Investigating staff morale and Batho Pele compliance of public oral healthcare professionals

SM Griesel

orcid.org 0001-8599-6334

Mini-dissertation submitted in partial fulfilment of the requirements for the degree *Master of Business Administration* at the North-West University

Supervisor: Mrs. K Nell

Graduation ceremony: May 2018

Student number: 23293454

ABSTRACT

Since the introduction of democracy in 1994, South Africa has made remarkable progress in transformational healthcare in an attempt to provide redress for those affected by the previous apartheid policies. A primary healthcare approach was adopted built on a framework of quality, accessible and affordable service delivery to all South Africans. Batho Pele principles were introduced to provide a framework against which service delivery in the public sector and in particular the public healthcare sector can be measured. Batho Pele means putting people first. However, irrespective of the progress made since 1994, the South African public healthcare system has performed poorly despite the country's quantum of spending on healthcare. Various elements have been highlighted as contributing factors, such as tolerance to the ineptitude and failure of leaders, management and governance in the public healthcare sector and the inability or failure to deal decisively with the crisis faced within the healthcare workforce. These factors have negative consequences for all parties involved - patients and healthcare professionals alike. The powerless patient is left to bear the brunt of sub-optimal care and negative experiences whilst the healthcare professional is faced with staff shortages, health system deficiencies and an unsupportive management environment. In situations such as the aforementioned, it is understandable that the public healthcare professional will find it difficult to provide quality patient oriented service whilst upholding their professional code of conduct and ethics.

The literature review started with a broad investigation of the South African healthcare system, the proposed National Health Insurance and public healthcare expenditure. It was then narrowed down to the public healthcare professional in context and the factors affecting the professional's morale, efficacy, flourishing and coherence in the workplace. The role of the public healthcare professional in Batho Pele compliance was also discussed followed by a discussion on the role that management plays in the creation of a conductive work environment for employees.

A non-random convenient sampling method was utilised during this research. Participants were limited to clinically oriented oral healthcare professionals employed at Medunsa Oral Health Centre. The purpose of this research was to investigate a specific closed group of individuals, eliminating the need for generalisation and external validity. A structured self-administered questionnaire based on Likert-style questions assisted the researcher in obtaining valuable quantitative data from the 68 participants which was then statistically analysed. The research was aimed at addressing two research objectives: 1) the identification of factors affecting staff morale among public oral healthcare professionals and 2) the influence those factors will have on the quality of service delivery in the public healthcare domain.

The research revealed that the general morale among public oral healthcare professionals employed at Medunsa Oral Health Centre was poor. Females had a lower morale than males. Dental assistants felt the most negative among designated workforces and contemplated leaving the institution the most. Female line managers posed a problem as factors such as victimisation and preferential treatment were noted. Employees also voiced their dismay with management. One-sided decision-making processes and mismanagement were raised as concerns. The annual Customer Satisfaction Survey (CSS) conducted by the quality assurance team of Medunsa Oral Health Centre revealed that patients were in general satisfied with the quality and effectiveness of service delivery at Medunsa Oral Health Centre. Waiting time was the main concern for patients, however, this cannot be directly linked to the morale amongst oral healthcare professionals as various other external factors need to be taken into consideration in this regard.

After an in-depth discussion of the results, the researcher made a conclusive statement which addressed the objectives of the study. The factors affecting staff morale were indeed identified, however, there was no negative effect on Batho Pele principle compliance. Recommendations were made to assist management in addressing the various factors of concern raised during the research. Recommendations included

team building initiatives, involving personnel in decision-making processes and addressing factors such as victimisation and preferential treatment in the workplace. Outsourcing of an employee-assistance program was also recommended.

Key terminology: Bath Pele, South Africa public healthcare, morale, motivation, flourishing, coherence, quality patient care, quantitative research.

ACKNOWLEDGEMENTS

All the glory to my Abba father God. I praise Him for his guidance, strength and mercy throughout my studies. I am eternally grateful.

I wish to express my sincerest gratitude to the following people whose encouragement, support and guidance have made the successful completion of this study possible:

- My wonderful husband Stephan Griesel. Thank you for managing our home whilst I was studying. Thank you for staying up late with me and thank you for your continuous support and understanding despite the extremely difficult position in which I placed you.
- My family and in-laws. Thank you for your continued support and love.
- Mrs. Karolien Nell, my study leader at North-West University. Thank you for your guidance and motivation.
- Mrs. Suria Ellis of the Statistical Consultation Services of the North-West University. Your eager assistance and extra phone calls to explain data will forever be appreciated!
- My colleagues at Medunsa Oral Health Centre for assisting me in gathering the data for this research.
- The management of Sefako Makgatho Health Sciences University and the dean of the School of Oral Health Sciences for granting me permission to conduct the research at the university and oral health Centre.
- A sincere thank you to Clarina Vorster, for the language and technical editing of the dissertation.

Finally, I would like to express my greatest appreciation to the Potchefstroom School of Business and Governance. It has been a wonderful journey where I have grown beyond comprehension. I thank you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF CHARTS

LIST OF DIAGRAMS

LIST OF ABBREVIATIONS

BPP	Batho Pele principles
CSS	Client Satisfaction Survey
DOH	Department of Health
HPCSA	Health Professions Council of South Africa
HSSE	Health Systems Strengthening for Equity projects
NHI	National Health Insurance
NHS	National Health System
NWU	North-West University
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
RWOPS	Remunerated work outside the public service
SDT	Self-determination Theory
SMU	Sefako Makgatho Health Sciences University
SMUREC	Sefako Makgatho Health Sciences University Research and Ethics committee
WHO	World Health Organisation

CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION AND BACKGROUND

For more than two decades, the South African government, and in particular the Department of Health, has built their framework for quality, accessible and affordable patient oriented service delivery on the foundation of Batho Pele principle compliance.

Batho Pele means putting people first. Thus, in addition to the commitment from the Department of Health, all public sector healthcare professionals have the responsibility to deliver quality and efficient patient oriented services in line with the principles as set out in the Batho Pele White Paper (SA, 1997:10). The following table summarises the Batho Pele principles:

Table 1. 1: Batho Pele Principles as set out in the Batho Pele White Paper (source: SA, 1997:15)

The Batho Pele principles:	
1. Consultation	Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.
2. Standard of service	Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.
3. Access	All citizens should have equal access to the services to which they are entitled.
4. Courtesy	Citizens should be treated with courtesy and consideration.
5. Information	Citizens should be given full, accurate information about the public services they are entitled to receive.
6. Openness & transparency	Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.
7. Redress	If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy. When complaints are made, citizens should receive a sympathetic and positive response.
8. Value for money	Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

It is evident from the above table that efficient and quality oriented public healthcare services are inherent to Batho Pele principle compliance. Not only should all individuals have equal access to service delivery, they are also entitled to efficient and courteous service. It is the responsibility of the public healthcare professional to comply with the promises made and to adhere to the Batho Pele principles (Crous, 2006:402-403, Legodi, 2008:2). Previous studies have implicated understaffed facilities, long waiting times, personnel inefficiency, lack of resources and funding and disinterest on the part of personnel as culprits when referring to non-compliance to the principles as set out in the Batho Pele White Paper (Khoza & Du Toit, 2011:8). Further investigation is therefore crucial if one wishes to identify possible causes and contributing factors to the negative perception of service delivery in the public healthcare sector and non-compliance to the Batho Pele principles.

It is no secret that the South African public healthcare sector is faced with significant challenges such as litigation, limited resources and facilities, poor service delivery and personnel related issues. Individuals employed in the public healthcare sector in South Africa work under extremely stressful circumstances. Yet, quality patient oriented service delivery is required despite the limitations placed on the service providers. From the aforementioned, one fundamental question arises: how can optimal productivity and quality patient oriented service delivery be ensured if the determining factors related to personnel performance are not addressed? (Ramasodi, 2010:53).

1.2 PROBLEM STATEMENT AND CORE RESEARCH QUESTION

Recent studies have shown that employee productivity is strongly affected by job satisfaction. It has been found that tendencies of absenteeism, higher employee turnover, tardiness and sub-standard quality work have been associated with reduced levels of job satisfaction. The truth however remains that, unless employees employed by the South African healthcare system are compliant to the Batho Pele principles of “putting people first”, the system will fail dismally. This in turn begs the questions: to

what extent is management responsible for employee morale and job satisfaction and to what extent does job satisfaction and morale among public healthcare workers contribute to the level of quality in service delivery of the public healthcare sector of South Africa?

In recent studies, it has been found that elevated levels of job satisfaction lead to increased levels of productivity. In turn, both intrinsic and extrinsic factors influence job satisfaction. Intrinsic factors relate to the kind of work and the tasks related to the work while extrinsic factors relate to the conditions under which the employee must work, such as co-workers, management, support, salary, recognition and communication (Kreitner *et al.,* 2002:65). It is important to keep in mind that all individuals are unique in desires and needs and are influenced by social, cultural and job factors (Ibeziako *et al.*, 2013:180).

For the public healthcare sector in South Africa to be productive and service oriented, individuals need to be appointed who will fit the full requirements of the position. On the other hand, the appointed individual must address his/her desire to contribute to the organisation in a meaningful way through the skills and abilities he/she possesses. Failure of either party to address the other party's needs will result in non-compliance with the principles of Batho Pele.

According to Martineau & Lehman (2006), employee satisfaction in the public healthcare sector has been associated with elevated levels of patient satisfaction and improved levels of service delivery. Management is therefore under the direct obligation to manage stress in the workplace, create a conductive environment for employee involvement and to reward positive and professional contributions so that an optimally functional healthcare system can suffice.

If one wishes to fully understand the concept of job satisfaction, it is vital to distinguish between employee attitude and morale. Employee attitude comprises of affective, cognitive and behavioural components and relates to an individual's feelings and

thoughts in a specific situation. Morale on the other hand, relates to an individual's needs and to what extent those needs are being tended to. According to the online Oxford Advanced Learner's Dictionary of Current English (2006), morale can be defined as: "The confidence, enthusiasm, and discipline of a person or group at a particular time". The importance of morale among public healthcare professionals in South Africa should therefore not be underestimated or taken lightly when the factors affecting Batho Pele compliance are scrutinised.

The important question then is:

Does the morale among public healthcare professionals influence the quality and efficiency of service delivery in the South African public healthcare sector and ultimately Batho Pele principle compliance?

1.3 RESEARCH OBJECTIVES

To achieve the above purpose, the following objectives should be met:

Objective A	To identify and describe the factors influencing staff morale among public oral healthcare professionals
Objective B	To describe the influence of staff morale on Batho Pele principle compliance and the subsequent effect on the quality of patient care

1.4 IMPORTANCE AND BENEFITS OF THE PROPOSED STUDY

This research provides valuable insight into the factors affecting employee morale and the effect it has on service delivery among public oral healthcare professionals at institutional level. The results of this research can assist hospital management and the Department of Health in gaining insight into some of the factors leading or contributing to sub-standard performance, negligence, absenteeism and elevated personnel turnover. This could further assist management in implementing strategies to address

staff morale (and ultimately non-compliance to the Batho Pele principles) or to identify areas of excellence and good performance and give recognition where it is due.

Although there have been numerous studies related to job satisfaction among health care professionals, studies specific to oral healthcare professionals are lacking. This study provides invaluable insight into employee morale, factors affecting employee morale and finally the influence this will have on service delivery in the public oral healthcare sector.

1.5 THEORETICAL FRAMEWORK

1.5.1 Literature review

For the purpose of addressing the objectives of this study, relevant articles, books, e-reference works, medical newsletters, journals, governmental publications and related theses and dissertations were consulted. Legislation captured in the Batho Pele White Paper (1997) served as foundation for the research, as it encapsulated the main purpose of quality service delivery in the South African public sector.

Databases of the North-West University Library Services were used to assist during the research process. These included:

- Academic Search Premier
- A-Z Journal list
- EbscoHost
- Google Scholar
- Medline and
- RefWorks

A structured self-administered questionnaire was used to collect data from participants during the research process. The research tool was based on aspects of interest identified in the literature review (please refer to Chapter 2 for the detailed literature

review). Written permission was obtained from Mr. N Khumalo to utilise certain aspects of the questionnaire he developed as part of his dissertation submitted to fulfil the requirements for the successful completion of his Masters of Commerce in Industrial Psychology degree at the University of Zululand, KwaZulu-Natal.

