THE IMPACT OF RESTRUCTURING ON THE DELIVERY OF HEALTH CARE SERVICES

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DECLARATION

I, BOITSHOKO FILISTAS JOHNSON, declare that this dissertation for the degree of Masters of Business Administration (MBA) with North West University hereby submitted, has not been previously submitted by me at this or any other University, that it is my work in design and execution and that all materials taken from other sources contained herein have been duly acknowledged.

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BOITSHOKO FILISTAS JOHNSON

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Boitshoko F. Johnson
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ABSTRACT

The purpose of the study was to determine the impact of restructuring on the delivery of health care services in the Mafikeng area. In some rural areas health care facilities are not accessible to the local communities as consumers are in most cases unable to reach the centres because of lack of transport, funds among others. Most of our communities are disadvantaged especially in case where mobile clinics cannot reach them. The study revealed that restructuring had a negative impact on the delivery of health care services. People who felt the major impact are the disadvantaged, who are from rural communities and should have benefited from restructuring. The study has recommended that nurse patient ratio and doctor patient ratio be improved to reduce the adverse effects of restructuring. Policies need to be revised to come up with better strategies and to reskill health care workers.

CHAPTER ONE

ORIENTATION

1.1 INTRODUCTION

Health services are one of the basic sectors of society and the economy. They touch the life of all population groups and thereby also of all workers. The ILO subscribes to the 'Health For All ' Strategy of WHO, which aims at achieving greater accessibility of health care through community-based provision of primary health care and other health services. While health challenges differ from country to country, there is near universal recognition of substantial inefficiencies in allocating human, material and financial resources. Therefore, many governments are rethinking the basic premises of the health care systems, which also shape the employment outlook for health care workers. Beyond its general concern about health protection for workers, the ILO attaches importance to the fact that the situation of health care and medical personnel is critical to the delivery of the services in the sector. Therefore, the ILO deals with this workforce (estimated employment 35 million worldwide) in specific labour standards and sectoral activities. Over the past three decades, the health professions have been growing rapidly in most countries, often more rapidly than the population. Due to demographic and epidemiological conditions, the demands on health services will further increase. So, probably, will employment opportunities in this field.

However, the impact on employment appears to be subject to national conditions, financial resources, and the availability of trained personnel. Increasing costs of health care services, structural adjustment policies and cost-containment measures seem to have a negative impact on the employment, working conditions and career prospects of health personnel. Health care has until now been largely in the public sector in many countries (except in the US where only 46% of expenditure was public in 1992). Nevertheless, reforms in this sector often include privatisation and increased use of market - type mechanisms. All governments recognise the importance of public supervision and regulation of the health sector, and many want to arrive at a public / private mix of health services. Restructuring can be a means of improving the efficiency and availability of health services; however, equal access to quality health services has to be ensured. There is a danger that a two - class health care system will evolve which would exclude the socially disadvantaged, especially in countries with inadequate insurance system and social protection.

1.2. STATEMENT OF THE PROBLEM

The delivery of health care in North West Province has either slowed or accelerated since the restructuring process. Therefore, the focus of this study was on constraints and aspects, which constitute delay in the rendering of service.

1.3. AIMS

The main aim of the study was to determine empirically the impact of restructuring of health care services on the lives of Mafikeng communities in the North West Province.

1.4 SCOPE OF THE STUDY

The topic in consideration is very broad and complex. The focus of the study however was conducted for the consumers of health care services in Mafikeng area.

1.5 SIGNIFICANCE OF THE STUDY

This study was conducted so as to come up with a better approach to the delivery of health care after restructuring and to improve the health care services. The Health Department will get assistance from this study so as to attend to the shortfalls they might not have been aware of in the past.

1.6. OPERATIONAL DEFINITIONS

1.6.1. RESTRUCTURING

A process whereby there is re-organising and re-arranging of a specific department. It can take many forms such as rightsizing, downsizing, privatising among others.

1.6.2. PRIVATISATTION

It is a process of transforming public sectors and turning them into private enterprises.

1.6.3. PUBLIC - PRIVATE - PARTNERSHIP

It is when public and private entities come together or work together with the aim of adopting the same style and practice in order to improve productivity in their workplaces.

1.6.4. BUDGET CONSTRAINT

It means heaviness or difficulties experienced when handling public and or private finances caused by other issues, which were not included when a budget plan was drawn.

1.6.5. PRODUCTIVITY

It means the level of production or output that is expected from each and every employee at work.

1.6.6. COST - CONTAINMENT

An act of maintaining the cost or trying to save through reducing your work spending and using the most cost effective measures as an attempt to work within the stipulated budget.

1.7. CONCLUSION

Theories about the delivery of health care were considered within South African context and therefore were used as the basis of this study. Literature bearing information on the nature of restructuring will be discussed extensively in the following chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter introduces the reader to a complex myriad of factors involved in health care restructuring. Roles of different players are key to giving profound information on health issues. An expansive view on strategies and constraints to deliver health care services to the impoverished communities constitute a backbone of this chapter. It will also be looked at objectively how health care issues are handled in other areas.

Moves towards equity are commendable, but the magnitude of the proposed budgetary adjustment is based on spurious population data and a per capita income weighting that penalises the people of the Western Cape for their productivity. Becker (1994) says it is generally accepted that budget reductions of more than 2.5% per annum jeopardise institutional survival. The plea that funding should be shifted from other government budgets to increase health funding as a whole rather than aiming for a mediocre common denominator will no doubt fall on disinterested ears, since the decision-makers, like their predecessors, have access to private health care. It is private sector expenditure, which makes South Africa's overall health care expenditure seem acceptable by WHO standards.

2. 2. INEQUALITIES IN THE SOUTH AFRICAN HEALTH CARE

Becker (1994) shares his view that the president, his cabinet members and an army of lesser officials will not want to join queues in health clinics and wait their turn for their share of people's medicine. No doubt there will be a dual system: one for the basic, where the provision of health care will be of the highest order, and a second-tier system for the masses. At least a free - market system with all its flaws is transparent, and the best treatment is available to whoever deems himself important or rich enough and to those who have responsibly made provision for their health rather than claiming a fictitious right to health. 'Everything has its price ' would be a more appropriate slogan.

Many people are careless about health - witness the prevalence of alcoholism and smoking, drug abuse, violence in family and community, reckless lifestyles, lack of attention to family planning. People will never be equal in that sense although matters can doubtless be improved. Do those with a healthy lifestyle have to compete for health care on equal terms with those who cultivate a destructive lifestyle? Do those who work hard and pay more taxes have to foot the bill for all those who take no responsibility for their health and glibly demand the right to health? We should all be on guard against this idealistic message, which quite unrealistically disregard the complexities of human nature and of modern society (Becker, 1994)

2.2.1. THE NATURE AND TYPES OF INEQUALITY IN HEALTH CARE

Inequalities in South African health care arise along various dividing lines according to which the distribution and provision of resources are regulated. They find expression in various degrees of accessibility, attainability, utilisation and quality of services and facilities in the health sector. As a result, marked inequalities in supply and consumption spill over into significant inequalities in the health status and in differential health risks and survival chances for certain population groups and people. Inequality in health care in South Africa is therefore no singular and simple problem. As elsewhere, its origins and guises are numerous. The main divides from which inequalities in this sector emanate are those of socio-economic status, wealth or purchasing power (rich/poor; insured/non-insured), race or colour group (white/non-white), and geographical area and conditions (urban/peri-urban/rural). Despite their mutual interplay in actual health care, they are nevertheless distinguished here for purposes of analysis (Becker, 1994).

Apart from these broader divides, inequality in South African health care also encompasses a myriad related dimensions: (i) it manifests itself in disproportionate distribution, over concentration and under concentration of personnel, services and facilities; (ii) it refers to unequal provision and availability of services and facilities, and to the accompanying over and under provision, over - and under servicing, and problematic phenomena such as over-/under hospitalising, over-/under doctoring and over-/under medication;

(iii) it is expressed in differential or unequal accessibility of services and facilities together with the phenomena of in-/exclusion from services and amenities, as well as obstructive and discriminatory measures which limit or bar admission or access to sectors of the health care system; (iv) it assumes the guise of differential attainability and even unattainability of services and facilities, especially in relation to the location of facilities and the deployment of personnel; (v) it refers to consumption or utilisation in as much as the clientele do not to an equal extent make use of available services and facilities, resulting in either excessive, unnecessary and unjustified consumption or under utilisation of services and facilities; and (vi) it also surfaces in the differential quality of services and facilities in the sense that some receive more and better services and facilities while others receive less and poorer. As a matter of fact, these inequalities are closely related to, and are indeed a mere reflection of, the socio-economic, racial and political disparities in the broader societal context, where access to wealth and political power so far has been regulated by a white political elite. On the one hand this served to strengthen the privileged socio-economic and political position of the whites, while on the other it perpetuated a vicious circle of repression, poverty and deprivation of non-whites (Becker, 1994).

2.2.2. SOCIO-ECONOMIC CONDITIONS

Variables associated with socio-economic conditions such as material wealth, employment status and purchasing power represent the first important dimension of unequal distribution and provision and of differential accessibility, attainability,

utilisation and quality of health care. The most important cause of these inequalities is financial ability, which determines whether people can afford health care, how much and what quality they can afford, and whether they must simply forgo health care (Becker, 1994).

