EVALUATION OF THE PERCEPTIONS AND UNDERSTANDING OF REHABILITATION PROFESSIONALS REGARDING THE HEALTHCARE PLAN 2030

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A thesis submitted to the Faculty of Community and Health Sciences of the University of the Western Cape, in fulfilment of the requirements for Master of Science degree in Physiotherapy

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DATE: DECEMBER 2017

<u>**ABSTRACT**</u>

Background: The healthcare plan 2030 represents the third wave of healthcare policies proposed by the post-apartheid Western Cape Department of Health. The focus of the plan is on creating equal access to quality patient-centred healthcare, which meets the aim of primary healthcare, namely to create better health for all. In the healthcare plan 2030, emphasis is laid on curative and preventative services with the rendering of rehabilitative and palliative care services at primary healthcare facilities. This study aimed to explore the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030. **Methods:** The researcher reviewed the healthcare plan 2030 to clearly understand the plan. Individual interviews and a focus group discussion with rehabilitation professionals were conducted to allow the researcher to understand the strategies they employ to ensure the provision of quality healthcare. These strategies were compared to the key aspects of the healthcare plan 2030 document review and linked to a theory of change to assess whether they would ensure successful implementation of the healthcare plan 2030. Ethical clearance and permission to continue with the study was obtained from the University of the Western Cape Research Ethics Committee and Western Cape Department of Health. The study population consisted of 20 rehabilitation professionals at three selected community healthcare centres, who participated in individual interviews and a focus group discussion. Using qualitative data collection methods, the researcher highlighted three emerging themes from the transcribed data, namely knowledge, implementation strategies, and resources. **Results:** Results from the document review suggest that the healthcare plan 2030 is not clear about its objectives or methods to make rehabilitation accessible at all levels while mainstreaming and strengthening these services. Findings also suggest that rehabilitation professionals lack an understanding of healthcare policies and of the roles expected of them by government. **Conclusion:** The study concludes that the healthcare plan 2030 can be successfully implemented if government addresses the barriers of limited human and financial resources. Recommendations are that communication between facility management and rehabilitation professionals is improved, policy workshops are created to inform rehabilitation professionals of new policies, human resources are increased and further research into policies is undertaken.

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KEYWORDS
Healthcare plan, health policies, rehabilitation professionals, rehabilitation services, community health centres

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DECLARATION

I declare that "Perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030" is my own work that has not been submitted for any degree or examination at any other university and that all the sources used or quoted have been indicated or acknowledged by means of complete references.

Luzaan Kock

……………………………. ………………………

Signature Date

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ACKNOWLEDGEMENTS

Firstly, I would like to thank my supervisors, Prof. Mlenzana and Prof. Frantz, who continually supported me throughout my thesis with their wisdom and patience but also allowed me the opportunity to work on my own. Prof. Mlenzana, Ma'am, thank you for blessing me with this opportunity. Miss Leila, thank you for taking time out of your schedule to assist me. Best of luck with the completion of your PhD.

I would also like to thank the rehabilitation professionals for taking time out of their busy schedules to participate in this study.

My colleagues at the Interprofessional Education Unit at the University of the Western Cape, thank you for the knowledge that I could always rely on your assistance when needed. The staff of the Department of Physiotherapy at the University of the Western Cape, thank you for your kind words and for sharing your Head of Department with me.

My beautiful family, thank you for the continued words of encouragement, the love and support you gave me during this time. Mummy and daddy, thank you for setting a perfectly high standard of what a parent should be. Adnill, sorry mate, I am the smart one now! Thank you for being one of my best friends. Brynmor, your commitment in what was the most challenging time of my life is evident of your love for me; I cannot wait to conquer the world with you. I am forever indebted to the four of you and I love you with all my heart. To my friends and extended family, thank you for your support whether it was a motivational message with a funny GIF or a cup of coffee because apparently you should not write a thesis over a glass of wine.

Finally, my King, I do not deserve all the grace bestowed upon my life but He thought me worthy. This achievement brings life to the verse that has kept me going all the years, "I can do all things through Him who gives me strength" Phil 4v13

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LIST OF ABBREVIATIONS

ADEPT	Analysis of determinants of policy impact
ANC	African National Congress
ASAHP	Association of Schools of Allied Health Professions
CBR	Community-based rehabilitation
CP	Collaborative practice
FGD	Focus group discussion
HPCSA	Health Professions Council of South Africa
HPSR	Health policy and systems research
ICF	International Classification of Functioning, Disability and Health
IPE	Inter-professional education
NCS	National Core Standards
NGO	Non-government organisation
NHI	National Health Insurance
PHC	Primary healthcare
PHCRS	Primary Health Care Research & Information Service
SADOH	South Africa, Department of Health
SAMA	South African Medical Association National council
SANC	South African Nursing Council
SMART	Specific, measurable, achievable, realistic and timed
WCDOH	Western Cape, Department of Health
WCRC	Western Cape Rehabilitation Centre

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CHAPTER 1

INTRODUCTION

1.1 ORIENTATION OF CHAPTER 1

The healthcare plan 2030 is one of the documents introduced by the Western Cape Province that focuses on improvement of health services for all service users at health centres. This study explores the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030. In this chapter, the background of the South African healthcare system, policy development in South Africa and rehabilitation are discussed. The study's problem statement, research question, aim and objectives are defined, and the background to the methodology is introduced.

1.2 BACKGROUND

The healthcare system in South Africa consists of a large public sector and a growing private sector. Healthcare in South Africa ranges from basic primary healthcare (PHC) at community level to highly specialised services at a tertiary level. According to the World Health Organisation (WHO, 2013), PHC is the first interaction an individual has with the healthcare system. Its aim is to achieve "health for all" by placing the people at its core. Achieving quality PHC was described as an underlying philosophy for the restructuring of the health system (African National Congress [ANC], 1994) and is noted as the driving force for equity in healthcare (South Africa Department of Health [SADOH], 2000).

Through a series of events, the South African National government set up strategic policies that identified health as a top priority, envisioning a long and healthy life for all of its citizens (SADOH, 2014). Primary healthcare was introduced to the country on a very modest scale in the early 1940s, even though it was only internationally adopted at the Alma Ata conference in 1978 (Kautzky, 2008). Once the ANC came into power and the national health plan 1994 was introduced, PHC was declared a free service at the point of delivery to children under the age of 5 and pregnant citizens. Prior to 1994, the South African healthcare system was sustained through racist legislation and inequality (ANC, 1994). In the national health plan 1994, PHC was highlighted as the heart of the plans to improve health services in South

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Africa. Rehabilitation is seen as an imperative component of PHC. In 1997, the Sub-Directorate for Disabilities and Rehabilitation initiated a process to develop a national rehabilitation policy. In 2000, a national rehabilitation policy was introduced by the SADOH (2000). This policy was supported by the South African National Constitution, which states every citizen has a right to access healthcare services, which includes rehabilitation services. Following the national health plan of 1995, provincial health plans were created to ensure good quality services to fall in line with the expectations created in the national health policies. In 2003, the DOH initiated development of a healthcare plan, 2010, the aim of which was to reshape the services to focus on primary level services, community-based care and preventative care (Western Cape Department of Health [WCDOH], 2003). The plan was to ensure equal access to quality healthcare (WCDOH, 2003), with a strong foundation of PHC services (WCDOH, 2007). In 2007, a comprehensive service plan was published for the implementation of the healthcare 2010. In this plan a framework was created to highlight the necessary changes in services in order for the health plan 2010 to succeed.

In November 2011, the Western Cape Minister of Health introduced a health plan 2020 focusing on a patient-centred approach (WCDOH, 2011). This plan built on the foundation laid by the 1995 health plan and the 2010 comprehensive service plan. In planning for 2020, improving wellness was one of the core focus areas of the WCDOH. Against the backdrop of a quadruple burden of disease in the Western Cape, prevention of disease and the promotion of wellness were deemed priority. In planning for the healthcare plan 2020, the 2010 plan was evaluated, and patient experiences and outcomes compared. Patient-centred quality of care was the main priority of the healthcare 2020. The goal was to ensure that patients are treated with dignity and respect in a clean and safe environment (WCDOH, 2012). Healthcare 2020 thus shifted the focus from mere treatment to the prevention of disease. The plan was based on improving accessibility to healthcare by expanding community and home-based services, services that focus on prevention, promotion of wellness, curing of disease/illness and a patient-centred approach to rehabilitation. The latter was thought to encourage interaction between rehabilitation professionals and the patient (Epstein, 2011).

With constant changes to the external environment such as demographic and socio-economic determinants of health and advances in technology (WCDOH, 2013), the healthcare plan 2020 was revised and became “The Road to Wellness” healthcare plan 2030, focusing on the steps required in addressing the burden of disease, increasing the wellness of communities and ensuring patient-centred quality care. The plan has four pillars as illustrated in Figure 1.1.

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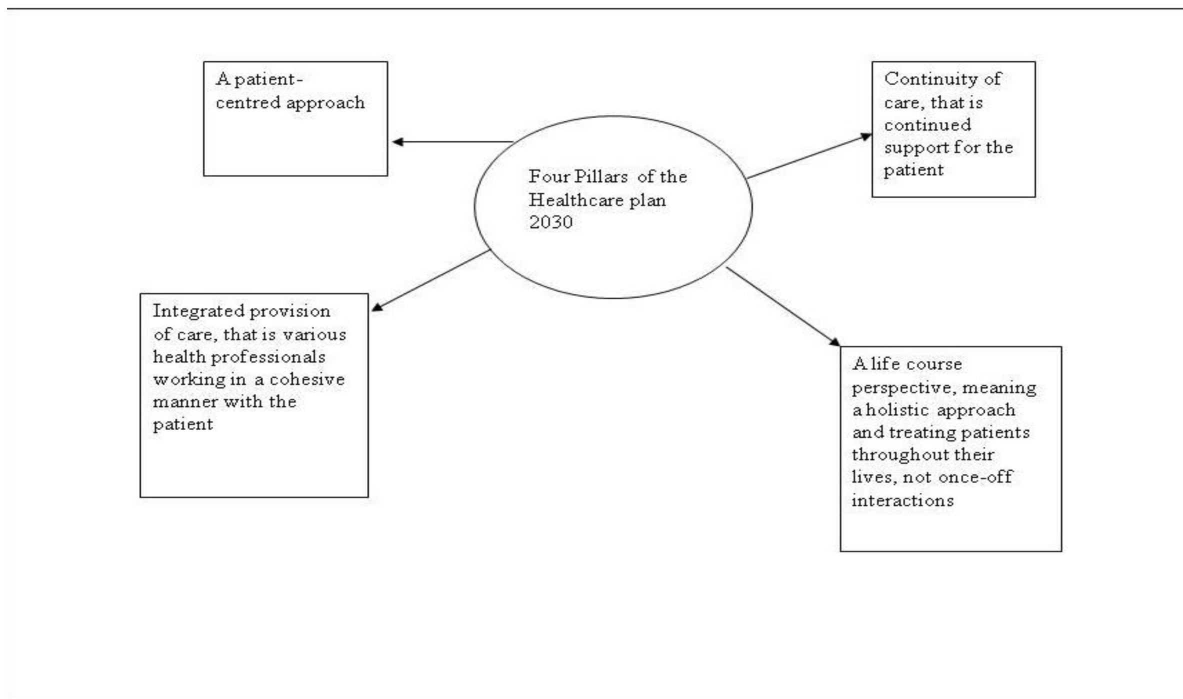

Figure1.1: Four pillars of the healthcare plan 2030

Source: Western Cape Department of Health, 2013

In the plan, emphasis is laid on curative and preventative services with the rendering of rehabilitative and palliative care services at PHC facilities. In the latest plan, provision of PHC service is seen as the most critical component, envisioning the strengthening of community-based services, PHC and district hospitals (WCDOH, 2013). Accordingly, PHC professionals need to be able meet the requirements of the provincial government as stated in the plan.

Within a healthcare policy, expected roles of professionals are highlighted in order to achieve the specific healthcare goals for a certain area (WHO, 2016). Professionals who are aware of policies are more likely to execute their roles as expected, compared to professionals who are unaware of policies (Montoya, 2014). Highlighting the importance of policy perceptions and understanding among healthcare professionals (or rehabilitation professionals) in order to achieve the goals set in the healthcare plan 2030 is thus crucial. Although countries introduce health policies based on the needs of the country, the role of the healthcare professionals may not always be clearly identified. In addition, those who must implement the policy may not understand or be aware of the policy.

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Because rehabilitation plays a key role in the health sector, clearly articulating the roles and contribution of rehabilitation professionals is essential. Various countries have introduced policies using different awareness strategies that could be applied in South Africa. In 2006 for instance, Geneva (Switzerland) introduced a mental health policy by using promotion and prevention strategies while engaging with the local communities (WHO, 2006). In 2010, the United States introduced a health policy project which focuses on maternal health, by making leaders and decision-makers aware of improvements to maternal health (United States Agency for International Development, 2011). There is a need for policy awareness campaigns to ensure that key stakeholders have an understanding of the policy.

In 2002, the national government of India introduced a national health policy after there were significant changes relating to health since the previous policy of 1983 (Government of India: Department of Health and Family Welfare, 2002). In this case, the national health policy had clear goals, listed within a stated timeframe, and the roles of government, non-governmental institutions and professionals were clearly listed. This could be a feature that could facilitate the implementation of a policy.

The national government of Ireland introduced a national health policy (Harvey, 2007) that focused on the delivery of health services for people with medical and social needs who were unable to afford those services. The roles of voluntary and community institutions were discussed in the policy, but the roles of the rehabilitation professionals were not discussed in the plan at all. Later, however, Ireland considered this when introducing a policy for the provision of rehabilitation services in 2009 (National Rehabilitation Hospital [NRH], 2009). In the policy, the benefits of rehabilitation were discussed, followed by recommendations which included development of a national policy for the provision of rehabilitation services in Ireland, the recognition of rehabilitation services as an important part of a national health system, and the development of a rehabilitation services workforce plan (NRH, 2009).

South Africa became a young republic, after the apartheid regime officially ended with the national election in 1994. The equal health system is a new concept introduced to the government, health professionals and patients. Comparing health plans to those of other countries is a way to ensure that plans created by the national or provincial governments are realistic, and can develop strategies that will ensure the successful implementation of these policies.

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1.3 PROBLEM STATEMENT

The vision of the healthcare plan 2030 is for society to have access to patient-centred, quality care. In order to achieve this vision, adequate service provision and providers are required at all levels of care with an emphasis on PHC. Currently, there are human resource shortages in the provision of rehabilitation services at the PHC level in South Africa, resulting in patients experiencing long waiting times and inadequate referral systems between rehabilitation professionals (Mlenzana, 2013). The lack of human resources leads to healthcare professionals at the primary level of care being overburdened and frustrated by a heavy patient load (Mlenzana, 2013). In the face of these challenges, it is important to understand how rehabilitation professionals aim to achieve the goals of the healthcare plan 2030. There is a gap in research of examining the perceptions and understanding of key stakeholders in healthcare policies, therefore a study on the perceptions and understanding of stakeholders is important if the government aims to be successful in achieving its goals.

1.4 RESEARCH QUESTIONS

What are the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030?

What strategies have rehabilitation professionals employed to ensure successful implementation of the healthcare plan 2030?

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1.5 AIM OF THE STUDY

This study's aim is to explore and describe the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030.

1.6 OBJECTIVES

In order to achieve the aim of the study, the following objectives are proposed

- To determine and highlight key aspects of the healthcare plan 2030 as it relates to rehabilitation professionals
- To explore and describe the perceptions, understanding and expectations of rehabilitation professionals at community health centres regarding healthcare plan 2030;

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- To describe whether the strategies rehabilitation professionals employed will ensure that the 2030 healthcare plan may be implemented and the stated goals of the plan be achieved.

