV status
- Advocating/providing precautionary measures for HIV-positive staff, such as TB preventive therapy and antiretroviral therapy
- Appropriately placing HIV-positive staff in low TB risk

<table>
<thead>
<tr>
<th>Guidelines for TB preventive therapy among HIV-infected individuals in SA (2010)</th>
<th>All HIV-positive individuals should be provided with isoniazid preventive therapy (IPT) once active TB has been excluded (HIV-positive health care workers recognised as a high-risk population and eligible for IPT)</th>
<th>DoH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increasing access to VCT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Providing personal protective equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reducing spread of infection with MTB in health care settings</td>
<td></td>
</tr>
</tbody>
</table>

*DOL – Department of Labour  **DOH – Department of Health (Gray et al., 2013)

Table 10
Epidemiological Studies of HIV Prevalence in South African Health Care Workers

<table>
<thead>
<tr>
<th>HIV Prevalence (%)</th>
<th>Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.7%</td>
<td>595 health care workers from KZN, MP, *FS, **NW</td>
<td>18</td>
</tr>
<tr>
<td>11.5%</td>
<td>Health care workers from 2 hospitals in ***GP</td>
<td>19</td>
</tr>
<tr>
<td>20.0%</td>
<td>Adherence supporters TB/HIV Care Association in WC</td>
<td>15</td>
</tr>
</tbody>
</table>

(Source: Gray et al., 2013)

* FS – Free State Province;

**NW – North West Province;

***GP – Gauteng Province
Addendum O: Epidemiological studies of TB prevalence in South African health care workers (Gray et al., 2013).

Table 11
Epidemiological Studies of TB in South African Health Care Workers

<table>
<thead>
<tr>
<th>TB prevalence/incidence</th>
<th>Setting/N</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence 275/100 000</td>
<td>Staff at four TB centres in MP</td>
<td>11</td>
</tr>
<tr>
<td>Incidence 690/100 000</td>
<td>Staff at a hospital in KZN (n=723)</td>
<td>12</td>
</tr>
<tr>
<td>Incidence 1 133/100 000</td>
<td>Health care workers at hospitals in KZN (n= 49 392)</td>
<td>13</td>
</tr>
<tr>
<td>Incidence 4 477/100 000</td>
<td>Desmond Tutu health care workers research staff in WC (n=182)</td>
<td>14</td>
</tr>
<tr>
<td>Prevalence 5%</td>
<td>TB/HIV care association community health workers in WC (n=215)</td>
<td>15</td>
</tr>
</tbody>
</table>

(Source: Gray et al., 2013)
Addendum P: Public and private health care practitioner profiles

**Table 12**

**Public sector health care practitioner profiles**

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Occupation</th>
<th>Language</th>
<th>Religion</th>
<th>Leave SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29</td>
<td>F medical practitioner</td>
<td>Xhosa</td>
<td>Christian</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>M medical practitioner</td>
<td>English</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>24</td>
<td>F therapist</td>
<td>Afrikaans</td>
<td>Christian</td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>f therapist</td>
<td>English</td>
<td>Christian</td>
<td>N</td>
</tr>
<tr>
<td>7</td>
<td>50</td>
<td>f nurse</td>
<td>Zulu</td>
<td>Christian</td>
<td>Y</td>
</tr>
<tr>
<td>8</td>
<td>28</td>
<td>f nurse</td>
<td>Zulu</td>
<td>Lutheran</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>37</td>
<td>f nurse</td>
<td>Zulu</td>
<td>Christian</td>
<td>N</td>
</tr>
<tr>
<td>10</td>
<td>35</td>
<td>f radiographer</td>
<td>Zulu</td>
<td>Christian</td>
<td>N</td>
</tr>
<tr>
<td>11</td>
<td>54</td>
<td>f radiographer</td>
<td>English</td>
<td>Hindu</td>
<td>N</td>
</tr>
<tr>
<td>12</td>
<td>29</td>
<td>f therapist</td>
<td>Zulu</td>
<td>Christian</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>28</td>
<td>f medical practitioner</td>
<td>Xhosa</td>
<td>Christian</td>
<td>Y</td>
</tr>
<tr>
<td>15</td>
<td>25</td>
<td>m medical practitioner</td>
<td>Xhosa</td>
<td>Christian</td>
<td>N</td>
</tr>
</tbody>
</table>

**Table 13**

**Private sector health care practitioner profiles**

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Occupation</th>
<th>Language</th>
<th>Religion</th>
<th>Overseas</th>
<th>Leave SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>46</td>
<td>m therapist</td>
<td>Afrikaans</td>
<td></td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>57</td>
<td>m</td>
<td>Afrikaans</td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>43</td>
<td>m medical practitioner</td>
<td>English</td>
<td>Hindu</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>69</td>
<td>f nurse</td>
<td>English</td>
<td>Christian</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>37</td>
<td>f nurse</td>
<td>English</td>
<td>Christian</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>7</td>
<td>55</td>
<td>f therapist</td>
<td>English</td>
<td>Christian</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>8</td>
<td>24</td>
<td>m radiographer</td>
<td>Zulu</td>
<td>Christian</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>26</td>
<td>f radiographer</td>
<td>Zulu</td>
<td>Christian</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>10</td>
<td>49</td>
<td>f radiographer</td>
<td>English</td>
<td>Anglican</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>12</td>
<td>40</td>
<td>f nurse</td>
<td>Afrikaans</td>
<td>Christian</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>13</td>
<td>53</td>
<td>f nurse</td>
<td>English</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>14</td>
<td>43</td>
<td>f therapist</td>
<td>Xhosa</td>
<td>Methodist</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>15</td>
<td>35</td>
<td>f dietician</td>
<td>English</td>
<td>Christian</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16</td>
<td>62</td>
<td>m medical practitioner</td>
<td>English</td>
<td>Christian</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Addendum Q: Descriptive analysis

Summary of public and private health care practitioner responses containing main points

Responses of health care practitioners divided into:

A. Public health care practitioners

B. Private health care practitioners

The following table refers to participants' demographic characteristics coded according to their public (Pub1, Pub 2, etc.) hospital/health care affiliation or private (Pvt1, Pvt2) hospital/health care affiliation.