1.5.2 Key terminology and definitions

Certain key terms are fundamental in addressing the objectives of this study. These include:

- **Morale:**

  According to the online Oxford Advanced Learner's Dictionary of Current English (2006), morale can be defined as: "The confidence, enthusiasm and discipline of an individual or group at a particular time". Please refer to Chapter 2 section 2.6 for an in-depth discussion of morale.

- **Staff:**

  Staff refers to employees or workers in service of an organisation or institution under an implied or expressed contract of hire. The responsibilities of the employee (staff member) is clearly defined and contained in the contract (Ngambi, 2011:762). Further reference to staff can be found in Chapter 2 section 2.6.

- **Standards:**

  Standards can be defined as desired levels of performance which serves as a basis for comparison. Used to compare actual service delivery to performance, it serves as a motivational tool to encourage excellence beyond accepted levels (Ngambi, 2011:763). Please refer to Chapter 2 section 2.11 for further discussion.

- **Quality care:**

When patient needs and expectations are met by employees in the public healthcare sector through consistent Batho Pele principle adherence, one can concur that the patient received quality care (SA, 1997:10). Please refer to Chapter 2 section 2.11 for further discussion.

- **Batho Pele Principles:**

This government initiative serves to motivate public servants to treat patients with respect, care, excellence and commitment. Encouraging continued service delivery improvement, it serves to motivate public servants to strive towards excellence (SA, 1997:10-14). Please refer to Chapter 2 section 2.11 where the Batho Pele principles are discussed depth.

1.5.3 Abbreviations

A table containing all the relevant abbreviations that are used throughout this research paper can be found on page xiii.

1.6 RESEARCH DESIGN AND METHODOLOGY

1.6.1 Description of the overall research design

A quantitative cross-sectional research method was utilised by the researcher to examine and analyse a specific closed group of participants (Bryman & Bell, 2014:81). Specific demographic variables which included age, race, gender and occupation were determined and correlated with factors related to staff morale and Batho Pele compliance in an attempt to address the study objectives as set out in section 1.3 above.

1.6.2 Participants

The research project was conducted at Medunsa Oral Health Centre, Sefako Makgatho Health Sciences University, situated in the north of Pretoria, Gauteng, South Africa. The included study population consisted of permanently employed healthcare professionals with both clinical and non-clinical responsibilities. This included dental assistants, oral hygienists, dental technicians, dental therapists, dentists and radiographers from all departments and clinical areas who were willing and available at the time the study was conducted. For the purpose of this study, support staff and senior management were excluded as the primary research question was not applicable to them. The sample group comprised of 83 potential participants.

1.6.3 Data collection and statistical analysis

A structured, self-administered questionnaire was utilised to collect data from the participants. Data was analysed by making use of descriptive statistical analyses which included aspects such as determining means, standard deviations, p-values and effect sizes. Cronbach's alpha was also determined to ensure reliability.

1.7 QUALITY AND RIGOR OF THE RESEARCH PROCESS

The researcher ensured objectivism and avoided bias throughout the research process to ensure reliability and validity of the data collection process.

A cross-sectional, descriptive research design was followed. Data pertaining to a series of variables at a single point in time (which may be on an individual, collegial, departmental or institutional level), was collected, analysed and conclusions were drawn from the results (Bryman & Bell, 2014:93). The criteria on which this quantitative research was evaluated included reliability, replicability and validity.

1.7.1 Reliability

- Reliability relates to questions asked about the quality of the measures employed to capture concepts. It depicts the consistency and dependability of the research instrument used during the research process. In this case, a structured questionnaire was utilised of which the internal consistency of the questions was estimated through Cronbach's alpha coefficient (Burns & Grove, 2005:376).

1.7.2 Replicability

- The researcher clearly indicated the procedure followed in selecting respondents, measuring design concepts, administration of research instruments and the analyses of the data obtained during the research process.

1.7.3 Validity

- It is possible to distinguish between four types of validity: internal, external, ecological and content validity. Ecological validity relates to the individual's "natural habitat". Some consider self-completion questionnaires as an encroachment on a person's natural habitat which therefore influences ecological validity negatively (Cicourel, 1982:11-12). Internal validity was ensured as precision standards were adhered to during the data collection process. Neutrality, competence and confidentiality were ensured throughout the research collection process (Rossouw, 2005:193). Content validity relates to the appropriateness of the questions used in the questionnaire and whether it corresponds with the objectives set out in Chapter 1 section 1.3 (Polit *et al.,* 2001:152). Content validity was thus ensured. External validity relates to the extent to which generalisation of findings beyond the sample used during the research process is feasible (Burns & Grove, 2005:218).

Since the research was limited to a closed group in a specific setting, external validity was not required.

The research design proved to be reliable, replicable and valid. It therefore complied with the evaluation criteria as stipulated above.

1.8 RESEARCH ETHICS

1.8.1 Introduction

A request to conduct the proposed research was submitted to the Chief Executive Officer (CEO) of Medunsa Oral Health Centre. Permission was granted by Dr P Motloba (see Annexure C). A protocol that abides to all terms and conditions stipulated by the Research and Ethics committee of Sefako Makgatho Health Sciences University (SMUREC) was also submitted for approval. Study site approval was granted by SMUREC (see Annexure D). In addition to the above processes, the protocol was also approved and ethical clearance was obtained from the North-West University's Research and Ethics Committee (see Annexure E). The research was conducted as partial fulfilment of a dissertation forming part of the Master of Business Administration (MBA) degree which the researcher is currently enrolled for. Any publication that may emerge from the research will not mention the research site's name unless written permission was granted by the Chief Executive Officer of the research hospital as well as SMUREC (the Research and Ethics Committee of the research site).

1.8.2 Participation

Participants were ensured of the following:

1.8.2.1 Participants not to be harmed

Participants to this study were not subjected to any form of emotional or bodily harm. Reassurance was given that, if at any time during the process of conducting the

research, a participant felt stressed or uncomfortable due to the sensitive nature of the content of the study, he/she was free to withdraw.

1.8.2.2 Informed consent

According to Khumalo (2010:33), a researcher must inform all participants in advance about the proposed research before the project commences. Participants were briefed about the process whereafter all questions arising from the information were addressed.

1.8.2.3 Anonymity and confidentiality

All information shared with the researcher will remain confidential. Participation will also remain confidential.

1.9 LIMITATIONS, CHALLENGES AND ASSUMPTIONS

1.9.1 Limitations and challenges

As stated previously, a quantitative research method was utilised during this research process. As the questions were limited by the researcher to address certain factors of interest, other personal factors unique to individuals were not evaluated and included in the research. Due to the work schedules and commitments of participants, the distribution, collection and timely completion of the questionnaires might have posed a challenge for the successful completion of this research project. Furthermore, fear of identification and possible victimisation also posed a threat to voluntary participation. However, the researcher provided reassurance to participants as described in Chapter 1 section 1.8 and in more detail in Chapter 3.

1.9.2 Assumptions

Burns and Grove (2005:54) stated that the philosophical framework of a study enhances its methodological assumptions. According to Brink *et al.* (2006:47-49), assumptions are

the basic principles accepted and assumed to be truthful without the need for proof or verification.

Results from various studies confirmed that negative experiences in the workplace are linked to elevated levels of dissatisfaction among employees which often lead to suppressed morale among staff members. In turn, low staff morale has been found to negatively impact productivity. This will ultimately lead to health-related concerns such as anxiety, stress and burnout (Ngambi, 2011:771). If previous research findings are assumed to be true without requiring any verification, one can conclude that organisations have the responsibility to ensure that the needs of employees are adequately addressed. With ever increasing responsibilities, pressure to perform and meet organisational goals, undue pressure is placed on employees. It is therefore the responsibility of the employer to create a positive work environment which is conductive to enhanced social-, emotional and professional performance (Zweni, 2004:94).

Studies have also proven that organisations with a positive work climate have elevated levels of staff morale – further assuming that organisations with increased levels of staff morale will reap the benefits of increased commitment, dedication and productivity from employees (Rothmann *et al.,* 2003:52-54).

This study aims to identify the factors related to increased or decreased levels of staff morale in the organisation under investigation, and the effect it will have on the quality of service rendering to the patient's dependent on the South African public healthcare system.

1.10 RESEARCH REPORT LAYOUT

This research report is structured as a mini-dissertation. The following chapters are included in the mini-dissertation:

Chapter 1: Overview of the research

In this chapter, the researcher presents the objectives of the study whereafter the relevance of the study, the outline of the methodology utilised by the researcher during the research process and ethical considerations are introduced.

Chapter 2: Literature review

This chapter firstly considers the macro-environment of healthcare in South Africa whereafter the focus narrows in on professionals employed in the public healthcare sector and their experiences within the healthcare context. Factors related to job satisfaction, motivation, management and flourishing in the workplace are discussed in depth.

Chapter 3: Research methodology

This chapter focuses on the methods employed to evaluate the factors affecting staff morale in the healthcare context to address the objectives as set out in section 1.3 above.

Chapter 4: Results

The results obtained from the research are presented, analysed, interpreted and explained to the reader.

Chapter 5: Discussion, conclusion and recommendations

Based on the results obtained in Chapter 4, conclusions are drawn and discussed. The researcher also makes recommendations where applicable.

1.11 SUMMARY

Being satisfied in one's profession affects not only one's motivation but also decisions regarding career development, personal health and relations to others. Literature supports the statement that, what contributes to one's job satisfaction or dissatisfaction, is not limited to the nature of the job, but also what is expected from a job by the individual. Health workers in particular are greatly at risk of experiencing job dissatisfaction in general, compared to other professions in other types of industries. As stated previously, low job satisfaction leads to low morale and impacts on staff turnover, absenteeism and commitment, which in turn reduce the efficiency and quality of healthcare services.

Job satisfaction is influenced by various factors that differ in nature as personal factors and expectations are involved, which makes generalisation risky. Significant challenges face the future of healthcare in South Africa for both the employer and the employee. The implication for managers in the healthcare sector is that, if they wish to attract and retain credible healthcare professionals, they will need to create an environment conductive to intrinsic job satisfaction and provision of additional benefits. The level of job satisfaction experienced by healthcare professionals is a trustworthy predictor of the well-being and general life satisfaction the individual will experience. Job performance will also be influenced, thus patient care will directly be influenced by the level of job satisfaction and employee morale.

Research has shown that there has been a growing need for improved teamwork, especially within the healthcare sector. By introducing team-building activities positive results such as stronger interpersonal relationships, improved communication between staff members, clarity on division of roles and responsibilities and ultimately greater job satisfaction and increased employee morale will occur (Ramasodi, 2010:25-28).

Literature has proven time and time again that the ability of an organisation to deliver quality care to patients and to support the community it serves is dependent on the

healthcare professional's level of job satisfaction and morale. Job satisfaction is dependent on organisational factors such as autonomy, support from management, workload, teamwork and staffing levels. If there is an imbalance with the above organisational factors, management needs to reassess and redress its structures and procedures as the company will suffer under the low levels of employee morale (Lemerle, 2005:1-3).

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

If one wishes to predict the stability of a system, certain important factors need to be taken into consideration, such as job satisfaction, work motivation, cultural diversity and rate of employee turnover. Motivation can be defined as the willingness of an employee to exert and maintain efforts toward attaining the goals set by the organisation (Woods & West, 2015:138-139). It is therefore safe to conclude that a well-functioning system would seek to boost factors predicting motivation, such as morale and satisfaction. A recent survey conducted by the ministries of health in 29 different countries revealed that low motivation was the second highest ranked factor after staff shortages contributing to workforce related problems in the healthcare sector (Department of Health, 2015:10-13). In this chapter, the public healthcare sector of South Africa and the professionals employed in this sector are discussed. Factors affecting and related to employee morale are also conceptualised.

2.2 PUBLIC HEALTHCARE IN SOUTH AFRICA

According to statistics, the estimated 2014 mid-year demographic profile for South Africa was 53.7 million people. Approximately 12.9 million of the population reside in Gauteng alone - this accounts for a staggering 25% of the total population in South Africa. KwaZulu Natal has the second largest population of 10.5 million people which accounts for 19.7% of the total population in South Africa (Department of Health, 2015:13).

