TRANSFORMATION OF SERVICE DELIVERY IN THE WESTCOAST WINELANDS REGION’S HOSPITALS: CHALLENGES AND PROSPECTS

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CHAPTER 1

INTRODUCTION: PROBLEMS OF SERVICE DELIVERY

This research report explores the transformation of service delivery in the Westcoast
Winelands Region's Hospitals. Chapter 10 of the Constitution of 1996 stipulates that
public administration should adhere to a number of important principles including:

"The maintenance of a high standard of professional ethics;
The provision of services impartially, fairly, equitably and without bias;
Responsiveness to people's needs;
The encouragement of the public to participate in policy-making; and
The provision of public services in a way that is accountable, transparent and
development-oriented." (Republic of South Africa, 1996)

The vision of the Constitution led to the formulation of the White Paper on Transforming
Service Delivery (the Batho Pele paper) of 1996. The reason for this White Paper was
to respond to an outdated delivery system that did not meet the needs of ordinary
people. To improve the quality of service and quality of care people received at state
institutions and to let the public have input into the type of services they receive.
Problem Statement

The Winelands Westcoast Region like the rest of South Africa has largely an inefficient, ineffective and inequitable service delivery system. Despite the laudable efforts to transform the health care system since the birth of democratic South Africa in 1994.

The process of transforming service delivery in the Winelands Westcoast Region has been an on-going one since 1998 (When the Batho Pele white paper were gazetted), yet it seems that the various institutions are still in their initial phases and that no progress has been made in the workplace.

HISTORICAL BACKGROUND

The citizens of South Africa, through the emotional scenes that characterized the 1994 elections, indicated their confidence in the ANC as their political leaders and called on them to act in their best interests to improve their lot. Ordinary people saw and continue to see, the political victory as only a first step of a process, which can only have true meaning if it leads to the true and full restoration of their dignity.

Like most departments the department of Health began restructuring in April 1994. This continuous process however has had little success in terms of transformation; for example, the plight of the lower categories worker has to a large extent remained
unchanged. Top down management with white males at the helm is still the order of the
day. Organisations, be they in the public or private sector, will die if they do not
continuously reorganise themselves to meet both internal and external challenges.
Because the environment that we operate in is never static. However, it is true to say
that the pace of restructuring differs depending on various issues, such as the skill of
personnel, the amount of personnel, available infrastructure or lack there off, and so
forth. The frantic pace of restructuring of the last few years were because of the
amount of work to be done to reposition the Department of Health to serve the interests
of the majority of the people of this country.

The reason for the process of restructuring was to respond to an outdated delivery
system that did not meet the needs of ordinary people. A significant portion of the
population has mortality rates and disease patterns similar to developing countries.
South Africa inherited a health care system attuned to meet the needs of a minority
whose disease patterns mirrored those of developed nations. Disproportionately more
resources on hospital based, curative and high technology interventions were spent.
Whilst neglecting primary care services, which would have more impact on the majority,
because of their preventative and early detection element (Pityana, 1997).
The net effect of this was a system in which enormous resources were spent
(estimated at 8.5% of South Africa's GDP in 1992/1993); yet South Africa's health
status indices for the majority were abysmal.
South Africa took pride in the fact that it carried out the first heart transplant in the world, yet seemed indifferent to the many children it sacrificed to preventable diseases such as measles, whooping cough, tetanus and many other curable illnesses.

South Africa also had a system that turned a blind eye to the deaths of black women during the course of pregnancy. One has to ask critical questions of any system that betrays even those critical to the preservation of the human species.

South Africa also trained its health professionals to provide care for disease patterns that are more widely found in the United States of America, the United Kingdom and Canada. It is therefore not surprising that health professionals trained here desert the country and seek greener pastures in these countries whilst the public sector, especially the rural areas of this country, experience a shortage of doctors, dentists, pharmacists, nurses, occupational and speech therapists. The lure of the pound and the dollar has greater appeal to many of these professionals (Pityana, 1997). The medical fraternity now complains at, the then health minister, Dr. Zuma's insistence that they should serve a third world community for one year.

When we look at the statistics pertaining to the intake of medical students at the Universities of Stellenbosch (US) and Cape Town (UCT) from 1990 to 2000, we find that there is a huge disparity in the intake of black (this includes African, Colored and Indian) and white students. At UCT the intake of black students has steadily increased and these students contribute to 60% of the current first year intake. In contrast to UCT
the US intake of first year black students for the year 2000 was only 20% (Die Burger, July 2000).

Looking at the migration patterns of these newly qualified practitioners we find that most of the blacks go into private practice, because they earn more money. Where as most of the white graduates prefer to work for the state, thereby creating the platform for another generation of white male managers within the public sector (SAMJ, 1999).

Another feature that characterised apartheid planning which contributed in no small way to the overall inefficiency of the system was fragmentation. A system of 14 health departments with no coherent co-ordination of their activities was inherited from the previous regime. Even within each of these departments there was a high degree of fragmentation – for example between the old Provincial Administrations and Local Authorities in the case of "White South Africa". It is inter alia against this background that the White Paper on the Transformation of the Public Service (WPTPS) came into being.

In contrast to the previous dispensation, the ANC Government's commitment to reconstruction and development, national reconciliation, democratisation and community empowerment, placed considerable emphasis on the need for the transformation of the public service. Changing it from an instrument of discrimination, control and domination to an enabling agency that serves and empowers in an equitable, responsive, accountable and transparent way to all its citizens. A major
component of the transformation process was the introduction of more equitable, efficient and effective provision of public services to all South Africans.

The paramount importance of what has been highlighted in the 1996 White Paper on Transformation of the Public Service (WTPPS), the Constitution of 1996, the RDP White Paper, GEAR, the Employment Equity Act of 1998, as well as in a number of subsequent policy documents from the Department of Public Service and Administration (DPSA). These policy statements culminated in the 1997 publication by DPSA of the White Paper on Transforming Service Delivery, under the title of Batho Pele or people first, which *inter alia* addresses the improvement of services in an unbiased way to the public.

**Guiding Assumptions**

Due to the disparity of health services in the past, the practice of treating the patient as a disease and not as a human being, is still widely practised at state hospitals. People, whether they are patients at an institution or not, are not treated with dignity and the respect they deserve, but are generally treated as a disease that needs to be cured.

At institutional level it seems that management is unwilling or unable to tackle the new challenges that are part and parcel of the democratic process. It appears that democracy and transparency is lacking, especially with regard to the Batho Pele
process and implementation of the *Batho Pele* principles. In terms of improved service delivery people are still waiting long times and in long queues before they receive treatment. The treatment they receive and the way they receive it reminds one of a factory production line, where they are not treated holistically, but where one part gets assembled at a time. The low morale of staff and their negative attitudes only exacerbates the situation. The lack of democracy and transparency in the workplace together with shortage of staff and lack of resources worsens the situation. Dirtiness at the institutions also contributes to the problem.

**Objectives**

The overall aim and objective of the study is to explore and develop an insight into the policy of transforming service delivery in the Westcoast Winelands Region. Especially, with regard to achieving the set objectives of the policy within the historical and current framework.

It is in this context that this study explores:

i. The impact of transformation policies,

ii. The effectiveness of the instruments and mechanisms established for the purpose of policy formulation, implementation and evaluation. The challenges and constraints.
iii. The progress to date regarding the successes and achievements and also the weaknesses and limitations with regard to implementation and execution and to propose,

iv. Recommendations for the short and long term.

Methodology

The study uses a mixture of qualitative and quantitative methods to gather reliable and comprehensive information.

i. Extensive literature research: This is done to acquire relevant information regarding health transformation in the Western Cape. Of cardinal importance here is the amount of state reports that was used to monitor and evaluate the transformation process. Ranging from minutes of meetings at institutional level to Public Service Commission reports.

ii. Personal interviews: Interviews with experts on transformation issues as well as interviews with transformation representatives and institution heads were done. So as to acquire information that otherwise would have been difficult to come by. This was done to establish a firm grasp of the underlying feelings of managers with regard to the challenges of transparency and democracy that they face in the workplace. The interviews were limited to ten open ended questions to standardize the process.
Although the managers were very reserved with their answers, the transformation representatives at the institutions provided me with valuable information about the challenges of implementation and execution. The interviews were conducted over a sixth month period, from March to September 1999.

iii. Questionnaires: Although the writer himself did not do the fieldwork at all the institutions (only at Stellenbosch hospital), it gives a meaningful and interesting view on the public and the personnel's feeling about the transformation process.

Initially I drafted a Batho Pele questionnaire and handed it out to all personnel at Stellenbosch Hospital to find out what they knew about the process, how they felt about it, how they thought we could accelerate the process and in what way they thought they should be included. The responses were so overwhelming, interesting, insightful and encouraging that we (my colleagues and I on the Regional Transformation Unit) decided to design a needs analysis questionnaire for all of the objectives of the Departmental Transformation Unit. The questionnaires were designed around Customer Service, Management Style, Personnel Issues and the Batho Pele questionnaire (with some minor changes). Due to the relatively small number of personnel at the participating institutions, it was decided to include all employees in the questionnaires. The exception was Paarl Hospital where only one hundred copies of each questionnaire were circulated. The staff involved amounted to a total of 1037. The reason for including all personnel was first to involve them in the process and let them
know that their views were valued. Secondly to really hear what they had to say and how they felt about the process.

Another reason for including all personnel was the huge amount of nursing staff at these institutions. We were afraid that we would not get a balanced view from the personnel if we only chose a certain amount of participants. Therefore we devised different ways of interpreting the results and we looked at the overall results. We looked at the results categorically (within each occupational group) and we looked at the results equated on a percentage basis. The latter two methods were used exclusively at Paarl hospital. With this technique we hoped to identify problem areas or clusters of people who needed some guidance in their responsibilities. This was done over a period of three months, from March to July 1999. The reason for doing the questionnaires over this time-span was for institutions to formulate realistic objectives to implement as quickly as possible. So that the personnel could see change was happening for the better. It also made things easier with the completed questionnaires. We first handed out questionnaires to the nursing personnel and after we received their completed questionnaires we progressed to the next occupational group.

Although there are nine hospitals in the region, two of which are provincially aided and one that is managed by Swartland hospital, only six hospitals were involved in this study. The reason being that these three hospitals were not included in the Regional Transformation Unit and in the transformation of service delivery process at that stage.
There is a huge limitation with the questionnaires because of the various factors that come into play. Due to the group dynamics within the organisation there is always the question of intimidation, of people influencing one another, of blatant sabotage by certain individuals and groups within the organisations. Lack of knowledge of the process would also contribute to the fact that some people would just copy someone else’s answers, as well as illiteracy.