1.7 SIGNIFICANCE OF THE STUDY

Implementing a successful healthcare plan is dependent on motivated service providers. If policymakers are to ensure that the designed policy is effective, there needs to be some form of monitoring and evaluation. This study can serve as a baseline of process evaluation by understanding the perceptions of the executors of the policy. Depending on the outcomes of the study, recommendations can be made to government regarding how to create awareness of the healthcare plan 2030 among all health professionals. Through creating awareness, acknowledgement of the healthcare plan 2030 may be gained from the health professionals in order to implement services that are relevant and appropriate for society. Once a committed workforce can be obtained, implementation of the healthcare plan can lead to good health outcomes for the population.

1.8 METHODOLOGY FOR THE STUDY

This study employs an exploratory and descriptive cross-sectional study design using qualitative methods of data collection. Qualitative data collection method allows a detailed explanation of the rehabilitation professional's perception and understanding of an implementation of a new policy (Craven, 2008). In-depth interviews with rehabilitation professionals from three purposefully selected primary health centres were conducted. The selected PHC centres operate in different districts of the Metro Region, Western Cape. This will be discussed further in Chapter 3.

1.9 DEFINITION OF TERMS

Key terms used in the study are listed below.

Community health: Community health focuses on the needs of a demarcated population group to achieve and maintain goals for improving health (Goodman, Bunnel & Posner, 2015)

Health: not only the absence of disease from the body but the absolute state of physical, mental and social wellness (World Health Organisation, 1948)

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Primary healthcare: First contact an individual has with PHC services (Australian Primary Care Nurses Association, 2012)

Rehabilitation professional: include doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, audiologists and dieticians (Arena, 2012).

Rehabilitation services: Services provided by health professionals that may include audiologists, occupational therapists, physiotherapists, speech language pathologists, nurses and doctors (McKell, 2000)

1.10 SUMMARY OF CHAPTERS

In this chapter, the background of the South African healthcare system, policy development in South Africa and rehabilitation were discussed. The healthcare plan 2030 by the WCDOH was introduced. Successful implementation of such a policy requires the understanding of key stakeholders. A corresponding gap in research was identified in this area. The research question, aim and objectives of the study as well as a summary of the methodology were provided.

In Chapter 2, literature is reviewed under the following headings: health policy and systems research, health systems in South Africa, health system development/strengthening, and health policy.

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In Chapter 3, the methodology is described, detailing the study design, study setting, population and sampling, data collection methods, data analysis, trustworthiness and ethical considerations.

In Chapter 4, the results of the study are presented in terms of the objectives of this study. The results are discussed under four headings: document review, profile of rehabilitation professionals, arising themes from interviews, and strategies that rehabilitation professionals employ to ensure successful implementation.

In Chapter 5, the study is summarized. The limitations of the study is discussed and recommendations are discussed under four headings: communication, policy workshops, investing in human resources and further research

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CHAPTER 2

LITERATURE REVIEW

2.1 ORIENTATION OF CHAPTER 2

In this chapter, appropriate literature will be reviewed focusing on health policies, councils of rehabilitation professionals, and rehabilitation in the healthcare sector.

2.2 HEALTH POLICY AND SYSTEMS RESEARCH

Health policies are based on the understanding of the current dynamics of health system functioning, and are sustained by the expression they find in health systems (WHO, 2017). Emphasis on policy implementation allows for better understanding of health systems. Health policy and systems research (HPSR) focuses on how institutions run in order to achieve collective health goals and how these institutions adapt to the implementation of health policies (WHO, 2017). There are five key characteristics of HPSR: multidisciplinary research, the focus on health services, concern for global and international issues, research of health policy, and promoting work that influences policy (Gilson, 2012). Multidisciplinary research addresses health problems through research rather than via a discipline-specific approach (Gilson, 2012), and covers all fields affected by a health policy. HPSR involves issues on global, international, national and subnational levels, and influences the health systems in low and middle-income countries (Gilson, 2012). Research relates to the development and implementation of policies and the influence policy executors have over the outcomes of the policy, as well as promoting actions that influence a policy.

The four elements of HPSR are health systems, health system development or strengthening, health policy and health policy analysis (Gilson, 2012). The first two elements create an understanding of the different elements and characteristics of a health system, thereby creating an opportunity to identify connections to improve the health system. Analysis of a policy creates an understanding of the factors that influence policy outcomes in order to support better policy implementation.

The current study aims to understand how the perceptions of the 2030 healthcare plan by rehabilitation professionals affect their implementation of the plan at different facilities. Because the aim of this study falls in line with the focus of HSPR, literature will be reviewed using an HSPR approach.

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2.3 HEALTH SYSTEMS IN SOUTH AFRICA

A health system is known by what it aims to achieve, which is general health improvement. A good health system delivers easily accessible health services to all citizens when needed (WHO, 2017). South Africa's health system is divided into non-governmental organisation (NGO) healthcare provision, private healthcare systems and the public healthcare system (Jobson, 2015). NGOs provide free healthcare services to both South Africans and non-South African residents (Segatti, 2011), focusing mainly on HIV/Aids and tuberculosis (Jobson, 2015). NGO healthcare provision plays a vital role in the overall function of South Africa's health systems as it forms a link with patients with disabilities and various sectors to deliver community-based rehabilitation (CBR). These sectors include government, non-government, social, health, education, employment, labour, media and the community (WHO, 2004). To ensure success of CBR, these sectors must work collaboratively and not in isolation.

CBR is an approach aimed specifically at improving the quality of life of patients with disabilities by removing barriers and encouraging social change rather than merely focusing on a medical cure (Khasnabis, Heinicke Motsch & Achu, 2010). To remove the barriers, CBR makes rehabilitation services accessible to all. It envisions a society where there is a decrease in the occurrence of disability and where patients with disability will be fully integrated into society (Mansor, 2015). CBR focuses on the five key domains of good health: health, education, livelihood, social life and participation (Figure 2.1).

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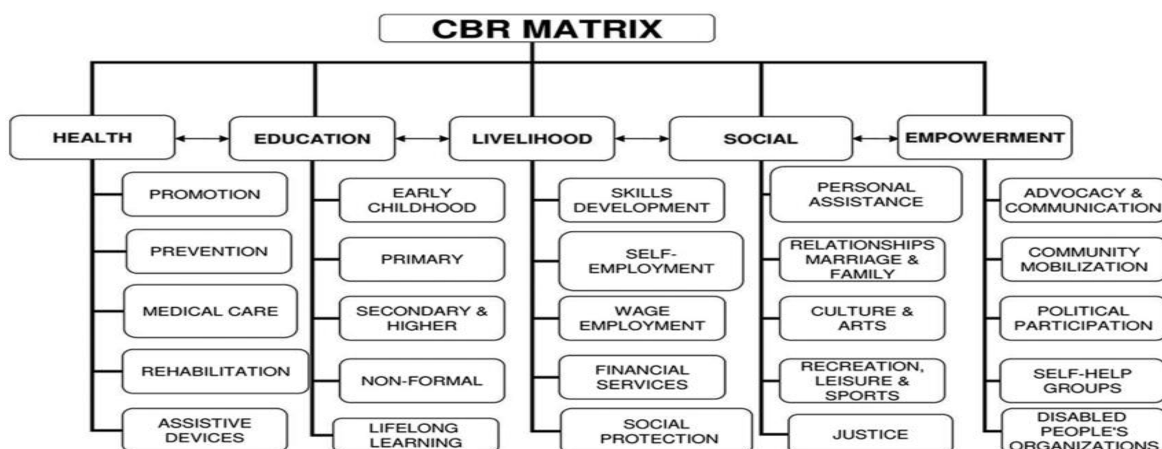

Figure 2.1: Community Based Rehabilitation matrix

Source: Khasnabis and Motsch, 2008

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There are five subdomains under each domain which make up the CBR matrix in Figure 2.1. Healthcare is focused on receiving health at existing health facilities and with the subdomains of promotion, prevention, medical care, rehabilitation and assistive devices. Education is related to early childhood, primary, secondary and higher, non-formal and lifelong learning which is obtained from a regular school or college. Livelihood relates to skills development, self-employment, wage employment, financial services and social protection. Social refers to an income-generating programme. Participation focuses on integration into the community by assessing advocacy and communication, community mobilisation, political participation, self-help groups and disabled people's groups.

The private healthcare system has services rendered by healthcare professionals who provide services on a private basis (Jobson, 2015). The South African private healthcare system was evolved to meet the demands of citizens for quality healthcare (Econex, 2013). The private healthcare system has seen an increase of 300% in 10 years (Ngoepe, 2016). According to Ngoepe (2016), only 17% of South African citizens can afford private sector care. South Africans who can, move to the private sector as facilities are in a better condition than in the public sector, the treatment received at the private sector is of a better quality, and the perception is that equipment used in the private sector is better (Difference Between, 2011).

According to Difference Between (2011), there are stark differences between private and public health systems. The first, obvious difference is that the private sector is managed by a group of people who manage the finances independently while public is managed using government funding. The cost of private healthcare treatment is much higher than in the public sector where services are usually free or are offered for a reduced fee. The waiting time in private is shorter than in the public health sector, where patients have increased waiting periods for appointments and operations. Owing to overuse, public sector equipment is not as modern and has a shorter lifespan than the equipment in private hospitals. The patient–health professional ratio is much higher and very skewed in the public sector compared to the private sector. With this background, it is important to establish how rehabilitation professionals manage with this increased patient load.

The public healthcare system provides services for free to people needing healthcare and its foundation is the PHC clinics (Jobson, 2015). As a result of the vast difference between public and private sectors, the South African Health Minister proposed the National Health Insurance (NHI) scheme, highlighting the high costs of the private healthcare system. The

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NHI is meant to ensure an equal health system that makes healthcare accessible to all South Africans (Ngoepe, 2016) In spite of 300% increase in private healthcare, a study conducted by Econex (2013) revealed that the South African private healthcare system provides healthcare services to nearly 40% of its population while 59% of specialists are active in the private healthcare system.

In order to determine the manner in which health systems adapt to health policies, the current health system needs to be understood. This study aims thus to describe the implementation strategies of rehabilitation professionals to successfully implement healthcare plan 2030, with a focus on unpacking current health system of South Africa.

2.4 PRIMARY HEALTH CARE

PHC is the first contact patients, families and community members have with the healthcare system (PHC Research & Information Service [PHCRIS], 2017). The PHCRIS (2017) states that because it is the first level of contact for patients, families and community members, the services should be located as close as possible to the patient's home and workplace. The main aim of PHC is better health for all (WHO, 2017). According to the PHCRIS (2017), PHC focuses on the main health problems in communities by providing promotive, preventative, curative and rehabilitative services. PHC is important for early diagnosis, treatment and referral to secondary and tertiary institutions. At PHC level, patients are treated for common illnesses, management of long-term illnesses and the prevention future illnesses by offering education, immunisation and regular screening for illnesses/diseases (University of Bristol, 2017).

According to Kautzky and Tollman (2008) South Africa has made good progress since the introduction of PHC into the country's healthcare system over 20 years ago, but is still far from reaching the Alma Ata's aim of "better health for all". There is a misconception of what PHC really is, creating unrealistic expectations of health service delivery and health outcomes (Dookie & Singh, 2012). Dookie and Singh (2012) explain that since the end of the apartheid regime, there has been an increase in accessibility of healthcare facilities for patients, but the gaps to successful implementation of PHC is made up of resource constraints, migration of healthcare professionals from public to private sectors, unequal distribution of professionals in public and private sectors, decreased staff motivation, poor skills levels and managerial incapacity. All of these factors play key roles in the

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implementation of PHC as it requires a well-functioning district health system in order to succeed (Dookie & Singh, 2012). Based on the emphasis on health promotion and disease prevention, there needs to be a strong orientation of rehabilitation in PHC (World Confederation of Physiotherapy, 2013).

2.5 REHABILITATION IN THE HEALTHCARE SYSTEM

Rehabilitation is a branch of medicine that empowers the patient more than the doctor in setting goals and restrictions (Rusk, 1972). Empowerment of patients helps in maintaining the state of well-being once the goals are reached. Rehabilitation is aimed at managing someone in order to reach their highest level of function while focusing on independence and self-determination (WHO, 2016). Rehabilitation refers not only to physical wellness but also to the sensory, intellectual, psychological and social well-being of the patient. This is emphasised by the six focus areas in rehabilitation: physical, spiritual, emotional, vocational, psychological and social. Figure 2.2 shows the dimensions of rehabilitation which addresses all aspects of the patient and not only the physical component (Singapore Cancer Society, 2016).

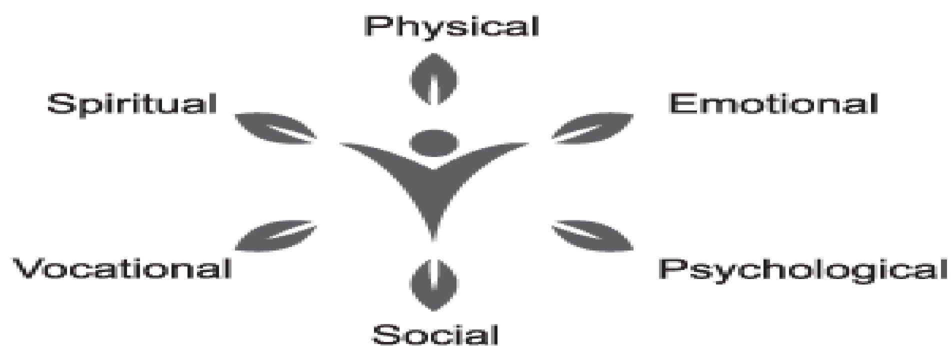

Figure 2.2: Focus areas of rehabilitation
Source: Singapore Cancer Society, 2016

Rehabilitation provides a holistic approach to treatment as the different professionals, assessments and evaluations are brought together (Norrefalk, 2003). Providing rehabilitation at every level of healthcare allows for more patients to be treated holistically, to improve the patient's quality of life (Stavrev, 2003). The holistic approach not only focuses on the diagnosis or disability, it also sets a focus on the patient and their interaction with their

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environment (Walter, 1999). Rehabilitation is an ongoing and goal-driven process that commences at the onset of patient's illness or injury and only comes to an end once the patient is reintegrated into the community (Vekerdy, 2016). It involves the ability to independently perform activities of daily living such as bathing and dressing. This shows the role rehabilitation plays in reintegration into the community following injury or illness.

2.5.1 Levels of rehabilitation facilities in South Africa

In light of the broad nature of the rehabilitation, it is grouped into five levels depending on the needs of the patient (Spectrum Health, 2016). The roles of rehabilitation professionals are different at these respective levels.

Young (2007) describes rehabilitation workers as a group of professionals with different roles in order to help a patient achieve goals which are unique to the patient. These rehabilitation professionals include doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, audiologists and dieticians (Arena, 2012). Thus, a rehabilitation professional is a qualified individual who assesses a patient in order to determine their role in encouraging the quality of life of that patient. Together, these individuals form a unit known as the multidisciplinary team. Institutions have occupational therapy technicians, care-givers, health promoters, and physiotherapy assistants. It is however not made clear whether they are all seen as rehabilitation professionals. As stated in the Health Professions Council of South Africa (HPCSA) guidelines, these individuals are allowed to practise under the supervision of a registered practitioner but they are still performing professional acts. There needs to be a clearer indication of what a rehabilitation professional is and what their role entails.

2.5.1.1. Acute care and inpatient rehabilitation

This level of rehabilitation provides 24-hour medical care to patients who require intensive multidisciplinary rehabilitation (Burke Rehab, 2016). Examples of these facilities are a hospice or a rehabilitation unit of a hospital. In the Western Cape, Life Vincent Pallotti Hospital is an example of acute care and inpatient rehabilitation.