Certain basic services such as access to water, electricity, sewerage and sanitation and solid waste management, are classified as social determinants of health. With figures relating to access such as 71.6% to water, 59.9% to electricity, 57.9% to sewerage and sanitation and 53.1% to solid waste management, it paints a bleak picture of the disease burden among the people of the country. Furthermore, South Africa is

experiencing a serious epidemic of HIV and Tuberculosis. South Africa is ranking third in the world after India and China with TB related infections (WHO, 2012). Approximately 6.4 million South Africans were infected with HIV by 2012, and the number is continuing to increase due to increased infection rates, multidrug resistance (MDR) and extensive drug-resistance (XDR). It was estimated that approximately 20% of the adult population in South Africa (15-49 years) would be infected with HIV by 2016 (Department of Health, 2015:13).

In South Africa, state funded healthcare is responsible for serving most of the country's population. The reality however, is that the public healthcare sector in South Africa has limited resources with tremendous pressure to address the infinite demand for quality healthcare (Essa, 2010:1). This in turn has a direct influence on the well-being, motivation, commitment and flourishing of the employees in the public sector responsible for delivering on the promises made by the government with the challenging circumstances and limited resources to their disposal.

With 84% of the population dependent on the public healthcare sector, it is interesting to note that South Africa has spent around 8.5% of its gross domestic product (GDP) on healthcare, which in monetary terms are approximately R332 billion, but only half of this amount has been spent on public healthcare. Fifty percent (50%) of the total spent was used in the private sector to cater for the socio-economic elite in South Africa, whilst the public sector must carry a far greater burden of disease and remain under-resourced (Skosana, 2016:10).

Studies conducted by Econex in 2010 revealed that South Africa had a shortage of approximately 65 000 doctors - more than double the amount of 27 000 that was registered at the Health Professions Council of South Africa (HPCSA) by 2012. It was also found that the public sector boasted a national weighted average vacancy rate of 49% for general practitioners and 44% for specialists. Interprovincial statistics also proved to be interesting as Limpopo had a vacancy rate of over 80% for specialists and

general practitioners whereas Gauteng and the North-West Provinces only showed vacancy rates of less than 20% (Anon., 2010:1). Identification of causal and contributing factors are needed to better understand the existence of the interprovincial differences and the high vacancy rates.

According to Strachan *et al*. (2011), there was a significant decline of 25% in the number of specialists and sub-specialists employed in the public healthcare sector in South Africa between 1997 and 2006. In numerical terms, from 3 782 to 2 928. On the other hand, the number of non-specialist medical practitioners employed in the public sector increased from 9 184 to 9 958 (an increase of 774) during the same period. These figures should however be considered in the context of the number of specialists and medical practitioners (MBChB) qualifying from medical schools during that ten-year period which amounts to 14 145 individuals.

Further, Strachan *et al*., (2011:525) found that a lack of positive reinforcement from the healthcare authorities to medical professionals was a significant contributor to the low retention rate of medical professionals in the public healthcare sector in South Africa. The researchers refer to “push factors” which compile medical professionals to leave the public sector. Some of the identified “push factors” include poor working conditions, insufficient resources for effective service delivery, limited career prospects, limited opportunities to further educate oneself, the impact of HIV, AIDS and TB, unsuitable and dangerous working conditions and economic instability.

In South Africa, there is a significant difference in the conditions of the public versus private healthcare sectors in terms of equipment, working conditions and remuneration, which in turn impacts job satisfaction, motivation and retention of medical professionals and ultimately influences the standard and quality of service delivery.

It is therefore not surprising to see the efflux of qualified healthcare professionals from the public sector to the private sector where resources are readily available, career prospects are self-driven and working conditions are optimal.

The Department of Health has made various attempts to incentivise doctors by introducing platforms such as the scarce skills allowance, OSD (Occupation Specific Dispensation), rural allowance and permitting medical professionals to work outside the public sector for remuneration (RWOPS). However, despite these efforts, there is currently still a lack of specific long-term solutions and recommendations to address the migration of healthcare professionals out of the public sector and into the private sector.

Studies conducted by Thomas and Valli in 2006, indicated that the occupational stress levels of employees in the public healthcare sector were higher compared to the stress levels experienced by the general working population. The study revealed that understaffing, limited resources, work/patient load, lack of control, demanding and difficult work schedules, unsafe working conditions, poor career prospects and salaries were the main sources creating the elevated stress levels. Gillipsie and Howarth (2012:14-15) also found high patient load and the fear of litigation as major contributing factors.

The cost of medical legal claims is escalating at a staggering pace in South Africa. The number of claims and the amounts claimed increased at a rate of more than 30% between 2006 and 2010 whilst the values increased by more than 550% for claims more than R1 million and 900% for claims exceeding R5 million in the last ten years (Pepper & Slabbert, 2011:1). These claims were for unprofessional conduct, which included charges such as insufficient care, refusal to treat a patient, misdiagnosis and practicing outside the scope of competency. It is therefore not difficult to understand that healthcare professionals would prefer not to be placed in a position with insufficient resources, excessive patient loads and lack of specialists to tend to difficult and challenging cases in an attempt to avoid stressful and possible litigating circumstances.

2.3 NATIONAL HEALTH INSURANCE (NHI)

National Health Insurance was designed to provide accessible quality healthcare to all South Africans irrespective of the socio-economic status of the individual. As stated in

section 2.2 above, only 50% of the 8.5% of the GDP allocated to healthcare goes to public healthcare which tends to 84% of the population, whilst the private sector hosts 80% of all specialist physicians yet only serve 16% of the population with the other 50% of the budget. It is with the above in mind that the National Health Insurance white paper was released in December 2015 for public participation. Speculations and rumours have clouded the concept, but little is actually known by the public about what it entails (Skosana, 2016:10). The Department of Health stated that the NHI was designed to finance high-quality healthcare which is affordable to all South Africans and to control the inflated prices charged in the private sector. It is said that the rationale behind the initiative is to make both public and private-sector healthcare providers available to the entire population.

In the NHI White Paper that was released in December 2015, the implementation timelines were stipulated. Implementation would stretch over a fourteen-year period and it would be divided into three phases:

1. **2012-2017: "Testing" of the NHI in 11 health districts**

- The main focus of this pilot phase is to correct mistakes in the system and to lay a foundation for the rest of the NHI
- Introduction of the Integrated School Health Program
- Establishment of District Clinical Specialist teams
- Establishment of the Office of Health Standards Compliance
- Contracting in of more than 300 private general practitioners to work in government clinics

2. **2017-2021: Financial restructuring**

- Redirection of funds from the Compensation Fund and the Road Accident Fund to NHI

- Redirection of subsidies from government departments to medical schemes to NHI
- Commencement of registration of individuals to be covered by NHI – “vulnerable groups” will be given priority
- NHI will be fully functional after this phase

3. 2021-2025: Enforcement of mandatory contribution (taxes)

- Private hospitals and specialists will be contracted by the NHI fund to provide services where the government is unable to deliver
- Medical aids will only provide top-up cover. E.g. elective procedures such as cosmetic surgery which is not covered by NHI

After full implementation, South Africa will only have one health system accessible to all its residents. Anyone with an NHI card will be able to access the service of any doctor, clinic, hospital (whether private or public) that is accredited by the NHI (Rispel, 2016:4).

It is important to note, that the scheme will provide service at a primary healthcare level, and that specialists and hospitals will only be accessed via referrals. It is said that the scheme will provide a “comprehensive” package of health-related services, yet it will not cover everything.

Critics have claimed that NHI is aimed at attacking the middle-class. However so, the truth of the matter remains that the implementation of such a reform on such a large scale is a mammoth task, requiring skill, resources, leadership and voluntary participation from role players (Skosana, 2016:7; Gray & Vawda, 2016:7).

A recent article published on Health-e identified three major faults in the transformation of South Africa’s healthcare sector (Rispel, 2016:18):

1. Tolerance to ineptitude and failure on the part of leadership, management and governing bodies.

2. A fully functional district healthcare system delivering primary healthcare is lacking.
3. The inability and ultimate failure to address the workforce crisis in healthcare.

2.4 PUBLIC HEALTH EXPENDITURE

Recent studies to explore the prevalence and severity of corruption in South Africa's healthcare sector used irregular expenditure as an indirect measure of corruption. Irregular expenditure refers to expenses incurred without complying with the relevant regulations and laws. The study revealed that over a four-year period which stretched between 2009/10 and 2012/13, the Auditor-General found approximately R24 billion of combined provincial health expenditure to be irregular.

During the 2012/13 financial year alone, 6% of the combined provincial health expenditure in the South African public healthcare sector was classified as irregular.

Expenditure patterns were also found to vary greatly and erratic between the nine provinces.

It is difficult to measure and validate corruption – we can therefore not concur that the loss of R24 billion was indeed due to corruption. We can however postulate scenarios where corruption, ineptitude and inefficient management systems play central roles. These are important aspects to remember when evaluating the long-term success of National Health Insurance (NHI) (Rispel, 2016:19).

The public healthcare system in South Africa has been slated by limited resources and inefficiency in the midst of dealing with the high demand for basic service delivery to the previously disadvantaged communities dependent on public services. Healthcare plays a pivotal role in the successful management of the South African economy. However, recent escalation in litigation and maladministration on the part of the Department of Health has seen the department reaching a state of being placed under

administration by the local government. This is turn resulted in moratoriums being placed on the appointment of new personnel, equipment not being maintained or purchased and facilities deteriorating (Rispel, 2016:20).

2.5 PUBLIC HEALTHCARE PROFESSIONALS

In addition to the advancement in medical technology and the increase in demand for more sophisticated and specialised patient care, the recent escalation in litigation, departmental maladministration, the moratorium on new appointments, poor equipment maintenance and facility deterioration, tremendous pressure has been placed on the public healthcare system of South Africa. Not only the patients but the individuals employed in the struggling system are severely affected by the above. Employees are necessitated to address increasing demands with limited resources to efficiently and effectively do so.

Research conducted by Borg in 1990, found that high levels of stress, associated with work load, lack of resources, inadequate collegial relations, limited promotion/ advancement opportunities, insufficient financial support and inordinate time demands contribute to reaching an ultimate state of burnout (Borg, 1990:111).

It is therefore crucial that the individuals who perform these services be recognised and tended to. There is a growing consensus that the significant healthcare challenges facing South Africa cannot be addressed correctly and cohesively without strengthening the public healthcare system and those individuals employed in that system.

The Health Systems Strengthening for Equity Project (HSSE) recently conducted a study in three African countries which revealed that, between 25% and 33% of healthcare professionals surveyed, seriously thought about leaving their current positions. Motivation proved to be a leading contributing factor as it related to lack of adequate supervision, poor managerial support, inadequate remuneration and insufficient opportunities for career advancement (Chipeta, 2014:235-237).

In the South African context, a recent study conducted by De Villiers and De Villiers (2004:24-26), found that the single most important factor influencing the decision made by healthcare professionals to leave the public sector was workload. It was also found that a lack of managerial support impacted negatively on the healthcare professionals' perception of working conditions in district public hospitals.

Armstrong (2006:120) found that the wants of an employee has direct impact on the morale, motivation and quality of life of that employee. By understanding the main factors contributing towards job satisfaction and intention to leave, management will be able to strategize to retain healthcare workers.

2.6 EMPLOYEE MORALE

2.6.1 Defining morale

According to the Oxford Advanced Learner's Dictionary of Current English (2006) morale can be defined as "the confidence, enthusiasm and discipline of an individual or group at a particular time". Woods & West (2014:386), defined morale in terms of the extent to which an employee's needs are met and the extent to which satisfaction is perceived to stem from one's work. Bowles and Cooper (2009:84) on the other hand believed morale is a "state of individual psychological well-being based upon a sense of confidence and purpose". According to Haddock (2010:1), staff morale is linked to the spirit among a group of employees. It encompasses shared feelings of trust, pride in achievement, purpose and self-worth and is built on a foundation of trust in the leadership and management of organisational success.