Table 14
Summary document containing main points

A: Public health care practitioners

<table>
<thead>
<tr>
<th>Pub1 (medical practitioner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>Over-crowded wards, poor ventilation, defective equipment. Poor booking system and organisation of patients Overburdened, unappreciated, demoralised, negative interaction with employer Difficult to work with nurses (tea &amp; lunch breaks, dragging feet)</td>
</tr>
<tr>
<td>Q2</td>
</tr>
<tr>
<td>Govt. shifts from one non-functional system to another System serves govt. not people Govt. unable to pay suppliers Health professionals paid poor salaries</td>
</tr>
<tr>
<td>Q3</td>
</tr>
<tr>
<td>Give credit and recognition, where it is due. Better pay. Improved working environment Manage patients better. Better equipment. More awareness campaigns, promoting disease prevention</td>
</tr>
<tr>
<td>Q4</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Q5</td>
</tr>
<tr>
<td>No, Love country, people</td>
</tr>
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</table>

Pub 3 (medical practitioner)

| Q1                          |
| Experience left a bitter taste. Better to avoid responsibility and accept fewer patients KZN department of health fall short compared to Cape one. Patients sent home on medication rather than admitted – due to lack of beds and resources. No national standard of health care across the board. Inequalities - public and private health sectors & within public sector |
Q2
Unprepared to answer - lack of information from government and own ignorance
On paper it sounds like a good idea, but not identifying many of the other issues facing our health sector. A way of getting get more money by adding another tax. Rather optimise resource allocation and minimise wasteful expenditure than want more money. Paying for something you never use. Future income might be controlled and governed by government policy influencing how much health care costs

Q3
No shortage of money in the health sector, but poor resource allocation and mismanagement. Bigger focus on efficiency and responsibility. Examples – Using expensive sterile gloves to mop floors; No paper towels to dry hands in casualty – causes infection and high health care costs. Responsibility – Lack of supervision of medical practitioners. Supervisors more active role in overseeing the quality of care provided. Hospital management - open channels to allow those involved in poor practice to be disciplined.

Q4
No

Q5
Would like to stay in South Africa, but will leave when there is political and economic collapse like in Zimbabwe (family security needs first) or unable to specialise through discrimination or through lack of resources

Pub 5 (therapist)

Q1
Lack of integrity and accountability – boss and colleagues look busy but get no work done Bullying the patient e.g. forcing mothers to breast feed to save money. Poor distribution of resources-overcrowded, basic equipment not available, uneven distribution of work, politics impair service delivery.

Q2
Know very little about it – discussed once or twice Poor will have better access to health care. Not a good idea that middle-class will use public health care – overload system
Have no confidence in public health care

Q3
Manage leave time- late arrival; leave early, longer lunch, time should be deducted from annual leave. Overtime work added to annual leave. Computerised filing system for patients. Spread resources across the country-limit no. of professionals per area Appoint interpreters. Less sitting around and more time at grass roots level for top management.

Q4
No

Q5
Will leave on temporary basis to grow professionally and then return
Pub 6 (therapist)

Q1
Frustrating – no resources, short-staffed Transport – patients have to travel far. No one wants to take responsibility to hear my view and suggestions. Overall communication is a problem. Positives - enjoy job, like helping people, find job rewarding. No one to supervise – work not carried over.

Q2
Do not know much about the new changes. Feel negative about the changes presently. Managers are not being pro-active regarding brainstorming and carrying out proposed changes.

Q3
Have a day, where we visit the clinic and bring our service closer to the people. Drop medication at the clinics for the patients – no need to travel to hospital Transport service from clinic to hospital for pensioners to collect medication. Better referral system between the primary, secondary and tertiary hospitals.

Q4

Q5
Love helping people. Must face challenges (better resources and better equipment). Must not accept that things will never change.

Pub 7 (nurse)

Q1
System very nice, challenging every day with new technology. Challenges - Shortage of staff, no working tools, poor pay, no thanks but looking for mistakes, working hours gives family no access to you.

Q2
Insufficient funds. Autocratic leadership by health department. Use example from overseas countries – equipment close to you. Equipment cheap and break easily. Fraud cases

Q3
Employ enough staff. Good quality equipment that does not break easily. Improve pay. Allocate more money for health. Change working hours. Review standards and protocols

Q4
No

Q5
Yes. For something different
Pub 8 (nurse)

Q1
Not being involved in decision-making. Shortage of staff/personnel-overworked Insufficient resources. Poor pay. Neglected as workers. Not being given enough chances to upgrade via studying.

Q2
Good policies, but the problem is with its implementation Propose changes, but without consulting the workers.

Q3
Day Care Centres inside Institutions for staff members’ children Better wages can motivate workers. Provide with accommodation to stay with our families - reduce absenteeism. Employ more staff to cover this shortage. Allow workers to study to upgrade qualifications.

Q4
No

Q5
Will leave to get better pay

---

Pub 9 (nurse)

Q1
No adequate equipment, e.g. mask, gloves, to protects ourselves Shortage of staff leads to working unpaid overtime. End up with no interest to do your work properly due to tiredness

Q2
Positive to those changes, because patients will receive a high standard of care People will have an access to Medical Aid - not dependent on having job. Give pills for people with HIV/AIDS

Q3
Increase the staff
Respond immediately to our grievances as staff Make a working place well equipped Working place must be in good condition, e.g. air conditioner, safety Proper training must be provided to staff; by organising workshops Increase number of doctors in hospitals.
People must not stand in long queues to get health care help or assistance Educate our communities about different diseases, so that they know the signs Build more clinics and hospitals.

Q4
No

Q5
No
### Pub 10 (radiographer)

**Q1**
Referring system in our district is a mess Insufficient communication in referral decisions
Insufficient staff and no budget to advertise posts for more staff. Leads to frustration and bad service. Reporting channels are not satisfactory. No one on ground level has powers to go to district or province or national without industrial action. Never enough money to buy equipment. Clinics- No water, no electricity or sewerage is not functioning well.

**Q2**
Will introduce it by force but it will never work. Specify staff shortages and training targets for the next 5 years - proposals on the number of staff needed get crushed by management (no idea what’s happening on the ground) Trying to implement HIV and AIDS strategic plan, but long way to go. No changes likely soon.

**Q3**

**Q4**

**Q5**
No. Only reason to stay is family. Poor pay compared to overseas

### Pub 11 (radiographer)

**Q1**
Very poor health care system. Shortage of qualified, experienced medical staff
Medical staff are overworked, demotivated and do not provide the service. Rural areas have insufficient medical facilities - difficult for the ordinary working class to access good, health facilities and care. Overworked public sector workers locum in private hospitals

**Q2**
Will not work until changes are made. Following issues must be addressed before implementing changes. Infrastructure needs improvement- medical personnel needs to be motivated, educated Job purpose- nurses, auxiliary health workers need to be more dedicated, responsible, caring and enjoy doing their jobs. Shortage of qualified personnel

**Q3**
Continuous training and education. Motivation. Medical personnel need to realise the importance of their jobs. Change in attitude towards work- All health care workers are unhappy (overworked and underpaid). Motivated, happy workers will solve and improve health care. Private sector - worry about more profits; public sectors - corruption is rife

**Q4**

**Q5**
No. No future for next generations
Pub 12 (therapist)

Q1
Do not feel appreciated. No govt. help to do courses to improve academic knowledge. Shortage of resources human and equipment (frustrating) Not getting paid enough.