Rehabilitation professionals in the multidisciplinary team work individually with the patient to achieve discipline-specific goals that all relate to the overall goal of the patient (Behm & Gray, 2012). Below is the interdisciplinary model (also referred to as the inter-professional model), illustrating the patient as the centre, with the rehabilitation professionals all having a direct link to the patient (see Figure 2.3). At this level of rehabilitation facilities,

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professionals are actively involved in the management of patients. The rehabilitation professionals are all linked to one another around the patient, proving the interaction between the different disciplines to provide holistic treatment for the patient. Once again, the discipline-specific goals are not elaborated upon, therefore the roles of the different disciplines are not made clear.

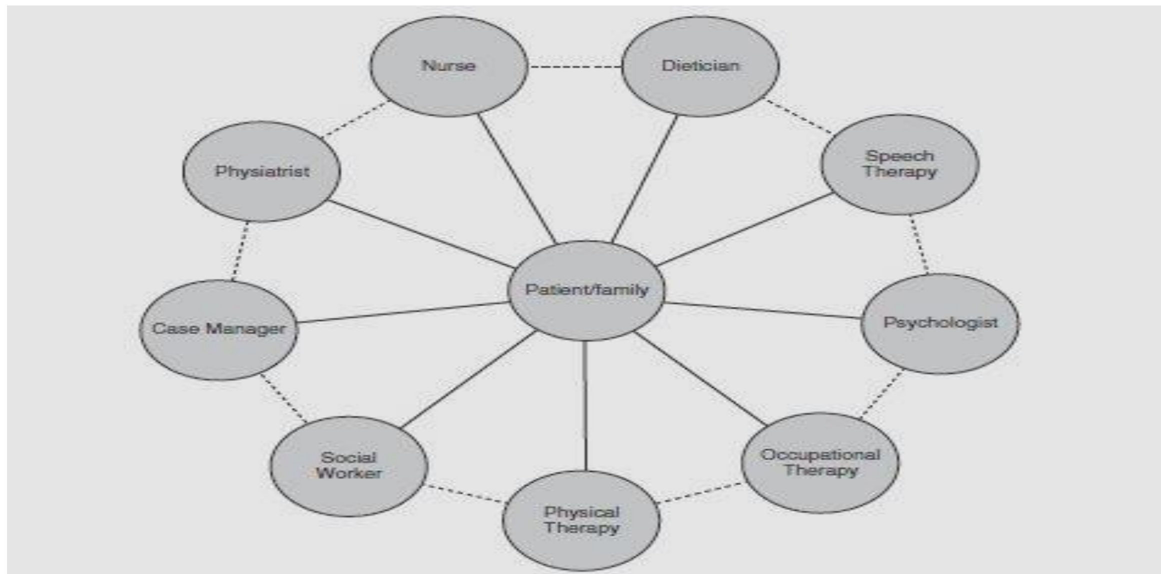

Figure 2.3: Interdisciplinary model
Source: Behm and Gray, 2012

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2.5.1.2. Subacute facilities

This level of rehabilitation is for patients who do not require intensive diagnostic or invasive procedures, but require more intensive rehabilitation than a skilled nursing facility can provide (Intercare, 2016). According to Montoya (2017), the patients at this level are not fully functional and stay at these facilities where they receive rehabilitative services until they are able to function independently. Rehabilitation centres such as Intercare, Tygervalley in the Western Cape, are examples of this level of care.

Rehabilitation at a subacute facility is offered to patients who require wound care, pain management and nutritional counselling (Workmen's Circle MultiCare Centre, 2016). They also offer restorative rehabilitation to patients with orthopaedic injuries and impairments resulting from neurological disorders (Workmen's Circle MultiCare Centre, 2016). The rehabilitation professionals presented at this level include doctors, physiotherapists,

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occupational therapists, psychologists, speech therapists, dieticians, optometrists and nurses (Intercare, 2016).

2.5.1.3. Long-term care facilities

Patients requiring this level of rehabilitative care need one or more treatment areas. They receive treatment two or three times a day. The Western Cape Rehabilitation Centre is the only example of this level of care in the Western Cape (Western Cape Government, 2017).

At this level, rehabilitation professionals treat patients with physical disabilities resulting from strokes, amputations or spinal cord injuries (Western Cape Government, Specialized Healthcare Facilities, 2017). The rehabilitation professionals at these long-term care facilities include doctors, nurses, physiotherapists, social workers, dieticians and speech therapists. These professionals are assisted by non-professional health carers such as home-based carers.

2.5.1.4. Outpatient facilities

These patients also require one or more treatment areas. Weekly treatment is required depending on the severity of the injury or illness. This level of rehabilitation occurs at community health centres or the outpatient departments of tertiary and district hospitals (Spectrum Health, 2016). For the purpose of this study, the focus is on this level of rehabilitation.

2.5.1.5. Home health agencies

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This level of rehabilitation offers specific rehabilitation services at the patient's home and treatment is given as the patient requires it (Spectrum Health, 2016).

2.5.2 Councils of rehabilitation professionals in South Africa

Rules of conduct when providing service to those in need of rehabilitation services are given to rehabilitation professionals once they complete their training, as they are expected to register with their respective national health councils. Allied health professionals such as physiotherapists and occupational therapists register with the HPCSA, doctors register with the South African Medical Association National council (SAMA) and nurses register with the South African Nursing Council (SANC). These councils through their rules ensure conduct that complements the National Patients' Rights Charter. In the guidelines, safety, access to healthcare, knowledge of medical schemes and conditions, choices of services, confidentiality, informed consent, continuity of care and rights to complain are addressed.

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The patients' rights are listed and elaborated upon; these rights are expected to be protected and respected by rehabilitation professionals who treat them.

In the HPCSA guideline (2008), the roles of the rehabilitation professionals are not stipulated. In booklet 2 of the HPCSA guideline, the rules of rehabilitation professionals are stipulated in terms of meeting the rights of the patient. The rules eliminate behaviour that is not allowed and specify required behaviour. The roles of the rehabilitation professionals are touched upon, as main responsibilities are given to the practitioner (HPCSA, 2008). In the annexure, rules of conduct are listed according to the different professionals who play a role in rehabilitation. If a rehabilitation professional fails to adhere to stipulated guidelines, the professional will be brought under evaluation and disciplinary steps may be taken against the professional. The roles of rehabilitation professionals registered with the HPCSA can be found in the scope of practice. Each profession is elaborated upon and their roles discussed. For example, psychologists are subcategorised into registered counsellors, psychometrics, clinical psychologists, counselling psychologists, educational psychologists, research psychologists, neuro-psychologists and forensic psychologists. The scope of practice is given to each of the divisions of each professional that registers with the HPCSA. This information can be accessed by all rehabilitation professionals, patients and the rest of the public.

In the code of conduct for doctors and medical practitioners, there are clear rules emphasising the expected conduct of the registered professionals (SAMA, 2016). The scope of practice for doctors and medical practitioners are not accessible to the public. In their code of conduct, SAMA (2016) fails to elaborate on the roles and responsibilities of the doctors or medical practitioners. This creates a gap in the knowledge of other health professionals regarding the roles of the doctors and medical practitioners.

The South African Nursing Council (SANC) provides nurses and nursing staff with the ethical principles which nursing practitioners are expected to adhere to. The scope of practice of registered nurses describes the expected roles of registered nurses and nursing staff (SANC, 2005). In the scope of practice, specific roles are listed to the different nursing ranks, namely registered nurse, registered midwife, enrolled midwife, enrolled nurse, enrolled nursing assistant. This gives a clear indication of the roles of nursing staff.

Once the respective rehabilitation professionals are aware of their expected role, for successful interdisciplinary, the other rehabilitation professionals should be made aware of

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their colleagues' roles. Understanding the roles of fellow rehabilitation professionals proves to be one of the key attributes to successful interdisciplinary teamwork (Nanncarrow, 2010). This has to be implemented at a level where all professionals have access to ways to learn about other professionals. Inter-professional education (IPE) has been implemented at learning/training institutions to encourage that students learn from two or more professions to enable effective collaboration and to improve health outcomes (IPE Collaborative Expert Panel, 2011). IPE in health involves an inter-professional educator teaching students by developing knowledge, skills and attitude to create good multidisciplinary interaction between the different health professionals (Shauna, Bhushan, Broeseker, Conway, Duncan-Hewitt, Hansen & Westberg, 2009). This provides means for health professionals to have a clear understanding of their expected roles. However, owing to lack of research to confirm the success rate of IPE, not all institutions of higher learning implemented IPE into their programmes (Illingworth, 2007). One of the barriers of successful implementation of IPE at tertiary level is lack of knowledge of the scope of practice (WHO, 2013). This occurs when rehabilitation professionals are not aware of the roles and duties of another rehabilitation professional. In a study of health professionals, Baker (2011) found that professionals' knowledge and skills were sometimes disregarded by other professionals. In the study, Baker (2011) reported how certain rehabilitation professionals felt that the lack of knowledge of the next professional's scope of practice led to "inappropriate consultations". This proves the importance of awareness of roles of rehabilitation professionals to ensure good health service delivery. Successful IPE implementation at a tertiary level ensures a good collaborative practice among qualified health professionals (WHO, 2013).

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Collaborative practice occurs when professionals from different disciplines come together with patient and family to deliver the highest quality of care to the patient (WHO, 2010). In CP there are four competency domains to successful implementation: values/ethics for inter-professional practice, roles/responsibilities, inter-professional communication and team and teamwork (Association of Schools of Allied Health Professions [ASAHP], 2011). The roles and responsibilities discussed by ASAHP highlights the importance of knowing the expected roles of all professionals in order to provide optimal healthcare to the patients. This allows for proper referral and continued professional and inter-professional development (ASAHP, 2011). ASAHP (2011) refers to scope of practice of the various professionals. As elaborated above, the scope of practice specifies the roles and responsibilities of the rehabilitation professionals, which gives clarity of vital importance.

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Professional boards serve as a guideline used by rehabilitation professionals to determine their roles in a health system. However, the roles are not always clearly defined. This highlights the necessity of understanding the rehabilitation professionals' perceptions of the roles expected of them from government. Gauging their views will provide an indication of how they adapt their actions at their facilities to implement a new health policy.

2.6 HEALTH SYSTEM DEVELOPMENT OR STRENGTHENING

To identify actions to develop or strengthen health systems, there are three factors that need to be considered: altering of structures of the health system, how the actions of the health system agents can be influenced, and implementing the changes that will most likely result in the intended effects of the policy (Gilson, 2012).

2.6.1 Altering of structures of the health system

A failing health system can lead to inequality and increase poverty of a country (Sambo, 2012). South Africa has transitioned its health system from health service delivery to a patient-centred approach.

2.6.1.1 Patient-centred approach

Even though the principle of a patient-centred approach was highly supported by the health departments across the world, its infiltration into healthcare systems is limited (Little, 2000). According to Little (2000), the lack of feasibility of implementing all domains of patient-centred approach is a reason for the limited infiltration in healthcare systems. There are five principle domains in the patient-centred model of consultation: determine the patient's experience and expectations of disease and illness, understanding patient as a whole, forming partnerships to have common ground regarding management, health promotion, and enhancing the doctor–patient relationship; a sixth domain was also highlighted, namely the realistic use of time (Little, 2000). In order for an approach or policy to be implemented successfully, it has to abide by the National Core Standards (NCS) of South Africa (SADOH, 2012).

The NCS is a benchmark for quality of healthcare created by the Office of Standards Compliance. The NCS was created to develop a general definition of quality care for health professionals, patients and the rest of the public and to use as a tool to assess, identify gaps and strengths of institutions (SADOH, 2012). There are seven domains to the NCS, which

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together are used as a measurement tool. All of these domains are to be upheld at the institutions: patient rights, patient safety, clinical governance and care, clinical support services, public health, leadership and corporate governance, operational management and facilities and infrastructure (SADOH, 2012).

2.6.2 Influence of actions of health system agents

In 2011 the South African government introduced a national health strategy where a problem statement was listed (South Africa, Human Resources Health, 2011) revealing what difficulties the government would face before a new plan could be implemented. It revealed a decline in the number of health professionals in the public sector, the disproportion of health professionals in the public sector compared to the private sector. The Board of Governors (2012) explains how shortage of staff can lead to overlapping of duties by other professionals in order to cover all patient needs. This situation also indicates why the understanding of role expectancy is being questioned.

2.6.3 Implementation of changes

Developing a theory of change assures policymakers that the system is on track in order to reach the desired outcomes of policy implementation (Learning for Sustainability, 2017). Theory of change evaluates how guidelines in policies are perceived and understood, and evaluates the results to assess the policy's intended impact in a healthcare system (Rogers, 2014). According to Learning for Sustainability (2017), exploring the current situation indicates the efficiency of policy which is achieved by highlighting the inputs, activities and outputs. Once the efficiency of a policy is determined, it indicates the policy's effectiveness. Similarly, exploring the current strategies rehabilitation professionals use to ensure successful implementation of the healthcare plan 2030 can reveal whether the implementation can be effective.

To strengthen and develop the health system, the Western Cape government created healthcare plan 2030, which is the focus of this study. This study addresses the three factors of health system development and strengthening by exploring key elements of the healthcare plan 2030, identifying the actions of rehabilitation professionals and assessing how the actions of rehabilitation professionals will impact on the policy outcome.

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2.7 HEALTH POLICY

A health policy is a formal document that describes the action needed to be taken to develop or strengthen the health system or to improve health (Gilson, 2012). The policy is based on the results of decision-making by policy actors such as healthcare professionals and patients (Gilson, 2012). There is a difference between a health policy and a healthcare policy (Taylor, 2013). While a health policy is aimed at merely improving health, a healthcare policy focuses on the rendering of health services (Taylor, 2013).

2.7.1 Journey of health policy development in South Africa

After the apartheid regime, the national ANC government that came into power in 1994 introduced a national health plan where emphasis was laid on equal access healthcare services (ANC, 1994). The ANC initiated the process of developing a health policy based on the PHC approach (ANC, 1994). In the health plan, the ANC commits itself to health promotion through prevention and education. As stated in the national health plan 1994, no plan can be considered final, as planning is an ongoing process and has to be evaluated and re-evaluated.

In 1997 the South African national government introduced the Integrated National Disability Strategy to specifically address rehabilitation needs which were considered to be rejected in healthcare at that time (South Africa, Integrated National Rehabilitation Strategy, 1997). The government found that people living with disabilities were not reintegrated back into their communities. This was a problem because of the high percentage of people living with disabilities in South Africa (South Africa, Integrated National Rehabilitation Strategy, 1997). Research showed that between 5–12% of the population was moderately to severely disabled (South Africa, Office of the Deputy President, 1997). In the strategy, the national government committed itself to the protection and promotion of the rights of the disabled community of South Africa.

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In 2007 the Western Cape provincial government introduced the Comprehensive Service Plan for the Implementation of Healthcare 2010. Quality care at all levels, accessibility of care, efficiency, cost effectiveness, a PHC approach, collaboration between all levels of care and reduction of chronic institutional care were listed as the underlying principles of healthcare 2010 (WCDOH, 2006). The idea with the introduction of the 2020 plan in 2011, was to

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regard healthcare as a continuing process (Dettling, 2011). Seven guiding principles were identified in the plan to guide the process: patient-centred quality of care, move towards an outcomes-based approach, retention of a PHC philosophy, strengthening the district health services model, equity, affordability and building strategic partnerships (WCDOH, 2011). The plans are adapted to changes in socio-economic and demographic determinants of health since the last plan. The South African government implemented the NHI system which was set to run for 14 years from 2012 onwards (SADOH, 2015). The NHI aims to deliver free comprehensive healthcare to all South Africans. Health policies created fall in line with the NHI to ensure accessible and affordable health service delivery. The healthcare plan 2030 is the follow-up of the previous plan to ensure this process is continued for better healthcare service delivery.