2.6.2 Terms related to morale

The concept of morale is closely linked to certain terms and concepts as is summarised below. The listed terms will enable us to shed some light on the factors contributing to

the level of staff morale experienced in organisations within the South African public healthcare sector:

2.6.2.1 Engagement

Employee engagement is defined as the investment of the complete self into a specific role (Rich *et al*., 2010:618). Individual characteristics such as job involvement, job satisfaction and intrinsic motivation are crucial to ensure employee engagement. Factors such as the company's concern for employees, fairness at work, feelings of accomplishment, day-to-day satisfaction and appreciation of ideas are some of the factors that drive employee engagement and which will ultimately influence well-being in the workplace.

For an employee to flourish in the workplace, self-autonomy, positive emotional affect, job engagement and cultural intelligence should be valued and tended to. An employee needs to feel joy and contentment at work. Surely nobody wants to feel anxious or sad at work! (Fredrickson, 2001:218). An employee has the inherent need to make personally meaningful choices, take initiative and pursue personally held goals and ideas as can be encompassed by the term self-autonomy (Lynch *et al*., 2009:290). As most workplaces are culturally diverse, all employees need to be sensitive to cultural differences, yet focus on positive cross-cultural interactions (Thomas & Kerr, 2004:44). All these factors are closely intertwined. Each factor influences another factor either positively or negatively and ultimately determines the individual's perception and experience of well-being in the workplace.

When one thinks of the concept of engagement, the term pledge comes to mind, as an engaged employee will go beyond his/her capacity to benefit the organisation if he/she feels engaged. Woods and West (2014:68) believe that an engaged employee will experience the organisation's successes and failures as a reflection of his/her own successes and failures. Khan (1990:702) suggested a link between engagement and

job performance. He also believed that engagement provided an inclusive view of an employee's authentic self.

Research done by Brown and Leigh in 1996 established that employee engagement was influenced by factors such as the characteristics of the organisation, differences between individuals and the behaviour of supervisors and managers (Brown & Leigh, 1996:361). It was also found that engagement can predict the level of job performance as employees who strongly identify with their jobs will focus their thoughts and energy on their work responsibilities.

Rich *et al.,* (2010:618-620) identified various factors that serves as drivers for engagement:

- Management's concern for and interest in employee well-being
- The level of challenge in assignments at work
- Decision-making authority
- A collaborative and conductive work environment
- Resource availability
- Opportunities for career advancement
- The reputation of the company as a good employer

2.6.2.2 Job satisfaction

The term job satisfaction refers to the extent to which an employee feels content with his/her job. In essence, the aforementioned statement means that the level of job satisfaction an individual experience, depends on whether the employee likes the job or specific individual facets of the job (e.g. nature of the work, supervision, mental challenges etc.). Woods and West (2014:30, 94) however reported on other schools of thought where job satisfaction was measured based on knowledge (cognitive job satisfaction) and feelings (affective job satisfaction) about the job. Locke (1976:1295)

also defined job satisfaction as the amount of pleasure or positive emotional affect experienced as a result of appraisal of one's job or experiences related to one's job.

2.6.2.3 Well-being and flourishing

According to the Oxford Advanced Learner's Dictionary of Current English (2006), well-being can be defined as: "the state of being comfortable, healthy or happy". Flourishing has now also been adopted as the term of choice to describe high levels of subjective well-being.

It has been found that employees who flourish in their work environment, engage in more successful behaviour which in turn leads to great value for the employee him-/herself, colleagues and the organisation as a whole and that employees who flourish are less likely to resign from positions, thus resulting in lower personnel turnover for an organisation (Swart, 2012:74).

The healthcare sector in South Africa is a highly demanding environment which creates strain, tension and anxiety which impacts negatively on employee wellness. It is therefore not unexpected that a recent study by Rothmann (2013:125) found that at least 50% of all organisational employees in South Africa are not flourishing in their current work setting. It is shocking as this state of dysfunctional well-being has major economic and social cost implications (Quick *et al*., 2016:459).

It is also important to remember that flourishing is not a fixed state. Due to the ever-changing and demanding nature of one's work environment, various elements will impact on the employee's ability to flourish in the workplace.

Flourishing comprises of three components, namely emotional well-being, psychological well-being and social well-being. Emotional well-being relates to work factors such as job satisfaction, positive affect (feeling pleased, good spirited) and negative affect (feeling depressed, upset, bored). Psychological well-being in turn refers to work

factors such as autonomy (satisfaction or the subjective desire to experience freedom to carry out a task), competence, relatedness, engagement, learning (acquiring and application of knowledge and skills) and the meaningfulness of the work. Lastly, social well-being refers to work related factors such as social acceptance, social actualisation (growth), social contribution (value adding), social coherence and integration (relatedness) (Rautenbach & Rothmann, in press). In order to ascertain workplace flourishing, a positive work climate needs to be established. This can be achieved by implementing positive practices in the workplace. Positive practices refer to the collective and constructive behaviours and activities demonstrated by a company towards its employees. The following dimensions of positive practices have been identified by Cameron *et al*. (2011:268):

- Caring
- Positive affect
- Compassionate support
- Forgiveness
- Inspiration
- Meaning
- Respect, integrity and gratitude

These positive organisational practices impact the employees' well-being as well as the performance of the organisation as it promotes positive emotions with the employees, yielding effective employee behaviour and increased organisational effectiveness. This in turn leads to reduced turnover, increased productivity and increased profitability (Cameron *et al*., 2011:268-270; Cameron & Wooten, 2009:165).

2.6.2.4 Enthusiasm and commitment

It has been found that employees who are more enthusiastic and exhibit commitment to their organisation are more productive on a continual basis and tend to stay longer with an organisation than employees with low levels of staff morale (Woods & West,

2014:138-141). Employees who experience the employer and company to be supportive will experience higher levels of motivation, commitment and flourishing. Organisational practices affect the well-being and performance of its employees and the performance of the organisation as a whole (Cameron *et al*., 2011:270).

2.6.2.5 Involvement of employees

A collaborative work environment allows employees to solicit input and enhances the creativity among workers. An environment which allows employees to contribute and have a voice is conductive to high levels of staff morale (Williams *et al.,* 2010:43).

Certain factors have been identified that drive employee commitment. These include:

- The concern and care for employees by management
- Fairness and equality at work
- Feeling of accomplishment
- Day-to-day satisfaction
- Appreciation for inputs and ideas

Mullins (2010:147) quoted IBM vice president, F. Castellanos as follow: “A sincere word of thanks from the right person at the right time can mean more to an employee than a formal award. What is important is that someone takes the time to notice an achievement, seeks out the employee responsible and personally gives praise in a timely way”.

Praise can lead people to success. Giving positive feedback on good performance serves as a strong motivator which can lead employees to then likely accept and respond to constructive criticism (Mullins, 2010:271). Mullins further went on to suggest a philosophy of “golden rule management”, which entails the following:

- Treat employees fairly based on merit
- Always make employees feel important

- Give praise where deemed deserving and this will in turn motivate employees
- Encourage input and feedback from employees – do not undervalue the ability of listening
- Have an open-door philosophy
- A good manager's success is reflected in the success achieved by his employees. Help others to achieve success
- You cannot hide behind policies and pomposity

2.6.2.6 Empowering employees

Empowering employees with information, resources and opportunities whilst holding them responsible for the outcomes, have been associated with higher levels of productivity and job satisfaction. It entails giving employees a certain degree of responsibility and autonomy to make the correct choices regarding their specific tasks in the organisation (Grimsley, 2014:33).

2.6.3 General factors affecting workplace morale

Bowles and Cooper (2009:112) compiled a list of factors which they deemed to be at the centre of workplace morale. These are factors to take into consideration when seeking employment or evaluating an employer as they will play a crucial role in the morale the individual will exhibit when employed at the proposed organisation:

2.6.3.1 Image

The image and perception of the company to the outside world will influence the perception the individual has of the company when contemplating applying for a position at the company.

2.6.3.2 Remuneration and benefits

An interesting revelation from recent studies conducted by Saari & Judge (2004:397) regarding the importance of job attributes, employees ranked wages as fifth most important job attribute with interesting work taking the top spot. The study however also revealed that managers thought that good wages were the most important factor for employees.

On the other hand, it is also important to note that money has an economic and symbolic meaning. It can provide status and power and it provides a means to measure one's achievement (Luthans, 2011:96). Fathaniy (2011:82) was also of the opinion that employees will seek greener pastures if compensation is not sufficient.

2.6.3.3 Career pathing and prospects

An individual will not remain loyal to a company if there are no future prospects or opportunities to advance his/her career. When external appointments are done without considering internal applicants, morale will also be affected negatively (Fathaniy, 2011:84). However, individuals will work harder and remain loyal and committed if they know that they have future prospects in a company.

Kosteas (2009:23) found that receiving a promotion or expecting a promotion in the near future raises the level of job satisfaction experienced by the employee. Promotions were found to be an important aspect of an employee's career and personal life, affecting numerous facets of the work environment. Satisfaction may be derived not only from a higher income relative to colleagues and peers, but also having a higher rank.

2.6.3.4 Working conditions and resources

Factors such as enjoyment and challenge of work, advancement, working hours, remuneration and other financial incentives, personality, and organisational factors such

as access to technology, quality of management, culture and organisational status all influence the level of job satisfaction experienced by employees.

One would expect that there would be a negative relation between working hours and job satisfaction in the sense that longer working hours would result in reduced levels of job satisfaction. However, studies conducted in Denmark and Portugal proved the contrary – there is in fact a positive correlation between job satisfaction and working hours (Al Jenaibi, 2010:13). This means that employees working extended hours were more satisfied with their work environment (though it should be noted that income may influence this relation as longer hours and higher income are also correlated).

When an individual has resources to his/her disposal and a conductive work environment, morale will be high. If, however the working conditions are such that resources are limited or depleted, a non-conductive work environment exists or there is insufficient space, morale will be affected negatively. A study conducted by Meyer (2006:158), found a statistically significant correlation between job satisfaction and the combined use of technology and expertise. Further supporting the above research outcomes, are the results obtained from a study conducted by Ghalia and Rateb (2010:47), indicating that there would be increased job satisfaction in terms of intrinsic and general perspectives of employees with increased investment in technology.

2.6.4 Low staff morale

Concurring an earlier statement, two of the main causes of low morale among employees are the organisational culture and the way in which the organisation is managed (Strachan *et al*., 2010:525). In the majority of cases an employee leaves the culture and mismanagement of an organisation and not the organisation itself. Makawatsakul and Kleiner (2003:52-55) are of the opinion that low staff morale spills over to organisational activities which then ultimately leads to a decrease in productivity. Uncommitted and unconfident employees were also associated with low levels of staff

morale (Kinjerski & Skrypnek, 2006:293). Organisations are therefore obliged to identify and deal with possible morale breakers and to drive morale improving factors.

The following list of factors have been associated with decreased levels of morale in the workplace:

2.6.4.1 Leadership

Leadership plays a pivotal role in determining staff morale in an organisation. Regardless of status, title or position, a leader should lead by example. Career planning and management poses a great threat to employee morale levels, as the leaders have the responsibility to develop and enhance employee skills in accordance with job requirements and possible future development into positions in the organisation. This however, often gets neglected (Fisher, 2015:1). Low morale is inevitable if a leader does not comply with the requirements and responsibilities of the position he/she is occupying.

2.6.4.2 Lack of recognition

Research conducted by Haddock (2010:68) reiterated the findings that an employee will only deliver the desired results and perform at an optimum level if he/she receives recognition for his/her efforts. The opposite is also true – an employee will not display a high level of commitment when he/she feels taken for granted or unappreciated. Effort and hard work will then decrease as a result. An environment of engagement and recognition must be cultivated by managers as disengagement and alienation are central to problems such as lack of motivation and commitment on the part of employees (Aktouf, 1992:428-429). Research by Goffman (1959:57) found that individuals tend to focus on external-, rather than internal cues. He believed individuals will experience heightened levels of self-consciousness about how others perceive and judge them. This will in turn distract and preoccupy the individual. Recognition is therefore a critical factor when dealing with employees.

2.6.4.3 Stagnation

Advancement is the term of choice when referring to the progression and development of an individual within an organisation. By improving skills and engaging in training and development, an employee's career can be fast-tracked to progress. This in turn serves to drive and motivate employee performance.