In South Africa, the wealthy, permanently employed and health-insured undoubtedly have the better health care, being in a position to avail themselves of high-standard private health services. In contrast, the poor, unemployed and non-insured find themselves in a relatively deprived position. For them health care is largely unaffordable and financially inaccessible, rendering them dependent on the State and / or on charity, or simply forcing them to forgo health care. Many factors nowadays aggravate this situation. On the one hand, there is the desperate and ever-worsening socio-economic position of an exceptionally large proportion of the population, among whom poverty, unemployment and irregular employment are prevalent. On the other hand, the prevailing free-market dispensation in health care, together with intensified measures to effectuate privatisation, contribute to a situation where financial ability and purchasing power play an increasingly important role in the provision and distribution of health services and facilities, also giving rise to stronger manifestations of inclusion and exclusion, overprovision, deprivation and excessive and under utilisation of health care (Becker, 1994).

2.2.3. RACE AND COLOUR DIVISIONS

Socio-economic inequalities are further complicated in that they largely coincide with existing race and colour divisions in the population. Whites find themselves, generally speaking, in a more favourable socio-economic position than their non-white compatriots. Whites are most often to be found in permanent employment and also have the larger share of health insurance by fare - thereby ensuring their preferential claim on the health care resources of the country. Blacks, on the other hand, are generally in a relatively unfavourable to desperate socio-economic position. Proportionally, few have the privilege of permanent employment and purchasing power for private health care, and fewer still are insured against disease and indisposition. This implies that membership of a specific race or colour group constitutes the second significant differential connected with inequality in health care. Many an inequality of this sort has systematically been created and maintained in South Africa's protracted apartheid history (Becker, 1994).

2.2.4 GEOGRAPHICAL FACTORS

Many people hold different views about the inequalities in health care systems. Becker (1994) shares similar views where he acknowledges that geographical area and geographical conditions constitute the third important divide from which gross inequalities in South African health care emanate. Health personnel and facilities concentrate in the urban and metropolitan areas, leaving rural areas, and the rural homelands in particular, in a relatively under provided and under

serviced position. This has yet another, deeper dimension: white business and residential areas in urban areas have disproportionately high allotment of health personnel and amenities serving mainly the white clientele, resulting in distortions such as overprovision, over servicing and overuse. Yet, in the corresponding non-peri-urban and squatter areas of those same cities, such services and facilities are meagrely provided or even entirely absent. These geographically related inequalities are further aggravated by geographical conditions and impediments. Most of South Africa consists of inhospitable, impassable and vast areas in which the rendering of and access to health care is very difficult. Where these areas especially the homelands are, also characterized by widespread poverty and backwardness, and a poorly developed infrastructure, the effects of geographical inaccessibility become far worse.

2.2.5 UNCLEAR ROLES

Hall (1997), expressed that there is a need to improve health care efficiency and effectiveness. Hospital organizations are exploring and implementing restructured patient care delivery models. The shift away from traditional patterns creates an opportunity for the redesigning of health care resource utilization and creation of new staff mixes. Many emerging models appear to provide substitute workers for the RN rather than complement the nursing role. One concern evident in the literature is the lack of evaluation of these staff mix models as they become more prevalent. The outcomes for patient, hospital system, and nurse remain unclear.

2.2.6 THE CAUSES OF STRUCTURAL INEQUALITIES IN HEALTH CARE

In order to contemplate any significant solution to the multidimensional problem of inequality in South African health care, firstly it was necessary to grasp its origins, that variety of forces which introduces, facilitates and reinforces the emergence and sedimentation of these inequalities. Apart from being the source of much concern and discontent in South African health care, these causative forces also indicate departing points from and guidelines along which reform and thus the equalisation of health care provision and distribution can be launched (Becker, 1994).

2.3 ALTERNATIVE APPROACHES TO THE DELIVERY OF HEALTH CARE

The health care system is facing many challenges system like finding cure for indigenous diseases. The modern conception of health indicates not only the absence of disease but a maximum degree of physiological and mental efficiency. Its aim is economic prosperity, social contentment and creative power.

The search for an alternative, accessible, equitable, appropriate, available and responsive health service for the South African population is based on the premise that the current system of health care delivery is none of these. There is a mismatch between the needs of South Africans and the existing health services. The emphasis on excellent, technically advanced, world class curative care, at the expense of health promotion and the prevention of common infectious and parasitic diseases which are still our major killing diseases - is a feature of the South African health care system. In the context of the dramatic political changes

that the country has seen over recent years, many aspects of local health care need reappraisal. Issues such as policy - making and planning, the development of human resources for health care, the establishment of district health systems, the roles of family physicians, communities, traditional practitioners and non-government organizations, require approaches very different from those that have existed to date. The vexed question of the public-private mix in health service delivery, including managed care, requires approaches that reflect the social transition which South Africa and the world are undergoing. The enormous challenge of reducing the inequalities in both health care and health status in South Africa, without sacrificing efficiency and quality, requires imagination and innovation (Pick, 1996).

2.3.1. HUMAN RESOURCES FOR HEALTH CARE

South Africa is blessed with excellent institutions for the training of health personnel. According to Pick (1996), there were 25 833 doctors in 1992, of whom 7 485 had a speciality, 4 041 dentists, of whom 258 were specialists, 9 583 pharmacists and approximately 27 000 supplementary health professionals registered in South Africa. There was an estimated 175 810 nursing professionals throughout the country in 1994. The doctor: population ratio, based on the number of doctors registered in 1994, is approximately 6.5: 10 000, which is better than that for the rest of Africa and compares favourably with some South American middle-income countries. However, this ratio is poorer than that of European middle-income countries such as Portugal, Greece and Spain, which have between

2 and 5 times as many doctors per 10 000 population as South Africa. The years between 1950 and 1990 saw a quadrupling in the number of registered doctors, with a corresponding improvement in the doctor: population ratio from 1:3 600 in 1930 to 1:1 348 in 1990. The ratio of general practitioners to population was 1:1 855 in 1989, whereas there was one private general practitioner to 685 of the insured population (Pick ,1996).

About two-thirds of all nurses work in the public sector. Most of those in the private sector are employed in private hospitals, while very few practices on a fee-for-service basis. Only 80% of all public sector nursing posts are filled. A special category of nurse has been trained in South Africa since 1976. These are nurse practitioners known as Primary Health Care Nurses (PHCNs), of whom about 100 qualify annually. The provision of dentists, pharmacists, physiotherapists and occupational therapists is subject to the same maldistribution except that it is worse (Pick, 1996).

2.3.2. WHAT ARE THE ALTERNATIVES?

Policy- making has traditionally been a process, which excluded the communities affected. It involved state officials who consulted with some experts but ignored people at grassroots level. While it is not easy to involve communities at the grassroots, the contributions could be valuable in identifying their perceived priorities as well as facilitating the implementation of policy. As long ago as 1944, the Gluckman Commission recommended the establishment of health conferences

through which communities could voice their views on health matters. This is one approach to policy formulation that could be usefully employed in present-day South Africa (Pick, 1996).

2.3.2.1. THE REGIONALIZATION OF HEALTH SERVICES

Pick (1996) defined the rationalization of health services as bringing some order to the allocation of health resources or delivery of services in a geographic area. The issue of access is one. In a situation where health services are regionalized, access is ensured and improved. Rationalization also leads to increased efficiency, as there is a reduction in the duplication of health services within a certain geographic area. And finally, rationalization is a tool for ensuring greater equity (by virtue of reduced inequity) of health service delivery. Other authors have also argued that rationalization implies the de-centralization of power. This de-concentration of influence at the centre offers an alternative approach to health services delivery, which will reduce the inequalities. Furthermore, a well-organized health service at the level of a region is a prerequisite for the successful provision of health care at the level of districts, which are smaller geographic units designed to bring health services much closer to the communities.

2.3.2.2. THE DISTRICT HEALTH SYSTEM

The district health system (DHS) offers an alternative approach for health care delivery at the local level and merits serious consideration in South Africa. In the context of the Health for All (HFA) movement, the term DHS has taken on a specific meaning, defined in 1986 by the WHO Global Programme Committee as:

'A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. Pick (1994), states that district health system consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services'.

All these elements are coordinated in order to provide comprehensive promotive, preventative, curative and rehabilitative health activities. The components of a DHS include: the individual and the family, the community, the health facility at first contact level, peripheral health unit, and the hospital at first referral level.

In order for the DHS to function efficiently, the following components are vital: the district health management team, the district health council, the district development committee, the health development tasks, the district health budget, and the district health information system. The district health management team should define the health needs; plan and coordinate health care activities to ensure the optimal utilization of resources (human, financial and material): ensure and

maintain good standards of care; arrange for the ongoing training of staff; collect data to determine community health needs, coverage, impact of interventions, data analysis and recording, and the use of information for health improvement. The district health council is a political body responsible for determining health policy for the area and should have representatives from the community, the district health officer, directors of the district hospital, senior nurses, representatives of non-governmental organizations working in health care, departmental heads from related sectors, such as education, agriculture, and social services. The district health council should also approve the budget, ensure a balance between the district hospital and other services and advise the district health team on any changes required in the implementation programme. The district development committee will focus on overall development, which includes literacy, leadership training, employment and safety, housing, sanitation, fuel and power supplies, drug supplies, food production, social mobilization for health and family life education. Support at the regional level is crucial for the success of the DHS. Its management will be underscored by a functioning health information system (Pick, 1996).