With the interviews the structured questions, even though they are open-ended, could still be non-informative. The possibility of a standardised answer from institution heads is always a possibility. They know each other and meet regularly and might be afraid to expose themselves.

Organisation of Study

The White Paper on Transforming Service Delivery introduced a new chapter in public sector service delivery. It aimed to pave the way for improved quality of care at state institutions. Especially within the ambit of the health sector it was imperative to provide the public not only with the best available care, but also to provide a dignified service. Where the well-being and improvement of the client is central and the patient is consulted and continuously part of the decision making-process.
This study is organized as follows:

Chapter 1.

In this chapter I look at how the health sector in South Africa was shaped and the policie(s) currently in place to change the future of the health sector in South Africa. I also look at the transformation units and their function from institutional level up to departmental level. The problem statement as well as the hypothesis is found in this chapter, together with the objectives of the study and the methodology used.

Chapter 2.

This chapter deals with the literature review and also focuses on the *Batho Pele* White Paper; its vision, mission, aims and objectives and also the mechanisms proposed to reach the set objectives. It also focuses on the five principles of the Health Departmental Transformation Unit, which kick-started the Batho Pele process in the Western Cape’s health institutions.

Chapter 3.

Chapter three deals with the developments to date. We look at the successes and achievements as well as weaknesses and limitations in implementation and execution of transformation programmes.
Chapter 4.

Chapter four focuses on the challenges we face and our prospects for the future.

Chapter 5.

Chapter 5 concludes the study and suggests recommendations for the short and the long term.
CHAPTER 2

SERVICE DELIVERY POLICIES IN POST APARTHEID SOUTH AFRICA

This chapter deals with the theoretical conceptualisation that underscores the work done by this researcher and also relates to the policy framework that lead to the policy on transforming service delivery in the public service. I also look at the structures from institutional level to departmental level, as well as their various roles and functions in relation to service delivery.

Literature Review

The transformation of service delivery is an area of great concern in South Africa today. The implementation of the White Paper on Transforming Service Delivery is one of the ways to provide a better health service to all, especially in the Westcoast Winelands Region's hospitals. Existing literature suggest that although there are improvements of service delivery to a certain extent, there are still acute issues that need to be addressed. A better life for all cannot be achieved with poor health care services.

Policy-Legislation

The Constitution of the Republic of South Africa (Act 108 of 1996) is the supreme law of South Africa and consequently provides guidelines regarding the improvement of

14
service delivery. Chapter 10 of the Constitution stipulates that public administration should adhere to a number of important principles including:

a) The maintenance of a high standard of professional ethics;
b) The provision of services impartially, fairly, equitably and without bias;
c) The efficient, economical and effective utilization of resources;
d) Responsiveness to people's needs;
e) The encouragement of the public to participate in policy-making;
f) The provision of public services in a way that is accountable, transparent and development-oriented.

The Reconstruction and Development Program (RDP) formed an integral part of the first democratic elections in South Africa in 1994, with its main objective the implementation of basic human rights. The RDP identified the meeting of basic needs of all citizens through more effective service delivery as one of five key programmes of the RDP. The basic needs of people extend from job creation, land and agrarian reform to housing, water and sanitation, energy supplies, transport, nutrition, education, health care, the environment, social welfare and security. Therefore government programmes needed to be effectively integrated, co-ordinated, outcomes-oriented and people-driven to meet these needs.

Whilst the need to meet these basic needs through improved service delivery can be justified on social and moral grounds alone, especially in the light of the country's past
history, the RDP stresses that there are additional imperatives. These relate in particular to the ways in which service delivery can help to provide the necessary infrastructural support to open up previously suppressed economic and human potential in both rural and urban areas. Leading in turn to community empowerment and an increased output in all sectors of the economy.

The White Paper on the Transformation of Service Delivery (WPTSD) of 1995 sets out to establish a national policy framework to guide the introduction and implementation of new policies and legislation. Aimed at transforming The South African public service in line with the following vision and mission.

"The Government of National Unity is committed to continually improving the lives of the people of South Africa by a transformed public service which is representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of all." (WPTSD, par. 2.1)

"The creation of a people centred and people driven public service which is characterised by equity, quality, timeousness and a strong code of ethics." (WPTSD, par. 2.2)

The vision and mission statements were premised on a fundamental re-definition of the role of the state and its relationship with civil society. Based on partnerships between them rather than the antagonistic relationship that had prevailed in the past. They were also premised on a major shift from the former mechanical model of public and development administration (with its emphasis on centralisation, hierarchy, the procedural observance of rules and regulations and insolation from the public) towards
a more organic, integrative and adaptive model of co-operative governance with the public.

The White Paper on Transforming Service Delivery (Batho Pele), published in 1997, identified and suggested ways of operationalising eight key principles of service delivery.

- 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.
- 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.
- Access and entitlement – all citizens should have equal access to the services to which they are entitled.
- Courtesy – in the provision of services, public employees should at all times treat their clients and customers with courtesy and consideration.
- Information – citizens should be given full and accurate information about the public services they are entitled to receive.
- Openness and transparency – citizens should be informed how national and provincial departments are run, how much they cost and who is responsible and accountable.
- Redress – if the promised standards of service delivery are not met, citizens should be offered an apology, a full explanation and a speedy and effective redress.
• Value for money – public services should be provided economically and efficiently in order to give citizens the best possible value for money.

In aiming to enhance public service delivery, the White Paper acknowledges the need for a fundamental management shift to a culture of public service or “people first” (hence the subtitle of the document, Batho Pele, which is the Sesotho term for people first). This includes assignment to individual line managers of the responsibility for delivering specified results for a given level of resources, matched with managerial authority for decisions about resource use. Requiring the delegation of managerial responsibility and authority to the lowest possible level. With transparency surrounding results achieved and resources used.

In order to facilitate the implementation of policies initiatives like Batho Pele, the Department of Public Service and Administration issued the new Public Regulations in 1997. These regulations specify (in part III [C]) that the executing authorities (Ministers/MECs) of all national and provincial departments shall establish and sustain a service delivery improvement programme for their departments that must include:

• A list of the type of actual and potential customers and the main services provided to them.

• The existing and future consultation arrangements with the department’s customers and potential customers.
• The customer's means of access to these services, the barriers to increased access, and the mechanisms or strategies to be utilised progressively to remove the barriers so that access to services is increased.

• The existing and future service standards for the main services provided.

• The existing and future arrangements on how information about the department's services is provided.

• The current and future complaints system of the department.

All departments and organisational components of government will be required to publish an annual statement of public service commitment, which will contain the department's service standards that citizens and customers can expect. With an explanation on how the department will fulfil these standards. They will also be required under part III (E) of the regulations to align their core objectives and functions, organisational structures, budgets and staffing in line with service delivery needs.

The key principles of improving service delivery entails customer participation, transparency regarding the process, creativity, responsiveness to the need of customers (internal as well as external), precautionary measures, benchmarks, capacity building, as well as concern for the future. (Small and Kleynhans, 1999: 2)

Improving service delivery does not merely entail providing signboards in the three official languages of the Western Cape, but should be a continuing process that speaks to the core of the client’s humanity. Hospitals must be places where people are treated
with respect, deference and dignity. People should not be treated as mere objects and feel intimidated and therefore fear attending institutions. A warm, welcome environment needs to be created where clients feel at home.

They should be comfortable and free to ask questions, query actions and voice their opinions with no fear of bias or reprisals. A place where people know that they will receive the best possible treatment in the quickest possible time by the most skilful practitioners. The aim therefore is to change the current situation where customers are treated more as a disease than a human being, where public servants serve with a factory-line mentality, and where service institutions is a place where you can spend your whole day waiting for service delivery. (Small and Kleynhans, 1999: 3)

The fact that policies are affected upon people means that the change-inducing process is often punctuated by the dialectical relations of power of either co-operation/resistance, compromise/intransigence, consensus/dissent, profoundly affecting both the pace and scope of change at an institution and in society at large (Williams, 2000: 170). For example in the case of health institutions, with the implementation of the transformation policy the argument from personnel was that they were already employing these practices and felt that management was putting a further burden on their shoulders due to vested interests, citing that their workload is to be increased to accommodate the shortage of staff.
Therefore the scope and pace of change in South Africa are also determined by the extent to which public institutions adjust to and also comply with the current directives of transformative planning. Since the dawn of time, social relationships are based on a specific ethos and logos, culminating ultimately in specific institutional practices. (Williams, 2000: 170)

Here it is important to cite two cases where institutional practices contradict national policy. With regard to the Employment Equity Act of 1998 that promotes affirmative action appointees at management level to previously disadvantaged groups, we still find that top management (Medical superintendent, Assistant director of Administration and Nursing) still heralds from the old regime: white, over forty and mostly male. Since the inception of this act there has never been a black appointee to the aforementioned positions at any of the Westcoast Winelands regions hospitals, with the exception of temporary Medical superintendent positions at some institutions. Even when one looks at middle management it is still overwhelmingly white and set to stay this way for years, because no one can be dismissed. The other loophole is that white females are also considered to be previously disadvantaged and this loophole is lavishly employed within the region.

Another example is the skills development Act that has been promulgated in 1998, up till now there has never been an intervention from management to implement this law. To engage lower category workers in training to empower them and enhance their skills and thereby making a fallacy of government policy and even laws.
Williams provides us with a historical perspective on why the implementation of a transformation policy will be difficult with the following words:

"...in view of the unequal relations of power bequeathed upon South Africans by the apartheid state, the vested interests accumulated through a differentiated, racialized social order serve as a structural constraint in changing institutional practices. Thus, institutions often defy as opposed to comply with prevailing regulations and codes of conduct that seek to facilitate forms of behaviour/relations of power that, for example facilitate the provision of equitable services, especially to historically neglected communities."

In this instance one can refer to the lack of finances for the transformation of service delivery process and this together with opposing organisational influences are the two main constraints impeding the successful implementation and progression of service delivery in the Westcoast Winelands Region. Section 196(4) of the Constitution of the Republic of South Africa gives the Public Service Commission a very specific mandate and that is to propose measures to ensure effective and efficient performance in the public service.

The Public Service Commission (1999) conducted a survey in the Western Cape Province to determine the progression of the implementation of the Batho Pele principles. In the Westcoast Winelands Region the institution they visited was Paarl hospital. The evaluation report, to sum it up in one sentence as the media did at the time the report was publicised, was that “the western Cape was only paying lip service to transformation of service delivery”, meaning Paarl Hospital received a poor report. The conclusions drawn were that customers were unhappy with the services rendered. Inter alia, waiting times were still unexceptionally high, civil servants uncourtely and rude
and complaints were brushed off. Furthermore the survey determined that customer’s basic human rights were violated.