2.7.2 Stakeholders' understanding of policy development

Engaging stakeholders for policy development plays a vital role in improving clinically sound public health policy decision-making (Lemke & Harris-Wai, 2015). According to Lemke and Harris-Wai (2015), stakeholders' perceptions and understanding are important in policy development to create transparent and trusted health policies.

The healthcare plan 2030 was published on the provincial department's website for feedback from any interested parties (such as patients or rehabilitation professionals). There was general support for the plan; criticism that was given by individuals was used by the government to improve the plan (Vallabhjee, 2011). The identity of individual commentators on the policy was kept confidential in the publication of the plan. These comments were not individually listed but a general overview of comments was provided. One of the main criticisms was that there was not a clear indication of the roles and skills required for professionals providing services in the community. This highlights the need to determine the perceptions and understanding of key stakeholders such as health professionals whose actions will influence the outcomes of the healthcare plan 2030.

2.8 HEALTH POLICY ANALYSIS

Health policy analysis is considered a central stand of HPSR as it can be used in a prospective manner to encourage a health policy change in order to strengthen healthcare systems (Gilson, 2012). Using health policy analysis prospectively allows the researcher to

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determine the expected outcome of a policy and is therefore relevant to this study as the health policy has not been implemented yet.

2.8.1 Analysis of determinants of policy impact model

The analysis of determinants of policy impact (ADEPT) model is an approach that allows analysis of policies using a theory of action (Rutten, Gelius & Abu-Omar, 2013). The ADEPT model attempts to explain policies and investigate the influence of policy development and implementation. This analysis is done by highlighting four determinants in the policy: goals, obligations, resources and opportunities. The aforementioned determinants provide the impact of the policy by considering the output and outcome, while the output determines the outcome. The output is the strategies that have been employed to ensure the goals of the policy have been achieved (Rutten et al., 2013). Policies that have not been implemented have intended outputs and intended outcomes.

2.9 SUMMARY OF CHAPTER

Using HPSR principles, literature was reviewed in this chapter on the South African health systems, health system development and strengthening in South Africa, South African health policies and health policy analysis.

The objectives of this study are in direct correlation to the five characteristics of HPSR and will, therefore, use HPSR to explore how facilities are run to achieve the goals of healthcare plan 2030. This is achieved by focusing on rehabilitative services and on the different rehabilitation professionals. The healthcare plan 2030 is reviewed and compared to international policies as South Africa is a developing country. The study also explores the strategies that rehabilitation professionals employ to ensure successful implementation of the healthcare plan 2030.

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CHAPTER THREE:

METHODOLOGY

3.1 ORIENTATION OF CHAPTER 3

In this chapter, the researcher discusses the methodology employed to conduct the current research. The aim of the study is to explore the perceptions and understanding of rehabilitation professionals. Methodology refers to the approach that the researcher chooses to conduct the research; this approach determines the study design and the research tools that will be utilised.

3.2. STUDY DESIGN

This study employs an exploratory study design using qualitative methods of data collection. The design is exploratory as it explores the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030. According to Jackson (2012), exploratory research designs are used to make preliminary investigation into relatively unknown areas of research. On the other hand, descriptive cross-sectional studies can provide insight into health-related views or characteristics in a population (Barratt and Kirwan, 2009). In qualitative methods of data collection, the researcher's results are based on the perceptions of participants on the meaning of the data (Creswell, 2001).

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3.3 STUDY SETTING

This study was conducted at PHC centres that operate in different districts of the metro region of the Western Cape Province. For logistical purposes, the three facilities were conveniently chosen from the metro region. These centres provide rehabilitation services to the communities within and beyond their catchment areas.

Centre A is a community health centre that primarily serves an urban population that is mostly unemployed. At this centre, patients access the rehabilitation unit through referral from other institutions or self-referral. The rehabilitation unit is run by a doctor and is comprised of a physiotherapist, an orthopaedic sister, a sessional occupational therapist, a sessional dietician, doctors, pharmacists and nurses.

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Centre B is a community day centre rendering rehabilitation services to both urban and rural communities. The patients at this centre are referred from primary health clinics in the catchment areas and through outreach programmes. Doctors from the secondary hospital in the area also refer patients to the centre. Based at this unit are a physiotherapist and two occupational therapists. A community service physiotherapist has not been appointed for the current year; the post is vacant. Doctors, nurses and pharmacists also play a role with the rehabilitation team at the centre.

The final centre, centre C, is a semi-independent rehabilitation centre linked to a community health centre and an academic university. This rehabilitation team is run by a doctor specialising in family medicine. Referral to this centre occurs primarily through the community health centre and walk-in patients from private doctors and other referring hospitals. The centre provides physiotherapy, occupational therapy and social work services, while students from a local university provide speech therapy on a part-time basis. Doctors, pharmacists and nurses play a role in the rehabilitation of patients. There is a health promotion officer who plays a key role in the promotion of good health in the area.

3.4 POPULATION AND SAMPLING

The study population is rehabilitation professionals who have obtained a tertiary qualification in the community health and medicine fields working at the selected centres. These rehabilitation professionals include general practitioners, physiotherapists, social workers, occupational therapists, dieticians, clinical nurse practitioners and orthopaedic sisters. They were included in the study if they interacted with persons in need of rehabilitation. Purposeful sampling was used for the study as this form of sampling is based on specific rather than random sampling. A total of thirteen professionals were interviewed at the three PHC centres, a further seven participated in a FGD until saturation was reached.

In light of staff shortages in the South African public sector, many primary health centres only have one discipline represented at the facility. Anonymity in these results is maintained by using codes to represent participants, with no correlation to the order of the demographic information of rehabilitation professionals in Table 3.1 FG1 represents participants in the FGD that took place at one facility.

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Table 3.1: Profile of rehabilitation professionals

Rehabilitation professional	Profession	Years in public sector
P1	General practitioner	7 years
P2	Physiotherapist	12 years
P3	Occupational therapist	6 years
P4	Dietician	4.5 years
P5	Occupational therapist	5 years
P6	Nurse	2 years
P7	Clinical nurse practitioner	15 years
P8	Nurse	8 years
P9	Physiotherapist	7 years
P10	General practitioner	21 years
P11	Nurse	1 year
P12	Pharmacist	6 years
P13	Social worker	7 years
FG1, P1	Nurse	1 year
FG1, P2	Nurse	3 months
FG1, P3	Clinical nurse practitioner	10 years
FG1, P4	Nurse	4 years
FG1, P5	Nurse	17 years
FG1, P6	Clinical nurse practitioner	13 years
FG1, P7	Nurse	5 years

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3.4.1 Inclusion criteria

The criteria for inclusion in the study were that all registered rehabilitation professionals were are able to render a rehabilitative service at one of the selected PHC centres without the presence of another practitioner, and had more than one year of experience.

3.4.2 Exclusion criteria

The exclusion criteria in the study were individuals who cannot render a service without the presence of a registered practitioner. Physiotherapy assistants and occupational technicians are examples of individuals who received training in specific areas of a field but do not have the tertiary qualification (Bachelor of Science in Physiotherapy/Occupational Therapy) to practice independently therefore, they were excluded from the study.

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3.5 DATA COLLECTION INSTRUMENTS

This study employed two data collection instruments, namely the analysis of determinants of policy impact (ADEPT) model for document review, an interview schedule for individual interviews and theory of change model.

3.5.1 Document reviews

Document reviews are important to explore background information, to determine whether actions of policy stakeholders conform to the expected policy impacts, and to assist in the development of further data collection tools (South Africa, Department of Human and Health Services, 2009).

One of the objectives of this study is to highlight key aspects of the healthcare plan 2030. The document review allows the researcher to explore the background information of the policy. Another objective of this study is to determine the implementation strategies rehabilitation professionals employ to ensure successful implementation of the healthcare plan 2030. On completion of the document review, the researcher could develop the interview schedule (see Appendix C) to achieve the second and third objectives of the study.

3.5.2 Individual interviews and FGD

A semi-structured interview schedule was used during individual interviews and FGD. Semi-structured interviews use several key questions with probes to explore the participant's view on an issue (Gill, Stewart, Treasure & Chadwick, 2008).

Semi-structured interviews are usually used in healthcare. This is relevant to the study as this format allows the researcher to explore perceptions and understanding of rehabilitation professionals of the healthcare plan 2030 without asking direct questions, enabling the researcher to probe participants to gain further insight into their knowledge.

3.5.3 Theory of change

Developing a theory of change can assure policy makers that the current actions of executors are on track to reach the goals of the policy (Learning for Sustainability, 2017). Once the current actions of rehabilitation professionals are known, a theory of change can be developed. This will provide an indication to WCDOH whether rehabilitation professionals' strategies align with the goals and intended outputs of the healthcare plan 2030. If the

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strategies align to the policy, it will indicate the ability of rehabilitation professionals to achieve the goals of healthcare plan 2030. If the strategies do not align, it will indicate to WCDOH that rehabilitation professionals are willing to adapt their practice to achieve the goals or demands from facility management and government.

3.6 DATA COLLECTION METHODS

This study employed three data collection methods, each of which is discussed below.

3.6.1 Document review (healthcare plan 2030)

Review of the Western Cape Department of Health (WCDOH) healthcare plan 2030 was undertaken using the ADEPT model (Rutten et al., 2010). This model was adapted from Von Wright's theoretical model of human behaviour which is based on the four determinants of wants, abilities, duties and opportunities. These were then interpreted as goals, resources, obligations and opportunities (Rutten et al., 2010). This model has been widely used and is recommended as a user-friendly tool to develop, analyse and evaluate policies (Rutten et al., 2012; Rutten, Gelius & Abu-Omar, 2011).

The model puts emphasis on determinants of the policy, output and outcomes of the policy. When doing policy analysis using this model, certain questions that unpacked the determinants were answered to enable rating of the quality of the policy to take place. Once all determinants were answered, the model suggested that the policy be further analysed based on outputs and outcomes of the implementation. During analysis of healthcare plan 2030 documentation, the researcher adapted this model and made adjustments, since the policy being reviewed was not yet implemented. The adjustments focused on intended outcomes and outputs rather than on actual outcomes and outputs. Once the analysis was done, the researcher developed themes and probing questions for an interview guide to use in the focus group discussion (FGD). Figure 3.1 which follows is an example of the ADEPT model.

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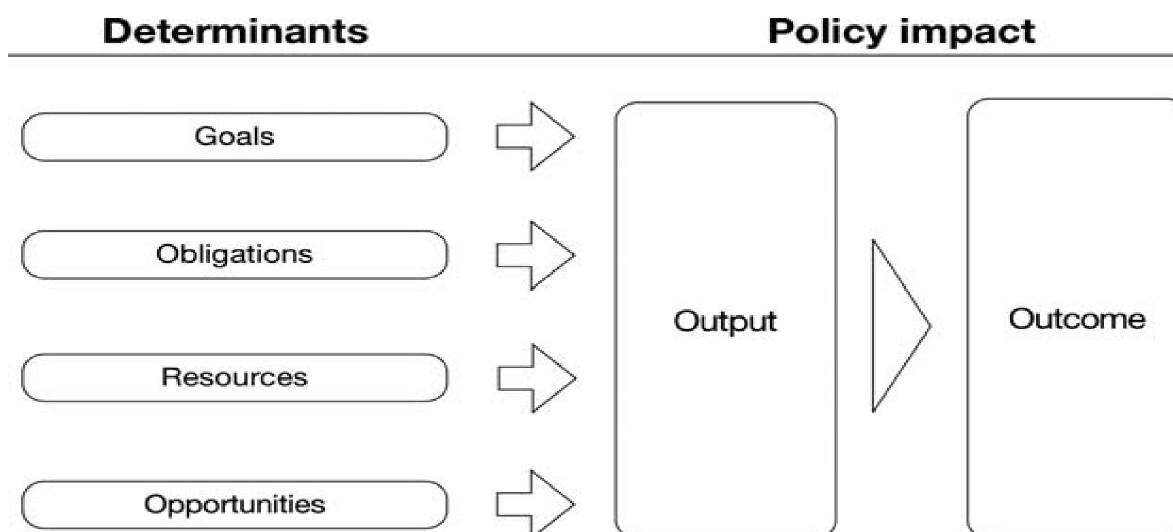

Figure 3.1: ADEPT model

Source: Rutten et al., 2010

3.6.2 Individual interviews and focus group discussion

This study used individual interviews and an FGD as methods of data collection. An interview schedule was set up by the researcher (Appendix C). Interviews were conducted with rehabilitation professionals at each CHC used in this study. Interview appointments were set up by the researcher based on availability of rehabilitation professionals. Negotiations were made to accommodate the participants: venues for the interviews were suggested by the participants, and the researcher ensured that these were quiet, spacious and convenient to the participant. Once that process was complete, the researcher reminded all participants when the data collection was going to be done. On arrival, all participants were given an information sheet (Appendix D) that explained the study. The participants were asked to give consent (Appendix E) as the researcher used an audio-tape recorder during the data collection process. The data collected from individual interviews was consolidated with an FGD until saturation was reached. An FGD with rehabilitation professionals, not included in individual interviews, was held to consolidate the data and the researcher gave participants a focus group form that emphasised the confidentiality of the information that would be shared during the FGD. Each interview took approximately 20 to 30 minutes. The FGD was based on the information gained from the healthcare plan 2030. Data source triangulation was utilized by supporting collected data with articles, books and internet sources.

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3.6.3 Theory of change

A theory of change is usually used to determine how and why an initiative works and normally has indicators for every expected step and a pathway to impact. In this study the theory of change was used to align the strategies rehabilitation professionals employ with the intended outputs in the healthcare plan 2030. Using the data collected from individual interviews and FGD regarding the strategies rehabilitation professionals employed, the researcher determined the outputs, outcomes and impact of the strategy and described whether (and how) it aligned to the healthcare plan 2030

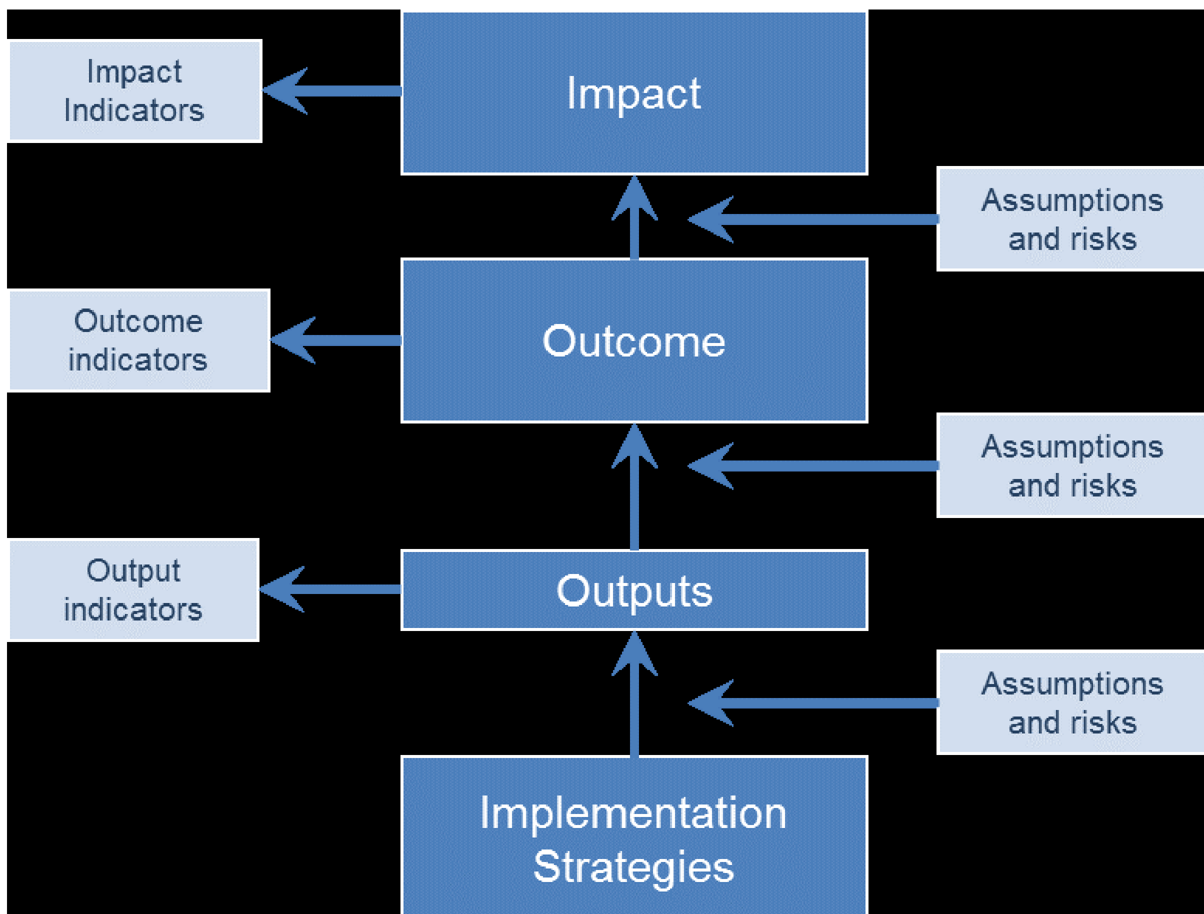

Figure 3.2: Theory of change

Source: Rogers, 2014

3.7 DATA ANALYSIS

Following the ADEPT model, a document review of the healthcare plan 2030 was done to determine the categories: goals, resources, obligations and opportunities. This was achieved by reading and highlighting content of the policy. The highlighted content was placed into the appropriate category.