2.3.2.3. THE ROLE OF FAMILY PHYSICIANS

Important players in the development of alternatives to the current health care delivery system are family practitioners which are approximately 8 000 in South Africa. It would be foolish not to acknowledge the important role they assume. The function of family practitioners in the provision of health care should be

expanded. Through community-orientated primary care, these practitioners will not only look after families but will begin to address aspects of community life that has a direct bearing on the health of their patients. Pick (1996), found that issues such as environmental hygiene and prevention would become important aspects of the work of family practitioners, who will also have skills in epidemiology and evaluation. This kind of primary care thus offers an approach to family practice, which has the potential to broaden the role of family doctors such that their contribution to the primary health care team will be enhanced. A feature of medical care the world over has always been the clinical independence of medical practitioners. The integration of family practitioners into the national health system should respect this traditional autonomy while recognizing that it may conflict with attempts to provide affordable, accessible and equitable health care for all.

The method of remuneration of family practitioners has been much discussed. It is useful to remind one selves that none of the three mechanisms for payment of family physicians, namely, fee-for-service, capitation and salaries, is ideal. Salaries offer no financial incentive to maintain the quality of care and work volume and may, in fact, encourage over-referral. The payment of capitation fees does not discourage over-referral as the practitioner's fee is secured beforehand. Fee-for-service payments have been found to be expensive, as they tend to encourage over-servicing, under-referral and are biased against preventive care (Pick, 1996).

2.3.2.4. HEALTH MAINTENANCE ORGANIZATIONS

While there are a number of different kinds of health maintenance organisation, they all have similar characteristics. They usually are privately run, operated for profit and are financially responsible for primary, secondary and tertiary levels of care for their members. Pick (1996) emphasises that where necessary this care should be contracted out. Costs are met by charging an annual capitation fee for all those enrolled in the scheme. It would be useful if there was an integration of health maintenance organizations into the overall health system such that spare capacity in public sector hospitals can be used by HMO's and the costs recovered by the public sector. In the event of public sector hospitals being overextended, the HMO's could be contracted to provide care for the public sector patient. This is again subject to there being some form of national health system in existence. Projections based on a study of three large HMO's in the US in 1986 showed that 20% fewer primary care doctors for children and 50% fewer primary care doctors for adults would be needed by 1990 than was projected by Graduate Medical Education National Advisory Committee. This can be ascribed to the more efficient health personnel mix in the HMO's (Pick, 1996).

2.3.2.5 MANAGED CARE

In its most simple form, the term "managed care" refers to some form of organized delivery system that links the financing of health care to the delivery of services. The original objective of managed care was to maximize the quality of care while minimizing costs, by providing a coordinated, seamless set of services

that emphasize prevention and primary care. However, because of the speed at which the industry is evolving, there is no single universally accepted definition of managed care. In fact, virtually identical managed care arrangements may be defined quite differently around the nation (Grimaldi, 1996).

Clearly, better models are needed for delivering comprehensive long-term care in rural communities where many vulnerable elders reside and disparities exist between health needs and resources. According to Aaronson1 (1996), health services organizations are products of the way in which the services they deliver are financed. A major impediment to the development of a continuum of long-term care, especially for rural community-based elders is the lack of a system of financing services for individuals with complex and, frequently, chronic care needs. Commercial managed care plans have been reluctant to enter rural markets (Mueller, 2001).

Quality is a necessary and important component of health services delivery. In urban areas, there are many providers from which to choose; however, rural areas have disproportionately fewer providers. Therefore, the likelihood that a chosen provider will offer substandard care may be greater in rural areas. The sponsoring hospital, community health centre, or other institution will have to maintain strict oversight to ensure that providers meet appropriate standards and employ measures to correct any quality problems as quickly as possible. This may be a costly but necessary process that requires additional staff (Mueller, 2001)

2.3.2.5. WHO SHOULD CARE FOR THE SICK IN SOUTH AFRICA

In South Africa people have been hamstrung up to now by rigid rulings by the statutory councils (such as the South African Medical and Dental Council, and the South African Nursing Council), which have prevented the emergence of combinations of health personnel best suited to the needs of particular communities. Pick (1996) discovered that it is clear that the needs for health care vary from community to community. No one combination of health personnel will meet the needs of all communities. The 'freedom of association' of health carers would be an exciting alternative to what has been the case so far.

Such an arrangement will permit doctors, nurses, dentists, pharmacists, physiotherapists and the like to work together in teams. Poor rural communities would have a different health care team than would affluent urban communities. The question of community health workers needs to be explored as it is not clear to what extent and how cost- efficiently this category of health worker will meet the needs of poor, under-served populations. It is conceivable that other categories of health worker, such as medical assistants or medical auxiliaries, may well have to be considered, although the enormous variability in their skills has made it difficult to accommodate them in the existing health care delivery system.

At the South African Health and Social Services / Progressive Primary Health Care Network Policy Conference in 1992, new categories of environmental health workers, health advocates and health technicians were proposed. This stemmed

from the experiences of participants in the conference, particularly those from rural areas. The Medical Dental and Supplementary Health Service Professions Act and Nursing Act, amongst others, will have to be amended in order to facilitate the eclectic mix of health personnel required to meet different needs.

2.3.2.6. THE ROLE OF THE COMMUNITY

According to Pick (1996), health centres are managed by health committees and the community contributes to the running costs of the under financed health centres in some countries, by paying a flat rate for services provided. In an alternative system of health care delivery the role of the community goes beyond the mere contribution to health care costs. The whole question of user fees is a controversial one. The role of health centre or clinic committees is thus crucial for the optimal functioning of the health services, at these committees act as the conduit through which health service providers are in touch with communities which they serve.

2.3.2.7. THE ROLE OF TRADITIONAL HEALERS

Mothers are the oldest traditional healers in society. Innovative ways in which the 'non-mainstream' health carers could be integrated into the overall health care system need to be devised. Given the vast numbers of South Africans consulting a wide range of traditional healers, it would be an extreme case of denial if we ignore this sector. Alternative healers have a contribution to make provided that harmful practices are not condoned. There are numerous examples of the

involvement of traditional practitioners in 'mainstream' health care. Their role in the care of psychiatric patients as well as in the AIDS campaigns are but two such examples (Pick, 1996).

2.3.2.8. NON-GOVERNMENTAL ORGANIZATIONS

Pick (1996) stresses that NGO's have an important role to play in providing the country with models for alternative health care. Organizations like the Progressive Primary Health Care Network, which encompass community-based health care projects, are able to pioneer alternative strategies to meet the health care needs of the South African people, unencumbered by the yoke of officialdom. It is clear, however, that their role is not to let the official providers of health care off the hook. Rather, they should show the way to a different health care system based on a different philosophy and worldview.

If a hundred National Progressive Primary Health Care Network projects flower in the next decade surely many will fail by conventional standards. In a sense, an appreciable failure rate should be welcomed, as an indication that real high- risk experimentation is being supported. Models involving not only the delivery of health care, but embracing literacy programmes, vegetable gardens, preschool education, water safety, sanitation and economic development, set the tone for an alternative health care delivery system based on the realization that the major determinants of health of populations are the physical, biological and social environments in which they find themselves and not only health care provision. In

arguing the case for alternative approaches to the delivery of health care in South Africa, some evidence has been produced on the need for alternatives. While only a select number of issues have been addressed, it is clear that changes are required if the health care system is to meet the needs of the people of South Africa. One can expect that, consistent with the new political order, there will be a change in health provision. The health system that we leave our children will depend on whether we are able to generate imaginative and feasible alternatives to what is currently being provided (Pick, 1996).

2.3.3. EQUALISING THE INEQUALITIES IN HEALTH CARE

Judging from the complex origins and diversified nature of inequalities in South African health care being a simple and straightforward approach to equalisation would not be applicable and feasible. Instead, a broad and multi-faceted approach seems necessary. Above all, it appears obvious that reform strategies that aim fundamentally to address inequalities in health care should commence at the root causes and their complex interconnectedness, thus stretching far into the broader, problematic societal order (Becker, 1994).

Furthermore, structural inequalities represent but one dimension of the structural problems haunting South African health care. An isolated concentration on equalisation without addressing the total nexus of problems would therefore be futile. For too long the country's health care problems were dealt with by 'reformist reforms' that is minor material improvements while leaving intact

current political and economic structures and rejecting objectives and demands which are incompatible with the preservation of the system. Entirely new ways of thinking and progressive measures appear to be imperative. The following are paramount:

1.**A re-evaluation of prevailing principles and value-orientations in South African health care** is necessary. In particular a retreat from dominant values sustaining the pluralistic health care system, which serve as an unlimited source of inequality, should be made. The values of racial superiority, market-justice and individualism must be played down in the health sector. At the same time values conducive of equality must be cultivated, especially those of co-operation, common good, altruism and equity (Becker, 1994).