The challenge of learning and change requires more than rationality. It includes the development of emotional, relational and political abilities by mainstream programs of education. Therefore engagement with the emotions and relations generated by organising stimulate anxiety and the defences that are mobilised in these circumstances can quickly become highly significant organisational barriers to learning and change (Vince and Broussine, 2000: 16). They continue by arguing that the desire to change or not to change can be attributed to learning as a political and personal experience within an organisation.

Although it is evident that various studies have been conducted regarding transformation of service delivery, it seems political will coupled with accountability within an institution is the mainstay in pushing forward to achieve the set objectives of the Batho Pele White Paper in transforming service delivery. Therefore the study will look at what has been achieved to date and what needs to be done to achieve the set objectives.

Transformation

Service delivery involves strategic plans, which in turn is predicated upon an interpreted approach to human development. It is within this broad theoretical
framework that the concept “transformation” derives its specific meaning in the South African context.

Transformation as a concept is central to social change in South Africa. Meaning that it impacts directly to the extent to which there is a structural shift from the dominant, exclusionary relations of power of successive colonial-cum-apartheid regimes to the more equitable, inclusive dispensation of the “new” South Africa. (Williams, 2000: 168)

What is transformation? There does not seem to be consensus around the concept of ‘transformation’. The perception of the transformation process differs considerably. There are, for instance, those who believe the change to be adequately reflected in a representative workforce. While on the other hand, there are those for whom change refers solely to service delivery. Trade offs seem to occur when a number of things are done at the same time – like transforming the culture of the workplace (and work) as well as attempting to provide an effective service. In the desire to satisfy the latter, little emphasis is given to issues of internal change or aspects of the organization culture. In which case the creation of an enabling environment, conducive to transformation, is not a connecting theme (ANC, 1998). In the eyes of these officials the transformation process is seen as a diversionary activity that interferes with the real job. In the eyes of those who do not share their views it is seen as a forfeited opportunity for them to understand the extent and complexity of the transformation process.
Many respondents within departments however, do have a deeper and more complex perception of transformation, regarding it as a process that unfolds over time. Which proceeds according to a strategic objective that has as its aim the transformation of the organisational culture of the department, one that would democratised the workplace and ultimately improve service delivery.

The Batho Pele paper sets out definite guidelines for monitoring and evaluation structures from national to departmental level. This resulted in the establishing of the Health Departmental Transformation Unit (DTU) in the Western Cape, which gave the mandate to the regions to establish Regional Transformation Units (RTUs). Subsequently the RTUs was mandated to establish Institutional Transformation Units (ITUs) at all institutions under the jurisdiction of the specific region’s Regional Director (See fig. 1 on p. 26). The function of the ITUs was to facilitate and coordinate the transformation process at institutions as well as to monitor, evaluate and advise on relevant issues. The fact that the ITUs had no executing power made it imperative for management to be very well represented on this committee. In practice these institutional committees not only functioned as evaluating bodies, but also had to formulate action plans and were held accountable, by institutional management, for the implementation and execution of it.
Transformation at institutional level has been an ongoing process since 1997 and it culminated in a workshop in October 1998, where the DTU identified four principles as the basis for transformation of the Department of Health in the Western cape, including the eight principles of Batho Pele.

These four principles: Service delivery, Management Style, Personnel Issues and Communication, that were identified by the departmental transformation Unit had attainable objectives, which were considered a starting point for institutions (Refer Appendix A).
Functions of Transformation Units

Transformation Units (TU's) report directly to the head of the organisation or department and have no executive powers. They only have an advisory function and do not have any executive authority, nor do they take over the responsibility of line functions. They are however, empowered to call for information required to make recommendations for transforming policies and practices, and to monitor, evaluate and report on the transformation process at institutions. This does not preclude the head of the organisation investing the TU from time to time with the authority to carry out specific tasks. The main functions of the TU’s are to:

- Initiate transformation activities, change management processes and programmes at their institutions.

- Make recommendations to the head of their institution on issues relating to transformation goals.

- Monitor, evaluate and report on the transformation process and report to the head of the institution and to the Regional Transformation Committee.

- Ensure that transformation objectives are integrated into the departments strategic business and operational plans at institutional level.
• Report to the regional and provincial co-coordinating committees on a regular basis.

• Report developments on transformation within departments to the public on an annual basis.

In establishing the regional transformation unit, each institution in the region had to elect a representative. As the election of the representatives was a transparent and democratic process, the elected members were mainly chosen from the worker ranks. The principles of Batho Pele together with the four priority areas from the DTU formed the crux of transforming service delivery at institutional level. Obviously this led to many challenges at institutions. After the initial information sessions where everyone was informed of the latest policy, the most important issue was the establishing of an Institutional Transformation Unit to coordinate the whole process. This was and still is a challenge at many institutions. Due to the fact that the White Paper does not give validity to acknowledge this structure, institutional management does not take it seriously, although they are well represented there. This led to the lack of implementation of this policy.

Therefore it seems that management only “pays lip service” to the whole process and does not support or give the unit the necessary resources and authority to execute comprehensible plans for improving service delivery. There could be many reasons for this behaviour, the fear of change, lack of clearly defined roles and responsibilities, lack of commitment and financial constraints. Due to our apartheid past, management is still
pure white and mostly male and over forty years of age. This presents another challenge within the realm of fear of change. People's fear of losing 'power'/control through democracy and transparency. The fear of being exposed to the extent that it is clear that everything is not well at the institution and the fear of being challenged by worker representatives. Thus it brings us to the question of resistance to change where management deliberately sabotages the process.

A cardinal issue from the worker side is the 'I don't care' attitude, where workers argue that they are already applying the Batho Pele principles in their daily tasks. The fact that they are under-staffed and overworked with very few resources also contributes to the problem. At the Regional Transformation Unit of the Winelands Westcoast Region on the 6th of June 2000, the feedback reports handed in by the different institutions showed poor or no progress. The question asked was, "What are the obstacles we face in achieving our goals of improved service delivery, democratisation of the workplace, empowerment of the community and personnel, representivity of the personnel corps, transparency in the workplace and financial constraints?" Was it because of an in executable policy or was it because of ineffective instruments and mechanisms of implementation and evaluation?
CHAPTER 3

THE CONTEXT OF SERVICE DELIVERY TRANSFORMATION

This chapter looks at the policy context of the transformation process, with specific reference to the spheres of government – national, provincial and local. The key role players, the goals, the set objectives and the policy instruments. We also take a glimpse at citizen participation.

Within the context of national transformation, the vision of the government is set out as follows. "The Government of National Unity is committed to continually improve the lives of the people of South Africa through a transformed public service which is representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of all (WPTPS; 1995: 14)."

Therefore the mission statement of the White paper states its aim as: "The creation of a people centred and people driven public service which is characterized by equity, quality, timouseness and a strong code of ethics (WPTPS; 1995: 14)."
The White Paper sets out the following goals:

To unify fragmented health services at all levels into a comprehensive and integrated National Health System;
To promote equity, accessibility and utilization of health services;
To extend the availability and ensure the appropriateness of health services;
To develop health promotion activities;
To develop the human resources available to the health sector;
To foster community participation across the health sector; and
To improve health sector planning and the monitoring of health status and services.

Transformation Processes

The development and implementation of effective policies and strategies to ensure public service transformation, involves a number of key and related processes. These include the following:

The process of *strategic review* entails a comprehensive review and audit of the structures, functions, composition and financing of public service departments and statutory bodies; at both provincial and national levels.

*Policy formulation and performance measures* will be put in place. Whereby priority goals will be broken down into broad realistic policy objectives and targets, as well as
the time frames for their achievement. In obtaining accurate assessment of the progress being made performance indicators or measures will be designed and used. To highlight those areas where improvement or corrective action is required.

Strategic planning and Implementation of policy objectives and setting of targets will be guided through:

- The setting of appropriate, specific and measurable objectives;
- The design and implementation of detailed strategies and action plans for their achievement;
- The mobilization of the necessary resources and their effective utilization;
- The identification of problems and constraints, and strategies for overcoming them;
- The introduction of effective systems for internal monitoring and review (WPTSD.26)

The Monitoring, evaluation and execution of performance management policies are imperative to ensure accountability and the success of the broad process. Internal mechanisms (performance auditing and appraisal) will need to be accompanied by independent external monitoring and evaluation of departmental transformation programs.

The work of all the relevant role players needs to be Co-ordinated. This includes government departments, at national and provincial level, as well as other key transformation agencies.
Communication, consultation and participation are a very important part of the transformation process. Therefore, to achieve its goals the involvement and support of the broad public and the majority of public servants is essential. To achieve this attention will be focused on development of an effective and coordinated communications strategy. That presents a clear, consistent and succinct picture of the vision and goals of the public service. Effective mechanisms need to be established for consultation and involvement of all stakeholders. So they could play a meaningful part in shaping, implementing and monitoring the on-going transformation process.

Research as a part of the continuing processes to Assess the situation is imperative. Areas for research include the following:

- The impact of transformation policies and programs;
- The effectiveness of the instruments and mechanisms established for the purposes of policy formulation, implementation and evaluation.
- Comparative studies of administrative reform processes in other countries.

Policy instruments

The anticipated key role players will be the Ministry and Department for the Public Service, the Service Commissions, Directors-General, Statutory Agencies and the Public Service and Administration Portfolio Committee.
The Public Service Commission is mandated under the constitution to make recommendations, give directions and conduct enquiries regarding the organization, administration, conditions of service, personnel administration, efficiency, effectiveness and comportment of the public service.

At provincial level the Provincial Directors-General (DG's) are responsible for the administration of the province together with the Provincial Premiers and Provincial Service Commissions. The main role of the DG's would be to ensure that the deputy DG's in charge of the various departments, carry out the detailed responsibilities in the transformation process. The White paper does not lay down a set of rules on how they should achieve this.

The transformation in South African society in general and its public service in particular is being driven by the following statutory foundation:

Constitution 1996 (Chapter 2. 10) Chapter 10 stipulates that public administration should adhere to a number of important principles including:

- The maintenance of a high standard of professional ethics;
- The provision of services impartially, fairly, equitably and without bias;
- The efficient, economical and effective utilization of resources;
- Responsiveness to people's needs;
- The encouragement of the public to participate in policy-making;
- The provision of public services in a way that is accountable, transparent and development-oriented.
Skills Development Act, 1998 (Chapters 1, 4, 5, 6 & 7). The purpose of this Act as described in section 2 is basically to develop the skills of all South Africans. To improve productivity and competitiveness and simultaneously improve the delivery of social and welfare services.

Participation

Transformation at institutional level has been an ongoing process since 1997 and it culminated in a workshop in October 1998. Where the DTU identified four principles as the basis for transformation of the Department of Health in the Western Cape, including the eight principles of Batho Pele. These are:

- Customer Service,
- Management Style,
- Personnel Issues and
- Communication. (Refer appendix A)

These principles that were identified had attainable objectives, which were considered a starting point for institutions.