In an organisation where future prospects are limited, an employee wishing to further his/her career will suffer greatly. External recruiting has been identified as a hurdle for current employees as this will lead to the loss of opportunities for progression within the organisation (Haddock, 2010:1-2).

Recent studies conducted by Rautenbach and Rothmann (in press), found that investment in career advancement predicted flourishing in the workplace.

2.6.4.4 Security

The tendency of management to leave employees in the dark concerning decisions affecting them, result in employees feeling vulnerable and unprotected. Management is under the obligation to involve employees when decisions need to be made that involves the future of the employees and the organisation. By involving employees and discussing matters with them, rumours in the workplace will be smothered which in turn is detrimental to employee morale (Haddock, 2010:2). Research suggest that trust levels for management are declining in many industries and organisations (Ashford & Mael, 1989:24). Trust is difficult to build, yet organisations routinely violate it.

2.6.4.5 Conflict between staff members

Coherence is another factor which plays a valuable role in workplace-well-being.

Research conducted by Basson and Rothmann in 2002, indicated that an employee's sense of coherence in the workplace may have a moderating effect on the relationship

between job stress and burnout. According to Antonovsky (1987:84), coherence has three dimensions, namely: comprehensibility, manageability and meaningfulness. If one perceives internal and external stimuli as comprehensible, experience situations as endurable, manageable and meaningful, a strong sense of coherence will exist among colleagues. Experiences which are unpredictable, uncontrollable and which create uncertainty will result in a weak sense of coherence, which in turn will contribute to increased levels of work related stress. It can therefore be deduced that a negative relation between coherence and burnout exist, as increased levels of coherence will result in decreased job stress and ultimately the prevalence of exhaustion and burnout.

A supportive diverse climate (supportive organisational context) will have a positive effect on the formation and expression of an individual's true identity in the work context (Ashford & Mael, 1989:26). Therefore, conflict among colleagues, departments and business communities at large are detrimental to staff morale in general.

Cultural intelligence is required as it entails the capability of an individual to effectively function within an organisation characterised by cultural diversity. Judgement should be suspended and personal attributes such as integrity, openness and hardiness should be instilled in an effort to acquire cultural intelligence (Ang & Van Dyne, 2008:110).

Every individual has basic psychological needs. When considering the Self-Determination Theory (SDT), three basic needs can be distinguished, namely:

- **Autonomy:** An individual's inherent desire to experience freedom and a sense of choice to carry out an activity (Deci & Ryan, 2000:14-23).

- **Competence:** An individual's desire to feel effective in a situation and during interactions in a certain environment. Feeling competent will result in adaptation to difficult circumstances while competence frustration will lead to feelings of helplessness and declining motivation (Deci & Ryan, 2000:14-23).

- **Relatedness:** An individual's inherent need to feel connected to colleagues. The individual wants to feel part of the group. When relatedness is experienced by the individual, a sense of communion and intimate relations between colleagues will ensue (Deci & Ryan, 2000:14-23).

In circumstances where the above basic psychological needs are not met, conflict between staff members can occur.

2.6.4.6 Communication

Honesty and transparency are crucial elements in any organisation. When management does not communicate with employees regarding issues pertaining to the organisation and the employees themselves, employees will lose morale as they will only come to hear about issues via rumours or the media. Poor communication will lead to poor understanding of business activities, ineffective and inefficient relations with management and decreased levels of morale (Bowles & Cooper, 2009:92).

According to Makawatsakul and Kleiner (2003:54), communication with employees is vital so that employees can comprehend the reasoning behind certain decisions and actions. Without proper communication channels, a backdoor will always be left open for rumours. Employees' sense of loyalty will dissipate whilst resulting in an ineffective and toxic work environment.

2.6.5 High staff morale

High morale among staff members create a positive perception of an organisation as it will charm and retain brilliant employees (Bowles & Cooper, 2009:96). Research has shown that a calmer working environment can be expected when staff morale is high. This in turn will assist the organisation in achieving company objectives and reduce poor attendance and stress. When an employee's health is enhanced and sick days are thus diminished, a positive correlation with high staff morale can be noted. It was

found that employees with high morale will experience higher levels of personal determination and a sense of responsibility to act on their responsibilities and to perform their tasks. Therefore, it is believed that individuals with high morale have positive attitudes which will result in increased performance and job commitment from such individuals (Kinjerski & Skrypnek, 2006:288).

According to Linz *et al.* (2006:415-417) there are two primary approaches according to which employee morale are developed. The two approaches are: organisational commitment and job satisfaction.

Loyalty (organisational commitment) is a major asset to an organisation. According to Ngambi (2011:769), individuals with high morale and loyalty will demand trustworthiness from an organisation. If an organisation fails to address employee related issues, productivity and profits will decrease (Makawatsakul & Kleiner, 2003:53). Improved financial performance and an increase in clientele satisfaction have been associated with organisations with high levels of staff morale. (Bowles & Cooper, 2009:54-57).

2.7 MOTIVATION

Luthans (2011:158) defined motivation as “a process that starts with a physiological deficiency or need that activates behaviour or a drive that is aimed at a goal or incentive.” Numerous definitions exist for motivation. But what is most evident, is that all the definitions included terms such as “desire”, “needs”, “wishes”, “want” and “goals”. Woods and West (2014:130-132) stated that motivation is concerned with why people exhibit certain behaviour and effort in the work setting as well as the processes determining intensity, goals and maintenance of goals over time.

The interrelationship between needs, drives and incentives are fundamental when considering motivational factors. A psychological/physiological need will activate behaviour or a drive aimed at reaching a certain goal or incentive.

Coetsee (2003:68-77) found that there is a significant interrelationship between motivation and job satisfaction, as a motivating climate can improve an employee's level of job satisfaction.

Six core phases pertaining to the motivational process have been identified by Woods and West (2014:142-144):

1. An employee identifies his/her needs
2. The employee seeks to satisfy these needs
3. The employee selects certain behaviour to reach specific goals that will meet his/her needs
4. The employee performs/acts
5. The employee receives either reward or punishment based on his/her actions
6. The employee reassesses the situation and deficiencies in his/her needs

Numerous well-known motivation theories exist. On closer inspection, one can classify them as follow (Woods & West, 2014:121-126):

1. <u>Content motivation theories:</u>

- The focus lies on explaining and predicting behaviour based on the needs motivation of the employee. Emphasis is placed on the satisfaction of needs.
- Specific motivation theories include:
    - Maslow's hierarchy of needs theory
    - Herzberg's two factor theory
    - Mc Clelland's acquired needs theory
    - Alderfer's existence, relatedness and growth theory

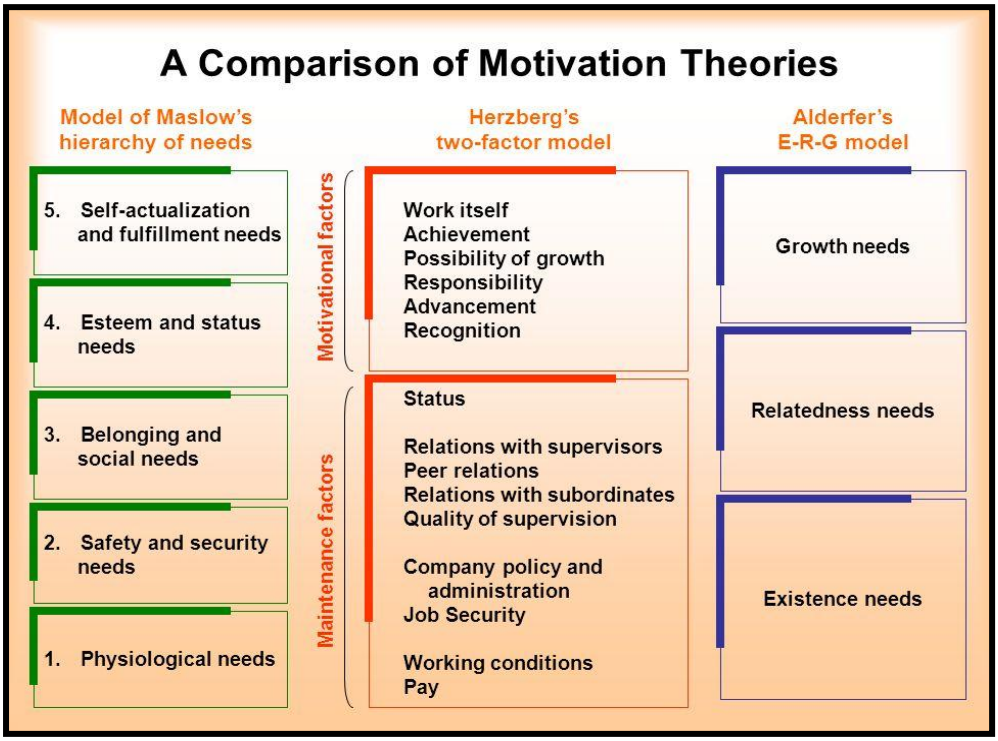


Figure 2. 1: Comparison of Content Motivation Theories (source: Fowler, 2015)

2. <u>Process Motivation Theories:</u>

- The focus lies on understanding how behaviour is chosen to fulfil one's needs.
- Emphasis is placed on the element of reward.
- Specific motivation theories include:
    - Vroom's expectancy theory
    - Adam's Equity Theory
    - Letham & Locke's Goal-setting Theory

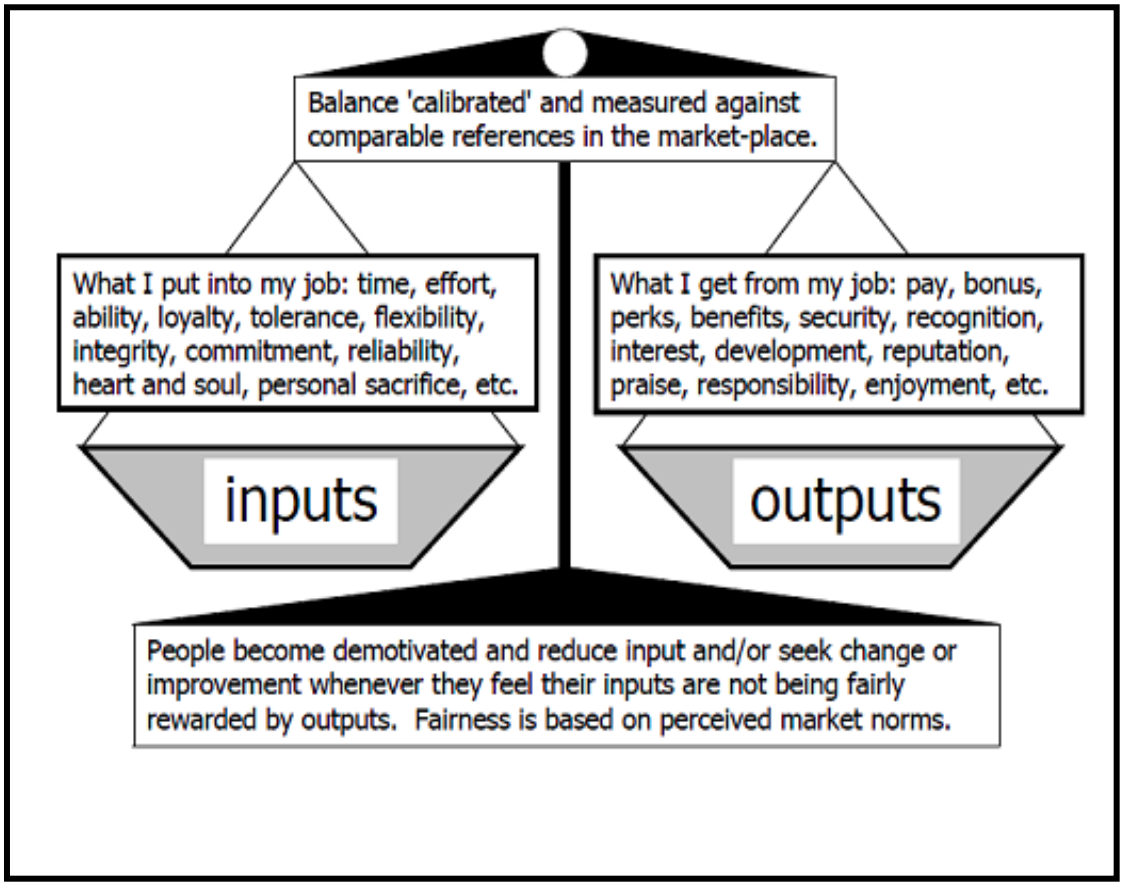


Figure 2. 2: Adam's Equity theory (source: Kandpal, 2015)