2. **A refocusing of prevailing policies with a concomitant reorganisation of existing structures of health care** also appear necessary, so as to render services and facilities more available, affordable, accessible and acceptable for the entire clientele, but also rendering them less fragmented, more co-ordinated and more effective in their functioning. This clearly means curtailing the roles played in the health care system by apartheid, the private sector, the provincial bureaucracies and the medical profession in particular (Becker, 1994).

3. **A redistribution of funds, personnel and other resources in the health sector** to accomplish more equal provision and more equitable allocation also

seems inevitable. This implies a scaling down of the major role of purchasing power, geographical area and race in the present distribution, provision and accessibility of health care.

4. In accordance with the abovementioned measures, it would subsequently be a prerequisite **to explore new value-orientations, new policy frameworks and measures, alternative models of care and other categories of health care providers,** which will be able to incorporate easier access, greater relevance and more acceptances into South African health care (Becker, 1994).

2. 4. INCREASING EFFICIENCY / PRODUCTIVITY

The development of intranets and extranets will open dozens of possibilities for expediting business processes and expanding the number of trading partners, physicians, health plans, consumers, pharmaceutical manufacturers. Examples include:

•Clinical trials - Conducting drug studies and clinical trials is becoming a major industry. Hospital and physician networks can create extranets that directly link patients in the trials via the Internet, resulting in a seamless web of telemedicine and clinical research.

•Clinical protocols - Hospitals and physicians can share clinical protocols, update algorithms as new research becomes available, track costs and outcomes, communicate with patients, provide reports to health plans and employers, and demonstrate quality improvement.

•Disease management - Internet linkages between providers, patients, and disease management programs can improve outcomes, reduce costs, and prevent early onset of acute symptoms.

•Reducing clinical variation and costs - The biggest target for Internet-based cost strategies is clinical care. Profiling software can quickly identify cost-effective practitioners, using national standards and "best-of-breed" benchmarks. Health insurers like Indianapolis-based Anthem Blue Cross are applying electronic assessment tools in cardiac surgery and only offering contracts to those heart surgery centres that meet Anthem's standards (Becker, 1994).

2.5 BARRIERS TO AN E - HEALTH FUTURE

According to Schaich (1999), health care providers and health plans seeking to promote their services by Internet linkages may have to wait for some consumers to catch up with the information age. Some e-commerce applications have drawn a quick and positive response, like purchasing books. For e-commerce to reach its full potential the availability of Internet access must become universal and consumers must be trained in Internet communication skills.

Even if every home had a computer or other Internet access device, some customers still "would prefer to talk to a live person rather than interact with a personal computer," says Doug Whicker, project leader for e-commerce at Wellmark Blue Cross and Blue Shield in Des Moines, Iowa. Market research by Aetna U.S. Healthcare showed that consumers are definitely interested in

accessing a website for service availability information such as physician location, but more reluctant to share their medical history or discuss a diagnosis online. Leading barriers that must still be overcome for e-commerce to be widely employed in health care include:

•Lack of universal Internet access

•Computer illiteracy

•Limited knowledge of how to "surf the Web"

•Cost of purchasing computers

•Service costs of online access providers

•Security/confidentiality concerns

•Unwillingness to share personal/medical information

•Unwillingness to put credit card information online

•Compatibility of systems between customer and Web-based organization

•Desire to do business "face-to-face"

•Failure of the organization to array its products/services for online commerce.

The greatest barrier to widespread adoption of e-health strategies may be health care's precarious "BBA-era" finance. Hospitals and doctors reeling from Medicare payment cutbacks under the Balanced Budget Act may be reluctant to invest in Internet strategies (Schaich, 1999).

A recent survey of academic medical centres by the University Health System Consortium found that 40 percent were losing money and could wind up clients of the Philadelphia-based Hunter Group, a turnaround management company that is

operating the University of Pennsylvania, as well as the Stanford University-UC San Francisco Health System.[17] The Hunter Group typically slashes 15 to 20 percent of capital and operating costs like information systems. For those with capital, it's very clear that "dot.com" initiatives reward the "early movers" who reinvent their market and leave competitors in a cloud of e-dust.

It seems like only yesterday since the arrival of "dot.com" companies in health care--and it was! Most e-health enterprises are barely two years old. Yet already the new e-health economy is moving into a second generation, escalating past "B2C" (business-to-customer") based on mouse-clicks and advertising to industrial-strength "B2B" (business-to-business) strategies, where revenues are based on transactions or subscriptions. Web-based solutions may apply to both sides of balance sheet--to reduce expenditures and create new revenue sources (Schaich, 1999).

Utilizing e-health strategies will expand exponentially in the next five years, as America's health care executives shift to applying IS/IT (information systems/information technology) to the fundamental business and clinical processes of the health care enterprise. Internet-savvy physician executives will provide a bridge between medicine and management in the adoption of e-health technology (Schaich, 1999).

The arrival of the Internet offers the opportunity to fundamentally reinvent medicine and health care delivery. The "e-health" era is nothing less than the

digital transformation of the practice of medicine, as well as the business side of the health industry. Health care is only now arriving in the "Information Economy." The Internet is the next frontier of health care. Health care consumers are flooding into cyberspace, and an Internet-based industry of health information providers is springing up to serve them. Internet technology may rank with antibiotics, genetics, and computers as among the most important changes for medical care delivery. Utilizing e-health strategies will expand exponentially in the next five years, as America's health care executives shift to applying IS/IT (information systems/information technology) to the fundamental business and clinical processes of the health care enterprise. Internet-savvy physician executives will provide a bridge between medicine and management in the adoption of e-health technology (Schaich, 1999).

2.6. LAYOFF POLICIES AS A COMPETITIVE EDGE

Policies serve as guiding principle of any business or organisation. They give direction to where the organisation is heading. Caudron (1996) and Band & Tustin (1995) found that the development of a layoff policy gives an organization a competitive advantage over organizations without such a policy. How an organization communicates concerns to employees is often through procedures and policies developed by the human resource department. Survey questionnaires were mailed to 1,400 vice presidents of human resources that held membership and whose names were provided through the Society of Human Resource Management. Over half of the organizations surveyed (57%) did not have layoff

policies. By type of organization, healthcare had the greatest number of policies in their organizations with 70% affirming their existence. The study concludes with the following five proposed reasons why layoff policies do not exist: "It can't happen here" syndrome, the cover-up syndrome, if you plan for it, people will panic, managers are trained to focus on growth and to avoid decline, there would be loss of control, and accompanying organizational sabotage, more policies equal less humane treatment (Tustin, 1995).

This paper further proposes that the development of a layoff policy gives an organization a competitive advantage over organizations without such a policy. The ill will related to layoffs from affected employees and the larger surrounding community has been well documented. Accompanying these stories is often a stigma that the layoff is capricious of. Many human resource professionals would agree that it is fair to have a layoff policy in place for objectivity in advance of the unfortunate event. Yet, our human resource practices reveal that this strategic lack of effort is the norm in most organizations (Tustin, 1995).

A primary difference for organizations in the future is that layoffs will be a strategic rather than a recession-driven necessity. Whereas layoffs in the past were used predominantly when companies were trying to stop a decline in earnings due to poor performance, declining sales, or increased competition, in the 1990s layoffs were popular even when things were going well (Smart, 1997; Aley, 1995; Downs, 1995). Any corporate strategy which is directed at gaining competitive

advantage including job redesign, multiskilling, redeployment, and layoffs will always have human resource implications (Caudron, 1996; Band & Tustin, 1995). And strategic planning for layoffs has been identified as a primary issue which human resource development professionals are being asked to address (BNA, 1997; Perry & Salem, 1993). In fact, the economic well being of companies in the future will rise and fall in cycles (Tustin, 1995).

Human resource professionals have new strategic responsibilities for exercising leadership in formulating layoff policies that are consistent with overall organizational objectives. This is a relevant responsibility for the human resource professional since the task of informing employees that they have been laid off is often relegated to them. How an organization communicates concern to employees is often through procedures and policies developed by the human resource department. For the survivors of an organizational downsize, the most logical first question is, "When will it happen again?" (Kuczynski, 1999). Yet, almost 94% of the human resource managers in one study had less than two months to plan and implement downsizing efforts (McCune, Beatty, & Montagno, 1988). Assistance has been evident for short-term goals like career counseling (Cameron, 1994) but rarely have long-term ramifications of retained employees been considered (Feldman, 1996; Keidel, 1991).

One of the benefits of implementing a layoff policy is the message sent to managers in the organization that they are expected to deal straightforwardly with

workplace problems. Successful management of the downsizing process is essential for a firm's marketplace viability (Shah, 2000). Policy development attempts to share information, especially in cases where ignorance could trigger rumors (Chelimsky, 1988). Most importantly, policy development may be viewed as the early stages of planned change. Successful organizations deal with change through a continuing series of reinforcing messages (Kanter, 1983), which implies planning and direction setting regarding the way in which to proceed.