The fact that black communities has been disempowered by the previous regime, mainly lead to the inability of members of these communities to adequately participate in the optimal delivery of their health services. Communities lacked the opportunity to participate in and be part of their own advancement. The apartheid government found it appropriate to encourage dependency and a handout system among communities,
instead of rewarding and enhancing their self-esteem. (De beers and Swanepoel, 1998)

Gilbert (1994) supports this view by maintaining that the failure of the South African state to advance its community development initiatives, could relate into lack of political will and commitment to empower communities. Therefore, the conception is born on the premise that health care entails the community making decisions about the way in which the services are planned, delivered and improved. Owing to their insight into local needs.

Health as a fundamental human right is integral to that of development. In order to make this practical and beneficial to communities, there need to be a meaningful socio-political strategy. Therefore government has a huge role to play in the development process through the creation of an enabling policy, providing expertise, infrastructure and funding.

It is therefore clear that government has a leading role in the broader social development. In order to fulfil this function optimally government needed to reorganize its socio-political and economic structures. Meaning that only through fundamental transformation could the injustices against communities be reversed and thereby recognising real empowerment of communities through change.

In order for optimal transformation to occur in the public service there need to be a meaningful interaction between the government and its citizens (Du Toit, 1997). It is
against this assumption therefore that government has embarked on the transformation of service delivery across the country.

Service delivery *per se* occurs through an organisation and in this discourse the organisations are the Westcoast Winelands Region's hospitals, which are considered bureaucracies of the state. Without expanding on the roles and functions of bureaucracies we will peripherally focus on two aspects of the bureaucracy, the character of policy and obedience.

The responsibility of bureaucrats lies in the quality of their professional service of advice and implementation. They are chosen, not by election to represent, but by appointment for their professional and/or technical skills. Their concern for policy is in its first instance with feasibility – whether it can be implemented and how – more than its acceptability. They take no responsibility for the policy itself. Their responsibility is that of the subordinate, to accept what representatives decide or approve as their instruction. The character of policy can be affected by the manner of its implementation. Lack of clarity in policy goals, whether they are the product of compromise or for whatever reason, will leave considerable leverage for administrators over their interpretation. Even the allocation of inadequate resources to a programme will ensure that decisions on priorities have to be made at the stage of implementation. Or the policy itself may intentionally leave considerable room for administrative discretion. The significance of implementation provides a strong argument for forms of local community representation
in the administration of policy, so that consumers of a public service have a voice in determining the mode of its provision.

A system is more democratic when the socio-economic and ethnic background of top government officials resembles the nation as a whole. Since government officials have power to make or influence political decisions, it is important to safeguard democracy through ensuring that top officials are broadly representative of the nation as a whole (Weber, 1921). Although that currently is the case at national and provincial level, we still have at institutional level management that's incumbents from the previous administration.

Therefore it cannot be regarded as fortuitous that Max Weber developed the conceptual distinction between power and authority in the course of his discussion of organisational structure. He made explicit reference to the theory of minority power in organisations in an early essay on organisations. But while drawing attention to the factors that favoured oligarchy, he stressed that obedience to commands was primarily dependent upon a belief in their legitimacy; a belief that the orders were justified and that it was right to obey (Visagie and Scholtz, 1998). It is from this reference framework where we encounter numerous obstacles in implementing policies, due to the perceived lack of credibility and legitimacy at institutional level.

The apartheid era saw the proliferation of civic organizations that claimed to represent the needs and interests of disadvantaged communities. The ability of citizens to
organise and represent interests who are not adequately represented by political parties has always been difficult. Especially during apartheid when community representatives struggled with access to resources, organisational capacity, access to information and the inability to deal with socio-economic conditions prevalent in their communities. (Reddy, 1996)

Access to information, among all the obstacles, had drastic repercussions for citizens and their ability to effectively participate in governance. For communities to understand the role of government, identify issues and to participate effectively they had to acquire the necessary and relevant information. Under the apartheid system, however, transparency and participation were discouraged while unilateral decision-making by local authorities was encouraged. Consequently most communities were excluded from the process of defining their needs.

Despite the problems around the planning and execution of health services, Dennill et al (1995) insist that community members should play a decisive role in identifying their health needs and priorities. As a major stakeholder in the health care process they need to reach consensus on their contribution towards solving their identified problems. Their role has to complement that of other role players, including the deliverers of service. Together with planning skills communities also need political capabilities. This will enable participants to make informed choices, especially in choosing their leaders and influencing them for positive results. Citizens should be tutored and guided to enable them to utilise the media and election campaigns to advance their aims. While the above
capabilities are imperative for an informed proactive community, it is clear that most people are either apathetic or apolitical. The above skills greatly influence the citizens' ability to participate in communal issues affecting them.

Due to various reasons any meaningful participation of citizens in governance can best occur at the local government level. As local government is the government closest to the people it interacts most often with the communities and thereby increasingly becoming an entry point for public involvement in the process of governance.
CHAPTER 4

SERVICE DELIVERY TRANSFORMATION: PRINCIPLES AND PRACTICES

In this chapter we look at the balance sheet of transformation of health services in the Westcoast Winelands Region since the promulgation of the Batho Pele white paper of 1998. We look at the developments to date, the successes and achievements and the weaknesses and limitations of transformation in the Westcoast Winelands Region hospitals.

Successes and Achievements in Service Delivery

This chapter explores the successes and achievements to date, as well as the weaknesses and limitations experienced since the start of the transformation process. Taking place on a national level as well as in the Westcoast Winelands Region. To bring into context the inability or unwillingness of managers within the region to take the initiative or be creative in improving services at their respective institutions.

Over many decades the vast majority of the South African population has experienced either a denial or violation of their fundamental human rights. Of which even basic health rights has been no exception. In line with the Government's endeavour to instil
fundamental human rights in the South African society, through the Bill of Rights (Chapter 2) as enshrined in the Constitution (Act 108 of 1996) and through its commitment to provide caring and effective services in which health rights are being upheld. The Department of Health has taken the responsibility to introduce a National Patients’ Rights Charter into the national health system.

This Patients’ Rights Charter, published under the auspices of the Public Service Commission of South Africa in 1998, is part of a national strategy to ensure the improvement in the quality of health services at all levels of care. It is to be a standard on patient satisfaction. At the same time it aims to protect the rights to health and health care, increase accountability and transparency, and secure commitment within both the public and private health sectors.

The following brief rights are displayed in a conspicuous manner in all health departments.

Every patient has the right to:

- A healthy and safe environment. Within the system it is impossible to provide such an environment. For example, we treat violent aggressive schizophrenics who can injure themselves by jumping out of second story windows or who could attack fellow patients. A lack of funds contributes to the non-installing of burglar
bars, etc. Because of inadequate facilities they cannot be housed separately from non-psychiatric patients.

Also our full-blown AIDS patients usually share the same rooms and bathrooms with other patients, which increases the risk of transference of bodily fluids, etc.

- **Access to health care.** In this region it's a pipedream. There are 20 Community Health Centres or Day Hospitals in the Westcoast Winelands Region. In Stellenbosch alone we have seven Day Hospitals with five mobile clinics that serve the people between the hours of eight and four on weekdays and are closed on weekends. In doing so they exclude a lot of people who cannot, because of circumstances, attend during office hours.

- **Confidentiality and privacy.** This is a contentious issue that needs to be debated further, especially with regard to stricter enforcement as well as monitoring and training of personnel. When one looks at the breach of confidentiality and privacy cases that has been investigated, it is interesting to note that none of the alleged perpetrators were sanctioned in a meaningful way. Some personnel even escaped without being cautioned.

- **Informed consent.** To the man on the street this is a vague concept. What happens is that the health care practitioner tells the patient what is wrong, how it should be corrected, and ask for consent – how informed it is is always debatable.
• *Be referred for a second opinion.* The only reason why patients are referred at any state institution for a second opinion is that the practitioner is unsure of his diagnosis or does not know what is wrong with the patient.

• *Exercise choice in health care.* It is always difficult to exercise choice of health care if you do not know that any other choices exist. Provided services are not advertised in any manner.

• *Continuity of care.* Due to the current circumstances at state institutions and the poverty that most patients experience, the principle of continuation of care is not always executable.

• *Complain.* Complaining with regard to service delivery is always a very difficult issue to straighten out, because of various reasons. Lack of resources is paramount when it comes to waiting times, etc.

• *Participate in decision-making that affects his/her health.* Participation is only possible if a person has access to knowledge and has the technical expertise to use this knowledge constructively. Historically decision-making has not been a participative process. In fact it has been the mainstay of top-down management. Thus, participative decision-making can only be realised once all parties are knowledgeable to the process. For example, patients in most instances are ignorant of medical terms and have to believe what the doctor/nurse tells them.
Therefore it could be perceived as zero participation and only top-down instruction.

- **Be treated by a named health provider.** All personnel are supplied with an identikit that identifies them by name, department and with a photo.

- Every patient has the **right to refuse treatment** without the fear that he/she will be discriminated against or penalised by health care practitioners, if patients change their minds or when they attend the hospital in the future.

- The implementation of **Institutional Transformation Units** at institutional level to guide, advise and also monitor the implementations of the transformation objectives and reporting on a biannual basis to the Regional Director was a plus point. Although it did not produce the desired results it was a starting point.

- **Training,** specifically geared towards implementing the *Batho Pele* principles were conducted by Moonera Khan from Directorate HRD and also by the Regional Labour Relation Officer Willem Small. As well as officials from the Department of Public Service and Administration (DPSA). This led to several regional transformation workshops where senior management, labour representatives and hospital board members participated in getting a better understanding of the transformation process. Their responsibility towards the process and the way forward. At these workshops all participants, with the aim to be implemented at
institutions, formulated objectives within the framework of the five principles of the Departmental Transformation Unit.

Rationalization and restructuring to ensure a unified and leaner public service saw reduction of staff by 5 160 since April 1996 (in the Western Cape Health Department), due to Voluntary Severance Packages, natural attrition and moratorium on posts. (PAWC, 1998)

In the process of democratising the state and the workplace, the health department is developing a communication strategy and has already established a public relations component. Personnel are encouraged to work towards a common Departmental vision, mission, goals and objectives in the execution of their work at the various levels of health service delivery. Institutional Labour and Health Service Committees had been established at all institutions and are functioning very well.