Q2
Do not understand how NHI is going to work. Very difficult to comment.

Q3
Treat all employees equally- support them to bring about effective teamwork. Offer courses, seminars, workshops for all disciplines.

Q4
No

Q5
Yes. Broaden knowledge, experience other countries, better pay.

Pub 13 (medical practitioner)

Q1
Medical practitioners are overworked and underpaid. Attitude amongst ourselves makes it even more difficult to perform our duties. Lack of the most basic resources frustrating. Get abused by patients, e.g. swearing. Difficult to respect people who threaten staff. Safety of staff (stabbed, raped, murdered). 2 years on internship and 1 year community service is good.

Q2
Don’t even think of NHI when basic equipment (urine dipsticks, gloves, BP cuff) are not available. Have to pay for medical aid for someone who is too lazy to wake up and get a job. Already paying too much tax.

Q3
Provide incentives for staff. Protect not prosecute staff – staff scared of being harmed.

Q4
No

Q5
Will possibly leave for financial reasons.

Pub 15 (medical practitioner)

Q1
Workload is exceedingly high (should manage 25 but manage 45 patients). Lack of teaching-due to high work load. As result of high workload quality of care given to each patient compromised Health care system is not meeting the needs of patients.

Q2
Change would bring a difference.

Q3
More regional hospitals. Train more specialists to run these regional hospitals. Teaching for junior health care practitioners. Resources are needed.

Q4
No

Q5
No. Shortage of health care practitioners and if we start leaving, it is going to get worse.
B. Private health care practitioners

<table>
<thead>
<tr>
<th>Pvt 1 (therapist)</th>
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<tbody>
<tr>
<td><strong>Q1</strong></td>
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<tr>
<td>Slice of the health care cake is getting smaller for service providers that work outside the private hospitals. Medical aids are allocating more and more of their funds to private hospitalisation, as the costs just keep rising. Patients are having to pay more and more for their day-to-day medical needs - difficult to have a financially viable private practice. Good health care service, but it is expensive and exclusive.</td>
</tr>
<tr>
<td><strong>Q2</strong></td>
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<tr>
<td>Very ambitious, morally defendable, totally unattainable and unrealistic in terms of the financial implications to our country. Implementation and management thereof also currently seem beyond the Government’s capabilities. Too few will have to pay for the many with too many needs. System might implode.</td>
</tr>
<tr>
<td><strong>Q3</strong></td>
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<tr>
<td>Use the money more effectively. Address rampart corruption, mismanagement and misappropriation of funds. System should become far more effective, well planned and managed.</td>
</tr>
<tr>
<td><strong>Q4</strong></td>
</tr>
<tr>
<td>No</td>
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<tr>
<td><strong>Q5</strong></td>
</tr>
<tr>
<td>Yes. If ability to earn a decent living in the health care sector is severely threatened by unattainable and unrealistic government health care policies, I will look for alternatives.</td>
</tr>
</tbody>
</table>
| Q1 | Poor care to patients and a very stressful environment for caregivers. Private sector is under pressure financially- downturn of the economy, influx of people abandoning the state sector, more people share in a smaller funders pool, govt. taxes medicine to fund their excesses. The state sector is virtually non-functional - cannot deliver health care due to lack of personnel and equipment. Working in state sector is soul destroying, given the levels of corruption and poor governance the situation is not going to change in the foreseeable future. Long term planning impossible- your income is dependent on private and state sector. Uncertainty and the looming threat of loss of income or employment eats away at the quality of life and peace of mind of health care workers. Present and future of patients are worse. In private practice there are pockets of excellent care, but standards vary enormously from place to place. Quality of referrals from primary care physicians are generally very poor (treatable illnesses are not found and referred other insignificant problems over serviced). Training of doctors are substandard - govt. allows it due to political pressure.

| Q2 | Changes are doomed to worsen a poor situation - none of the real problems are addressed Adequate policing of supply chains - tender system (tenders given to politically connected friends and family) Solution - Ordering and buying of equipment should be decentralised and become responsibility of the individual units delivering the service. Failure to comply with first world accounting practices should lead to loss of jobs and criminal prosecution. Performance of health care workers should be measured in patient outcomes not in hours spent at work. Failure to perform professional duties should be reported to professional bodies rather than be managed by clueless HR personnel. Once delivery of equipment to state facilities are efficient and health is on a level that satisfies the professional supervising bodies, the need for change should be re-assessed. A much simpler, less expensive, and efficiently run NHS can then be rolled out on a community-based level. If needed can be expanded based on the template of existing state/private ventures, but more govt. funding needed.

| Q3 | Training of medical practitioners should revert back to the six year course and the module structure abandoned. Students should master anatomy and physiology before they confront pathology and treatment. Number of candidates passing should not be manipulated: if 100% fail, they fail. The number of doctors qualifying should never reduce the quality of doctors qualifying. All hospital associated nursing colleges should be reinstated and out of hospital training policed very strictly.

| Q4 | Worked in the xxxx and xxxx. Systems in both countries worked well and both health care workers and patients were by and large satisfied.

| Q5 | Yes. Society is becoming unstable and the have-nots will not suffer in silence forever. Crime is out of control and government is getting worse day by day. |
| Pvt 4 (medical practitioner) |  |
|-------------------------------|  |
| Q1                            | Very frustrating. Attack by private health care funders and the state on private health care practitioners. Medical aids often delay, obfuscate, deny vital services for the very patients that pay their bills, to the detriment of patients. Medical practitioners are compelled to wait for pre-authorization (from a distant clerk) for a procedure. This does not guarantee payment. |
| Q2                            | Not sustainable for our size of economy, our disease burden or our population size. State needs to employ better calibre nurses, more medical practitioners. |
| Q3                            | Leave politics out – “free health care” is a political bargaining chip. Set up a few public/private ventures with intensive management; actuarial foresight and accounting skills. Leave clinical skills to the clinicians. |
| Q4                            | Yes. UK NHS is overburdened and abused by the Public. Several types of illnesses because of poor lifestyle (e.g. smoking, drugs). Delay in obtaining basic investigations, e.g. outpatient ultrasound has 3-4 week waiting period. |
| Q5                            | Yes. Political stability elsewhere, better remuneration, shorter working hours, better. |