Many managers choose to deny the possibility of layoffs and have traditionally resisted providing notices regarding layoffs (Leana & Ivancevich, 1987). Yet this form of denial may inhibit the necessity to plan. Managers are procrastinators when there is bad news to convey. In this fallacy, managers and surgeons may be similar. Surgeons are trained to save lives and have an avoidance reputation for conveying negative information to patients. To convey negative information seems equivalent to failure for both managers and surgeons. However, advance warnings of layoffs may cut back current spending and defer major purchases, decreasing the likelihood of financial disaster and thus limiting the actual number of layoffs that will be necessary (Kanter, 1983).

Traditionally, managers have been reluctant to develop layoff policies, fearing that such notification would trigger work slowdowns, sabotage, and higher turnover. The evidence suggests just the opposite, indicating that advance notification of layoffs does not result in lower productivity or increased sabotage (Leana &

Feldman, 1988, 1989, 1992). If the layoff is viewed as a business necessity and employees are informed in a fair way, the criteria for selection is fair and they are adequately compensated, resistance and retaliation are lessened (Brockner, 1987).

Carefully developed and communicated policies are vital to human resource development. The successful organization in today's competitive marketplace will be able to respond to difficult situations quickly and thoroughly. Those who have not prepared ahead run the risk of adding chaos to a changing work environment. Decisions can be made more rapidly and more consistently if policies have been formulated and communicated throughout the organization. The keys to developing a successful strategy for dealing with layoff potential in the workplace are preparation, communication, and compassion. Policy development ensures the consideration of these components. It appears that organizations without some sort of layoff guidelines are more likely to be accused of subjective, unreasoned responses to crises. As has been evident with other difficult issues like sexual harassment, organizations can do more to avert lawsuits by adopting fair employee policies, by documenting their own compliance, and communicating the rationale for the policies adoption.

Supervisors need guidelines to outline the explanations necessary and the expectation of typical problems that are likely to evolve. The strategic component of human resource development includes consideration of repeated events such as layoffs. Human resource professionals need to provide managers with guidelines for informing employees. In the era of employment where training and recruitment

is especially expensive, it is a competitive advantage to anticipate situations where the organization might develop negative impressions within the community. A layoff policy assists with answering questions that arise before the layoff, during the process, and after as an event that affects all employees of the organization (Smith & Walker, 2000).

2. 7. THE DIGITAL TRANSFORMATION OF HEALTH CARE

The arrival of the Internet offers the opportunity to fundamentally reinvent medicine and health care delivery. The "e-health" era is nothing less than the digital transformation of the practice of medicine, as well as the business side of the health industry. Health care is only now arriving in the "Information Economy."

The Internet is the next frontier of health care. Health care consumers are flooding into cyberspace, and an Internet-based industry of health information providers is springing up to serve them. A recent Harris Poll reported that in the past year, 70 million (74 percent) of the estimated 97 million people online have visited one or more of the Web's 20,000 health-related sites for medical information.

Some consumers are turning to their local hospitals or health plans for health information, but many are employing the Web to search on a global basis for the latest medical research or evaluated treatment data (please see Table 1). "B2C" (business-to-consumer) e-commerce is an emerging health care market for drug refills, durable medical equipment, or alternative medicines. An estimated 60

percent of consumers using health websites have purchased other products online (Schaich, 1999).

Today's rapidly rising Web traffic on health sites is only the beginning. A recent study by Northwestern University and KPMG in Chicago affirms that Baby Boomers are the quintessential generation to demand what they want, fueled by Internet-available medical information. Health care providers with well-developed websites, like Houston's MD Anderson and the Cleveland Clinic, will reinforce their brand identity and gain customer loyalty by providing easy Internet access to detailed health information. Many hospitals and health systems are just starting to focus resources on Web-enabled e-commerce and business applications, such as marketing, physician directories, and employee recruitment, according to national data from the Health Information Management Systems Society.

Although "B2C" (business-to-consumer) Internet solutions are growing rapidly, the real opportunity for the Internet is "B2B" (business-to-business). The next wave of e-enabled applications will focus on creating new customer channels, e-commerce, e-engineering core processes, and supply chain management (Schaich, 1999).

An estimated 25 percent of the nation's $1.2 trillion health budget is considered to be excessive administrative costs or unnecessary medical treatments.[5] That is a $300 million business target of the e-health economy, using Internet-enabled processes like disease management and supply chain management. Only 6 percent

of the health care industry uses the Internet for buying supplies today, compared to 25 percent of companies in other industries. In the digital marketplace, buying medical products on the Internet can reduce costs 5 to 15 percent, or more, taking advantage of Web-enabled comparison-shopping through companies like medicalbuyer.com (Schaich, 1999).

The Internet's global networks offer just what the health field has needed, a low-cost technology that would bridge competing hardware and software to provide a "seamless web" of communications pathways. In the process, they are reinventing medicine. Dot.com companies are moving rapidly to create new information sources and value-added transaction channels for health care providers, payers, purchasers, and suppliers.

In past surveys, doctors have cited "lack of time" as a primary reason for low use of the Internet for clinical information. But the latest report on physician usage of the Internet indicated that doctors now cite that "lack of meaningful content and services" is the number one reason they do not rely on the Web more often for clinical purposes. These data suggest that issues of access and computer literacy are being overcome. In the future doctors may increasingly turn to the Web as a primary source of clinical information and medical data.

Health care consumers are turning to the Web as an increasingly trustworthy source of health-related information, and consumer choices are rapidly expanding. Primary uses of the Web by health consumers in the future will include:

•Disease-specific health information

•Directories of providers

•Health plan eligibility and benefits information

•Report card ratings of health plans and providers

•Patient support groups, "chat" rooms

•Online health advice and counselling

•Personal health risk assessment

•Ordering books on health-related topics

•Searching medical literature for latest medical advances

•Participation in clinical studies for pharmaceutical manufacturers

•In-home monitoring of chronically ill by disease management programs

•Ordering prescription drug refills, over-the-counter remedies, and durable medical equipment

•Developing a personal electronic medical record

•Monitoring personal health improvement and fitness programs (Schaich, 1999).

Internet access for patient self-scheduling is likely to be a popular service enhancement, allowing patients to scan their doctor's calendar and make an appointment. The system can also provide Internet reminders electronically to patients, 24 hours prior to their appointments. The convenience of the Internet contrasts with today's appointment process, which often requires waiting long minutes on hold, or following confusing voice-mail instructions for help from a telephone-based central scheduling system (Schaich, 1999).

This is not a vision; it's already happening across the nation. Support groups of patients who share a diagnosis or treatment are among the most active health care users of the Internet. Patients share the latest medical literature and research findings, and provide commentary on the efficacy of their treatments. Pharmaceutical companies and device makers are actively working with Web-based support groups in collaborating on research studies to obtain active participation in clinical trials, as well as facilitating the early distribution of newly-approved drugs or devices. These Internet-linked "communities" of patients, providers, plans, and purchasers offer hope for collaboration and cost-efficiency in providing medical care in the new millennium (Schaich, 1999).

What's next? Online health advice and telemedicine. With little regulation in place yet, some health care consumers and providers are venturing into new territory--dispensing health advice online, and even prescribing pharmaceuticals, for a fee. The practice is frowned upon by professional organizations, and the focus of frustration for state-based regulators is concern about health professionals doing business across state boundaries without state licenses. Online consultations for patients seeking Viagra are already available, through websites such as viagrapurchase.com, with 48-hour delivery of the drug.

One Internet-start-up company is organizing a national network of 40,000 physicians to provide house calls for a premium fee. Many of the medicine's sub specialists and specialized clinical facilities can be expected to organize virtual

chains and market them through the Internet on a national and international basis, for example, oncology, diabetes, plastic surgery, women's health.

The Internet is being seen as a lower-cost alternative to "legacy" health information systems, already in place in every hospital and physician office in America. E-health solutions can provide connectivity using the "thin client" concept, where vendors own the hardware and may also provide data warehouse storage (Schaich, 1999).

In this business model, providers may rent software instead of owning it, paying ASPs (application service providers) for the use of the software on a transaction or subscription basis.The development of intranets and extranets will open dozens of possibilities for expediting business processes and expanding the number of trading partners--physicians, health plans, consumers, pharmaceutical manufacturers. Examples include:

•Clinical trials - Conducting drug studies and clinical trials is becoming a major industry. Hospital and physician networks can create extranets that directly link patients in the trials via the Internet, resulting in a seamless web of telemedicine and clinical research.

•Clinical protocols - Hospitals and physicians can share clinical protocols, update algorithms as new research becomes available, track costs and outcomes, communicate with patients, provide reports to health plans and employers, and demonstrate quality improvement.

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•Reducing clinical variation and costs - The biggest target for Internet-based cost strategies is clinical care (Schaich, 1999).

Profiling software can quickly identify cost-effective practitioners, using national standards and "best-of-breed" benchmarks. Health insurers like Indianapolis-based Anthem Blue Cross are applying electronic assessment tools in cardiac surgery and only offering contracts to those heart surgery centres that meet Anthem's standards (Schaich, 1999).

2.8 HOSPITALS GOING BANKRUPT

Holzemer (1996), asserts that profits earned from the healthcare industry appear to be at an all-time high and that individual hospitals are going bankrupt. Hospitals are not generating sufficient income to pay their expenses given how they have traditionally operated. The merger and consolidation of competitors result in significantly fewer hospital beds in certain geographical areas. In addition to the strategy of closing hospital beds, severe budget restrictions are impacting upon all remaining services within the hospitals.