A Provincial Human Resource Development and Training (HRDT) strategic plan was developed. This was done with the participation of the HRDT units at the regions, the supra-regions and the directorate: HRDT. Key priorities have been identified for implementation during 1999/2000 and will be implemented according to affordability.
Fast track training programs to promote skills development opportunities for historically marginalized groups are in progress for senior managers, middle-level managers, supervisors, functionaries and general staff. This is dependant on the resource capacity and the availability of training opportunities offered by internal and external Departmental training authorities. A capacity development program for community health committees (CHC) is also in progress.

Quality assurance strategies based on monitoring and evaluation of service delivery will be implemented. With regard to Patient waiting time, response time of emergency services etc. The aim is to promote a professional work ethos and a caring health service.

Nationally, free treatment of pregnant women and children under the age of six years and also free primary health care to all people were implemented. The building of twelve new clinics especially in underserved areas in the region were completed. The implementation of the policy shift from tertiary health care to primary health care so that care can be preventative rather than curative, thereby decreasing pain, suffering and cost.

The introduction of an essential drug-list and standard treatment guidelines, compiled with the help of health care workers nationwide, ensures reliable availability of pharmaceutical supplies. Keeping prescriptions to the barest essentials in providing guidelines and encouraging health care professionals to use the cheapest drugs. Prescribing a maximum of 5 items for patients with chronic diseases and a maximum of
3 items for patients with an acute disease. Linked with this has been the improvement of pharmaceutical distribution, which was largely achieved through creative partnerships with the private sector. Thereby reducing unnecessary spending on expensive medicine and medicine in general.

A need for frontline personnel to have a basic understanding and command of the Xhosa language was identified at Paarl, Stellenbosch and Swartland Hospital respectively, because a large number of patients can only converse in Xhosa. In the past other personnel and even fellow patients were used as interpreters. This situation inevitably compromised the privacy and confidentiality of the patients. Therefore a Xhosa introductory course was instigated at all the hospitals in the region in 2001.

Every hospital in the Westcoast Winelands Region has an organization called the Hospital Action. This organization consists of community members whose sole aim is to generate funds for the hospital. They do this in various ways, by asking donations from big business and private individuals or by asking donations from patients for elective procedures (non emergency medical and surgical procedures). When endeavours like the above Xhosa course are undertaken, management almost always derive the necessary funds from the Hospital Action.

This new code of conduct for public servants, introduced and published in 1999 by the Public Service Commission of South Africa, act as a guideline to employees. As to
what is expected of them from an ethical point of view, both in their individual conduct and in their relationship with others. Section C.2 of the code guides us as follows:

"An employee:
- Promotes the unity and well-being of the South African nation in performing his or her official duties;
- Will serve the public in an unbiased and impartial manner in order to create confidence in the public service;
- Is polite, helpful and reasonably accessible in her or his dealings with the public; at all times treating members of the public as customers who are entitled to receive high standards of service;
- Has regard for the circumstances and concerns of the public in performing her or his official duties and in the making of decisions affecting them;
- Is committed through timely service to the development and upliftment of all South Africans;
- Does not unfairly discriminate against any member of the public on account of race, gender, ethnic or social origin, colour, sexual orientation, age, disability, religion, political persuasion, conscience, belief, culture or language;
- Does not abuse her or his position in the public service to promote or prejudice the interest of any political party or interest group;
- Respects and protects every person's dignity and her or his rights as contained within the constitution; and
- Recognises the public's right of access to information, excluding information that is specifically protected by law".
Weaknesses and Limitations of Transforming Service Delivery

The weaknesses and limitations in transforming service delivery in the Westcoast Winelands Region largely stems from a fear of change and a lack of creativity within organizations, to embrace new challenges and opportunities. Although lack of skill and capacity of managers also plays no small part in this transformational process, the strong influence of organizational culture should not be dismissed.

Rationalization and restructuring

With regard to ensuring a unified and integrated and leaner public service, the reduction of staff should not be equated with the achievement thereof. Staff reductions have been led by the financial crisis of the Administration and the Department. Staff losses has mainly been a result of natural attrition and voluntary severance packages, which cannot be considered as an effective management tool. Because the staff losses could not be strategically managed in accordance with the need to unify, reshape and restructure the health services. In the Westcoast Winelands region, the effect of drastic staff losses impacted negatively on the quality of the services delivered. This situation can be directly attributed to an increased workload rather than the loss of experienced personnel.

While the region subscribes to the national and provincial policies on Affirmative action, the department has yet to develop an implementation programme with targets,
indicators and time-frames with regard to *representivity and affirmative action*. The policy is particularly difficult to implement because of the freezing of posts and budget cuts that limit new appointments. Mechanisms must be put in place to measure progress. Baseline data for all personnel according to race, gender, disability, category and rank need to be developed.

While efforts are made to widen the access to basic health services and to *redress past imbalances*, this places an increased burden on the staff. Their patient load increased by 33% at the Community Health Services Organizations. Patient attendance numbers has increased from 1.8 million to 2.4 million in 1999. This increase in patient numbers should be considered against the reduction in personnel numbers from 2,100 to 1,930. This is likely to compromise the quality of care. It is the perception of both staff and management that client dissatisfaction has decreased. However, this will need to be confirmed (PAWC, 1998).

While there have been progress in the establishment of institutional management and labour committees at all institutions, attention is drawn to the tendency towards centralisation of day-to-day managerial decisions. In *democratisation of the workplace* this situation undermines the ability of institutional managers and supervisors to develop meaningful participatory management systems and to include all categories of personnel in the decision making process. Democracy and transparency at most institutions are non-existent. The top down decision-making process still reigns.
Human resource development and training (HRDT) in any department or region is always a very contentious issue. The West Coast Winelands Region has remained consistently under resourced in this area. Despite attempts to make budgetary provision to fill posts in these components, the moratoria have prevented this on several occasions. The region has unfilled frozen posts and is inadequately understaffed. However, despite the budget constraints the department has identified the human HRDT posts as a priority and a limited budget allocation has been made at regional level, to improve the situation in key areas.

The Directorate does not have a budget for training activities and is dependent on the Provincial Administration of the Western Cape (PAWC) and external donors to fund priorities. There is no doubt that a dedicated training and development budget allocation will need to be made if personnel are to be invested in.

There is an urgent need for HRDT co-ordinators to be appointed with a supportive infrastructure, at all health facilities. In addition, HRDT units should be established at all institutions as soon as resources become available.

The need for a staff support programme is a priority and measures should be put in motion to address this. The need to promote a caring and professional service ethos will require that caregivers be cared for, particularly in stressful work situations. Of particular note is the support required by emergency and trauma personnel and all front-line health workers. Currently there is no post-traumatic stress disorder counsellor
to debrief personnel. Also there is no Employment Assistance Program in place to help personnel in crisis. In addition training opportunities should be provided to empower staff with enhanced skills in conflict and stress management.

*BTU meetings*, as with most meetings that people deem to be less important, were dismally attended. The constitution of the Health Transformation Unit (BTU) has a secundi for every primary member. Since its inception the attendance of the primary members from managements’ side were poor, without secundii being delegated, the meetings had in some instances no mandate to proceed. At institutional level, because the ITU’s had no decision making power, immense problems were created with management not supporting proposals and taking on a *laze faïrre* attitude. It seems management at institutions is either not sure that the ultimate responsibility for the success is theirs or that they are not interested. The fact that there is not specifically budgeted for this process, means that projects that involve the incurring of expenses are continuously postponed or not even considered implementing.

*Over ambitious Goals* were seen as part of the implementation obstacles. By trying to implement simultaneously the objectives of the BTU together with the *Batho Pele* principles, in most cases without proper benchmarks, led to an inadvertence among personnel and management. Many of whom did not understand the process and was not informed properly through information sessions. There was a misconception in that it was believed that it only centred among affirmative action and restructuring and personnel thought that they might lose their jobs or be transferred to other institutions.
Another problem was and still is a shortage of staff. Personnel say they are overworked and already serve the public to the best of their ability and don’t need Batho Pele principles, because they are already implementing it. The problem is exacerbated by the fact that some of the personnel in the lowest categories cannot read or write.

*Over ambitious Time Frames* exacerbated policy implementation within the Westcoast Winelands Region. The department of health still has no affirmative action or employment equity plan in place. Therefore it was impossible to adhere to the set time of the year 2000 to create a total representative public service in terms of race and gender. These cornerstones of transformation have now become the Achilles heel of the entire transformation process of the health department. It would only be fair to acknowledge that any bureaucratic process is slow and time consuming at best and utterly frustrating in the worst case scenario.

The time frame of two years set to implement the five principles were too short and not well thought through. The policy makers did not take into account the possible obstacles with regard to implementation. Their still is a need for more training of personnel regarding Batho Pele and customer service, because the public in most instances are not perceived as customers. In all fairness it must be said that the set timeframes to achieve the goals were a bit over ambitious. However valuable lessons were learned from this experience.

There clearly is a lack of support from above and below in the Winelands Westcoast Region due to various reasons. Representation at institutional level in most cases still
represents the previous administration. Senior management consists mostly of white males, with blacks (including Asians, Africans and Coloreds) at the lowest category level. The fact that union representatives who in most instances are black, embrace the transformation process, leads to obvious direction clashes. Management's lack of attitudinal change in handling of the issues represents a clear lack of vision. When you look at it realistically one finds that old management practices still prevail: Lack of democracy and lack of transparency. The problem is that management wants to implement it on their terms; dictating what issues need to be addressed, by whom and in what way. Even though transformation is a non-negotiable process that should include all personnel.

Because the people at ground level see it as another management policy, and in some instances do not fully grasp the concept, resistance is the only way to assert themselves and let their voices be heard. This leads to strategies being ineffective in execution. On the one hand you have management who wants to hijack the process and implement it on their terms or wait for it to fail by only "paying lip service" to it. On the other hand you have this disgruntled worker corps who would like to see a change in management and leadership. Personnel would especially like to see a positive change in their own working conditions. The onus thus rests on the Institutional Transformation Officer and the Institutional Transformation committee to devise means and ways to cajole everybody into optimal participation by providing diluted strategies to please everyone.
Financial constraints are sighted for the stagnation of the process. In implementing the Batho Pele principles no additional finances need to be spent by the Department. It only needs to reprioritise expenditure and the achievement of efficiency savings. The management at the various institutions also need to make the community equal partners and thereby raise awareness among the community and implement fundraising projects.

There is a definite need among personnel for a refreshing course and an update course due to the lack of skills and capacity in the workplace. In rural areas, where it is of paramount importance, frontline personnel have not had any training for ten or more years. Thus leaving personnel disempowered and insecure in the workplace.