3. Reinforcement theory:

- The proposition here is that an individual's behaviour can be explained, predicted and controlled through the consequences of his/her behaviour.
- Types of reinforcement include:
    - Avoidance
    - Positive reinforcement
    - Extinction
    - Punishment

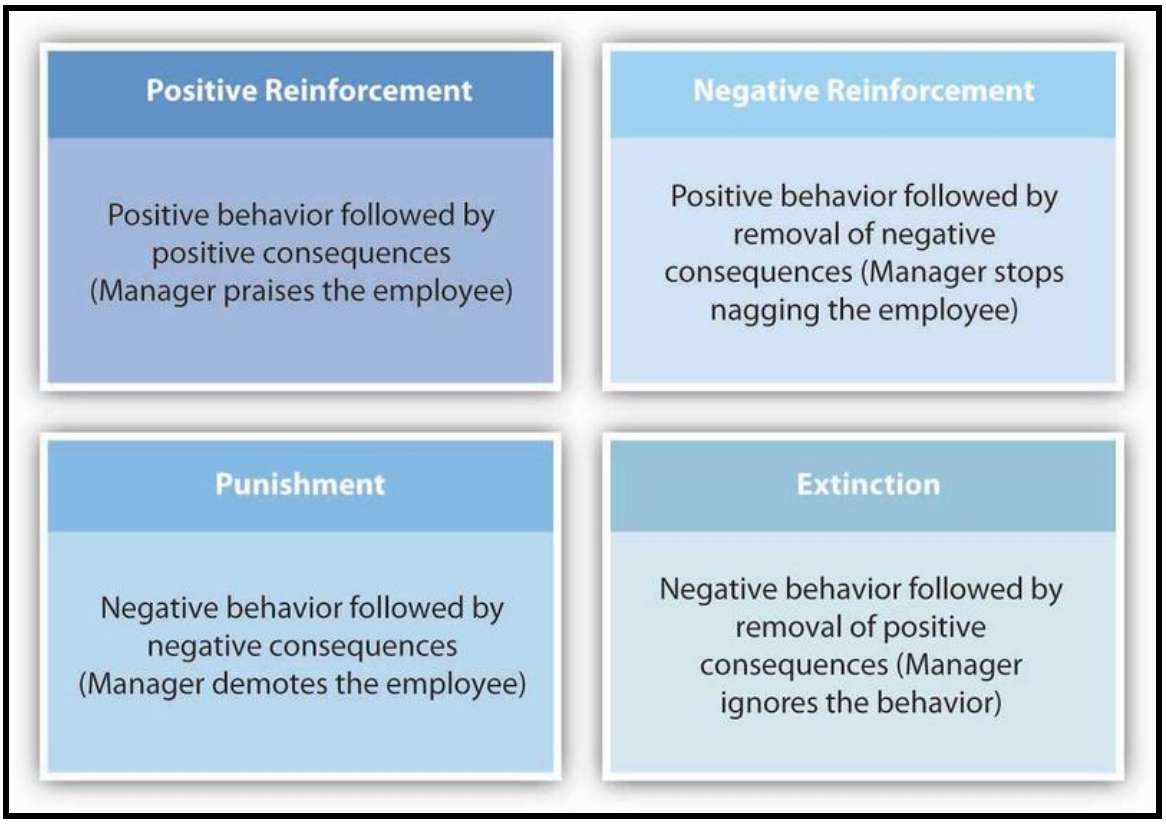


Figure 2. 3: Reinforcement Theory (source: Beatty & Schneier, 1975)

By integrating all the above theories, five strategies can be deduced which will assist in motivating employees in the workplace (Woods & West, 2014:121-126):

- Employees should be treated fairly and all sources of demotivation should be removed or dealt with
- Exceptional work should be valued and recognised
- Employees should be motivated and guided to have goals and objectives
- Give feedback - whether positive or negative
- Jobs should be designed in such a way to make them rewarding to employees

In the public healthcare sector, however, working conditions and access to functional equipment and resources have impacted negatively on motivational levels among employees, ultimately leading to low levels of work satisfaction.

Unfortunately, the public sector has not succeeded to date with specific operational solutions or recommendations to address low staff morale and the migration of healthcare professionals to the private sector (Maloka, 2012:12-14).

2.8 BURNOUT

Burnout can be defined as the "persistent, negative, work-related state of mind in 'normal' individuals that is primarily characterised by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviours at work" (Shaufeli & Enzmann, 1998:110). According to Maslach and Jackson (1986:2), burnout encompasses three components, namely: emotional exhaustion, depersonalisation and reduced personal accomplishment. Exhaustion relates to feelings of overextension and depletion of emotional and physical resources, whilst reduced personal accomplishment relates to feelings of personal competence, productivity and achievement in the workplace (Rothmann *et al*., 2003:55-57). Burnout should therefore not be confused with stress, as job stress is experienced by an individual when the demands of a workplace exceeds the individual's adaptive responses. An individual perceives certain threats and weighs it against the disposable resources to address the threats. Individual and circumstantial factors will influence how the individual responds to the threat. Common to the healthcare sector, burnout is considered as an occupational hazard.

Individuals in the healthcare sector experience both physical and psychological-emotional stress. A demanding work environment with long hours create a psychologically uncomfortable situation for the individual which might induce negative emotional reactions, reduce efficiency and job satisfaction, and ultimately lead to a decreased intent on the part of the employee to remain a member of an organisation (Piko, 2006:313-318).

2.9 JOB STRESS

Job stress can be divided into two components: Job pressure/demands and job resources. Job pressures relate to aspects of the job that requires continuous physical or mental effort which in turn is associated with certain physiological and psychological consequences. Factors functional in achieving work goals, reduce job demands and stimulate personal growth and development relates to job resources. Any imbalance in terms of job pressure and -resources will result in increased job stress which can ultimately contribute to the occurrence of burnout in the workplace (Rothmann *et al*., 2003:55-57).

2.10 ORGANISATIONAL STRUCTURE AND CULTURE

When considering the aforementioned definitions of staff morale, one can conclude that staff morale (whether positive or negative), does indeed have an impact on the functioning of any organisation. In the workplace, staff morale is related to a combination of factors, such as changes in the internal and external environment and the approach leadership follows to adapt to those changes (Ngambi, 2011:772).

The culture of an organisation refers to the rules, beliefs, behaviours and values in which the employees must function and work. It has been found that staff morale is driven by the culture the organisation creates for its employees (Bowles & Cooper, 2009:112). In response to the culture created in the workplace, the employees may exhibit either low or high levels of morale.

Daughtery (2011:2) found that high staff morale was associated with commitment, dedication and supportive roles whilst low staff morale was associated with frequent absenteeism. Linz *et al*. (2006:417-418) were of the opinion that high labour turnover and unresolved grievances could also be linked to low staff morale which ultimately distracted the company from achieving their goals and objectives.

It is therefore crucial to identify the factors contributing or leading to either low or high staff morale.

2.11 THE ROLE OF MANAGEMENT

Research conducted by Clark (2008:1, 3) identified several factors which bear on the morale among staff members in an organisation, and it is the responsibility of management to take them into consideration:

- Management's approach to and treatment of employees
- Working conditions such as health and safety, working hours (and overtime) and remuneration
- Is the leadership effective? Is authority and responsibility being distributed fairly and intelligently?

Clark (2008:3) also reiterated that management should ensure authenticity and display their humanitarian side.

O'Maolalaidh (2000:32-36) is of the opinion that if management wishes to increase staff morale in an organisation, the importance of the following three aspects should not be taken lightly:

- The importance the job has for the employee combined with the sense of accomplishment the employee experiences based on competent job performance.
- The encouragement and incorporation of teamwork in the workplace so that self-esteem, unity and group pride will develop.
- Management should truly care about the welfare of those employed in the company. Those who contribute and show commitment to the organisation should be rewarded. All employees deserve to be treated equally and with respect.

Quick fix self-help guides are readily available from various well-known authors to assist management in addressing morale concerns among employees. One of these step-by-step guides have been developed by Hames.

A list of six interventions compiled by Hames (2011:1-3) were said to assist with addressing staff morale related issues in the workplace:

- **Special events or occasions in an employee's life should be recognised**

  Research has confirmed that employers who acknowledge special events or occasions in an employee's life such as birthdays, children excelling in school or family tragedies have better relations with staff members. Acknowledging excellence and showing interest goes a long way.

- **Encourage participation and contribution**

  An environment encouraging participation and sharing of ideas and thoughts should be priority. Management should start by listening to employees.

- **Recognition of excellence and reward**

  Managers should give recognition to employees who exceed the basic requirements to fulfil their job and who is excelling. Employees will become motivated to go the extra mile if they are rewarded for their extra efforts.

- **Create a productive and conductive work environment**

  Management should ensure that functional equipment is readily available to employees. The environment should be conductive so that the employees can fulfil their duties without frustration. Job specific requirements should be ensured such as functional chairs and desks, technology and a temperature controlled

office if management wishes to create a conductive and productive work environment.

- **Be approachable**

It is evident that the social atmosphere in a workplace can either be detrimental or conductive to morale. A tense, stressful and confrontational atmosphere will most certainly have a dismal effect on morale among co-workers. Yet, on the other hand, research has proven that managers who smile more and who attempt to interact with employees on a more social level from time to time will relieve feelings of tension and stress and improve staff morale.

- **Trust**

The foundation of any organisation should be trust. By creating a culture where employees' capabilities are trusted (and vice versa), where communication with and management of employees are based on mutual respect and trust, management will experience commitment and loyalty from their employees.

The concept of transformational leadership has won ground globally. Bass (1998:54) explained the concept of transformational leadership as the establishment of oneself as a role model by gaining the trust and confidence of followers. Eagly *et al.* (2003:575) added that such leaders state future goals and develop and implement plans to achieve them. Bass (1998:111), further went on to state that transformational leaders behave charismatically to inspire employees to identify with them. These leaders inspire followers to aim for higher goals, they challenge employees to seek new behaviours and they display individualised consideration for employees by showing concern for employee needs for growth and development.

The role management plays in the environment in which the healthcare professional must function can be summed up by Kinjerski and Skrypnek's (2006:293) statement:

“Management's ability to direct and understand the employee in the workplace is the ability to release that employee's full potential.”

2.12 STAFF MORALE AND BATHO PELE COMPLIANCE

The foundation for quality healthcare service delivery in the public sector is based is Batho Pele principle compliance. Batho Pele depicts an attitude, an approach to efficient, quality service delivery. It should be integrated into every aspect of the public sector (SA, 1997:32). Service delivery in the public sector should therefore provide the public with basic services whilst those services should raise the standard and quality of living for the majority of individuals dependant on it (Hemson & Owusu-Ampoman, 2005:512). However, what efforts are being done to uplift those who deliver the services and who must comply with the Batho Pele Principles? Do they not also need a supportive and conductive working environment to ensure optimal performance and compliance with the Batho Pele Principles?

The following obstacles to staff morale and ultimately Batho Pele compliance have been identified:

- Infrastructure concerns such as no/limited work space, telephones, computers, non-functional equipment and expired materials cause frustration and lower staff morale. This in turn affects the extent to which the employees can deliver efficient and quality service.
- Freezing of posts and cutting budgets due to financial constraints have played a pivotal role in the demise of the public healthcare system in South Africa. Critical positions such as specialists remain vacant while employees are overloaded with work and responsibilities exceeding their knowledge and skills. Procurement of materials and equipment have also been halted by the reduction in funding. This results in additional strain on efficient service delivery (SA, 2010b:52).

- After the introduction of rural and scarce skills allowances in May 2003, it was implemented in March 2004. In 2008 Occupation Specific Dispensation (OSD) was implemented. Both the aforementioned allowances were introduced to attract more healthcare professionals to the public sector and to retain those who are contemplating leaving the public sector for the more lucrative and resourceful private sector. However, the ideal did not match the result as the dedication among public sector employees declined and the concern over income, benefits and incentives became the focus point (Maloka, 2012:21).
- Due to the high workload, public healthcare professionals often suffer from burnout. This leads to a negative attitude towards the employer, dissatisfaction with the occupation, sub-standard service delivery, reduced productivity and frequent absenteeism. These are all symptoms of low staff morale (SA, 2010b:10).