| Pvt 5 (nurse) |  |
|---------------|  |
| Q1            | Nurses only interested in pay. Have no compassion for patients. Cannot even carry out a simple instruction. |
| Q2            | Will not be able to find the nurses to do the work. |
| Q3            | Have better trained more caring nurses and to have the medical procurement services more proactive. Do away with hospital health, e.g. life care insurances (not medical aids). Medical practitioners not to over service patients. |
| Q4            | No. |
| Q5            | Yes. For fear of safety in South Africa. |

| Pvt 6 (nurse) |  |
|---------------|  |
| Q1            | Happy to be working in the private sector. Worked for xxxx (private) for xxxx years and have seen many changes, mostly for the better Focus on the importance of quality nursing care and customer satisfaction. Dealing with Medical Aid can be difficult at times; explaining limits and co-payments to sick people. Not been to a public sector hospital for some time - hearing about a shift in focus, quality etc. |
| Q2            | The way it has been communicated has caused some confusion. Not really sure how this will impact on me as a RN (registered nurse) and Unit xxxx. |
| Q3            | Focus on the needs of the nurses, equipment, linen, support system training. For quality nursing care, you must have clean linen to put on the patient’s bed. |
Pvt 7 (therapist)

| Q1 | Most medical aids have very limited cover for xxxx-therapy. Not always affordable for patients. xxxx-therapy becomes a luxury rather than a necessity. Rates charged depend on area of patients. Blue-collar workers can afford less than wealthy people can. |
| Q2 | Main problems- inefficiency and inequality. Inefficiencies in management and low productivity and corruption rather than funding Huge inequalities that do need to be addressed. Better health care - improved management, general efficiency and productivity. |
| Q3 | All health care professionals need more training in management and ethics. Health care professionals need to be educated better about NHI and motivated about its implementation. |

Pvt 8 (radiographer)

| Q1 | Shortage of staff Work overload. Poor service delivery Access to Health care. Gov. 75%, Private 25% of population. Service from the government is very basic (primary) and in most cases provide for the highly disadvantage socio-economic group (low-class level). Private sector caters of the mid-class and high-class group and their health services are highly rated. Shortage of staff within the public sector is caused by professionals leaving the gov to the private sector. Puts a lot of pressure on the few staff left behind, as they have to work extra hard, while they are being underpaid. Public sector health care workers have an ‘I don’t care. It’s not mine’ attitude. In the private sector, everyone is responsible and accountable, which is a key factor to a good service delivery |
| Q2 | Difficult to say - proposed NHI has not gone into operation. Make medical aids available to everyone. Not an easy task because these services from NHI will still be offered by the state. Should the NHI achieve its proposed objectives, it would be great. |
| Q3 | Get more medical staff by adjusting their packages to match the ones offered by private sectors. Medication, equipment should be sent to the institutions in time so that service delivery is not impacted. Dept. Education and Health to ensure that a greater number of medical professionals are produced annually so that all institutions have enough staff. |
Q5
Yes. For work- Love to travel, would want to work in a country that is on a higher level than SA e.g. Europe, North America, learn more about other countries’ cultures and how things are done there.

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<thead>
<tr>
<th>Pvt 9 (radiographer)</th>
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<tbody>
<tr>
<td>Q1</td>
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<tr>
<td>Health care system. Private (for middle- to high-class). Public (for low-class citizens who are the majority of the very sick). Private hospitals are quite expensive - need money to use it. Available to the minority. Medical aids are the major contributors and this is where the financing comes from. In public hospitals, you will find that they do not have human resources, material and even financing. May be due to mismanagement of funds and equipment. Have ‘top of the range’ equipment but it is not in working condition. A large number of very sick patients do go to public hospitals and sometimes find no help.</td>
</tr>
<tr>
<td>Q2</td>
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<tr>
<td>Everyone has a right to good health care. Motive behind the NHI is good because they want to bring service to those who need it. The government has a lot hospitals but do not manage them properly. There is a lot of negligence. They should first manage these hospitals properly. The same problems that public hospitals experience should not happen at private hospitals.</td>
</tr>
<tr>
<td>Q3</td>
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<tr>
<td>The staff must have it at heart that they are here for the patients all the time. Management should see that fraud that hinders good quality health care does not happen. People need to search their hearts once again.</td>
</tr>
<tr>
<td>Q4</td>
</tr>
<tr>
<td>No.</td>
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<tr>
<td>Q5</td>
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<td>No.</td>
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### Pvt 10 (nurse)

**Q1**
Current Health care System can be divided into two. Those who can afford to belong to the medical aids or who can pay their own medical bills privately and therefore have freedom of choice. Those that are at the mercy of the state and get their medical care from public hospitals and clinics and have no choice often of where and by whom they are attended to private medical health care in South Africa is rated highly - excellent medical practitioners and faculties. Medical aids and medical costs have increased rapidly over the past decade and although patients belong to and pay high premiums for Private medical care – Private medical institutions are run as businesses and therefore do not accommodate or always have empathy to those who cannot afford the fees. Some private doctors see status and financial rewards instead of the patients’ needs first. Some government medical institutions have dedicated and experienced medical practitioners and medical staff working under very trying conditions. This often causes frustrations and results in them leaving to private health care or emigrating. Government then has to offer over-inflated salaries to lure medical staff back into their institutions. Services at public hospitals often suffer from mismanagement of funds and can result in a breakdown of medical care to the patients. Primary Health Care Clinics play a vital role in helping hospitals. They alleviate the problems of overworking and allow patients to be treated close to their homes.

**Q2**
Changes within the health care systems will really benefit the patients dependent on gov health care. Will have access to improved faculties and medical staff expertise. Sceptical about the implementation and how it is all going to function and cannot see it happening for a long time to come. Financially it will be very taxing on all parties. For the middle class who will be forced to contribute to the proposed scheme it will be very expensive. Private patients will doubt the proposed system at first being fearful that they will not receive care that is at the present level.

**Q3**
Biggest problem - Educate people on birth control. Parents must be accountable and responsible for their children. Children should all be educated in basic hygiene and how to look after themselves in schools. Primary Health care clinics should be accessible and available to all. Measures should be put in place to monitor these facilities and rectify problem areas. Medical staff in public hospitals should be encouraged to take pride in their professions and be accountable for their actions. Salary should not be their main priority. Ongoing training and enthusiasm instilled in staff by their seniors. Structures must be put in place to ensure that funds allocated for projects and hospitals are spent prudently. Promotions to higher positions should be given on merit and not to friends and family.