At some institutions management holds old assumptions that turned staff attention inwards towards bureaucratic regulation and internal inefficiency. These staff members reflected a belief that the current structures and processes were appropriate and that people needed to enter through lower positions and work their way through the organization. The view was that through a traditional process of career development, based on seniority, the department would be consolidated and common visions build. This approach to human resource development with its perception that promotion is a right unmediated by productivity is often the substance of grievances, which challenges management for practices of so-called “reverse discrimination.”
Another view; sincerely stated but in the same vein as the former, was that fast track development programmes for new recruits were inappropriate, because they could be damaging to the levels of standards traditionally maintained by the institution.

Senior staff in all hospitals recognises the importance of in-service training. Whilst there are meetings for senior managers organized by the regional office, there is no overall regional training system designed to reach all medical and associated occupations, nursing and administrative staff.

In the larger hospitals there are programs for nursing education, but these do not exist for nurses in smaller hospitals. The only opportunity for such staff members is the occasional attendance of a course elsewhere. At one time there was an arrangement for senior nursing staff at Paarl hospital to make educational visits to smaller hospitals, but this no longer happens.

Medical staff in district hospitals attends courses from time to time or rely on visiting specialists where available. The larger hospitals like Paarl and Stellenbosch may organize medical meetings several times a year, but smaller hospitals staffed by part-time medical officers are not well catered for. Administrative staff mainly relies on attendance of ad-hoc courses or meetings.
General comments

The deleterious effects of staff reductions and the tendency towards centralized management, brought about by the central imposition of financial controls, must be brought to the attention of the DTU. Recent staff reductions should not be equated with having achieved a leaner and more integrated public service. In some areas this has led to a poorer quality of service and in some instances to a cessation of services.
CHAPTER 5

CHALLENGES AND PROSPECTS OF EFFECTIVE SERVICE DELIVERY

This chapter deals with the challenges and prospects faced within the region to date. We also look at the fieldwork and research results.

In 2000 the Public Service Commission did a survey of department's compliance with the Batho Pele policy in the Western Cape as a whole, including the Westcoast Winelands Region. One of the findings of the survey was that managers of service delivery units, for instance, hospital and clinic managers could only achieve service delivery maintenance. These managers should be empowered to make the necessary changes to achieve service delivery improvement.

It was also found that those managers often lack skills in basic management practices. These practices include the following:

- Deciding exactly what needs to be done, setting achievable and concrete objectives. These objectives should revolve around improvement of service delivery.

- Clearly allocating responsibility to achieve the set objectives, by implementing clear and logical organisational structures.
• Delegating authority to the responsible manager, preferably to the head of the service delivery unit, to make the required changes to achieve the set objectives.

• Designing a performance management system to provide managers/supervisors with constant feedback on how well they are doing.

• Holding managers/supervisors accountable for performance.

Under the guidance of Commissioner B. Wentzel the commission aims to implement a ‘Performance Management best practice for Hospital/Clinic Managers’ project. With the objectives of the project to:

- Improve the effectiveness and efficiency of hospitals/clinics. (Service Delivery)

- Improve the performance management practices of hospitals/clinic managers. (Performance management is defined as “Ensuring that the objectives of the organisation are achieved”. Since performance management is such a key management practice and because service delivery unit managers, like hospital/clinic managers occupy such a pivotal position in the health care structure, the project can potentially have a very big impact.)

- Produce a performance management best practice guide for hospital/clinic managers. (The aim will be to provide practical, implementable advice. The implications of the best practice guide for departmental organisation structure, policies, systems and procedures will be spelled out.)
Amendment to Hospital Ordinance of 1946 has not yet been passed by parliament. In terms of the provisions of the current ordinance, the management and control of provincial hospitals must be vested in a medical superintendent. Therefore the aim of the Amendment is to provide for the situation where a Chief Executive Officer (CEO) could now manage provincial hospitals. A person has experience in business, administration, financial management or any other related field (PSC, 2001).

Most of the medical superintendents has little or no business or financial management experience and as such are not always capable of exercising fiscal discipline or sound budgetary management. Most of them leave financial issues, such as budgeting, to subordinates. Therefore if financial management of provincial hospitals is placed in the hands of an experienced CEO it could only lead to an improved state of affairs (PSC, 2001). The downside of this proposal is that a hospital is not a business and we cannot close down a department just to stay solvent.

Since late 1999 the Provincial Treasury approved 50% of revenue retention for institutions and it has been implemented. This has slightly improved the culture around revenue generation and collection. Yet most personnel are not even aware of this new state of affairs, and those that do always ask the same questions. What is management doing with the money? We don’t see any improvements around here! Ample proof of poor communication between management and personnel.
All primary health care facilities within the Westcoast Winelands Region have water, sanitation and telephones as well as refrigerators and diagnostic kits. Recently a frail care centre as well as an ambulatory Rehabilitation centre (Elangeni) was opened in Paarl. Staff members are experiencing uncertainty due to the planned transfers of PHC services to the local government. This goes hand in hand with the uncertainties regarding the powers of Category C and Category B municipalities promulgated by the Local Government Municipal Systems Act (Act 32 of 2000). Both of the above is seriously affecting planning, decision-making and staff morale. All this pushes the issue of longer clinic hours for people who are not able to attend clinics during office hours aside. There is a lot of concerns that need to be discussed and addressed around longer open hours, over-time remuneration, safety and security, transport, etc.

The Voluntary Counselling and Testing Program (VCT) is spearheaded by the National Department of Health’s HIV/AIDS and STD’s unit. Through this program the funds were channelled to regional offices for the training and placement of lay counsellors to provide this service at Community Health Care Centres. To date ten has been appointed, trained and placed at centres throughout the region (Regional Report, 2000: 12). Increasing the acceptability and demand for the service as well as encouraging openness about one’s HIV status. Even though stigmatisation and discrimination are still serious problems experienced in the field.
Fieldwork/Research Results

The survey was done over a reasonably short space of time, from March 1999 to September 1999, and this included the interviews as well as the questionnaires. Garth Morkel (Director of Service Delivery Transformation in the Western Cape) and Vusi ka Jele (from the South African Management Development Institute) who gave training on Batho Pele in the Westcoast Winelands Region (Refer appendix U for questions) were the experts interviewed.

At institutional level I interviewed the institution heads (Medical Superintendents) as well as the Institutional Transformation Representatives (ITRs). As each institution has two ITRs this amounted to eighteen people I needed to interview. Of the eighteen potential interviewee's, I only interviewed fourteen. Two of the institutional heads never responded and two asked me to send them the questions, because they could not accommodate me.

The Batho Pele questionnaire as well as the other questionnaires was developed, not from a purely scientific reference base where scientific techniques and methods were employed to help the structuring of the questions, but from a user-friendly reference point. It was structured in a way that was user friendly, simple, clear, concise, easy to understand, easy to respond to, easy to complete easy to understand and with the minimum of open-ended questions.
With the exception of the *Batho Pele* questionnaire, the formulation of questionnaire 2 to 5, were solely derived from the Departmental Transformation Unit’s five principles to start transformation of service delivery in the Western Cape (Refer p. 27).

The main findings were that everybody thought that the success of the transformation of service delivery process is important in the improvement of quality care to the communities we serve. We need to restore the communities’ trust in personnel and to accommodate the community holistically within our health care facilities. No one disqualified the attainability of the DTUs objectives. Everybody agreed that budgetary constraints are the main obstacle for the implementation of most of the formulated plans. Albeit that no institution made financial provision for the process. All the institution heads said that their personnel were well informed about the process, although some of the ITRs agreed, the others argued that it was not contested.

Approximately 50% of the respondents said that there was about a 50/50 split among personnel embracing and those not embracing the process. Various reasons were sighted, but the main reasons were fear of change and general apathy towards anything instigated by management.

With regard to met objectives and plans to meet those objectives it was a sorry tale, with a lot of excuses and a bit of mud slinging.
At most institutions the ITU were still born and at others they are just keeping up appearances. Nothing concrete has been implemented. The ITUs are considered by personnel as talk shops where nothing gets done.

Everybody was optimistic that the process will succeed with the right amount of commitment, dedication, democracy and transparency from management’s side. The findings of the questionnaire was interesting in so far that it gave us a good idea of what the employees thought of the process, what they expected from it, how they saw their respective roles within the process and what we could expect from them.

The Batho Pele questionnaire, which was the first one to be circulated among personnel as a pilot project, prompted us on our way forward. Giving us good insight into the level of cognisance of Batho Pele. It also manifests what could go wrong, from a researcher’s point of view, in the gathering of quantitative information.

What is most interesting to note from the aforementioned questionnaire is that while only 60% of respondents indicated that they knew what the principles of Batho Pele entail, 90% of respondents indicated that they were treating the public according to these same principles. The discrepancies in the results of this questionnaire and the rest to follow, although we simplified the questions as much as possible, only leads me to the conclusion that people interpret questions differently due to various factors (Refer p. 10).
What was most significant in the results of the Batho Pele questionnaire is that only 45% of respondents thought that it could be successfully implemented at the various institutions. 70% of respondents believed that it would not bring a change to their working environment and the way they do their duties. Indicating most respondents’ lack of insight into the process and the profound impact it will have on service delivery if managed and implemented correctly.

The fact that 82% of respondents (Question 5) indicated that they were unaware of any implementation plans at their institution gives us an idea of the dissemination of information from management to grass roots level.

Before questionnaires 2 to 6 were introduced at all institutions, we embarked on a diligent and comprehensive information campaign, where all categories of employees were reached and extensively informed about the aims and objectives. Not only of our questionnaires, but also of the transformation of service delivery process. Questionnaire 2 is divided into three parts – (i) participative management, (ii) mutual respect and (iii) organization. The Institutional Management and Labour Committee mentioned in part (i) is a committee established at every government institution to foster good relationships between management and labour. Any issue can be discussed that is of mutual interest to both parties.

The main conclusion that could be drawn from part (i) is that most respondents feel that management is autocratic and that there is no transparency in the
decision making process. In part (ii) it is essential to note that 60% of respondents have no trust in management. That they feel that management is not encouraging and supportive enough and that management also does not promote healthy interpersonal relationships. In part (iii) most answers were in the negative. Most respondents felt that management does not promote positive change and are not fair and consequent with discipline (Questions 5 and 3). What is interesting from question 4, in relation to question 3, is that most respondents were not familiar with the grievance and disciplinary procedures.

Training at any institution is always a contentious and hotly debated issue and the Westcoast Winelands Region proves to be no exception. The results of this survey clearly indicate the need for further training of personnel in all categories. Although 90% of respondents believe that more in-service training programmes should be facilitated and 95% experience a need for further training directly related to their work, only 45% of respondents are motivated to attend courses. The fact that 95% of respondents indicated that management does not do needs analysis for training and personnel are not regularly exposed to personnel evaluation, is a matter of grave concern within the health sector paradigm. The relevance of courses was also exposed in this survey and in future should be attended to.
The idea with the leadership questionnaire was to extricate the dormant leaders and leadership abilities. As you know with in each organisation there are natural leaders who can promote or block any type of transition or change.