CHAPTER 3

RESEARCH DESIGN

3.1 INTRODUCTION

Knowing what the client wants is the key factor to success in any type of business. News media, government agencies, large corporations and individuals need to know what the public thinks. Associations need to know what their members want. Large companies need to measure the attitudes of their employees and their customer in order to make good business decisions. The best way to find this information is to conduct a survey. The survey method of obtaining information is based on the questioning of respondents. Respondents are asked a variety of questions regarding their behaviour, intentions, attitudes, awareness, motivations and lifestyles characteristics. A survey was conducted in this study.

3.1.1 POPULATION

A population is the aggregate of all the elements that share some common set of characteristics and that comprise the universe for the purpose of the research problem. In this study consumers of health care services form a population, which will be sampled according to probability sampling technique.

(Matima, 2001:82)

3.1.2 SAMPLING

It is very important to explain what a sample is from the outset. A sample is a sub-group of the population selected for participation in the study (Matima, 2001:82).

3.1.3 PROBABILITY SAMPLING

Probability sampling techniques vary in terms of sampling efficiency. Sampling efficiency is a concept, which reflects a trade-off between sampling cost and precision. Precision refers to the level of uncertainty about the characteristics being measured (Matima, 2001:82). The study will be a success if a simple random sampling is used.

3.1.4 SIMPLE RANDOM SAMPLING

It means that a group of people is selected at random from a complete list or map of a given population. The simple random sampling technique was used for this study and the following are the characteristics of simple random sampling:

- In a simple random sampling each element in the population has a known and equal probability of selection.
- Furthermore, each possible sample of a given size has a known and equal probability of being the sample actually selected.
- The sample is drawn by a random procedure from a sampling frame.

- To draw a simple random sample, the researcher first compiles a sampling frame in which each element is assigned a unique identification number (Matima, 2001:83).

3.1.5 RERSEARCH QUESTIONS

More ideas about the advantages and disadvantages of restructuring were explored. Research questions are as follow;

- How was the process of restructuring done?
- How did it affect health care workers and health care consumers?
- Whether the process still goes on, or has it stopped?

3.2 DATA COLLECTION METHODS

In this study only primary data was used. Data was collected by means of questionnaires.

3.2.1 QUESTIONNAIRES

Questionnaires were designed in order to get further information about the concerns health care service consumers had. The purpose of having questionnaires was to make sure that the opinions customers have about health care service are made clear and consistent with what the problem is.

3.3 DATA ANALYSIS

Data were analysed with the help from the department of statistics; data collected by means of questionnaires sent out to respondents were analysed and presented in the form of tables, graphs and charts. More details on analysis of data will be dealt with more comprehensively in the next chapter (chapter 4).

3.4 CONCLUSION

The nature of the problem will to a large extent determine the type of the instrument used to collect data, and it was clarified why questionnaires were used in this study- the research has to do with opinions, attitudes and so forth. The advantages of using random sampling over other techniques was clarified and decisions were made based on the merit of the problem. More light will be shed to the study according to the responses that will be reported in the next chapter (chapter 4).

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

In this section the researcher reports on the results of the empirical investigation conducted to determine the nature and scope of the impact of health care restructuring on the lives of Mafikeng communities. The responses obtained would serve as the attainment of the aims of the study.

4.1.1 PRESENTATION OF RESULTS

The results are presented in the form of tables and diagrams below.

Table 4.1 Gender

Gender	Frequency	Percent
Male	34	40%
Female	52	60%
Total	86	100%

Table 4.1 reveals that 34(40%) of total respondents are males while 52(60%) respondents are females. Based on figures depicted in table 4.1, the majority of respondents are females. Gender plays an important role in decision making.

Fig 4.1. A Representation of gender.

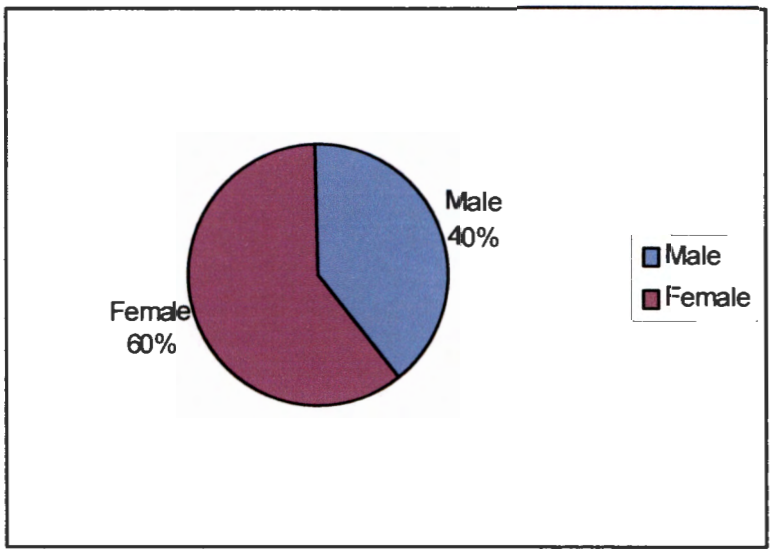

Figure 4.1 above gives a visual display of the representation of gender in this study. It helps the study in ensuring that readers are able to see the results pictorially.

Table 4.2 Race

Race	Frequency	Percent
Black	55	64%
White	14	16%
Asian	17	20%
Total	86	100%

Table 4.2 reveals that 55(64%) of total respondents are Blacks, 14(16%) are Whites and 17(20%) are Asians. Based on figures depicted in table 4.2, the majority respondents are Blacks. The results above indicate that of the available respondents, blacks are the ones who suffer terrible consequences of restructuring.

Fig 4.2. A distribution of population

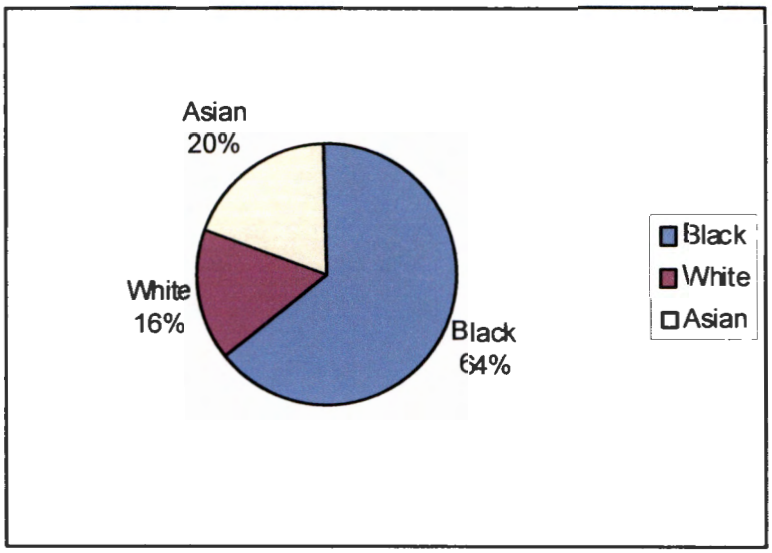

Fig.4.2 above gives an enhanced visual display of the population distribution. It makes it easy for the reader to see which population group or race is in majority and also suffers the restructuring consequences.

Table 4.3 Marital status

Marital Status	Frequency	Percent
Married	34	40%
Single	21	24%
Widow	17	20%
Divorced	14	16%
Total	86	100%

Table 4.3 reveals that 34(40%) of total respondents are married, 21(24%) are single, 17(20%) are widows and 14(16%) are divorced. Based on figures depicted in table 4.3, the majority respondents are married people. The importance of the marital status in this

study was to make it clear that the opinion held by one status group will differ with that other status groups.

Fig.4.3 A distribution of marital status

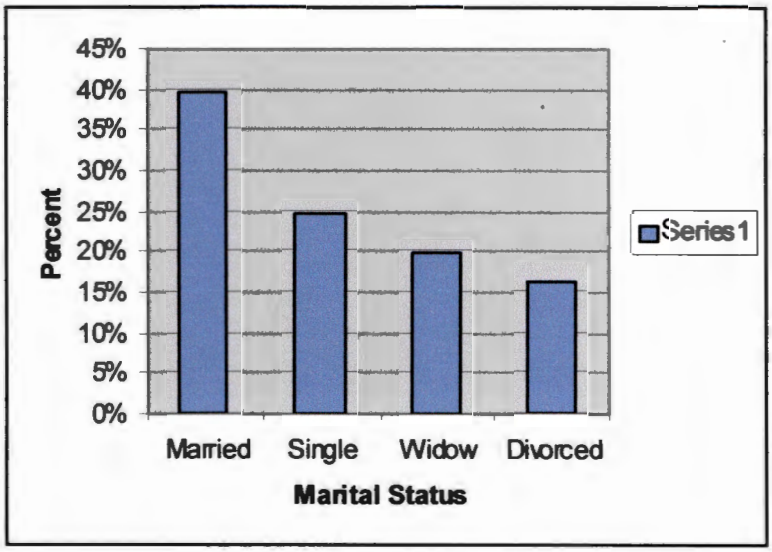

Figure 4.3 above gives a visual display of marital status of people who participated in the study. The results have shown that married people were the ones who were in majority.