**Q4**
No.

**Q5**
Not at this stage. Might emigrate if children emigrated and medical care becomes problematic and standards drop.

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### Pvt 12 (nurse)

**Q1**
Stopped caring for patients properly - Depletion of medical aid, understaffing and lack of experience by some nurses. Proper training is a huge problem.

**Q2**
Will place extra stress on nurses that are already overworked. The lack of properly trained staff is going to be a huge problem.
### Q3
Proper training Better salaries. More staff that are trained. To put better motivations out for staff to perform.

### Q4
Yes. xxxx. Supposed to be there for xxx years, but was back in South Africa after xxx months. The people there are rude and very self-centred. The isolation I experienced was the worst. The big difference in culture was also a huge barrier.

### Q5
No, never again.

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<tr>
<th>Pvt 13 (nurse)</th>
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<tr>
<td><strong>Q1</strong></td>
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<tr>
<td>Hierarchies rather than interdisciplinary teams e.g. medical practitioners are not recognising and expertise of other HCPs such as nurses Time can be saved by improving nurses' skills. Nurses have a tendency to want to improve themselves just for financial rewards. Few see Nursing as a 'calling' rather than a 'job'. Unwillingness of gov nurses to pay for upgrading their knowledge.</td>
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<tr>
<td><strong>Q2</strong></td>
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<tr>
<td>No incentive for anyone to 'go the extra mile'.</td>
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<tr>
<td><strong>Q3</strong></td>
</tr>
<tr>
<td>A managed care system should be used across the health care system especially for chronic disease management. People should have the right/power to self-care i.e. to take some responsibility for their own health. Some health care workers are in it for their own enrichment and will do the minimum care possible. Gov sector should keep specialised people where they are most valuable and not move them around. Diabetes management should be recognised as a specialisation in South Africa, Interacted daily with doctors across the world dealing with diabetes.</td>
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<tr>
<td><strong>Q4</strong></td>
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<tr>
<td>Yes. xxxx 2 weeks in special clinic. xxxx NHS system not much better than our health department - patients treated as 'sausages in a machine'. Recently completed a xxxx in (specialty) management through xxxx university. All three South African nurses completed the course with distinction. Attended many conferences, courses and meetings internationally SA private sector we can hold our own but in the state sector a trend of mediocrity seems the norm.</td>
</tr>
<tr>
<td><strong>Q5</strong></td>
</tr>
<tr>
<td>No. Will only to go to possibly xxxx for short courses. Feel positive about the future of South Africa. People should be encouraged to strive to improve themselves, financially, health wise, and education.</td>
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<tr>
<td><strong>Q1</strong></td>
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<tr>
<td>Society doesn't understand that there are other health practitioners except doctors. Whoever provides health service is a “doctor”. Need to change that perception. Team practices don’t exist in private, maybe in government. Each person doing own thing. We need a body – to comply and work as a team Try and reduce length of time in hospital. Various problems - long queues, clinic not well equipped, no ambulances Govt. can be do better in public health care</td>
</tr>
<tr>
<td><strong>Q2</strong></td>
</tr>
<tr>
<td>I am not sure</td>
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</table>
Q3
Improve clinics. Improve gov. hospitals. Invest in all the health care professionals, e.g. bursaries to all disciplines Promotion of career guidance in schools

Q4
No. Seen xxxx (foreign country) children

Q5
No.

Pvt 15 (dietician)

Q1
Public sector is under resourced - patients get poor service. Private sector is not regulated, resulting in patients being overcharged e.g. staying in hospital for longer periods than is needed, getting unnecessary consultations. Motivated medical practitioners who want to work in the public sector do not get sufficient recognition e.g. suboptimal salary packages. Medical practitioners do not respect or value the opinions of other health care professionals especially nursing staff – no ‘multi-disciplinary team’. Medical practitioners do not communicate with the patients at all. Referrals to other health care professionals are not based on ‘who can do the job best’ but rather given to friends.

Q2
Theoretically a good idea, but practically the public sector does not have the infrastructure in place to support such a move.

Q3
Offer staff better incentives to go back to the public sector Improve care at a ‘grass-roots’ level i.e. at the clinics. Better supervision and mentorship in the public sector. Setting up to ‘prevent’ rather than cure e.g. annual review services for diabetic and cardiac patients. Growth monitoring and promotion and immunisation must be done more effectively Performance of staff must be regulated better, e.g. medical practitioners must be in the wards/consulting not running lucrative private practices.

Q4
Yes. xxxx – 2 years xxxx in (xxxx) unit
xxxx – 2 years general ward work, (speciality) annual review service, xxxx at health care practitioner surgeries

Q5
Yes. Would like to live in a country where my opinion as a health care professional counts and is respected. In other countries more opportunities for professional development. Would prefer not to work in private sector, but forced to since experience outside of South Africa as well as teaching experience not recognised.

Pvt 16 (medical practitioner)

Q1
Big division in the health care systems Private: Relatively well organised Is a business, with all associated financial, procurement, staff, administrative, tax etc. demand and stress. Public: Too many patients, lots of pathology with very limited resources Big problem is low efficiency of the Public health care institutions, poor management, and lack of empathy from many health care practitioners. There is a trend to work as little as possible, if there is no pressure from management or supervisors.
Q2
Ideal solution would be difficult as there are lots of sick people, not enough budget from the government and high unemployment. Way forward would be a slow and gradual involvement of the private sector and privatisation of some public hospitals. Will only work if medical practitioners receive a corresponding fee for service. The government will probably pay less to send the patients to private health care providers and pay a fee for service. Some of the Public hospitals cost huge amount of money to run and have low efficiency.

Public hospitals have no real incentives to attract good specialists. Should introduce such incentives. Public hospitals are getting too politicised and unionised. New health care system should expand the Private sector and involve more private practitioners in the public care

Q3
Integrate partially public and private sector, by relaxing the rules and regulations Negotiate service at lower fees for public patients in private facilities. Make attractive conditions for private medical practitioners to work sessions in public hospitals. Create strong politically independent management of public hospitals. Appoint competent managers in Public hospitals and give them more disciplinary power Allocate more funds for primary health care and utilize the funds wisely. Relax the registration process for well-qualified foreign medical practitioners. Establish joint ventures with powerful overseas medical institutions and create local branches. Bring foreign specialists in the public sector on a rotational basis

Q4
Yes. Every system, where medical practitioners are underpaid or over regulated is deemed to be fail. Medical fraternity is in demand all over the world and good specialists are sought after Systems that are efficient have a way to stimulate the remuneration of medical practitioners. The efficiency of systems where medical practitioners are paid a flat or low salary is doomed to failure.