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Qualitative data collection methods assisted the researcher in gaining an in-depth understanding of the views of participants (Watzlawik & Born, 2007). An advantage of qualitative data collection method is that there is no "objective truth". Using six-step thematic analysis, the voice recordings were listened to several times to ensure that the correct verbatim information was transcribed and understood. All the voice recordings were transcribed verbatim. The transcripts were each read individually by the researcher and notes were made in the margins to highlight interesting codes emerging. To interpret the codes, the researcher followed an inductive method of analysis to categorize the concepts into subthemes. This was repeated for each transcript then the common subthemes were grouped into themes. The supervisors verified this process and consensus was reached on the final themes.

The document analysis drew out the key aspects of the healthcare plan 2030 while the semi-structured interview guide consisted of specific questions concerning strategies to ensure success, consequently enabling the researcher to gauge the participants' current outputs against the expected outcomes in the healthcare plan 2030. One of the focus areas of the ADEPT model is outputs and outcomes. The intended outputs and intended outcomes were highlighted, determining the outputs expected by the Western Cape government. Based on the document analysis and interviews, the theory of change process was plotted for this study.

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3.8 TRUSTWORTHINESS

For trustworthiness of the study, the aspects of transferability and dependability of the study were considered. Member checking was done to ensure that what the researcher had transcribed was accurate. To improve credibility, data source triangulation was utilized during this study. Information obtained from research was used to support data collected in the document review, individual interviews and FGD. Inclusive bias was applied when the researcher conveniently selected community health care centres included in the study. To avoid further bias, once the transcripts were complete, the transcripts were forwarded to the respective rehabilitation professionals to confirm that they had expressed the views as recorded.

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3.8.1 Credibility

Credibility confirms that the data collected is credible based on the perspective of the participant (Trochim, 2006). Qualitative research is employed to gain understanding of the research participants, therefore the participants can confirm the credibility of the results.

To ensure that the data was credible, each interview was recorded and notes were taken. The researcher conducted the interviews and summarised the interview during and at the end of the interview.

3.8.2 Transferability

Transferability of qualitative research is the ability to transfer the results to a different context (Trochim, 2006). The researcher provided sufficient detail of the context of the data collection procedure, setting and participants in order for others to determine whether the environment was similar to another situation, thus justifying whether the findings could be applied to another setting. Finally, the study was reported with detailed information and methodological rigor which ensured that others could repeat the study.

3.8.3 Dependability

Trochim (2006) describes dependability as the means of the researcher to adapt to changes in the environment in which the research is being conducted.

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Owing to rehabilitation professionals' diaries being overbooked, the researcher was unable to arrange for several FGDs as initially intended. Therefore, the researcher conducted individual interviews and one FGD with the rehabilitation professionals.

3.9 ETHICS

Ethical clearance and permission to conduct the study was obtained from the University of the Western Cape Research Ethics Committee (Appendix A), the WCDOH (Appendix B), facility managers of the three facilities and the rehabilitation professionals.

The rehabilitation professionals were informed that their participation would be entirely voluntary and that they would be able to withdraw at any time from the process without giving any reason.

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Participants were assured that this research would not influence their employment in any way. The purpose of the study was explained to the participants; forms were given to them before data collection, so that they could sign to indicate their willingness to participate in the study, and an information sheet regarding the study was provided for clarity on questions that the participants might have had. Consent to be audio-taped was also requested from the participants during the FGD. The undertaking was given that the results of the study would be made available to all stakeholders at the three rehabilitation centres and to the district and provincial Health Offices of the Western Cape. Participants were assured that if anyone showed signs of emotional distress during interviews, they would be referred to a counsellor to address the causes of the problem.

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CHAPTER 4

RESULTS AND DISCUSSION

4.1 ORIENTATION TO CHAPTER 4

In this chapter, results of the study are discussed by addressing the objectives of the study. The objectives of the study were to determine and highlight the key aspects of the healthcare plan 2030, to explore and describe the perceptions, understanding and expectations of rehabilitation professionals regarding healthcare plan 2030 and to explore and describe the strategies that rehabilitation professionals employ to ensure that the 2030 healthcare plan may be implemented and the stated goals of the plan be achieved.

The results are presented and discussed under four headings, using tables and figures in addition to detailed discussion. The first of these is document review, followed by profile of rehabilitation professionals. Thereafter, the themes developed from the understanding and perceptions gained from the rehabilitation professionals during the individual interviews are presented. In conclusion, the strategies employed by rehabilitation professionals to ensure successful implementation are explained.

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4.2 DOCUMENT REVIEW

The ADEPT model was used as a data collection tool to determine key aspects of the healthcare plan 2030. The model was directly applied to find the goals, obligations, resources and opportunities of the healthcare plan 2030.

4.2.1 Healthcare plan 2030 review

Findings regarding the healthcare plan 2030 are presented in Table 4.1and are then discussed individually in terms of goals, obligations, resources and opportunities.

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Table 4.1: Healthcare plan 2030 review

1. Goals	Comments on goals
▪ Access to patient-centred quality care ▪ Reducing infectious diseases ▪ Improving healthy lifestyles ▪ Preventing injuries and violence ▪ Improving maternal and child health ▪ Strengthening women's health ▪ Improving mental health ▪ Mainstreaming and strengthening rehabilitation services within the general health service platform ▪ Creating opportunities for growth and jobs ▪ Improving education outcomes ▪ Increasing availability and access to safe and efficient transport ▪ Increasing wellness ▪ Increasing safety ▪ Developing integrated and sustainable human settlements ▪ Mainstreaming sustainability and optimising the use of resources ▪ Promoting social inclusion and reducing poverty ▪ Integrating service delivery for maximum impact ▪ Increasing opportunities for growth and development in rural areas ▪ Building the best provincial government in the world ▪ Decreasing incidence of infectious diseases ▪ Preventing violence and road injuries ▪ Promoting healthy lifestyles ▪ Improving women's health ▪ Improving maternal and child health ▪ Strengthening mental health ▪ Expansion and strengthening of community-based service	▪ Despite being goals of the healthcare plan 2030, they are not officially spelled out as the goals of the policy. ▪ The goals are concrete as they stretch across all aspects of the health sector. ▪ The goals are focused on improving community health.
▪ **2. Obligations** ▪ National and provincial governments' priority to deliver quality health services ▪ Striving for patient-centred quality of care	**Comment on obligations** ▪ There are no clear obligations listed in the healthcare plan 2030. These are general principles listed that

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▪ Adopting an outcomes-based approach ▪ Commitment to PHC philosophy ▪ Strengthening the district health service model ▪ Promoting equity ▪ Operating with efficiency ▪ Developing strategic partnerships	serve as a guideline to successful implementation of healthcare plan 2030, serving as obligations for the policy.
3. Resources ▪ Human resources ▪ Financial management ▪ Infrastructure and technology ▪ Information communication technology	**Comment on resources** ▪ The resources are listed in order to ensure positive outcomes of the policy.
4. Opportunities	
Organisational opportunities ▪ Support services will be strengthened to enhance culture of learning and innovation ▪ Service platform ▪ Additional capacity to target services	**Comments on organisational opportunities** Support services will be created in order to create better services and strengthen the organisation. These support services are: ▪ Human resource management ▪ Financial management ▪ Appropriate infrastructure ▪ Medical technology ▪ Information management ▪ Communication technology.
- *Political opportunities* ▪ Represent the third wave of health reform in the Western Cape ▪ Building the best provincial government in the world ▪ Collaboration between provinces and national health department ▪ In line with previous policies	**Comment on political opportunities** ▪ The WCDOH will harness support from different sectors and cooperation between political levels.
Public opportunities ▪ Geared towards prevention and health promotion ▪ Creating opportunities for growth and jobs ▪ Increasing opportunities for growth and development in rural areas ▪ Early detection of chronic disease	**Comment on public opportunities** ▪ Better involvement of the population
Policy impact	
Outcome ▪ Creating equal access to patient-centred quality healthcare	**Intended outcome:** ▪ The continuation of the healthcare plan 2020 plan: better health for all

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Output	**Intended output:** ▪ Quality service to patients ▪ Equal access to health service ▪ Caring, competent and committed staff ▪ Work together to improve health outcomes

4.2.2 Goals

A health policy is the process which health service providers undergo to achieve health-related goals (WHO, 2017). If the goals are not clearly listed, the policy executors could be unaware of the necessary processes to follow to achieve the goals. The "specific measurable achievable realistic and timed" (SMART) principle measures the goals of a programme or policy. According to Jung (2009), goals need to be specific to ensure that all stakeholders are aware of their roles in the implementation of the policy. Goals also need to be measurable to assess whether implementation of the policy has been successful or not; they must be achievable to ensure that they are realistic, and finally, must be relevant to ensure that the intended impact of the policy addresses a need (Jung, 2009). The healthcare plan 2030 is timed to make monitoring of the effect of the policy implementation accurate.

The healthcare plan 2030 is focused on access to patient-centred quality care (WCDOH, 2013). To achieve this outcome, clear goals need to be listed to create clarity for all stakeholders. In the healthcare plan 2030 document, goals are not officially listed as goals; they are listed as "priority focus areas for intervention" (WCDOH, 2013). The priority focus areas are reducing infectious diseases, encouraging healthy lifestyles, prevention of serious injuries and violence, improving maternal and child health, promoting maternal health and improving mental health. Further goals are discussed under the subheading of "specialised hospitals" (WCDOH, 2013). The major investment is to strengthen rehabilitation services within healthcare. Goals of the healthcare plan 2030 are also listed as "strategic objectives" where goals relate to the improvement of population health and the opportunities that will arise for the public with the implementation of the healthcare plan 2030 (WCDOH, 2013). All of these are goals to reach to achieve the essence of the healthcare plan 2030: access to patient-centred quality care.

With regard to rehabilitation, the goal of the healthcare plan 2030 is for rehabilitation services to be accessible at all levels of care while focusing mainstreaming and strengthening

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of rehabilitation services within the general health services platform (WCDOH, 2013). According to Mlenzana (2013) rehabilitation services are compromised by long waiting times, inadequate referral systems, disrespect between rehabilitation professionals, and decreased time for health education. To addressed these factors, and in turn, to achieve a patient-centred approach in rehabilitation, Mlenzana (2013) developed a rehabilitation model.

As indicated in Figure 4.1, through communication between patient, caregiver and service provider, this rehabilitation model can achieve access to rehabilitation services, patient-centred rehabilitation, caregiver and family involvement, education and treatment choices.

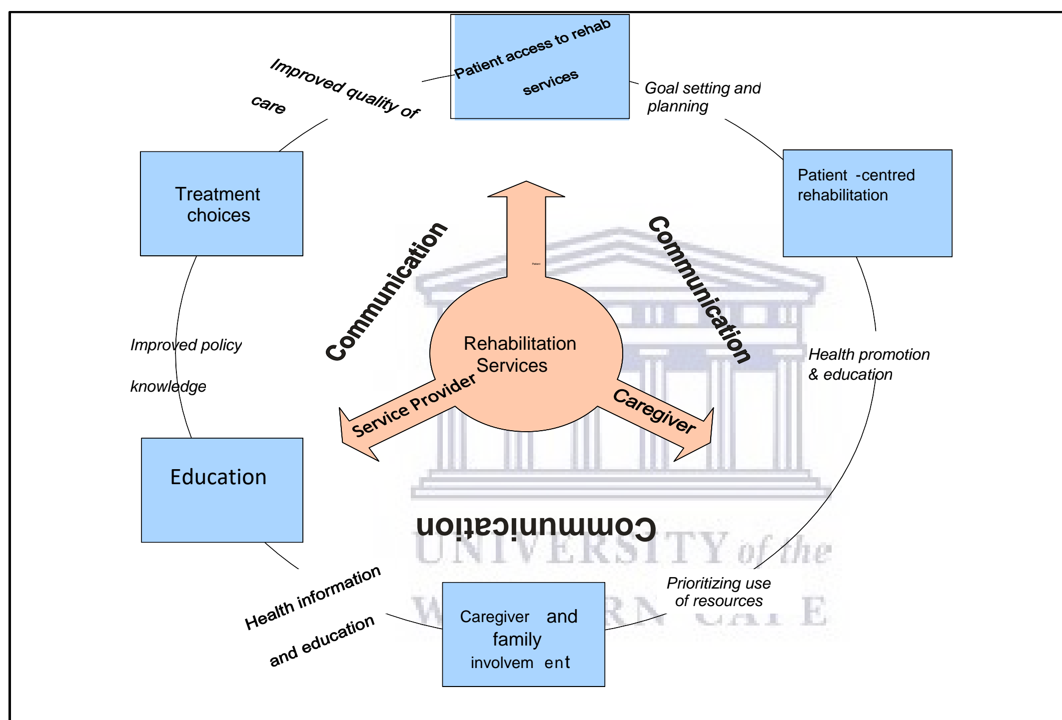

Figure 4.1: Rehabilitation model

Source: Mlenzana, 2013

Despite rehabilitation playing a vital role in medicine, the extent of its value is not recognised in the healthcare plan 2030. The goal for rehabilitation is vague, and rehabilitation professionals are unable to deduce their role from this goal. Once again, this reinforces the need to gauge what rehabilitation professionals consider their expected roles to be from government.

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4.2.3 Obligations

The awareness of obligations in a policy allows policymakers to assess whether stakeholders will be in support of the policy implementation or not (Schmeer, 1999). It also allows for stakeholders to employ different implementation strategies to ensure successful implementation (Schmeer, 1999).