The results were quite interesting in that most participants have assumed leadership roles, whether at work or in the community. Because we work in a structured set-up and most respondents were nurses the answer to question 7 was obvious. What stands out in this survey (questionnaire 5) is that only 3% of respondents indicated that their admission experience was a good one, together with the 35% that indicated good treatment during their stay in hospital. In analysing this statistics it is interesting to note how negative the all round public perception is of our institutions and of the personnel. With 40% of participants stating that they think the nursing personnel are not adequately trained for their duties and 20% indicating a poor general impression of the hospital.

The most bothering answer, however, is the answer to question 10 (a). Where 20% of respondents had no comment on the attitude of the doctors and 15% thought their attitude was poor (in relation to their judgement on nurses). There could be various reasons for this. One being that some patients still think of doctors as demi-gods, or that some people had minute encounters with them and could not form an opinion of their attitude.
In questionnaire 6, 45% of respondents had no comment on the attitude of doctors. This could be due to the fact that most respondents was only attend to by primary health care practitioners or that they only attended specialist clinics and has built a good rapport with the attending physician and felt that no comment was in order. Or maybe they were afraid it could count against them in the future. Although 65% of respondents indicated poor general impressions about the service at the hospital, better response were received on questions one and two. Indicating a bit of a discrepancy of the respondents understanding of the question(s). Interesting to note is that 55% of participants had no comment on the reason why they thought they had to wait a long time before being attended to and 30% indicated that it was because of nursing personnel being unsure of their duties.

Conclusion

Although the positiveness of the human spirit came through very brightly in the interviews and questionnaires, the realities faced in the working environment dampened the spirit. Most of the participants new that Batho Pele aimed to improve service delivery, but how it was to be achieved eluded them. Most participants were unaware that the process had already started at their various institutions.
With regard to participative management, mutual respect and organisation, the results were very negative. Participants vented their anger and their feelings towards management in an unrivalled way in the comments section of the questionnaires.

They also broadly explained what they thought needed to be done to rectify the situation. The interesting thing about these comments was the calling for fairness and consequentness from management's side.

Training and leadership was also a cause for concern from the participants view and a lot needed to be done to improve the situation at institutions. Most of the participants had not attended a training course within the last five years and felt that management does not provide opportunity for further education and training.

The outpatient questionnaire circulation, a hundred questionnaires were circulated, was done on a very busy day and on a quiet day at the outpatient departments. The results of both days' questionnaires were similar. There was a clear indication from the public that they thought the service and attitude of service providers could improve.

One hundred questionnaires for the inpatients were circulated. The same sentiments, received from the outpatient participants, were echoed by the inpatients.
Recommendations

The process of transformation of service delivery is a very dynamic and capricious one. Pregnant with the hopes and dreams of the best quality care imaginable in the Westcoast Winelands Region, but for those hopes and dreams to realize; commitment, loyalty, vision and a comprehensive strategy are needed to ensure success. Accordingly the remainder of this thesis provides both short-term and long-term recommendations to expedite and sustain the effective transformation of health care services in the Westcoast Winelands Region.

Short-term Recommendations

The first aim would be to ensure that the Institutional Transformation Units (ITU) function properly. That it should be representative of all category personnel including management. That it should be given executive powers to implement programmes in consultation with management. There should be continuous communication between the ITU, management, personnel and the community.

Institutional management should be held accountable and responsible for the progress of improving service delivery or the lack there off. And if need be institutional heads must be punished financially for lack of implementation or lack of progress. A committee should be established that would visit institutions on a
regular basis, preferably three monthly, to assess an institutions’ progress or lack there off, and to assess their level of progress. This committee should consist, equally, of community members; health care professionals; and administration staff. This committee should be of an independent nature, and should only report directly to the Public Service Commissions Office. Who should make the necessary recommendations to the regional director and who should filter it through to the institutions.

Management should implement an aggressive strategy to democratise the organization and be transparent on all aspects involving personnel, from recruitment to budgeting; to regain the trust and respect that has been lost. People need to be informed through official channels, so they are kept up to date with changes in the organization and don’t hear things through the grapevine.

Management should always be fair and consequent in their actions and provide reasons and criteria for decisions made. Thereby leaving no room for speculation. Institutions should formulate and implement simple, realistic, attainable objectives; derived from the needs analysis questionnaire study that has been done. For example, replacing current signboards with signboards in the three official languages of the Western Cape.

Implement training programmes to inform all personnel about transformation of service delivery. So they understand why it is important, what it is all about and how everyone will eventually benefit from the successes. Everyone should be
involved in the process so they could internalise it and make it their own, by getting everyone’s input and by keeping them informed about progress.

Institutions should create a simple, easily employable and executable grievance policy for the public. So that their grievances could be addressed swiftly and to the aggrieved persons’ satisfaction. By the appropriate official and with no negative consequence. Public grievances should be monitored on a monthly basis and evaluated. Problem areas should be identified and rectified with the appropriate training or counselling, which ever is needed.

**Long-term Recommendations**

Institutions should also liase with community organisations (cultural organisations, sport clubs, etc.) schools, non-governmental organisations, churches and farming communities to get optimal input from these organisations. To supply in their needs and in formulating a strategy for the future to accommodate everyone.

Involve local businesses continuously to assist and help financially in proposed projects and also gain their input, not as outsiders, but as part of a project team. By doing this expert advice could be gotten without appointing consultants at exorbitant fees.
Constant liaising with local newspapers and radio stations to promote the local health services in general and to inform the public about the services rendered at the institutions and of upcoming changes. To inform the general public of diseases of general incidence such as Diabetes, hypertension, tuberculosis, HIV/AIDS, malnutrition, sexually transmitted diseases, cardio-vascular diseases, etc; of social issues such as rape, alcoholism, physical abuse, drug abuse, unwanted pregnancies; the epidemiology and consequent results of disorientated families and such.

A help-desk should be established at every institution to help and assist the public with enquiries of services and aid organizations. Not necessarily on health issues alone, but on social issues that affects the human being as a whole. A help-desk where members of the public could go for help with legal issues, ask for help on how to apply for a grant or for old age pension, where to go if they want training, who to contact if people want to do voluntary work, etc. This would of course require some additional resources as well as efficient liaising between different role players within the community.

Management should provide employees with training opportunities to enhance their skills and to empower themselves. They should also schedule in-service training programmes on a monthly basis and do continuous evaluation on skills acquired and skills required. There should be a training program established planned for a one year period in advance. That should see to it that all employees are
accommodated according to their needs and abilities as well as the needs of the institution.

Open days should be arranged on a quarterly basis to introduce the hospital to the community at large. Making special provision for schools and other academic institutions and by trying to incorporate their respective career days or career weeks. Pre-schoolers should also be accommodated in this format as well as the neighbouring farming communities; especially by integrating the women on farms project and working closely with other health care practitioners that provide services for farm and factory workers.

Staff morale boosting projects should be launched. There should be a monthly employee of the month elected or voted for by the customers, with an award attached to it. Personnel with personal as well as work related problems should also have readily available access to an independent employee assistant (A social worker or psychologist who has relevant experience in dealing with people from previously disadvantaged communities). There should also be a protocol in place for debriefing of personnel who had traumatic experiences in the workplace. Personnel who have moral or religious objections against termination of pregnancies should also be accommodated as far as possible.
ANC, 1998. Transforming civil society in contemporary South Africa. Pretoria


Westcoast Winelands Progress Regional Report. 1999


CUSTOMER SERVICE.

OBJECTIVE 1.
To improve the environment in the institutions.

Actions:
- Erect user-friendly signboards
- Establish information desks for patients
- Improve safety and security for patients and staff
- Discourage a production line mentality of service delivery

OBJECTIVE 2.
To reduce the outpatient waiting time and length of stay.

Actions:
- Monitor outpatient waiting times
- Determine the length of stay for in-patients
- Determine the procedures used for cancellation of appointments
- Encourage the introduction of a staggered appointment system
- Reduce unnecessary admissions
- Monitor staff availability

OBJECTIVE 3.
To improve safety and security at hospitals without additional cost.
Actions:

Request institutions to review the performance of their security staff

Remind staff of security procedures

Encourage institutions to deal with offenders swiftly and justly

OBJECTIVE 4.

To ensure a constantly reliable supply of medicines

Actions:

Instigate an investigation

Request a report with recommendations

Respond quickly to the report

OBJECTIVE 5.

To provide a clear and precise interaction between patients and the service provider in the patients own language

Actions:

Identify where these services are needed

Decide on a cost effective way of providing this service

Arrange for the placement of interpreters
MANAGEMENT STYLE

1. PARTICIPATORY MANAGEMENT

OBJECTIVE 1.

Monitor the organisational structures and the work environment for a change of culture that facilitate the achievement of a participatory management style

Actions:

Compile an audit of structures

Compile an audit of management meetings at institutional level

Develop a tool to support the audit on assessing the attitudes of managers

Monitor the implementation of the Hospital Board Bill to ensure representation.

2. MANAGERIAL EFFECTIVENESS

OBJECTIVE 1.

To use a model to assess managerial effectiveness.

Actions:

Set goals and measure effectiveness of managers

Involve supervisors and subordinates in the review

Set transformational objectives

Monitor deficiencies

Facilitate improvements
3. **DECENTRALISED MANAGEMENT**

**OBJECTIVE 1.**

Decentralise as many management functions as possible through delegation of authority, in line with modern management practices.

**Actions:**

Review regional offices for structure and vacancy rates

Monitor the district health system to assess the extend of decentralization

Involve the staff in budgeting processes and assess how far down the line finances can be delegated

Investigate performance indicators and accountability measurements

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2. **GENERIC FUNCTIONS**

**OBJECTIVE 2.**

To monitor decisions made in the department to ensure that the decision take account if the transformation goals and objectives

**Actions:**

Review decision-making structures/organisms within the Department and the Administration

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84
PERSONNEL ISSUES

1. TRAINING

OBJECTIVE 1.

To initiate an audit of training needs and evaluate gaps in competencies that could be met by training and development programmes

Actions:

Compile an audit of training needs at institutional level

Facilitate the implementation of appropriate training programmes

Place personnel appropriately according to skills for service delivery

Implement orientation programmes for all personnel

Measure the effectiveness of training

2. LEADERSHIP

OBJECTIVE 1.