Q5
No. South Africa is a beautiful country, good people and wonderful landscapes and climate. Need to make this country united and use our resources to the maximum. Need more democracy, less politics, good politicians, strong private sector, better education and a better health care system.
Summary of public and private health care practitioners' positive or negative responses to five open-ended questions with all identifying information removed to protect respondent’s identities

N = negative
P = positive

A. Public

Question 1: How are you experiencing the current health system?

Public negatives
1. No space, crowded. Overcrowded in facilities/lack of space
2. Poor facilities
3. Equipment defective, malfunctioning, substandard, insufficient
4. Poor management/resource allocation/responsibility
5. Unproductive staff/lack of accountability
6. No supervision of staff
7. No standardisation/protocols/teamborke/forcing poor practices onto patients
8. Understaffed/overworked/underpaid/demotivated staff
9. Poor communication/unsatisfactory reporting channels with management and district level upwards/management out of touch with what is happening ‘on the ground’
10. Politics interfere with health system
11. Autocratic health department leadership
12. Insufficient resources
13. Not given financial help to upgrade knowledge or sufficient training
14. Medical facilities in rural areas are insufficient and difficult to access
15. Corruption/mismanagement of funds
16. Abused by patients/feel unsafe
17. Patients have no freedom of choice
18. Certain services not functioning properly, e.g. ambulances, clinics
19. Equipment supply tenders given to friends not handled professionally
20. Medical practitioners do private work and neglect hospital work

Public positives
1. Like helping people in need
2. Challenging with new technology
Question 2: What are your views about the proposed changes within the health care system?

Public negatives
1. System will be dysfunctional and serve government, not people
2. Lack of information about the system from the government difficult to express an informed opinion
3. Another ploy by government to get more money through taxes
4. Rather optimise resource allocation and minimise wasteful expenditure
5. Forced to pay for something you never use
6. Effort by government to control health care costs
7. Health care system might be overloaded
8. Doubtful whether managers can carry out proposed changes
9. Good policies, but problem with implementation (nothing will change soon and policies will never work)
10. Should rather plan ahead and set training and staff targets
11. Changes can only be implemented with better infrastructure, more motivated staff and less staff shortages
12. Rather have basic equipment available before introducing changes

Public Positives
1. Better access to health care for poor
2. Medical aid not dependent on having a job

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

1. Give more credit and recognition, where it is due (more incentives for staff to perform well
2. Better pay and working conditions
3. Better management of patients
4. Better equipment and management of the equipment purchasing(bidding procedure) and delivery process
5. More awareness campaigns that prevent diseases
6. Better resources allocation and management
7. More focus on efficiency and responsibility
8. Detailed management of leave time
9. More involvement of management at grass roots level and less ‘cupcakes and tea’
10. Better organisation of medication delivery to patients (e.g. drop at clinics and transport for pensioners in rural areas)
11. Improve referral system between the primary, secondary, and tertiary hospitals
12. Review standards and protocols
13. Help for health care staff who want upgrade their knowledge
14. Better facilities for families of staff (day care centre, accommodation near hospital)
15. Good communication with staff concerning grievances
16. Take steps to prevent overcrowding of health care facilities
17. More facilities (hospitals, clinics, ambulances)
18. Cultivate a team spirit among health care staff (better teamwork)
19. More training and education of staff (courses, workshops)
20. Motivation of staff (need to realise the importance of their jobs)
21. Make sure staff are safe

Question 4: Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

No - Pub1, Pub3, Pub5, Pub6, Pub7, Pub8, Pub9, Pub10, Pub11, Pub12, Pub13, Pub15
All – no

Question 5 would you consider leaving South Africa and if so, why?

yes - Pub3, Pub5, Pub7, Pub8, Pub12, Pub13 - 6
no - Pub1, Pub6, Pub9, Pub10, Pub11, Pub15 - 6

Public reasons for ‘yes’
1. In the event of economic and political collapse e.g. like Zimbabwe
2. Will leave temporarily for work reasons
3. Leave to experience something different
4. Better pay
5. No future for next generations
6. Travel, broaden knowledge, experience different cultures

Public reasons for ‘no’
1. Love country and people
2. Face challenges and not accept that things will never change
3. Stay for sake of family not pay
4. Leaving will make health care system worse

B Private

Question 1: How are you experiencing the current health system?

1. Practice less viable for work outside private hospitals
2. Private health care expensive and cost increasing
3. Private sector under financial pressure
4. Difficult to plan financial future
5. Private health care generally good
6. Medical aids delays in giving authorisation/making payment/limitations in payment for health services
7. Difficult to explain medical aid issues to sick people
8. Happy to work in private sector
9. Rates charged not standard for all areas of residence
10. Differences between public and private sector health care
11. Patients have freedom of choice
12. Private health care run as businesses and therefore, financial issues can become more important than patients
13. Role of primary health care clinics
14. Perception that only doctors are involved in health care
15. Private sector not regulated - over charging and non-essential services
16. Politics and unions play too big a role in public hospitals

Question 2: What are your views about the proposed changes within the health care system?

Private negatives

1. Given population size and disease burden it is ambitious, morally defendable, but totally unattainable (do not have infrastructure) and unrealistic
2. Implementation and management thereof beyond the government’s capabilities
3. Too few will have to pay for the many with too many needs
4. Will worsen a poor situation; none of the real problems are addressed
5. Police supply chains and measure performance of health care workers in terms of patient outcomes
6. Simpler, cost-effective, and efficiently run NHI
7. Changes not well communicated. Health care professionals need to be better educated about NHI and motivated about its implementation
8. Will fail due to inefficiency (not easy to offer by state) and inequality
9. Government should first manage their many hospitals properly
10. Will be very expensive to the taxpayers
11. Training staff and extra stress on existing staff
12. No incentives to do a good job
13. Slow changes with gradual involvement of private sector
14. Rather send the patients to private health care providers and pay a fee for service

Private positives
Motive is good – want to bring service to those who need it

Question 3: What suggestions do you have to improve the health care delivery system in South Africa?