Table 4. 4 Age distribution

Age(yrs)	Frequency	Percent
20 - 30	11	13%
31 - 40	32	37%
41 - 50	28	33%
51 and Above	15	17%
Total	86	100%

Table 4.4 reveals that 11(13%) of total respondents are between 20 and 30 years, 32 (37%) are between 31 and 40 years, 28(33%) are between 41 and 50 years and 15(17) are

51 years and above. Based on figures depicted in table 3.4, the opinion made is influenced by age. People who are between 31 and 40 years are in majority. They are the ones who sufferer the most in terms of health care services.

Fig. 4.4. Age distribution

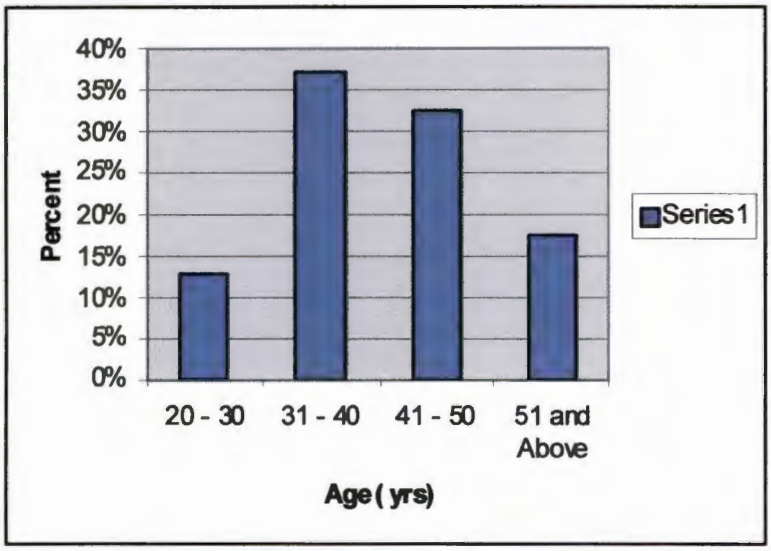

Figure 4.4 above gives a visual display of the results in table 4.4

Table 4.5 A percentage distribution of level of education

Level of Education	Frequency	Percent
Primary School	31	36%
high School	30	35%
Tertiary	5	6%
Never Attended School	20	23%
Total	86	100%

Table 4.5 reveals that 31(36%) of total respondents' level of education is up to primary school, 30(35%) up to high school, 5(6%) did tertiary education while 20(23%) never

attended school. People whose education level is up to primary school are in the majority. Their level of education can be a constraint in their health care system.

Fig. 4.5 A distribution of level of education

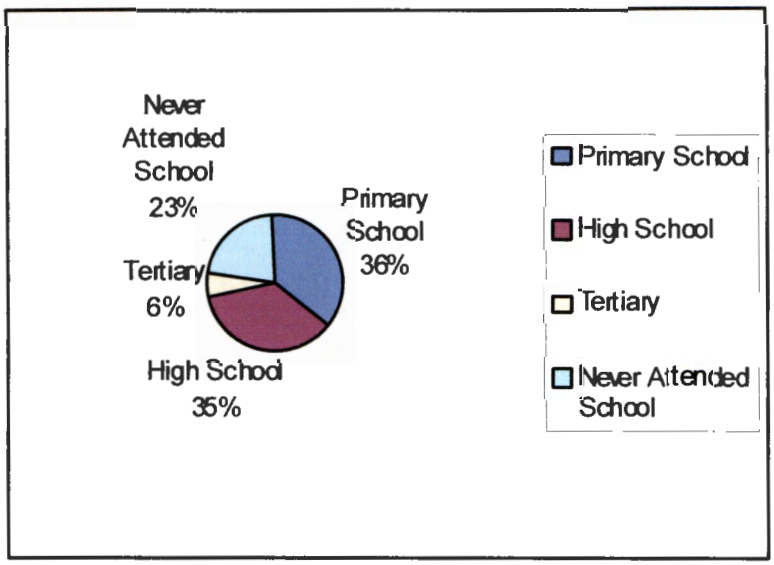

Figure 4.5 above gives a visual display of the results in table 4.5

Table 4.6 A percentage distribution of residential area

Residential Area	Frequency	Percent
Rural	47	55%
Urban	15	17%
Semi-urban	24	28%
Total	86	100%

Table 4.6 reveals that 47(556%) of total respondents are from a rural residential area, 15(17%) are from an urban area while 24(28%) are from semi-urban area. Based on

figures depicted in table 4.6, the majority is from rural area. People who suffer the negative consequences of restructuring are from rural areas.

Fig. 4.6 A percentage distribution of residential areas

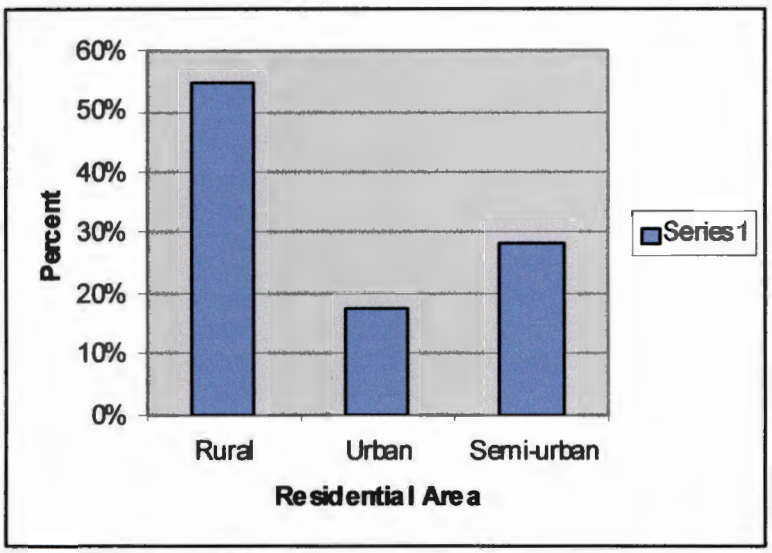

Figure 4.6 above gives a visual display of the results in figure 4.6

Table B7 Accessibility

Response	Frequency	Percent
Yes	42	49%
No	44	51%
Total	86	100%

Table B.7 reveals that 42(49%) of total respondents say that the services are accessible while 44(51%) say that services are not accessible. Based on figures depicted in table B7, the Health care facilities are not accessible. The few respondents who say that health care services are accessible might be the ones coming from urban areas. When there is no access to services then there is a major problem, which needs to be addressed soon.

Table B8 A percentage distribution of waiting period

Waiting Period	Frequency	Percent
Less than 1 hour	3	3%
1 to 2 hours	37	43%
More than 2 hours	46	53%
Total	86	100%

Table B.8 reveals that 3(3%) of total respondents say that the waiting period is less than 1 hour, 37(43%) say that waiting period is 1 to 2 hours while 46(53%) say that waiting period is more than 2 hours. Based on figures depicted in table B8, respondents wait for more than 2 hours to receive their service. It is not acceptable for patients to wait for more than 2 hours. They might die while waiting to be examined. This is an area that needs maximum attention.

Table B9 A percentage distribution of alternatives means

Alternatives	Frequency	Percent
Mobile clinics	48	56%
Transporting people to the centers	12	14%
No means at all	26	30%
Total	86	100%

Table B.9 reveals that 48(56%) of total respondents say that there are mobile clinics, 12(14%) say that means of transporting patients to the centres are available while 26(30%) say that there are no means at all. Based on figures depicted in table B9, mobile

clinics are alternatives means. The alternatives might only be available to the urban areas and semi urban areas. However, it does not serve any importance to have an alternative means of patient transport to places, which have every thing. Rather these means could be extended to impoverished communities.

Table C10 A percentage distribution of transport availability

Opinion	Frequency	Percent
Yes	10	12%
No	53	62%
Unsure	23	27%
Total	86	100%

Table C10 reveals that 10(12%) of total respondents say that transport means are available, 53(62%) say that there is no means of transport available while 23(27%) are unsure. Based on figures depicted in table C10, there is no means of transport available. The rural communities suffer the most in this regard.

Table C11 A percentage distribution of opinion

Opinion	Frequency	Percent
Strongly agree	4	5%
Agree	17	20%
Unsure	28	33%
Disagree	33	39%
Strongly disagree	3	4%
Total	85	100%

Table C11 reveals that 4(5%) of total respondents say that they strongly agree that Health workers are well trained, 17(20%) agree that health workers are well trained, 28(33%) are unsure while the resulting figure of 36(43%) respondents hold the opinion that Health workers are not well trained. Based on figures depicted in table C11, Health workers are not well trained. This calls for health care workers to be trained fully with respect to health issues since respondents are not sure if training they received is sufficient or not.

Table D12 A percentage distribution of affordable facilities.

Opinion	Frequency	Percent
No	45	54%
Yes	8	10%
Unsure	31	37%
Total	84	100%

Table D12 reveals that 45(54%) of total respondents say that the health care facilities are not affordable, 8(10%) say that the health care facilities are affordable while 31(37%) say that they are unsure as to whether the health care facilities are affordable or not. Based on figures depicted in table C12, the facilities are not affordable at the clinics. Therefore government and heath organisations need to pay much attention to making the facilities affordable.