It is the responsibility of the national and provincial government to deliver quality healthcare services to citizens, services that correspond with the Batho Pele principles (WCDOH, 2013). The principles discussed in the healthcare plan 2030 indicate what is expected of health service providers. These expectations are obligations to provide quality, patient-centred care, have an outcome-based approach to health service provision, abide by the PHC philosophy develop a district health service model, provide equal health services, efficient operating systems and create strategic partnerships (WCDOH, 2013).

Although not listed as "obligations" specifically, section B of the plan states the obligations of government structures under the heading "Our Approach to Wellness". The approach to wellness lists the barriers to successful implementation of healthcare plan 2030. It states that healthy food is expensive, creating difficulty for people from low socio-economic backgrounds to maintain healthy lifestyles, therefore exposing them to certain health risks (WCDOH, 2013). It also states that poor water and sanitation causes higher chances of contracting infectious diseases creating another need for access to good healthcare (WCDOH, 2013). Despite being a constitutional right, many South Africans do not have access to basic sanitation and clean water (Bhagwan, 2015). According to WHO (2011) good, basic sanitation reduces the death rate from diarrhoea by one third. The patient's ability to self-care plays a crucial role in full recovery, highlighting the obligation of the patient in the implementation of the healthcare plan 2030 (WCDOH, 2013).

The expanded vision is to achieve excellent state of healthcare delivery with caring, competent and committed staff (WCDOH, 2013). The staff will form partnerships with modernised health systems, infrastructure and technology, all stakeholders and partners (WCDOH, 2013). To achieve such healthcare delivery, rehabilitation focuses on community-based services. These services improve the patient's functioning for reintegration into the community and having the best possible quality of life (WCDOH, 2013). It is the obligation of rehabilitation professionals to deliver quality community-based services which is encouraged by the International Classification of Functioning, Disability and Health (ICF).

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The ICF is a framework and universal language describing health and health-related states by exploring the impairment, activity limitation and participation restriction (WHO, 2001). Participation restriction focuses on what is inhibiting the patient from reintegrating back into the community. The contextual factors of the CIF illustrated in Figure 4.2 explore the environmental and personal factors that limit or facilitate the patient's condition, disability or injury (Rehab Scales, 2007).

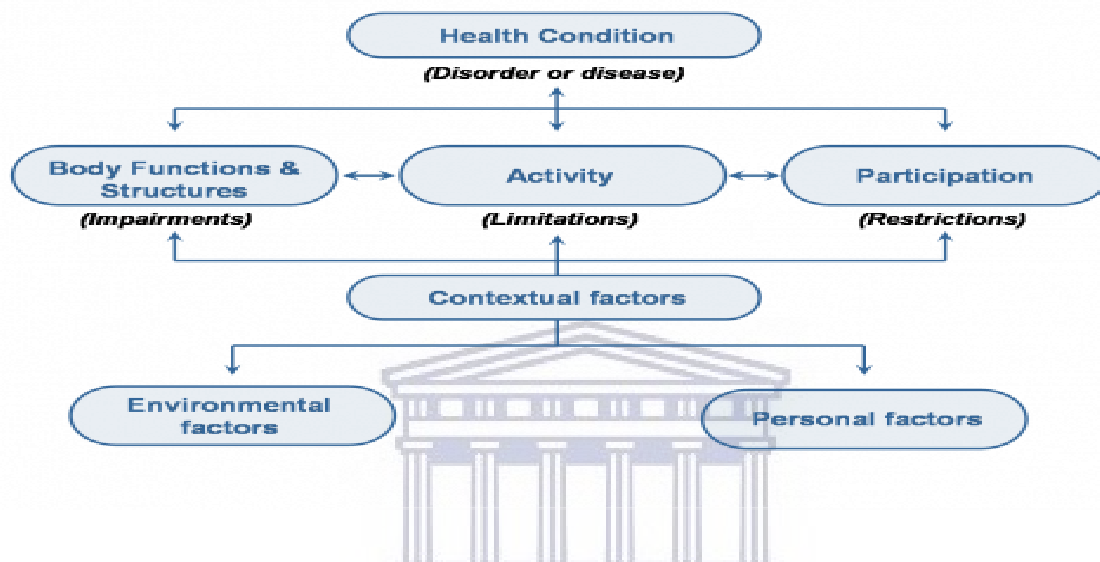

Figure 4.2: International classification of functioning, disability and health

Source: Rehab Scales, 2007

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4.2.4 Resources

Adequate resources play an important role in the successful implementation of a policy. Adequate management of human resources is vital in the provision of quality healthcare (Kabene, Orchard, Howard, Soranio & Leduc, 2006). If the management of human resources is not referred to, then it cannot be determined whether the facilities are equipped to meet the requirements for successful implementation of a policy. Similarly, the management of financial resources plays an important role in the successful implementation of a policy. According to Marais (2013), the healthcare system in South Africa is performing poorly as a result of poor leadership and structural weakness of facilities, causing poor management of financial resources. It is therefore important to know whether human and financial resources have been considered when creating the healthcare plan 2030.

Ideal resources for successful implementation of the healthcare plan 2030 are fully elaborated upon in the healthcare plan 2030. According to the WCDOH (2013), human resources

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function is one of the most important resources in health services. Human resources also play a significant role in successful policy implementation as they are the executors of the policy. Human resources depend not only on the number of staff members but also on the skills development to ensure competency of staff (WCDOH, 2013). The WCDOH (2013) states that the following, in terms of human resources, needs to be achieved to ensure successful implementation of healthcare plan 2030: re-motivating staff to align themselves with the vision and principles of healthcare plan 2030, creating a stimulating environment where staff feel a sense of purpose, and creating an environment where staff feel they are being listened to. A different management programme will be adopted to achieve this.

In the budget allocation of the healthcare plan 2030, departments have to ensure that the most cost-effective interventions that will still deliver optimal health services (WCDOH, 2013). The services rendered must relate to the costs to ensure value for money; assessment of cost efficiency will be improved (WCDOH, 2013).

With regard to rehabilitation, the Western Cape government has a specific rehabilitation facility, the Western Cape Rehabilitation Centre (WCRC) which is located in Mitchell's Plain, and provides specialised, multidisciplinary inpatient and outpatient rehabilitation. Assistive devices, orthotics and prosthesis are available at WCRC to ensure full reintegration of patients back into the community (WCDOH, 2013). The healthcare plan 2030 does not, however, mention the specific resources at the rehabilitation facilities.

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4.2.5 Opportunities

4.2.5.1 Organisational opportunities

New support services ensure better service delivery to result in better facilities/organisations (WCDOH, 2013). These support services are human resource management, financial management, appropriate infrastructure, medical technology, information management and communication technology (WCDOH, 2013) Stronger bonds between healthcare facilities and partners and universities are discussed under "What does it mean for our stakeholders and strategic partners" (WCDOH, 2013). To ensure that the healthcare facilities are easily accessible to the public, contractual relationships with non-profit organisations in transport are also considered (WCDOH, 2013).

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4.2.5.2 Political opportunities

The healthcare plan 2030 will involve various sectors and political levels (WCDOH, 2013). Should PHC services be rendered in schools and other institutions outside the WCDOH, there will be agreements between the Department and the custodians of the sites, resulting in a strengthened bond between the departments. The WCDOH (2013) aims to be the best-run provincial government in the world, as listed in the strategic objectives for the implementation of the healthcare plan 2030. The implementation of the healthcare plan 2030 will provide leadership in health development by collaborating with other provinces and the SADOH (WCDOH, 2013).

4.2.5.3 Public opportunities

Social and community network is a determinant of health and the public plays a role in the health service platform as they are taught health promotion to improve public health (WHO, 2008). There are five strategies for health promotion actions: creating a public health policy, creating supportive environments, building community action, strengthening personal skills and re-orientating health services (Platt & Watson, 2002). By strengthening community action, patients are actively involved in their health. Another public opportunity of the healthcare plan 2030 is the creation of growth and job opportunities (WCDOH, 2013), to improve general conditions as the high rate of poverty results in decreased health outcomes. Community screening will be done for early detection of chronic diseases to decrease mortality rates (WCDOH, 2013). With these opportunities for the public, the public's confidence in the WCDOH will strengthen, thereby improving social capital in the province (WCDOH, 2013). Regarding rehabilitation, community-based services promote recovery, and prevent hospital admissions and readmissions – especially of people with mental illness (WCDOH, 2013). The principles of emergency medical services are also discussed; services are expected to be delivered within short time frames and well-trained personnel will attend to all emergency situations (WCDOH, 2013).

The opportunities listed will ensure more effective work for rehabilitation professionals as support services are being put into place to provide better health service delivery. Among these support services are human resource management and financial management. It is important to explore the views that rehabilitation professionals have on these support services.

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4.2.6 Policy impact

Policy impact refers to the policy outputs and policy outcomes. The outputs of a policy determine the policy outcomes. The healthcare plan 2030 is currently being reviewed and has not yet been implemented so the policy impact cannot be determined with certainty. With new policies, the policy impact becomes intended policy impact. The intended outputs of the healthcare plan 2030 are quality service to patients, equal access to health service, and having competent and committed staff working together to improve health outcomes. These intended outputs will ensure that the intended outcome of the policy is reached.

It may be concluded that the healthcare plan 2030 falls in line with the ADEPT model while only showing one gap in the policy. This gap was a clear outline of goals of the healthcare plan. Despite listing goals for rehabilitative services as accessible rehabilitative services and the mainstreaming and strengthening thereof within the general health services platform, the healthcare plan 2030 does not speak directly to the various professions forming part of rehabilitation services. Using the healthcare plan 2030, rehabilitation professionals can therefore, not know the goals of rehabilitation specific to their relative professions.

4.3 INDIVIDUAL INTERVIEWS AND FOCUS GROUP DISCUSSION

The results from individual interviews and FGD will be presented and discussed in terms of the available literature. A demographic data table with a brief summary of the rehabilitation professionals who participated in the study is also presented, along with analysis of the data according to predetermined themes and emerging themes. The results and discussion sought to answer the aim of the study which was to explore the perceptions and understanding of rehabilitation professionals regarding the healthcare plan 2030 as well as their implementation strategies to ensure successful implementation of the plan. Quotations from interviews and the FGD are extracted and presented in italics, while irrelevant material is indicated by use of ellipses.

4.4 REHABILITATION PROFESSIONALS' DEMOGRAHICS

The 20 rehabilitation professionals who participated come from various professional backgrounds. There were two general practitioners, eight nurses, two physiotherapists, one social worker, two occupational therapists, one pharmacist and three clinical nurse practitioners.

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One of the characteristics of HPSR is multidisciplinary research (Gilson, 2012). The participants in this study come from a multidisciplinary background to highlight issues from research done across the board rather than using a discipline-specific approach.

4.4.1 Themes identified

The themes that emerged from the individual interviews and FGD with the rehabilitation professionals are detailed in Table 4.3. The themes and subthemes are supported by direct quotations from the interviews and discussions in relation to relevant literature.

Table 4.2: Emerging themes and categories

Theme	**Category**
Knowledge of rehabilitation professionals	- Institutional policies - National policies - Role clarification
Implementation strategies	- Scope of practice - Number of facilities - Debriefing sessions - Collaborative practice
Resources	- Human resources - Financial resources - Infrastructure

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4.5 KNOWLEDGE OF REHABILITATION PROFESSIONALS REGARDING POLICIES

The knowledge of rehabilitation professionals regarding health policies emerged as a key theme from the individual interviews. Rehabilitation professionals had knowledge of institutional and national policies but mixed views on the role clarification within these policies.

4.5.1 Institutional policies

Institutional policy was the first category highlighted from the knowledge of rehabilitation professionals. Rehabilitation professionals were aware of the institutional policies actively

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running at their respective facilities. This is supported by direct quotations from the individual interviews and the FGD with the rehabilitation professionals.

> *"Policy on clothing for work which I am very familiar with."* (P3)

> *"Another policy, if you gonna drive a GG car, you must have authority to drive the car. That is a policy. Not anyone can just jump in the car and drive, someone must authorise you to drive the car."* (FG1, P6)

The participants appeared to be well aware of operational policies but not healthcare policies.

4.5.2 National policies

Rehabilitation professionals were aware of active health-related national policies, as indicated by the extracts below.

> *"… treatment guidelines, there's clinical governance framework, there's ideal clinic, there's NCS … Then there's health and safety policy, major disaster policy."* (P1)

> *"The 2030, the national rehab policy, obviously also the healthcare act… guidelines for assistive devices … bigger policies, bigger things, frameworks like ICF, the national convention rights of people with disabilities."* (P2)

Rehabilitation professionals were aware of names of national health policies. According to Montoya (2014), professionals who are aware of policies are more likely to execute their roles as expected, compared to professionals who are unaware of policies. Successful implementation of a healthcare policy relies on health service providers having knowledge of the policy and having an understanding of its intended impact (Purohit, 2014). They will then be able to employ the skills required to successfully implement the policy (Purohit, 2014). Rehabilitation professionals need to be aware of the role expected from government as they will be able to either improve or learn the required skill in order to ensure successful implementation of the healthcare plan 2030. In the current study, while being aware of names of national policies, rehabilitation professionals lacked the understanding of the national policies, including healthcare plan 2030. Most of the participants were unable to explain what the healthcare plan 2030 aimed to achieve. Reasons given for not understanding the policy included its length, not having enough time to read it, and forgetting what they had been told about the healthcare plan 2030. This is important to note as it means that awareness campaigns are needed especially in the field of rehabilitation as rehabilitation is seen as complex as it operates in the physical, social and environmental domain of the person. Thus

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rehabilitation professionals needs to understand how policies guide the interaction with patients at the different levels.

4.5.3 Role clarification in rehabilitation

Role clarification is the third category highlighted from the knowledge of rehabilitation professionals. Some rehabilitation professionals were aware of their roles while others were unaware. This is how they expressed themselves:

> *"I walked out there knowing what is expected of me … because they did break it down and they translated it into our various departments, for example finance"* (P7)

> *"To be honest, I don't know what they expect … rehab could be playing a really vital role in helping us achieve what we're aiming for. I don't think that that role is really recognised."* (P5)

Role clarification is vital for the successful implementation of the plan as it ensures the use of discipline-specific skills of various professionals to improve overall health (Carpio, Fuller-Wimbush, 2016). According to Dayal (2010), when clear rules or roles are not defined in policies, health facility managers and staff members have to rely on their own experiences of a situation to make a decision. One manager's experience differs from that of the next, thus highlighting the need for rules or guidelines to guide managers (Dayal, 2010). A miscommunication between management and staff can lead to staff not delivering the intended output of the policy. This is emphasised by Ham (2009) who found that miscommunication can result in a vast difference between the intended policy impact the policymakers were aiming to create and the service being rendered in practice.

As proposed by Dayal (2010), facility managers confirmed that at their respective facilities, roles are often communicated indirectly through monthly targets, scope of practices and codes of conduct. From these, they create their own understanding of their roles in the implementation of the policy. This, in turn, results in rehabilitation professionals with the same qualification, treating similar conditions at the same level of rehabilitation having different perceptions of their roles in achieving the goals set by government. Rehabilitation professionals who are not aware of the healthcare plan 2030 requirements believe that the facility management will ensure the delivery of the expected services in terms of monthly targets, scope of practice and code of conduct. The monthly target is the number of patients to whom the rehabilitation professional offers services per month.