1. Involvement of more private practitioners in public health service
2. Use money more efficiently
3. Address rampant corruption, mismanagement, and misappropriation of funds
4. System should become far more effective, well planned and managed
5. Decentralise ordering and buying of equipment
6. Measure performance of health care workers in patient outcomes not in hours spent at work
7. Report failure to perform professional duties to professional bodies
8. Training of doctors should revert back to the six-year course and hospital associated nursing colleges should be reinstated
9. Leave politics out of health care. Create strong politically independent management of public hospitals
10. Have clean linen and equipment
11. More training in management and ethics
12. Greater number of medical professionals produced annually so that all the institutions have enough staff
13. Health care staff should have interests of patients at heart all the time (take pride in their work and be accountable for their actions). Enthusiasm instilled in staff.
14. Managers should prevent fraud and corruption.
15. Parents made responsible and accountable for their children
16. All children should be taught basic hygiene
17. Primary Health Care Clinics should be accessible and available to all. Allocate more funds for primary health care and utilise the funds wisely
18. Structures put in place to ensure that funds allocated for projects and hospitals are spent wisely
19. Promotions to higher positions should be given on merit not to family and friends
20. Staff motivated to perform duties well
21. State sector management of staff with specialised skills (use where they are most needed)
22. Teach people to take responsibility for their own health.
23. Managed Care System especially for chronic disease management Specialised topics, e.g. diabetes, nursing
24. Career guidance in schools
25. Better care at clinics
26. Better supervision and mentorship in the public sector
27. 'Prevent' rather than cure
28. Growth monitoring and promotion and immunisation must be done more effectively
29. Regulate staff performance
30. Partially integrate public and private sector
31. Make attractive conditions for private doctors to work sessions in government hospitals
32. Appoint competent managers in public hospitals and give them power that is more disciplinary
33. Relax the registration process for well-qualified foreign medical practitioners
34. Establish joint ventures with powerful overseas medical institutions and create local branches
35. Bring foreign specialists in the public sector on a rotational basis

Question 4 Do you have any experience in your field outside of South Africa? If you do, please discuss your experience.

Private no - Pvt1, Pvt6, Pvt7, Pvt8, Pvt9, Pvt10, Pvt14 - 6
Countries: UK (3), Scotland (1), Wales (1), USA (1), Saudi Arabia (1)

Overseas work experience

1. Health care systems in UK and USA work well. By and large health care workers and patients are satisfied
2. UK NHS is overburdened and abused by the public
3. Isolation and cultural difference
4. UK NHS system not much better than SA Health Department
5. xxxx work in Scotland and Wales.
6. Medical practitioners must be paid proper salaries (no flat or low salaries). Else system will fail.
7. Efficient systems stimulate remuneration of medical practitioners.

Question 5: Would you consider leaving South Africa and if so, why?

no - Pvt6, Pvt7, Pvt9, Pvt12, Pvt13, Pvt14, Pvt16 – 7
yes - Pvt1, Pvt3, Pvt5, Pvt8, Pvt10, Pvt15 - 6

Private reasons for ‘yes’

1. Ability to earn decent living in the HC sector is severely threatened by unattainable and unrealistic government HC policies
2. When society becomes unstable
3. More political stability, better remuneration, shorter working hours
4. If family emigrate and medical care becomes problematic and standards drop
5. Leave to conduct short courses in neighbouring countries e.g. Zimbabwe
6. Live in country where opinion as a health care professional counts and is respected
7. Professional development
8. To get recognition for experience outside SA

Private reasons for ‘no’

1. Everything not always better overseas
2. Live in a beautiful, diverse country
3. Negative overseas working experience
4. Feel positive about South Africa’s future
5. Help utilise South African resources
6. Help make South Africa a better country (more democratic, less politicised, good
politicians, strong private sector, better education and health care system)

Descriptive statistics – age, gender, religion, language, overseas experience and intentions to leave South Africa

Table 15
Mann-Whitney test for comparing public and private sector ages

<table>
<thead>
<tr>
<th>Sector</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>12</td>
<td>9.42</td>
<td>113.00</td>
</tr>
<tr>
<td>Private</td>
<td>14</td>
<td>17.00</td>
<td>238.00</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16
Test Statistics

<table>
<thead>
<tr>
<th>age</th>
<th>Mann-Whitney U</th>
<th>Wilcoxon W</th>
<th>Z</th>
<th>Asymp. Sig. (2-tailed)</th>
<th>Exact Sig. [2*(1-tailed Sig.)]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35.000</td>
<td>113.000</td>
<td>-2.524</td>
<td>.012</td>
<td>.011</td>
</tr>
</tbody>
</table>

a. Grouping Variable: sector

z = -2.524 with p-value = 0.011. As can be seen from the test result and the table below, the mean age of private sector participants is significantly greater than that of public sector ones.

Table 17
Mean and standard deviation of age

<table>
<thead>
<tr>
<th>Sector</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>32.17</td>
<td>12</td>
<td>10.223</td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td>45.64</td>
<td>14</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-------</td>
<td>----</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>39.42</td>
<td>26</td>
</tr>
</tbody>
</table>

**Table 18**

*Gender per sector*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Sector</th>
<th>Public</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>female</td>
<td></td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
</tbody>
</table>

Over 70% of the participants are female.

**Table 19**

*Religion*

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>19</td>
<td>90.5</td>
</tr>
<tr>
<td>Hindu</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

5 participants did not indicate their religion.

**Table 20**

*Language*

<table>
<thead>
<tr>
<th>Language</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrikaans</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>English</td>
<td>11</td>
<td>42.3</td>
</tr>
<tr>
<td>Xhosa</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>Zulu</td>
<td>7</td>
<td>26.9</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table 21**

*Have overseas work experience*

<table>
<thead>
<tr>
<th>Overseas</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>20</td>
<td>77</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100</td>
</tr>
</tbody>
</table>

Less than one quarter have overseas work experience. None of the public sector participants has overseas work experience.
### Table 22

**Will consider leaving South Africa versus language**

<table>
<thead>
<tr>
<th>Leave SA</th>
<th>Afrikaans</th>
<th>English</th>
<th>Xhosa</th>
<th>Zulu</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>26</td>
</tr>
</tbody>
</table>

The numbers that intend to, and do not intend to leave South Africa are almost equal. There is no evidence that the language of the respondent plays a role in the decision to leave (chi-square = 0.525, p-value = 0.913).
Addendum R: NVivo Qualitative Analysis