Table E1 Chi-square Tests of Independence on Gender

	Health care services used in areas without Health Care facilities or clinics			
Gender	Mobile clinics	Transporting people to the centers	No means at all	**Total**
Male	17	6	11	34
Female	31	6	15	52
Total	48	12	26	86

Chi-square value= 0.974, degrees of freedom (df)= 2, p-value = 0.03

Since the p-value=0.03 < 0.05 level of significance, then opinion on health care facilities is dependent on gender of consumers.

Table E2 Chi-square Test of independence on Race

	Is there a clinic, health centre or hospital nearby?		
Race	Yes	No	**Total**
Black	16	31	47
White	7	8	15
Asian	19	5	24
Total	42	44	86

Chi-square value= 6.756, df = 2, p-value = 0.03

Since the p-value = 0.03 < 0.05 level of significance, then opinion on the availability of clinic or hospital is dependent on race.

Table E3 Chi-square Tests of Independence on Residence

	Is there a clinic, health centre or hospital nearby?		
Residence	Yes	No	**Total**
Rural	16	31	47
Urban	7	8	15
Semi-urban	19	5	21
Total	42	44	86

Chi-square value = 12.98, df = 2, p-value = 0.001

Since the p-value 0.001 < 0.05 level of significance, then opinion on the availability of health centre is dependent on the residential area of consumers.

4.1.2 CONCLUDING REMARKS

Data were analysed and presented in the form of tables and graphs. The results were interpreted and the study revealed that the majority of respondents were married black women, aged between 31 and 40 years, living in rural areas, went up to primary school education, unable to access Health care facilities. Solutions to the problem will be discussed in the next chapter.

CHAPTER 5

FINDINGS, SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter introduces the reader to the discussions of the findings, implication of the results, summary, recommendations and conclusion. The issue of restructuring had been dealt with extensively throughout this study. The main intent of restructuring was to improve health care service delivery through amendments of policies and ensuring implementation. Refurbishment of the infrastructure and equipment was at the top of priorities to ensure successful delivery of the health care service.

5.2 FINDINGS

It was mentioned from outset that the aims of the study were to determine empirically the impact of restructuring of health care services on the lives of the South African communities and also to determine from literature the nature and scope of restructuring. From the Chi-square tests conducted, it was found that the opinion on alternatives used in areas without health care facilities was dependent on gender of consumers.

What it meant was that majority respondents were females who mentioned that there were no alternative means of health care facilities used in their areas. This will obviously have a negative impact on communities who do not have access to

facilities. The purpose of mobile clinics and other alternative facilities were to ensure delivery of health care to disadvantaged communities.

On the issue of availability of clinics, hospitals or health centres nearby, the test has shown that majority respondents suffering negative consequences were blacks. Cinics, hospitals and other health care centres were built specifically to take health care to people. Knowing that health care centres and clinics were built to restructure health care, and not satisfactorily available, lives of the blacks have been impacted negatively. It becomes a critical issue to realise that race plays a major role in accessing the facilities.

The results on availability of health care services show that majority of respondents who do not have access to services were from rural areas. Those from urban and semi urban areas were better of since their statistics were low. The lack of availability of resources is a major constraint towards the delivery of health care services.

From the literature it was found that quality is a necessary and important component of health services delivery. Other categories of health workers such as medical assistants or medical auxiliaries need to be considered although their variability in their skills made it difficult to accommodate them in the existing health care delivery system.

The role of clinic committees is crucial for the optimal functioning of the health care services. Alternative healers have a contribution to make provided that harmful practices are not condoned. Health care system is a faced by major challenges like to consider where to turn strategically while demonstrating value in an increasing competitive market. Where there are no resources, communities live with disparities and vulnerability.

Geographical factors constitute the important divide from which inequalities in health care systems emanate. White business and residential areas in urban areas have disproportionately high allotment of health personnel and amenities serving mainly the white clientele

5.3 IMPLICATIONS

Following the concerns and views consumers of health care services had about restructuring of health care system before the study was undertaken, one would expect the results to be negative thus validating those concerns. It is very true based on the majority of responses that restructuring has impacted the delivery of health care services negatively. Health care services do not reach people who are poor and live in rural areas. The study has shown that people who are disadvantaged the most are those who have acquired primary education. This raises a major concern; that health care system undermined rural communities.

5.4 SUMMARY

The study has indicated that health services touch on lives of all population groups. Governments are rethinking the basic premises of the health care systems, which will shape the employment outlook for health care workers. This was an introduction of restructuring issues. The impact on employment appeared to be subject to national conditions. Many people are subjected to many inequalities in health care systems. There are people whose health statuses are at risk since they lack funds to improve them. The backgrounds of people as well as the areas they come from seem to be the deciding factor of the type of accessing the health care facilities. These inequalities are indeed a reflection of socio-economic, racial and political disparities in the broader social context. The literature also revealed that access to wealth, and political power has been regulated by a white political elite.

The wealthy, permanently employed and health-insured have better health care since they are in a position to avail themselves to high-standard private health services. The poor, unemployed and non-insured find themselves in deprived positions. Health care is unaffordable and inaccessible. It has been reflected from the literature that geographical settings and conditions constitute major divide from which gross inequalities in the health care system emanate. Rural areas are characterised by poorly developed infrastructure, widespread poverty and backwardness. To increase efficiency in the delivery of health services, the literature suggested that hospital and physician networks be developed. Hospitals and physician networks can create extranets and intranets, which will provide

direct link of patients on a seamless web of telemedicine. Lack of Internet access has been identified as a major constraint in the health care system when dealing with health care issues. People's views were looked at objectively and the research was undertaken to find out what solutions could be used to cure the escalation of the problem. The results of the study are the outcomes of the questionnaires, which were specifically set according to the concerns of the health care consumers. Some concerns were answered directly from the literature material. The outstanding question was whether restructuring has stopped or not. It came as a recommendation that further study could be done on this study

5.5 RECOMMENDATIONS

Based on what the study discovered, the study recommends the following:

- It is recommended that the nurse- patient ratio and doctor-patient ratio be improved so that patients' needs can be met and overstretching of health care workers can be reduced. This will reduce burn out syndrome and long queues, which discourage patients.

- It is recommended that health centers be increased: this will be achieved through transforming ordinary clinics into health centers which operate 24 hours, thus making health care available to all communities.

- It is recommended that policies be revisited to ensure that health care consumers of all races are included.

- It is recommended that health care workers be developed and reskilled to increase their capabilities.

- It is recommended that a further research be conducted in this study.

5.6 CONCLUSIONS

How was the process of restructuring done? This question was successfully dealt with. Policies were revised to improve health care. Traditional healers were introduced to make input towards finding solutions to curb incurable diseases like HIV and AIDS. District health system which offers an alternative approach for health care delivery at local level was introduced. It is based more on primary health care and it comprises first and foremost a well-defined population.

How did restructuring affect the health care workers and health care consumers? According to the results obtained little has been done to develop health care workers who are supposed to render health care services. Restructuring did take place indeed but only favoured high-ranking officials. Consumers from metropolitan areas and elite suburbs benefited more than those in rural areas. The results show that health care facilities and alternatives are not available and accessible to rural communities although restructuring took place.

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APPENDICES

QUESTIONNAIRE

To be completed by consumers of Health Care as well as Health Care Workers.

Please read this questionnaire carefully and choose the correct /suitable answer by marking with an " X ". You are not expected to write your name, this questionnaire is strictly confidential.

A. DEMOGRAPHIC PROFILE

1. Indicate your gender below.

a	Male	
b	Female	

2. What is your population group?

a	Black	
b	White	
c	Asian	

3. State your marital status?

a	Married	
b	Single	
c	Widow	
d	Divorced	

4. How old are you?

a	20-30	
b	31-40	
c	41-50	
d	51 and above	

5. What is your level of education?

a	Primary education	
b	High school	
c	Tertiary / University	
d	Never attended school	

6. Where do you stay?

a	Rural area	
b	Urban area / Town	
c	Semi-urban area /location	

B. ACCESSIBILITY

7. Is there a clinic, health centre or hospital nearby?

a	Yes	
b	No	

8. While visiting the health care facility, how long do you normally wait before being attended to by the health care worker?

a	Less than one hour	
b	One to two hours	
c	More than 2 hours	

9. Which alternatives are used in areas without Health Care facilities or clinics?

a	Mobile clinics	
b	Transporting people to the centres	
c	No means at all	

C. AVAILABILITY

10. In your opinion, would you say that transport is always available for referral of patients?

a	Yes	
b	No	
c	Unsure	

11. Would you, in your opinion, say that Health Care Workers are well – trained to do the job?

a	Strongly agree	
b	Agree	
c	Unsure	
d	Disagree	
e	Strongly disagree	

D. AFFORDABILITY

12. Are the services at the clinics and health care facilities affordable?

a	No	
b	Yes	
c	Unsure	

Thank you for taking your time in filling up this questionnaire. Your support and co-operation is highly appreciated.