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Two findings are highlighted in this theme: miscommunication between management and rehabilitation professionals, and the importance of knowledge of a policy. Miscommunication between management and rehabilitation professionals can result in rehabilitation professionals not knowing what their new policy roles are as they do not know what management is trying to achieve with the new policy. While the head of rehabilitation at one facility had an understanding of the plan, other rehabilitation professionals providing service to patients at the same facility, did not. Knowledge of rehabilitation professionals influences their ability to understand the role expected of them by policymakers. Rehabilitation professionals need to understand their role in order to ensure the goals of the policy are achieved. Rehabilitation professionals in managerial positions did not filter down policy information to the rehabilitation staff. Miscommunication between management and rehabilitation professionals may result in rehabilitation professionals not being able to execute their expected roles. Another rehabilitation professional expressed that rehabilitation was not being deemed an important branch of medicine as there was a lack of communication between management and rehabilitation department. As stated by Ham (2009), this miscommunication may result in a discrepancy between the intended impact of healthcare plan 2030 and the actions of rehabilitation professionals in practice

The significance of knowledge of healthcare policies was also identified as a finding. This was emphasised by the rehabilitation professional enrolled for a postgraduate diploma in health policy development. This participant reported that understanding the healthcare plan 2030 facilitated the adaptation to increased demands from management. It was not seen as an add-on or extra work because the intended policy impact was understood by the rehabilitation professional. Another participant, at the same facility, did not have a clear understanding of healthcare plan 2030. This participant perceived new policies as government's manner to increase their workload. This emphasizes the importance of rehabilitation professionals having an understanding of healthcare plan 2030. Rehabilitation professionals lacked an understanding of health policies, specifically the healthcare plan 2030. Successful implementation within rehabilitation is therefore dependant on the knowledge of rehabilitation professionals regarding the healthcare plan 2030.

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4.6 IMPLEMENTATION STRATEGIES OF REHABILITATION PROFESSIONALS

Often, rehabilitation professionals are obliged to employ implementation strategies in response to health policies, because they are not fully equipped to successfully carry out the policy requirements. Implementation strategies emerged as a key theme from the individual interviews. Implementation strategies used include working outside their scope of practice, servicing more than one facility, social support and collaborative practice. These implementation strategies are elaborated upon as subthemes in the sections below.

4.6.1 Scope of practice

Working outside their scope of practice is the first category highlighted under implementation strategies. Owing to the lack of state funding, when a rehabilitation professional moves out of the public sector into the private sector, the post is not immediately filled. To ensure that patients still get rehabilitation services, rehabilitation professionals must work beyond their scope of practice to offer the service to the patient. This is what participants had to say about extending their services:

> *"Imposing duties onto allied workers who appear to have more "free time", giving us tasks which do not actually fall within our job descriptions."* (P9)

> *"Our next closest speech therapist is at Tygerberg and they can't really see someone who hasn't been there before, so, and they're far away, so not easy to access – so we overlap."* (P13)

The healthcare plan 2030 aims to provide quality service to patients to achieve overall wellness of the public in terms of infectious diseases, violence and road injuries, healthy lifestyle, women's health, maternal and child health and mental health (WCDOH, 2013). Often facilities do not have representatives for each type of rehabilitation at their facility, therefore other rehabilitation professionals work beyond their scope of practice to ensure that the expected rehabilitative service is rendered to the patient. Interviewed participants reported that patients often default on their treatment as the facilities where they can receive treatment are beyond their reach. Rehabilitation professionals then work beyond there scope of practice to ensure that patients receive the required rehabilitation. The expectation from management for rehabilitation professionals to work beyond their scope of practice is met with apprehension. Rehabilitation professionals reported to have inundated programmes and working outside of their scopes of practice is deemed an add-on. Having a clear understanding of the healthcare plan 2030 will encourage rehabilitation professionals to use a

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collaborative approach to meet the needs of the patient as opposed to working outside their scope of practice.

4.6.2 Number of facilities serviced by rehabilitation professionals

Overcoming the limited number of facilities available is the second implementation strategy highlighted from individual interviews. Some rehabilitation professionals service more than one facility to "fill the gap" created by insufficient coverage of service types offered at each facility.

> *"Staff members are moved between facilities and sometimes expected to just manage the burden."* (P5)
>
> *"I go to smaller clinics in area so I'm not even here every day."* (P13)

Satellite facilities are built to make health services accessible to patients, but owing to limited financial resources, rehabilitation professionals are obliged to service their facility as well as satellite facilities. The vision of healthcare plan 2030 is to provide access to quality health (Western Cape Government, 2013). To prevent patients from having to travel long distances to find appropriate treatment, rehabilitation professionals work in more than one facility in the area. Despite making rehabilitation services more accessible to the community, rehabilitation professionals report that servicing those satellite facilities results in complications at their main facilities. On the days when rehabilitation professionals are rendering services at the satellite facilities, their specific rehabilitation service is inactive for at their main facility. Walk-in patients cannot be assisted on those days and patients would have to make an appointment to be treated.

4.6.3 Social support

Creating a social support structure for rehabilitation professionals is an implementation strategy that ensures successful implementation of a policy. Staff members have meetings to discuss workload issues and solutions, and they form prayer groups for spiritual support.

> *"In the mornings we have meetings just to debrief. How do you feel, if you have a problem, what is your problem… and then we try and help."* (FG1, P4).
>
> *"Yes, and then we pray for God to give you strength for that day to deal with this*." (FG1, P1)

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With the high number of rehabilitation professionals leaving the public health sector, those remaining need to care for their own mental and emotional capacities to ensure good service delivery. The expanded vision statement of the plan is to achieve an excellent state of healthcare delivery, staff will be caring, competent and committed by 2030 (Western Cape Government, 2013).

In the current study rehabilitation professional highlighted the reactions of patients towards them which at times were not very positive. Participants attributed this to a lack of understanding of the workload of health professionals. Participants also indicated the need for support systems for staff to be able to cope with the daily challenges of the job. These support systems included supporting and motivating each other and prayer group in the mornings. This challenge raises the risk that if rehabilitation professionals are demotivated, it will be extremely difficult to achieve the goal of caring, competent and committed staff by 2030. Managers need to create and strengthen this platform to assist rehabilitation professionals mentally and emotionally.

4.6.4 Collaborative practice

Collaborative practice is the final implementation strategy employed by rehabilitation staff to ensure that the goals of a policy are met.

> *"We getting to see patients also together and family together, so we find that it's quite useful."* (P3)

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One of the four conceptual pillars of the healthcare plan 2030 is that health (rehabilitation) professionals work together to improve health outcomes (Western Cape Government, 2013). Collaborative practice happens when professionals from different disciplines come together with patient and family to deliver the highest quality of care to the patient (WHO, 2010). Patients often have to apply for leave to go for treatment whether it is two hours or a full day. Working collaboratively means a patient only needs to take off one day to receive treatment by more than one rehabilitation professional. Treating a patient together this also means that the patient does not miss out on a full day's work and can still return to work. When rehabilitation professionals do not work collaboratively, patients are either required to take a leave day or half days more than once a month. This leads to patients defaulting treatment or missing appointments.

In addition to highlighting the implementation strategies used by rehabilitation professionals, this theme brings two closely related findings into view. One is that rehabilitation

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professionals' workload is increasing to accommodate the new policy; the other is that the lack of understanding of the policy leads to unhappy and disgruntled rehabilitation professionals. As stated by the participants in this study, their monthly targets are increasing to meet the increasing demands set by government, without receiving more human resources to assist in these increased demands. Rehabilitation professionals are thus faced with an increased patient load. Not understanding the gist of the policy means that rehabilitation professionals do not understand why their workload is increasing. This increase in workload and consequent increase in dissatisfaction results in more rehabilitation professionals leaving the public health sector. Facility managers are aware that rehabilitation professionals (and other staff members) do not always have an understanding of a health policy and will therefore make changes to the daily running of various disciplines which often includes increasing the monthly target. This assures facility managers that their facility is in line with the national policy. However, if rehabilitation professionals are unaware of the policy's goals, they will interpret the change simply as additions to their current workload, which ultimately leads to more rehabilitation professionals leaving the public health sector. This adds even more pressure to rehabilitation professionals who remain behind.

4.7 RESOURCES

During the interviews, participants received copies of the researcher's ADEPT model summary of the healthcare plan 2030 (see Table 4.1 above). Once they had a basic understanding of the healthcare plan 2030, the rehabilitation professionals were asked what barriers their facilities had to overcome, in order to ensure successful implementation of the healthcare plan. Facility resources thus become the last key theme to emerge from the individual interviews. Rehabilitation professionals reported that they needed to employ the implementation strategies listed in section 4.6 above to deal with insufficient human and financial resources, which are discussed as categories below.

4.7.1 Human resources

Human resources was the first category cited as having an influence on the successful implementation of the healthcare plan 2030, as indicated by the interview quotation extracts which follow.

> *"Government also need to hire a lot of people because there is a huge shortage of staff … I don't see that it will make any difference to the national health insurance."* (P10)

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> *"So if I'm not coming on duty I'll do the duty that I was supposed to do when I was absent because of the shortage of staff."* (FG1, P5)

Dookie and Singh (2012) confirm the migration of healthcare professionals from the public to the private sector in South Africa. Dookie and Singh (20112) report that, based on percentage of patients treated in the public sector, an unequal distribution of professionals exists in public and private sectors. According to a study conducted by Econex (2013), the public sector is providing healthcare to more than 60% of South Africa's population. Lack of human resources is a major concern when implementing the healthcare plan 2030. There is a general lack of staff at healthcare facilities, especially in rehabilitation services. The government cannot replace lost staff at the facilities owing to the lack of financial resources. Having adequate human resources ensures the successful implementation of healthcare plans. This position is supported by Dussault and Dubois (2003) who state that human resources play a vital role in health policies.

4.7.2 Financial resources

Financial resources were the second category influencing successful implementation of healthcare plan 2030. Lack of funding hampered successful implementation of the healthcare plan 2030, as illustrated by the following quotations:

> *"From a human resources component is less 'cause we're having less staff … there's less money and the communities that we work in is really dangerous communities*." (P1)

> *"Then you look in reality at allocation of funding and at allocation of posts and you realise actually rehab isn't there."* (P12)

The maldistribution of financial resources in the public sector highlights the inefficiency of the current South African health system (Ataguba & Akazili, 2010). Insufficient financial resources directly influence the service that rehabilitation professionals deliver in terms of human resources and physical resources such as equipment.

The lack of financial resources leads to a decrease in equipment and quality of infrastructure. Plans to build new healthcare facilities have been placed on hold in order to save money (Child, 2017). There is a need for new or improved infrastructure of community health centres. These facilities are often overcrowded and people wait for many hours to receive service (Western Cape Government, 2013). Unless there is an improvement in the financial state of the country, new facilities cannot be built, meaning that long hours of waiting time

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for patients cannot be decreased. Healthcare 2030 focuses on delivering quality healthcare; therefore, it is important to be able to provide patients with the necessary equipment such as assistive devices to ensure better health.

The theme of insufficient resources not only determines the view and understanding of rehabilitation professionals of the healthcare plan 2030, but it also highlights what the barriers are, according to the rehabilitation professionals, to successful implementation of the healthcare plan 2030.

4.8 THEORY OF CHANGE

Having a patient-centred approach is the essence of healthcare plan 2030. The different strategies implemented by participants in this study were investigated. Using these strategies, a theory of change was created to assess whether the current actions of rehabilitation professionals will result in the intended policy impact of better health for all (see Table 4.4 below).

4.8.1 Risks of theory of change

It is not always possible to prepare for all the risks when creating a theory of change. The anticipated risks for the healthcare plan 2030 include partnerships and political risks.

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4.8.1.1 Partnerships

The possibility of conflict amongst rehabilitation arises with the implementation of a new policy. Rehabilitation professionals are at risk of becoming demotivated which, in turn, will result in possible tension in the institution.

4.8.1.2 Political risks

Various political influences pose a risk to the development of the theory of change including national and provincial elections. The healthcare plan 2030 was created by the WCDOH therefore an election can change the ruling national or provincial government. Changes in national policies can also influence the healthcare plan 2030 as provincial policies are required to align with provincial government.

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Table 4.3: Theory of change

Inputs	Implementation strategies (outputs)	Intended outputs	Outcomes	Intended outcomes
Healthcare plan 2030: **Patient-centred approach**	Working beyond scope of practice	Quality service to clients	Patients are not being turned away from facilities owing to shortage of staff	Creating equal access to patient-centred quality healthcare
	Servicing more than one facility	Equal access to health services	Every rehabilitation professional is accessible at facilities	
	Social support	Caring, competent and committed staff	Less tense staff members	
	Collaborative practice	Work together to improve health outcomes	Decreased time spent with a patient No overlapping of duties	

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This theory of change shows that the implementation strategies which rehabilitation professionals have employed fall in line with the intended outputs and outcomes of the healthcare plan 2030. Each of the strategies is considered as an output and is linked to the intended output.

By working beyond their scope of practice, rehabilitation professionals are ensuring that patients are not turned away from the facility. Often, selected rehabilitation professionals only service from tertiary hospitals. When patients cannot receive rehabilitation at the clinic closest to them, the patients often end up defaulting on their treatment because of high travelling fees, bad weather or having to sacrifice a day’s wages to travel to a facility. Even though rehabilitation professionals are not trained to render the services of their colleagues, their roles often do overlap. Therefore, their actions fall in line with the intended output of delivering quality service.

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By servicing more than one facility, rehabilitation professionals also enable patients to have access to services close to their homes or places of employment. Accessibility is a major component of healthcare plan 2030. Even though they cannot do so every day, patients are enabled to receive treatment at a convenient satellite facility. This meets the intended output of equal access to health services.

Rehabilitation professionals often become demotivated and contemplate going into the private sector as they are inundated by work in the public sector. Social support equips rehabilitation professionals with coping mechanisms and advice on how to manage difficult patients and workload. As long as the rehabilitation professionals remain in the public sector, rehabilitative services can be rendered to the community. This ensures that rehabilitation professionals can meet the intended output of being caring, competent and committed staff members.

Collaborative practice improves health outcomes as it allows rehabilitation professionals to act in the capacity of their trained skill. These skills are used in collaboration and are therefore cost-effective, increase patient satisfaction and decrease repetition of treatment by different rehabilitation professionals. All these factors have shown a positive influence on the health outcomes of the client. Increased health outcomes lead to better health by creating equal access to patient-centred quality healthcare. Consequently, the strategies employed by rehabilitation professionals are supporting the intended policy impact.

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4.9 SUMMARY OF CHAPTER

In this chapter, the results of the study were discussed. The key aspects of healthcare plan 2030 were highlighted by means of a document review. Themes that emerged from the interviews were supported by direct quotations from the interviewees and from the FGD. Strategies that rehabilitation professionals employ to ensure the success of healthcare plan 2030 were detailed. Policy analysis and the strategies of the rehabilitation professionals were used to develop a theory of change.

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CHAPTER 5

CONCLUSION

5.1 ORIENTATION TO CHAPTER 5

In this chapter, the conclusion of the study is elaborated upon, recommendations are made and opportunities for further research are highlighted.

5.2 SUMMARY OF THE STUDY

The objectives of this study were to highlight the key aspects of healthcare plan 2030, to explore and describe the rehabilitation professionals' perceptions and understanding of the healthcare plan 2030, and to discuss the strategies the rehabilitation professionals employ to ensure successful implementation of the healthcare plan 2030.

The healthcare plan 2030 conforms to the ADEPT model, while only showing one gap in the policy, namely providing a clear outline of goals of the healthcare plan. Despite listing goals for rehabilitative services as accessible rehabilitative services and the mainstreaming and strengthening thereof within the general health services platform, the healthcare plan 2030 does not speak directly to the various professions forming part of rehabilitation services.

Key findings related to the perception of rehabilitation professionals were that there is often a miscommunication between facility management and rehabilitation professionals, that knowledge of health policies is important, that rehabilitation professionals are faced with constant increases in workload, and are unhappy and disgruntled. It was found that rehabilitation professionals expected government to address the limited human and financial resources as these were inhibiting successful implementation of policies. Limited resources are a known grievance of rehabilitation professionals in the public sector; these professionals have therefore employed strategies to ensure successful implementation of the healthcare plan 2030.