To determine potential leadership ability through the use of suitable models and to provide training and development opportunities to enhance leadership skills

Actions:

Promote leadership that is representative

Ensure that leadership is legitimate

Identify leadership characteristics
Review the need for structural changes where necessary to encourage progressive leadership styles
Show evidence of innovative decision-making
Determine ways in which to measure the effectiveness of leadership
Develop dormant/latent/ potential leadership ability

3. HUMAN RESOURCE ISSUES

OBJECTIVE 1.
To optimally utilize the ability of the personnel in the department
Actions:
Place personnel where they are needed for effective and efficient service delivery
Develop a policy on re-deployment of personnel based on service needs

COMMUNICATION

OBJECTIVE 1.
To ensure the establishment and sustainability of an effective and consistent two way communication, between the DTU, and, institutional management and personnel
Actions:
Use all available communication mechanisms / create the means to achieve
this if inadequate
Ensure that interruptions to service delivery must be kept to a minimum when
reporting back from DTU meetings
Encourage active and vibrant two-way communication and use informal
networks

OBJECTIVE 2.
To ensure effective two-way communication between the DTU and the
community
Actions:
Utilise community papers, community radio and regular media releases
Utilise NGO/Community Forums

OBJECTIVE 3.
To ensure that an appropriate environment and mechanism are utilized for the
active participation of personnel and the community within the Department at
all levels
Actions:
Identify all mechanisms that could be used at provincial, regional and district
levels. Assess the efficacy of the interactions between Department and
OBJECTIVE 4.

To improve the attitudes, behaviour, and actions of public servants in their daily interactions with their colleagues and the public.

Actions:

Assess the behaviour and actions of public servants

Monitor the implementation of Batho Pele
APPENDIX B

QUESTIONNAIRE 1.

BATHO PELE

1. Do you know what the principles of Batho Pele entail?

2. What do you think is the aim of Batho Pele?

3. How did you obtain information about Batho Pele?
4. Do you need more information about Batho Pele? If yes, specify.
5. Are you aware of any plans at your institution to reach the objectives of Batho Pele?

6. Do you treat the public according to the Batho Pele principles?
7. If you don’t work directly with the public, do you deliver a supporting service to colleagues who work directly with the public? If yes what type of service?

8. Do you feel that Batho Pele that will bring a change to your working environment and the way you do your duties?

9. Do you think the principles of Batho Pele will be successfully implemented at your institution?
10. Do you have any suggestions to help for the implementation of Batho Pele at your institution?

*Institutional Management and Labour Committee
**QUESTIONNAIRE 2**

**EVALUATION OF INSTITUTIONAL MANAGEMENT**

### i. Participative Management

<table>
<thead>
<tr>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the IMLC* in place?</td>
<td>95</td>
</tr>
<tr>
<td>2. Are IMLC meetings held regularly?</td>
<td>60</td>
</tr>
<tr>
<td>3. How do you experience the institutions management style</td>
<td></td>
</tr>
<tr>
<td>(i) Democratic</td>
<td>20</td>
</tr>
</tbody>
</table>

### 4. Are management decisions inclusive of supervisor’s opinions? | YES% | NO% |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>63</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Does management provide for input before decisions are made? | YES% | NO% |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>81</td>
<td></td>
</tr>
</tbody>
</table>

### 6. Does your institution have a broad management structure? If so, is it representative of all departments and employees? | YES% | NO% |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

*Institutional Management and Labour Committee*

### ii. Mutual Respect.

<table>
<thead>
<tr>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does management give personnel the necessary recognition?</td>
<td>34</td>
</tr>
<tr>
<td>2. Is management constantly friendly and courteous?</td>
<td>46</td>
</tr>
<tr>
<td>3. Is management encouraging and supportive?</td>
<td>24</td>
</tr>
<tr>
<td>4. Is management trustworthy?</td>
<td>40</td>
</tr>
<tr>
<td>5. Does management promote healthy inter personal relationships?</td>
<td>35</td>
</tr>
</tbody>
</table>

### iii. Organisation

<table>
<thead>
<tr>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does management provide room for personal development?</td>
<td>34</td>
</tr>
<tr>
<td>2. Does management promote teamwork?</td>
<td>46</td>
</tr>
<tr>
<td>3. Is management fair and consequent with discipline?</td>
<td>24</td>
</tr>
<tr>
<td>4. Are you familiar with the grievance and disciplinary procedures?</td>
<td>40</td>
</tr>
<tr>
<td>5. Does management promote positive change?</td>
<td>35</td>
</tr>
</tbody>
</table>
### QUESTIONNAIRE 3

**PERSONNEL ISSUES**

1. **Training**

<table>
<thead>
<tr>
<th></th>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you get the opportunity to go on courses?</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>2. How are you notified of new courses?</td>
<td>19</td>
<td>81</td>
</tr>
</tbody>
</table>

(i) Management 13   (ii) Supervisors 59   (iii) Notices 28

<table>
<thead>
<tr>
<th></th>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do you feel fair criteria is used in determining who attends a particular course?</td>
<td>13</td>
<td>87</td>
</tr>
<tr>
<td>4. Are you motivated to attend courses?</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>5. Have you had previous in-service training?</td>
<td>30</td>
<td>70</td>
</tr>
<tr>
<td>6. Does your supervisor motivate you for in-service training?</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>7. Do you feel that there should be more in-service training courses offered at your institution?</td>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>8. Do you experience any need for further training directly related to your work?</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>9. Are you happy in your work, and in your department</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>10. Are the courses you have attended relevant to your current job?</td>
<td>38</td>
<td>62</td>
</tr>
<tr>
<td>11. Do you possess a job description?</td>
<td>17</td>
<td>83</td>
</tr>
<tr>
<td>12. Are you exposed to regular personnel evaluation?</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>13. Does management create opportunities for training?</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>14. Does management do needs analysis for training?</td>
<td>5</td>
<td>95</td>
</tr>
<tr>
<td>15. Does management promote In-service training?</td>
<td>35</td>
<td>65</td>
</tr>
</tbody>
</table>
### QUESTIONNAIRE 4

#### 2. Leadership

<table>
<thead>
<tr>
<th>Question</th>
<th>YES%</th>
<th>NO%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you in any leadership position at your institution?</td>
<td>28</td>
<td>72</td>
</tr>
<tr>
<td>2. Have you ever been in charge of certain aspects of your work/outside your work area?</td>
<td>69</td>
<td>31</td>
</tr>
</tbody>
</table>

#### 3. If yes, do you do it?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>(i) Regularly</th>
<th>(ii) Sometimes</th>
<th>(iii) Seldom/never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>59</td>
<td>30</td>
<td>11</td>
</tr>
</tbody>
</table>

#### 4. Do you think you have leadership abilities, but are

<table>
<thead>
<tr>
<th>Reason</th>
<th>(i) Shy</th>
<th>(ii) Afraid</th>
<th>(iii) Negative</th>
<th>(iv) Have no motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>12</td>
<td>7</td>
<td>44</td>
<td>35</td>
</tr>
</tbody>
</table>

#### 5. Have you ever attended a course on leadership?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>12</td>
</tr>
</tbody>
</table>

#### 6. Do you serve on any committees within or outside your working environment?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>45</td>
</tr>
</tbody>
</table>

#### 7. Were you ever in a position where you wanted to take the leadership, but was denied the opportunity?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>70</td>
</tr>
</tbody>
</table>

#### 8. If yes, what was the problem?

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Supervisor</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>(ii) Management</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>(iii) Other</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

#### 9. Do you feel ready to assume leadership positions at work?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>35</td>
</tr>
</tbody>
</table>

#### 10. Do you experience any need to develop your leadership skills?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>45</td>
</tr>
</tbody>
</table>
**QUESTIONNAIRE 5**

**INPATIENT QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Poor</th>
<th>No Comment</th>
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</thead>
<tbody>
<tr>
<td>1. Can you remember admission to the hospital?</td>
<td>95</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Were you immediately treated?</td>
<td>25</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you think the nursing staff is adequately trained?</td>
<td>60</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Were your medication given on time?</td>
<td>80</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Did the nursing staff immediately tend to you?</td>
<td>25</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Did you receive clean linen and pyjamas</td>
<td>80</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. How did you experience admission?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. How did you experience your stay in hospital?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How were you treated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. How was the attitude of the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11... What are your impressions with regard to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Hospital facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Services delivered in the hospital?</td>
<td></td>
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**UNIVERSITY of the WESTERN CAPE**

97
**QUESTIONNAIRE 6**

**OUTPATIENT QUESTIONNAIRE**

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<th>Poor</th>
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<tbody>
<tr>
<td>1. How did you experience your visit to the outpatient department?</td>
<td>35</td>
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<td>25</td>
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<tr>
<td>2. How were you treated at the outpatient department?</td>
<td>35</td>
<td>35</td>
<td>30</td>
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<tr>
<td>3. What do you think of the waiting room?</td>
<td>20</td>
<td>15</td>
<td>65</td>
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<tr>
<td>4. What were your general impressions about the service at the hospital?</td>
<td>20</td>
<td>15</td>
<td>65</td>
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<tr>
<td>5. How was the attitude of the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Doctors</td>
<td>15</td>
<td>25</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>b. Nurses</td>
<td>30</td>
<td>40</td>
<td>20</td>
<td>10</td>
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</table>

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<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Were you treated immediately</td>
<td>10</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>7. Did you wait long for treatment?</td>
<td>25</td>
<td>45</td>
<td></td>
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</tbody>
</table>

---

8. If yes, what do you think were the reason?

<table>
<thead>
<tr>
<th>(i) Shortage of personnel</th>
<th>(ii) Personnel unsure of their duties</th>
<th>(iii) Inadequate administrative procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>30</td>
<td>5</td>
</tr>
</tbody>
</table>
Questions to transformation representatives and institutional heads.

1. What do you think of the Transformation of service delivery process?
2. Do you think the objectives of the BTU are attainable, if not, why?
3. Are your personnel knowledgeable about the process, and if not, how do you intend to disseminate the information?
4. Do you think your personnel will embrace/are embracing the process? If no or yes can you motivate?
5. What objectives have you met, and what changes did you implement to meet these objectives?
6. What provisions have you made with regard to finances?
7. What obstacles do you foresee in the successful implementation of the process?
8. How do you intend to accommodate the community?
9. Are your ITU representative of all category employees, if not, why?
10. Do you think this process will succeed?
APPENDIX D

Questions to the two transformation experts.

1. What do you think of the Transformation of service delivery process?
2. Do you think the objectives of the BTU are attainable, if not, why?
3. Are your personnel knowledgeable about the process, and if not, how do you intend to disseminate the information?
4. What provisions have you made with regard to finances?
5. What obstacles do you foresee in the successful implementation of the process?
6. How do you intend to accommodate the community?
7. Do you think this process will succeed?
8. Are there any directives from your department to boost staff morale?
9. How do you envisage the public sector in five years?
10. Is Batho Pele the first step in Thabo Mbeki's African Renaissance plan for South Africa?