2.13 SUMMARY

Key to building a cohesive organisation, is addressing the values of both the organisation and the employees. A recent survey conducted by Barrett on the values in the healthcare workforce identified certain values with limitation potential. These include bureaucracy, control, hierarchy, long hours, uncertainty and confusion. Although there is a general consensus that the desired values among all categories of staff must include care, competence, integrity, accountability, responsiveness and respect, an enormous challenge remains: how do you translate those desired values into the daily reality of the department whilst addressing the needs of the employees?

Central to the strategic planning processes of the Department of Health, is the vision of creating an environment of "access to client-centred quality care". However, as healthcare is considered a helping profession, it is essential that factors such as burnout, work engagement, job stress, coherence and flourishing be discussed in the

context of a service/helping industry as this will impact on the realisation of the department's vision.

Self-actualisation and job satisfaction play central roles in creating a conductive, positive and functional work environment. How you feel about your work and the environment in which you must work, will affect your motivation, the decisions you make regarding future career prospects and opportunities, your health and your relationships with others. The factors that contribute to job satisfaction (or dissatisfaction) are not limited to the nature of the job itself as it includes the expectations we have of the job. Healthcare workers in particular, are greatly at risk of experiencing job dissatisfaction compared to other professions. Literature has proven that decreased job satisfaction often leads to low morale, which in turn leads to a reduction in work commitment, a higher staff turnover, increased absence and poor work commitment. In the public healthcare sector this will lead to a reduction in the efficiency and quality of services (Rothmann *et al.*, 2003:52-55).

The South African healthcare system is faced with significant challenges for both the employee and the employer. If the employer wishes to attract and retain professional, credible healthcare workers, an environment must be created where intrinsic job satisfaction can be obtained whilst delivering quality patient centred service.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research is not purely information gathering. It has distinct interrelated characteristics such as an open system of thought, critical examination of data and generalisation whilst setting limitations to the generalisation (Struwig & Stead, 2004:3). Researchers and scientists conduct research to understand and explain certain phenomena - in essence, why things are the way they are (Balnaves & Caputi, 2001:90).

With the above statement as basis, this chapter's purpose is to explain, in detail, the methodology utilised by the researcher to address the following objectives of the study:

Table 3. 1: Study objectives

Objective A	To identify and describe the factors influencing staff morale among public oral healthcare professionals
Objective B	To describe the influence of staff morale on Batho Pele principle compliance and the subsequent effect on the quality of patient care

This chapter provides information pertaining to the overall research design, data collection method and site, data analysis, validity and reliability of the research as well as ethical considerations that needed to be taken into consideration.

3.2 DESCRIPTION OF OVERALL RESEARCH DESIGN

Research design refers to the logical strategy followed to gather information and evidence about a desired knowledge. It is the blue print for conducting studies (De Vos, 2001:55). The researcher had a distinctive research approach using contextual and descriptive research strategies, which enabled her to gain an overall picture of the research objectives at hand:

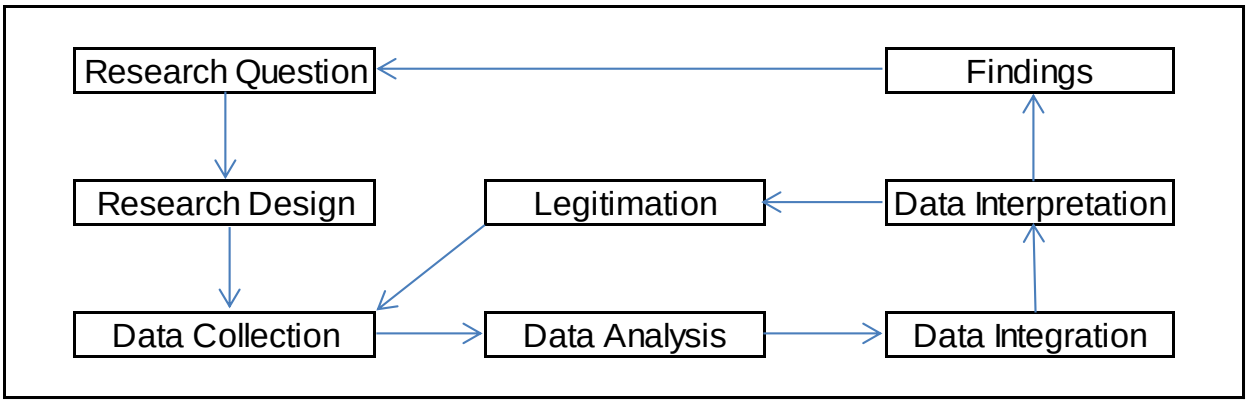


Figure 3. 1: Strategic research approach utilised by researcher (adapted from: http://www.rasch.org/rmt/gifs/rmt183h.gif)

A non-random convenient sampling method was utilised during this research. As the literature review in Chapter 2 indicated, certain trends and themes pertaining to morale in the workplace have already been discovered and confirmed by many other researchers. The purpose of this research was to investigate a specific closed group of individuals in a specific environment. The aim of this research was thus not to generalise beyond the case being investigated. External validity was therefore not a criterion to consider. Through utilising a quantitative research method, the researcher examined a single case intensively. The data for that specific case was then analysed. The necessity for objectivism throughout this research process further supported the chosen research method.

3.3 POPULATION / SAMPLING

3.3.1 Location

The research was conducted at Medunsa Oral Health Centre located in the northern part of Tshwane, Gauteng, South Africa. As a tertiary training dental hospital, Medunsa Oral Health Centre plays a pivotal role in enabling public access to general and specialised dentistry. The majority of patients utilising these services reside in the surrounding areas of Garankuwa, Soshanguve, Hammanskraal, Pretoria North and

Brits. However, referrals are received from community healthcare centres, clinics and district hospitals offering a limited scope of dental care. Medunsa Oral Health Centre forms part of Sefako Makgatho Health Sciences University where academic tuition and clinical training are given to future medical professionals and in this case dentists, dental therapists and oral hygienists.

3.3.2 Study population

Permanently employed oral healthcare professionals with both clinical and non-clinical responsibilities were included in the study population. This included oral hygienists, dental assistants, dental therapists, dentists, registrars, dental technicians and radiographers from all the departments that were available at the time the study was conducted and who were willing to participate. Individuals who wished to exercise their right not to participate in the study were excluded. All participants had to be registered as healthcare professionals with the Health Professions Council of South Africa (HPCSA) and their relevant councils in their respective fields of qualification. Participants included males and females. A multicultural study population was used during the research. Various ethnic groups were represented among the black participants. Most participants resided in Pretoria North and surrounding suburbs. However, a small number resided in Johannesburg, Centurion and Midrand.

As the primary research objectives were not applicable to support staff and senior management, they were omitted from the research process.

The exclusions were as follow:

- Staff members who served on senior management with limited or no daily (clinical) patient interaction: heads of clinical units, heads of departments, the clinical manager and the dean.
- Non-clinical support staff members: cleaners, IT, administrative- and financial staff, security, procurement and personal assistants.

3.3.3 Sampling size

The following table summarises the number of individuals per profession whom the researcher aimed to involve in the research process:

Registrars	7
Dentists	28
Radiographers	3
Dental Therapists	2
Oral Hygienists	3
Dental Assistants	40
TOTAL:	83

The sample group thus consisted of 83 clinically oriented staff members. The sample size was however influenced by the availability of participants (Burns & Grove, 2005:355).

3.4 DATA COLLECTION

A structured, self-administered questionnaire was utilised as research tool to collect data from participants. The questionnaire was divided into four sections: section A, -B, -C and D. Section A comprised of socio-demographic questions such as gender, race, years of service and designation/occupation, whilst section B focused on aspects related to the overall experiences and views of the participant in his/her work environment. Section C referred to the participant's perception and experience of the overall staff morale in the hospital. Section D provided open ended questions. A five-point Likert scale ("strongly disagree" to "strongly agree") was the measurement tool of choice. The questionnaire was based on the questionnaire used by Mr Njabulo Khumalo which formed part of a dissertation he submitted in 2013 with the University of Zululand, KZN titled: "The assessment of staff morale at the University of Zululand in Kwazulu-Natal, South Africa." Mr. Khumalo gave written consent to the researcher to utilise the

questionnaire during this research. Please refer to Annexure F for the adapted questionnaire that was utilised during the study.

The Statistical Consultation Services of the North-West University, Potchefstroom Campus was approached to assist in determining whether the questionnaire was suitable as research tool for the purpose of this study. Previous researchers have found that simplified, concise and to the point questions were more applicable to this type of study (Legodi, 2008:31; Mbanga, 2006:40) and that answers would be limited if closed-ended questions were to be used (Brink *et al*., 2006:149). Therefore, confirmation whether the questionnaire was suitable for the purpose of this study was obtained.

After obtaining ethical clearance from the North-West University's Ethics and Research committee, the researcher had to obtain ethical clearance from Sefako Makgatho Health Sciences University Research and Ethics Committee (SMUREC) to conduct the research at the proposed research site. In addition to the above ethical clearance requirements, the researcher also obtained permission from the acting dean of the School of Oral Health Sciences, Medunsa Oral Health Centre to conduct the research at the dental hospital. Please refer to the following annexures for the relevant supporting documentation:

- Annexure A: Request letter to the acting dean of the School of Oral Health Sciences, Sefako Makgatho Health Sciences University, to conduct the research at the dental hospital
- Annexure B: Request letter to SMUREC for ethical clearance
- Annexure C: Approval letter from the acting dean of the School of Oral Health Sciences to conduct the research at the dental hospital
- Annexure D: Ethical clearance from SMUREC
- Annexure E: Ethical clearance from NWU Ethics and Research committee

The researcher addressed the targeted participants on a departmental (where possible) and individual basis after ethical clearance and permission were granted from the

relevant parties. During contact with participants, the researcher explained the rationale behind the research, motivated employees to participate and reiterated confidentiality and protection of identities as numerous participants were weary of being identified. Voluntary participation was also reiterated.

The researcher personally distributed the research instruments (questionnaires) to participants. Each questionnaire was accompanied by a blank envelope in which the participant was to place the completed questionnaire. Accompanying the above was a consent form which had to be returned to the researcher separately to ensure anonymity of participation. The researcher collected completed questionnaires daily for a period of one week by doing rounds in the hospital with two sealed boxes - one for the completed questionnaires in the sealed unmarked envelopes and the other for the completed consent forms. Participants could therefore see for themselves that their identities could not be linked to their completed questionnaires. This confirmation assisted the researcher to obtain 68 out of the 70 distributed questionnaires within the five-day period. An excellent response was noted. Only two of the 70 distributed questionnaires were not completed as the participants did not want to partake in the research. As stated in section 3.3.3, 83 candidates were identified as potential participants. However, 13 candidates could not be reached as they were either on annual-, sick- or study leave during the period that the research was conducted.

The researcher considered appointing a research assistant to assist during the data collection process. The research assistant could assist participants (where needed) to ensure the correct and timeous completion of the questionnaire. This would also have assisted in attracting possible participants who did not feel comfortable identifying themselves to the researcher. However, since the response and participation was so overwhelmingly positive, the services of a research assistant were not needed.

3.5 DATA ANALYSIS

The process where a data collection tool is utilised to collect, organise, manage and reduce data is called data analysis. By categorising and summarising data, the researcher is able to understand and provide answers to the posed research questions or objectives (Van der Walt & Van Rensburg, 2006:226).

Collected data was described and summarised by utilising descriptive statistical methods (Brink *et al.,* 2006:171) as it allowed the researcher to organise the data obtained from the completed questionnaires in a manner that would give meaning to and provide insight into the factors affecting staff morale at Medunsa Oral Health Centre from various angles (Burns & Grove, 2005:461).