The objectives and methods to achieve the goal of rehabilitation in the healthcare plan 2030 need to be made clear. This is supported by the evidence that rehabilitation professionals are willing to adapt their actions to support successful implementation of a new policy. It was also found that rehabilitation professionals would be more willing to accept government or facility management proposals for changes in scope, if rehabilitation professionals

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understood why these changes were required. This could be achieved by improving the knowledge of rehabilitation professionals regarding policies.

5.3 LIMITATIONS

Various limitations in the conducting of this study were experienced, as detailed below.

5.3.1 Ethical clearance and permission

There was a delay in receiving ethical clearance and permission from the WCDOH to carry out the study. The selected PHC facilities fall under different substructures in the Western Cape. The awaited letters granting ethical clearance and permission were sent to these substructures, not to the researcher, which resulted in a delay to continuation of the study.

5.3.2 Scheduling of appointments

Owing to the overbooked and unpredictable nature of rehabilitation professionals' schedules, four individual interviews had to be rescheduled and three individual interviews had to be conducted telephonically. The researcher maintained contact with the rehabilitation professionals via email. However emails are not always a primary source of communication for rehabilitation professionals, which resulted in an increased turn-around time.

5.3.3 Quality of audio-tapes

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The quality of audio-taping of interviews was affected by background noise and by the participants turning away from the recorder. Background noises were of staff moving in and out of the interview room, and notifications over intercoms. This resulted in some difficulty transcribing the individual interviews and FGD.

5.4 CONCLUSION

The healthcare plan 2030 aligns itself well with the ADEPT model; however, goals need to be listed clearly to ensure that rehabilitation professionals are more aware of specific goals and the intended impact of the policy. Policy obligations need to be specified in terms of the various fields to ensure that all executors of the policy (including rehabilitation professionals) are aware of what they are expected to do. Rehabilitation professionals consider that healthcare plan 2030 can be successfully implemented at their facilities if limited human and financial resources are addressed by government. These limited resources are viewed as a

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barrier to the successful implementation of the healthcare plan 2030. Using a theory of change, the implementation strategies were found to conform to the key aspects of the healthcare plan 2030.

5.5 RECOMMENDATIONS

Based on the findings of the study, the following recommendations can be made:

5.5.1 Communication

Facility management and Western Cape government should consider options to ensure adequate means of communication between managerial staff and rehabilitation professionals. This will assist rehabilitation professionals' understanding of healthcare policies, which in turn, will improve their understanding of the role expected of them by government. Government can look into sending regular emails informing rehabilitation professionals about the changes to policy or about new research around policies. Facility managers are encouraged to have more staff meetings to inform rehabilitation staff about active policies and their goals. Currently, there is a lack of understanding of the healthcare plan 2030 amongst rehabilitation professionals. Improved communication will inform rehabilitation professionals of the key aspects of a policy, ensuring that the stated goals of the healthcare plan 2030 are achieved.

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5.5.2 Policy workshops

Hosting policy workshops will allow for rehabilitation professionals to gain information about a policy from experts. In these workshops, rehabilitation professionals can ask questions and make suggestions. This way, the roles can be clarified and rehabilitation professionals can be actively involved in creating the conditions they work in. Awareness and understanding of a policy allows rehabilitation professionals the ability to align their implementation strategies to expectations of government regarding the healthcare plan 2030.

5.5.3 Investing in human resources

A lack in human resources results in rehabilitation professionals having to do work which falls outside their scope of practice. Consequently, if rehabilitation has a role in the implementation of a policy, that rehabilitation professional must often provide services in more than one discipline. This is not an environment conducive to good rehabilitative

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practice. It is thus recommended that the WCDOH invests in more human resources. Rehabilitation professionals included in this study expressed that, based on their understanding of the healthcare plan 2030, implementation can be successful if there is sufficient human resources.

5.5.4 Further research

The researcher recommends that further research be done on all levels of healthcare to ensure successful implementation of the healthcare plan 2030 across the board. This will assist government in determining what is required at various levels to achieve the intended outcome of the healthcare plan 2030.

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DEPARTMENT OF RESEARCH DEVELOPMENT

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APPENDICES

A. ETHICAL CLEARANCE AND PERMISSION FROM UNIVERSITY OF THE WESTERN CAPE

UWC RESEARCH PROJECT REGISTRATION AND ETHICS CLEARANCE APPLICATION FORM

This application will be considered by UWC Faculty Board Research and Ethics Committees, then by the UWC Senate Research Committee, which may also consult outsiders on ethics questions, or consult the UWC ethics subcommittees, before registration of the project and clearance of the ethics. No project should proceed before project registration and ethical clearance has been granted.

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A. PARTICULARS OF INDIVIDUAL APPLICANT

NAME: Luzaan Kock	TITLE: Miss			
DEPARTMENT: Physiotherapy FACULTY: Community and Health Science				
FIELD OF STUDY: Physiotherapy				
ARE YOU:				
A member of UWC academic staff?	Yes	☐	No	x
A member of UWC support staff?	Yes	☐	No	x
A registered UWC student?	Yes	x	No	☐
From outside UWC, wishing to research at or with UWC?	Yes	☐	No	x

B. PARTICULARS OF PROJECT

PROJECT NUMBER: TO BE ALLOCATED BY SENATE RESEARCH COMMITTEE:
EXPECTED COMPLETION DATE: November 2016
PROJECT TITLE: The Perception and understanding of Rehabilitation Professionals Regarding the Healthcare Plan 2030
THREE KEY WORDS DESCRIBING PROJECT: Healthcare plan, Rehabilitation professionals, community health centers

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PURPOSE OF THE PROJECT:		
M-DEGREE: MSc. Physiotherapy		D-DEGREE:
POST GRADUATE RESEARCH:		

C. PARTICULARS REGARDING PARTICULAR RESEARCHERS		
TITLE:	FAMILY NAME:	INITIALS:
PRINCIPAL RESEARCHER:		
OTHER RESEARCH PROJECT LEADERS:		
OTHER CO-RESEARCHERS:		
THESIS: STUDENT RESEARCHER: Luzaan Kock		
THESIS: SUPERVISOR: Dr N. Mlenzana, Prof. J Frantz		

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C. GENERAL INFORMATION
STUDY LEAVE TO BE TAKEN DURING PROECT (days):
IS IT INTENDED THAT THE OUTCOME WILL BE SUBMITTED FOR PEER REVIEWED PUBLICATION? YES ☐ NO ☐
COMMENTS: DEPARTMENTAL CHAIRPERSON:

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SIGNATURE OF THESIS STUDENT RESEARCHER – WHERE APPROPRIATE:

DATE

SIGNATURE OF THESIS SUPERVISOR – WHERE APPROPRIATE:

DATE

SIGNATURE OF PRINCIPAL RESEARCHER – WHERE APROPRIATE:

DATE:

SIGNATURE OF DEPARTMENTAL CHAIRPERSON:

DATE:

NOTE: THESE SIGNATURES IMPLY AN UNDERTAKING *BY THE RESEARCHERS*, TO CONDUCT THE RESEARCH ETHICALLY, AND AN UNDERTAKING BY THE THESIS SUPERVISOR (WHERE APPROPRIATE), AND THE DEPARTMENTAL CHAIRPERSON, TO MAINTAIN A RESPONSIBLE OVERSIGHT OVER THE ETHICAL CONDUCT OF THE RESEARCH.

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D. DESCRIPTION OF PROJECT AND RESEARCH ETHICS STATEMENT

Abstract

Background: In 2011 the Western Cape Government introduced the healthcare plan 2030; the plan emphasises curative and preventative services at primary healthcare facilities. In order for the Western Cape government to achieve the goal of the healthcare plan 2030 health care professionals who understand the goals and objectives of the policy to ensure relevant outcomes linked to the policy. Healthcare professionals providing rehabilitative services are currently limited thus resulting in challenges to perform the required services. In order to strategise for successful implementation of the 2030 healthcare plan, it is important to have a key understanding of how the key stakeholders view the healthcare plan. Aim of the study: This study thus aims to explore and describe the perceptions and understanding of the rehabilitation professional need to be understood. Research

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design: This will be explored through a qualitative study that uses the ADEPT model as a framework for this study. Study population: Participants for the study will be purposively selected from primary healthcare facilities in the cape metropole. In addition the Healthcare 2030 policy document will be analysed. Data collection methods: The study will comprise of a policy analysis component first and then focus group discussion will be conducted to explore the perceptions and understanding health care workers. Data analysis: The ADEPT model will be used to guide the policy analysis. The transcripts of each focus group discussion will be read individually by the researcher and notes made in the margins to highlight interesting concepts emerging. The different types of concepts will be listed and categorized and common categories will be grouped into themes. To ensure that the information gained is accurate a tape recorder will be used and the researcher will conclude and summarise the findings after each question.

Ethics:

Permission will be obtained from the Research Committee of the University of the Western Cape, the Department of Health, facility managers and participants. The participants will be informed that their participation would be entirely voluntary and that they can withdraw at any time from the process without stating any reason. Participants will be assured that this research will not influence their employment in any way. Confidentiality will be maintained by not mentioning any participants or centers' names during the interview. The purpose of the study will be explained to the participants; focus group binding forms will be given to them before data collection, so that they can sign them, indicating their willingness to participate in the study, and an information sheet regarding the study will be provided for clarity on questions that the participants will have. Consent to be audio taped will also be gained from the participants during the focus group discussions. The undertaking will be given that the results of the study will be made available to all stakeholders at the three rehabilitation centers and to the District and Provincial Health Offices of the Western Cape. The undertaking will also be given that where participants will show signs of emotional distress during interviews; they will be referred to a counsellor to address the causes of the problem.

Form issued by: Professor Renfrew Christie, UWC Dean of Research, February 2002.
(959 2949; 959 2948 secretary, 959 3170 fax, email: rchristie@uwc.ac.za)

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B. ETHICAL CLEARANCE AND PERMISSION FROM THE WESTERN CAPE DEPATMENT OF HEALTH

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP19_742
ENQUIRIES: Ms Charlene Roderick

University of Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Dr Nondwe Bongokazi Mlenzana, Ms Luzaan Kock, Ms Rochelle Petersen

Re: **To explore and describe the perceptions of rehabilitation service providers in the implementation of a rehabilitation model at primary health care level.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

TC Newman	**Surina Neethling**	**023 348 8102**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

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C. INTERVIEW SCHEDULE

Demographics

Age

Years of experience

Profession

1.1 When did you complete you studies?

1.2 How long have you been a government employee?

1.3 How long have you been employed at this institution?

Policies

2.1 Tell me about any policies that you are aware of regarding to the running at your institution and department.

Probe: rehabilitation policy, healthcare plan 2010; 2020 and 2030

2.2 Tell me more about you understanding of the policy. How were they introduced to you?

Probe: Did you have any workshops, presentations done? If yes, what was your understanding of the policies?

2.3 When this policy was introduced to you, how did you implement it in your department?

Probe: How are you finding it? Good/bad: Why?

2.4 What are the specific expectations of roles discussed?

Give them a summary of ADEPT model

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

Healthcare plan 2030

3.1 Before the healthcare plan 2030, when was the last time you heard about a policy? Which policy was it and who introduced it to you?

3.2 If the policy mentioned was implemented at your institution, how did it affect your work?

3.3 When did you hear about the healthcare plan 2030? Who introduced it to you?

3.4 What is your understanding about the healthcare plan 2030?

3.5 Was it ever formally introduced to you as a staff member?

3.6 If yes, what specific expectations of roles were discussed?

3.7 Your understanding of this policy:

- As a _____________, how do you see this healthcare plan 2030 changing the approach to management of the patient? Elaborate as much as you can.
- In the healthcare plan 2030, the focus shifts to a patient centred approach. What is your understanding of this?
- How do you see this approach of patient centred model? Is it feasible? Is it going to work? Etc.

3.8 If you had more time to read this policy with more understanding, how would this change your approach to implementation?

3.9 If it is implemented, how can it be successful?

- What specific areas would you like the focus to be on in a policy workshop? Why these areas specifically?

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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- *Personal*
- 4.1 How does your experience advantage (or disadvantage) you with the implementation of new policies?
- 4.2 What is your perception of the role of rehabilitation professionals expected by government?
- 4.3 When the healthcare 2030 is implemented will it be the first change in policy you're a part of? If no, what challenges did you face as a rehabilitation professional with the implementation of previous policies?
- *Institution*
- 5.1 What type of patients do you treat?
- **Probe:** types of disability
- Age group
- 5.2 What is the consultation process/procedure that you follow with your patients?
- 5.3 What is the rehabilitation process/procedure that you follow with your patients?
- 5.4 With regards to logistics, is the institution equipped with enough staff members for the community?
- 5.5 If you answered no to the above question, how does your institution cope with the insufficient staff?
- 5.6 Based on your knowledge of the healthcare plan 2030, can it be successfully implemented at your institution? Elaborate on your answer.
-
- *Staff*
- 6.1 At your institution, how many rehabilitation staff members are you aware of (based on the definition as described in thesis, will read it to the rehabilitation profession if needed)?
- - How does this number affect the treatment patients receive?
- - How often do you meet as a rehabilitation team?
- - Explain the different topics covered in these meetings
- - How do the outcomes of these meetings influence your work environment?
- 6.2 How often do you have staff meetings with all employees at your institution?
- - **If they don't have, ask:** How will they implement the policy if they don't have meetings
- - **If yes, ask:** who the people involved in this meeting?

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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E. INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 3647 Fax: 27 21-959 1217

E-mail:luzaankock@gmail.com

INFORMATION SHEET

Project Title: The Perception and understanding of Rehabilitation Professionals Regarding the Healthcare Plan 2030

What is this study about?

This is a research project being conducted by Luzaan Kock at the University of the Western Cape. We are inviting you to participate in this research project because you are a rehabilitation professional at the selected primary health care facilities chosen as part of this study. The purpose of this research project is to explore the perceptions of rehabilitation professionals with regards to the healthcare plan 2030. This project can assist the Western Cape Department of Health to ensure that rehabilitation professionals have an understanding of the healthcare plan 2030.

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What will I be asked to do if I agree to participate?

You will be asked to join a focus group discussion where the healthcare plan 2030 will be discussed and explain. This focus group discussion will be audio taped and the information will be transcribed and used in the final submission of this project. The focus group will be held at the respective facilities and the appointments will be made two weeks prior to the date of the focus group discussion. This focus group discussion will be a maximum of 1 hour long and will only be done that one day. No medical examinations required.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your confidentiality your name will not be mentioned, only the researcher will have access to the recordings. If we write a report or article about this research project, your identity will be protected. This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

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What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

The benefits to you include knowledge on the proposed healthcare plan 2030 of the Western Cape Department of Health. We hope that, in the future, other people might benefit from this study through improved understanding of the healthcare plan 2030.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. Your employment will not be influenced in any way in this study.

What if I have questions?

This research is being conducted by Luzaan Kock Physiotherapy Department at the University of the Western Cape. If you have any questions about the research study itself, please contact Luzaan Kock at 083 431 9955/ luzaankock@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr Nondwe Mlenzana	Prof José Frantz
Head of Department	Dean of the Faculty of Community and Health Sciences
University of the Western Cape	University of the Western Cape
Private Bag X17	Private Bag X17
Bellville 7535	Bellville 7535
nmlenzana@uwc.ac.za	chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from SR*)

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F. CONSENT FORMS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3647 Fax: 27 21-959 1217

E-mail: luzaankock@gmail.com

CONSENT FORM

Title of Research Project: **The perception and understanding of rehabilitation professionals regarding the healthcare plan 2030**

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name………………………………………..

Participant's signature…………………………………..

Date………………………

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