Table 23
**Key issues: experiences**

<table>
<thead>
<tr>
<th>Emerging issues</th>
<th>Mentions</th>
<th>Public n=12</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male n=2</td>
<td>Female n=10</td>
<td>Male n=5</td>
</tr>
<tr>
<td>Understaffing resulting in poor service delivery</td>
<td></td>
<td>2</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Lack personal development</td>
<td></td>
<td>1</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Insufficient equipment</td>
<td></td>
<td>1</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Negative attitudes of senior staff towards subordinates and patients</td>
<td></td>
<td>1</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Health facilities are overcrowded</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Limited teamwork resulting in poor intra and inter-departmental communication</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Lack of accountability</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Poor remuneration</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expensive health services</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Poor resource planning and distribution</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Irregular supply of utilities (water, electricity) as well as the often</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>experienced dysfunctional sewage system and poor ventilation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Politics</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lack of staff capacity development</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unsafe workplace environment</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Q2. Views about the proposed changes within the health system

Table 24
**Views expressed by the public and private health care personnel studied**

<table>
<thead>
<tr>
<th>Views</th>
<th>Public</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male n=2</td>
<td>Female n=10</td>
<td>Male n=5</td>
</tr>
<tr>
<td>The poor will have better access to health care</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>It will never work; will worsen the current</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>already bad situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Rating</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Public sector does not have the infrastructure in place to support such an initiative</td>
<td></td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Not sure of its impact</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Place extra stress on nurses that are already overworked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motive behind the NHI is good although the changes will take time</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 25
*Views disaggregated by profession*

<table>
<thead>
<tr>
<th>Views about the proposed changes within the health system</th>
<th>therapist</th>
<th>radiographer</th>
<th>medical practitioner</th>
<th>therapist</th>
<th>medical practitioner</th>
<th>therapist</th>
<th>nurse</th>
<th>Dietician</th>
<th>nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The poor will have better access to health care</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>It will never work, will worsen the current already bad situation</td>
<td>3</td>
<td>2</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Public sector does not have the infrastructure in place to support such a move.</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Not sure of its impact</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Place extra Stress on Nurses that are already overworked</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Motive behind the NHI is good although the changes will take time</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

401
Q3. Suggestions to improve the health care delivery system in South Africa

<table>
<thead>
<tr>
<th>Suggestions that emerged</th>
<th>Public</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>More awareness campaigns are needed to promote disease prevention</td>
<td>1</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Institute or strengthen continuous training of health personnel</td>
<td>2</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Improve health care services at grassroots level</td>
<td>2</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Use indigenous languages/vernacular when providing health services, especially in the rural areas</td>
<td>2</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Improve supplies at health facilities (equipment, linen, install fans, windows, air conditioning, gloves, stethoscopes, BP machines, security)</td>
<td>1</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Improve referral system between the primary, secondary and tertiary hospitals</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Increase hospitals and clinics, especially in rural areas</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Provide incentives for staff and better salaries especially for the Public sector</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Increase number of health personnel, especially to cover the rural areas</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Teamwork and communication</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Improve the bidding procedure</td>
<td>-</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Improve resource planning and efficiency in utilisation (of the resources)</td>
<td>1</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Computerise filing system to improve management of patients’ records/information</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Employees to improve their attitude towards work and patients</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Review service charges to make health services affordable</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Abandon sliding scale marking system for exams</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Do away with hospital health, e.g. life care insurances</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>
Q4. Experience working outside South Africa

Table 27
Responses on whether one had worked outside South Africa by the time of this study

<table>
<thead>
<tr>
<th></th>
<th>Total n = 26</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male n=2</td>
<td>Female n=10</td>
<td>Male n=5</td>
</tr>
<tr>
<td>Number of participants who had worked outside South Africa in one’s field</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of participants who had not worked outside South Africa in one’s field</td>
<td>20</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 28
Participants who had worked outside South Africa disaggregated by occupations

<table>
<thead>
<tr>
<th></th>
<th>Total n = 26</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>medical practitioner</td>
<td>nurse</td>
</tr>
<tr>
<td>Number of respondents who had worked outside South Africa in one’s field</td>
<td>6</td>
<td>23.08</td>
</tr>
<tr>
<td>Number of respondents who had not worked outside South Africa in one’s field</td>
<td>20</td>
<td>76.92</td>
</tr>
</tbody>
</table>
## Table 29
**Experiences of those that had worked outside South Africa**

<table>
<thead>
<tr>
<th>Summary of experiences</th>
<th>Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 6</td>
<td>Country</td>
</tr>
<tr>
<td>Experiences of those that had worked outside South Africa</td>
<td></td>
</tr>
<tr>
<td>Experienced good governance system in health care service delivery in both countries. Also learnt a great deal about patient driven health care systems.</td>
<td>UK and USA</td>
</tr>
<tr>
<td>Had a rich experience working in a specialist xxxx unit in Scotland. In Wales, gained experience in xxxx condition including working at the GP surgeries as a xxxx.</td>
<td>Scotland (2 years) and Wales</td>
</tr>
<tr>
<td>Worked in the UK National Health Service as a xxxx. Noted that the NHS is ‘overbur- dened’ and ‘abused by the public’.</td>
<td>UK</td>
</tr>
<tr>
<td>It was a challenging experience working outside South Africa as the respondent explicitly expressed. ‘The grass is not greener on the other side unless it is all about money’.</td>
<td></td>
</tr>
</tbody>
</table>

√
The respondent described the people of Saudi Arabia as rude and self-centred. Found the socio-cultural values, norms, and practices quite different from that of South Africa and as a result, became socially isolated. The difficulty to fit in the socio-cultural framework of Saudi Arabia made the respondent return to South Africa after only 3½ months instead of the planned 2 years.

Observed that the UK NHS performs almost the same as the South African Health Department that is, it is not efficient, and effective as the respondent thought before being in UK. “Patients are treated as ‘sausages in a machine’.” Had a rich experience interacting with doctors from around the world with expertise and experience in xxxx.

Q5. Considering leaving South Africa

Table 30

Q5.1 Responses from public and private participants

<table>
<thead>
<tr>
<th>Response</th>
<th>Public n=12</th>
<th>Private n=14</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>9</td>
<td>15</td>
<td>57.69</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>42.31</td>
</tr>
</tbody>
</table>
Table 31
*Q5.4 Considering leaving South Africa (disaggregated by sex and age)*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>20-30 n=10</th>
<th>31-40 n=5</th>
<th>41-50 n=4</th>
<th>51-60 n=5</th>
<th>61-70 n=2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>therapist</td>
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<td>1</td>
</tr>
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<tr>
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<tr>
<td>medical practitioner</td>
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<td>medical practitioner</td>
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</tr>
<tr>
<td>nurse</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>radiographer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>dietician</td>
<td>1</td>
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<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>nurse</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>radiographer</td>
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<td></td>
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</tr>
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<td>therapist</td>
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</tr>
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</tr>
<tr>
<td>nurse</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Total count</td>
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<td>8</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>