As stated earlier, quantitative analysis was the basis of this research. The data retrieved from the questionnaires was coded and entered into a Microsoft Excel spreadsheet using Microsoft Office 2010. The Statistical Consultation Services of the North-West University, Potchefstroom Campus were called in to assist with data analysis. Statistical software SPSS version 17.0 was used for descriptive and inferential statistical analysis.

Data obtained from section B of the questionnaire were grouped into four main categories and eleven sub-categories:

1. Management and communication

    i. Management
    ii. Hospital and Systems
    iii. Support and Human Resources

2. Workplace vision, mission and expectations

    i. Vision and mission

3. Work engagement

   i. Support and compensation
   ii. Self-efficacy and fulfilment
   iii. Colleagues

4. Future prospects

   i. Growth and development within the hospital
   ii. Intent to leave

5. Staff support and motivation

   ii. Performance management and employee assistance
   iii. Morale/staff support management

Data from sections C and D were evaluated separately and then correlated with the various other sections, categories and sub-categories during data analysis.

Data analysis pertaining to frequencies, percentages, average scores (means), standard deviations, p-values and effect sizes was conducted. Data was analysed in terms of frequencies, factor analysis, reliability, comparison of findings and correlations between factors.

The researcher's main focus was aimed at providing a vivid, complete picture of the obtained data. To provide clarity and prevent confusion, the data has been summarised in a table and/or graphic format in Chapter 4. The summarised description of the data obtained should provide a clear and complete picture of the factors influencing the objectives of the study.

3.6 RELIABILITY AND VALIDITY

3.6.1 Reliability

As stated previously, the questionnaire was divided into four sections and a Likert-type scale was used. It is therefore essential that Cronbach's alpha coefficient is calculated and reported on to ascertain internal consistency or reliability for any scale or sub-scale. The following table indicates the rule of thumb followed during the evaluation of Cronbach alpha coefficient values obtained during the study:

Table 3. 2: Guideline for Cronbach alpha coefficient evaluation (source: Maloka, 2012:44)

Cronbach alpha value	**Internal Consistency**
$\alpha < 0.5$	Unacceptable
$0.5 \leqq \alpha < 0.6$	Poor
$0.6 \leqq \alpha < 0.7$	Questionable
$0.7 \leqq \alpha < 0.8$	Acceptable
$0.8 \leqq \alpha < 0.9$	Good
$\alpha > 0.9$	Excellent

A T-test was also used to determine and demonstrate the difference between the two participant groups (male versus female) and whether there was any significant difference. The Kaiser-Meyer-Olkin measure of sampling adequacy test (KMO) and the Bartlett's Test of Sphericity were also conducted. The aforementioned tests are used to measure the suitability of the data for factor analysis, as it measures sampling adequacy for each of the variables in the model and for the model in its entirety (Ellis & Steyn, 2003:51-53).

It should be reiterated that this study is based on a specific grouping of professionals in a specific setting, thus a non-random convenient sample. The aim of this study was not to generalise but to rather evaluate, comment and give recommendations in terms of

this specific scenario where the entire population was involved in the study. The focus was thus on the practical relevancy of the outcome of this study in this particular setting and statistical inference and p-values would not be of value in this scenario. However, note for the sake of completeness that p-values were determined and included. Cohen (1992) developed a guideline according to which practical significance of data can be interpreted, and which is applicable to this situation:

Table 3. 3: Cohen's guideline for practical significance interpretation (source: Maloka, 2012:45)

Value	Effect	Significance
0.2	Small	- New research should be replicated to determine if there is indeed an effect or whether results are practically insignificant
0.5	Medium	- May point to practical significance - An improved survey / experiment may result in a more significant outcome
0.8	Large	- Practically significant results - Practical importance

According to Burns and Grove (2005:374), reliability can be considered as an indication of the extent of random error in the chosen method of measurement – it indicates the replicability of one's measures on a retest. As this study is conducted in a specific context, results are limited and only applicable to the Medunsa Oral Health Centre.

3.6.2 Validity

Objectivism and honesty on the part of the researcher was crucial throughout the study, as bias could result in systematic errors in sampling/measurement occurring - resulting in incorrect conclusions being drawn. It is with the above statement in mind that validity should be ensured. Validity in essence refers to cogency or factual soundness (Oxford Advanced Learner's Dictionary of current English, 2006).

The use of a well-designed structured questionnaire comprising of Likert-scale style questions, assisted the researcher in obtaining sound and trustworthy data as different interpretations on the results were not possible. The researcher ensured competence in data collection techniques before ensuing the data collection process (Rossouw, 2005:178-179), whilst maintaining a neutral and objective approach.

Questions were carefully selected for incorporation into the data collection tool to ensure face and content validity. Appropriateness and correspondence with the study objectives were the basis for selection (Polit *et al.,* 2001:309). Inappropriate or questionable interpretation questions were omitted.

The findings are therefore a true reflection on the factors influencing staff morale and subsequent Batho Pele compliance of public oral healthcare professionals at Medunsa Oral Health Centre.

3.7 ETHICAL CONSIDERATIONS

As basis for any form of scientific research, certain norms, standards and values should be adhered to. This serves to guide the researcher in carefully considering and refraining from possible ethical dilemmas that might occur during the course of the research process. All aspects of participant safety should be adhered to and human rights violation should be avoided at all cost (Mouton, 2006:280). The researcher addressed the following ethical considerations during the course of the study:

3.7.1 Research approval

Firstly, ethical clearance was obtained from the North-West University's Ethics and Research committee. The following ethical clearance number was allocated: EMSPBS17/03/06-01/04 (see Annexure E). The researcher also obtained ethical clearance from Sefako Makgatho Health Sciences University Research and Ethics Committee (SMUREC) to conduct the study at the proposed research site (see

Annexure D). In addition to the above, the researcher obtained permission from the acting dean of the School of Oral Health Sciences, Medunsa Oral Health Centre to conduct the research at the dental hospital (see Annexure C). As discussed below, participants gave consent to participate in the research by signing an informed consent form after the purpose of the proposed study was explained to them and comprehension was ensured (see Annexure G).

3.7.2 Informed consent

According to Khumalo (2010:67), it is the responsibility of the researcher to inform all participants about the proposed research project before commencement. Participants were informed and all questions and uncertainties were addressed.

Before the commencement of the research, participants had to complete an informed consent form. In the form the following information was stipulated:

- The study would form part of the requirements for the researcher to successfully complete a mini-dissertation towards obtaining a Master degree in Business Administration (MBA) through the North-West University
- Voluntary participation was reiterated. Participants were reassured that if they feel uncomfortable at any stage of the research, they could withdraw
- Reassurance was given that no names or identities would be revealed by participating in this research
- Confidentiality and anonymity would be ensured at all times
- Participants were informed that no names or identities would be revealed in the final report of findings

3.7.3 Participants not to be harmed

Individuals who participated in this research were reassured that they would not be subjected to any form of emotional or bodily harm, and that if at any time during the

process of conducting the study, they felt stressed or uncomfortable due to the sensitive nature of the content, they were free to withdraw.

3.7.4 Anonymity and confidentiality

Participants were reassured that participation and the information shared with the researcher would remain confidential. Participants were assured that their signatures on the consent forms would not be disclosed to any other party.

3.8 SUMMARY

This chapter described the methods chosen to research the objectives of the study. Focus was placed on instrumentation, data collection procedures, participants, sampling and data analysis, whilst addressing key elements such as ethics.

The findings obtained through the processes described above are presented and discussed in depth in the following chapter.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

In this chapter, the reader is presented with a detailed description of the results and findings of the conducted research. The findings are also interpreted to assist with comprehension.

Referring to Chapters 1 and 2, the theoretical basis for this research was the philosophical framework of Batho Pele principle compliance (1997), the Patient's Rights Charter (1999) as well as theoretical aspects pertaining to morale in the workplace. In order to provide a comprehensive report on the results obtained, the objectives of the study should be reviewed again. Please note a tabled version of the information below is available in Chapter 3 as Table 3.1: Study objectives.

Study objectives:

- Objective 1: To identify and describe the factors influencing staff morale among public oral healthcare professionals.
- Objective 2: To describe the influence of staff morale on Batho Pele principle compliance and the subsequent effect on the quality of patient care.

Objective 1 was addressed by utilising self-administered questionnaires which had to be completed by the identified healthcare professionals as discussed in Chapter 3. Objective 2 was addressed by obtaining data from the quality assurance department of Medunsa Oral Health Centre as a customer satisfaction survey (CSS) was conducted during July 2017. By correlating the findings of the two objectives the researcher will draw certain conclusions and report on the results obtained. Recommendations will also be made where applicable.

4.2 REALISATION RATE

A non-experimental path was followed to obtain a quantitative, descriptive study design (LoBiondo-Wood & Haber, 2006:602). The results were evaluated in two parts – data obtained from oral healthcare professionals and data obtained from the customer/patient satisfaction survey. Firstly, the results obtained from the oral healthcare professionals are considered:

4.2.1 Data obtained from oral healthcare professionals

Research findings were based on 68 completed and returned questionnaires that were distributed to the relevant individuals identified in the sample group as discussed in Chapter 3. A total of 70 questionnaires were distributed, however, two participants withdrew and declined participation resulting in a final sample size of 68 participants and a response/return rate of 97.14%. Members of the sample group were limited to individuals involved in both clinical and non-clinical activities whilst excluding senior management and support staff. Due to the application of the Likert-scale format as well as ticking relevant boxes in terms of demographic information, ambiguity and inconsistency with answering were eliminated.

The questionnaire comprised of four sections which were evaluated on an individual basis, cross correlated and compared based on certain factors which were identified and deemed important.

4.2.1.1 Results on a section to section basis

4.2.1.1.1 Section A

Results from section A contained demographic information ranging from race, age, occupation, years of service and highest qualification. The results obtained are depicted in the following pie charts and corresponding descriptions:

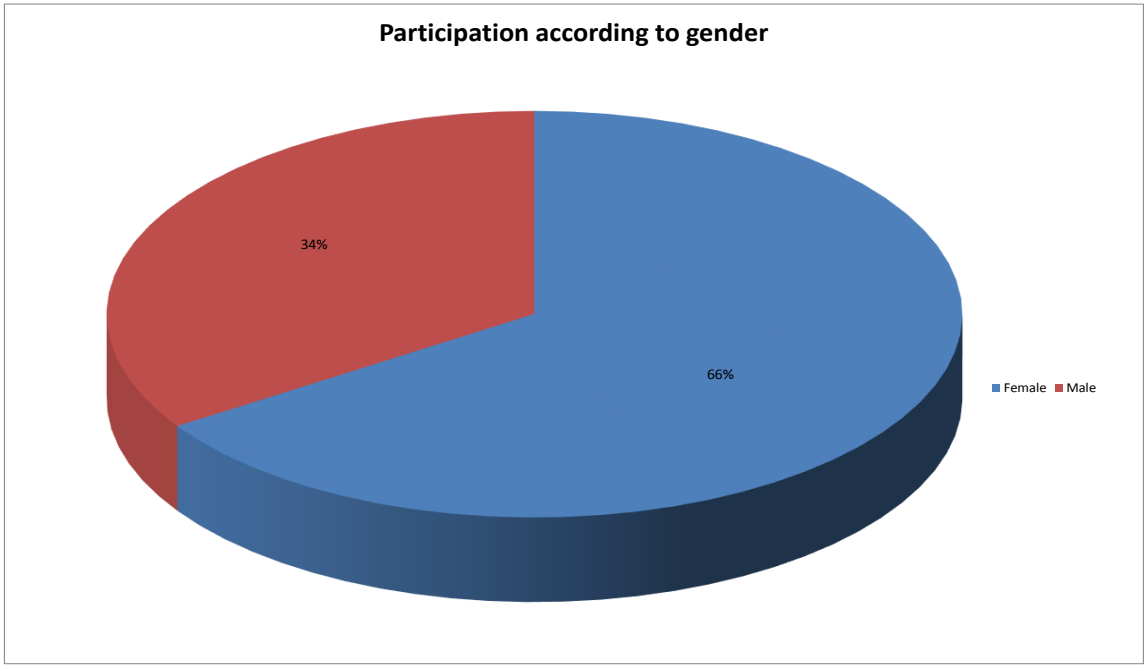


Chart 4. 1: Participation according to gender
The 68 participants comprised of 65.7% (44) females and 34.3% (24) males.

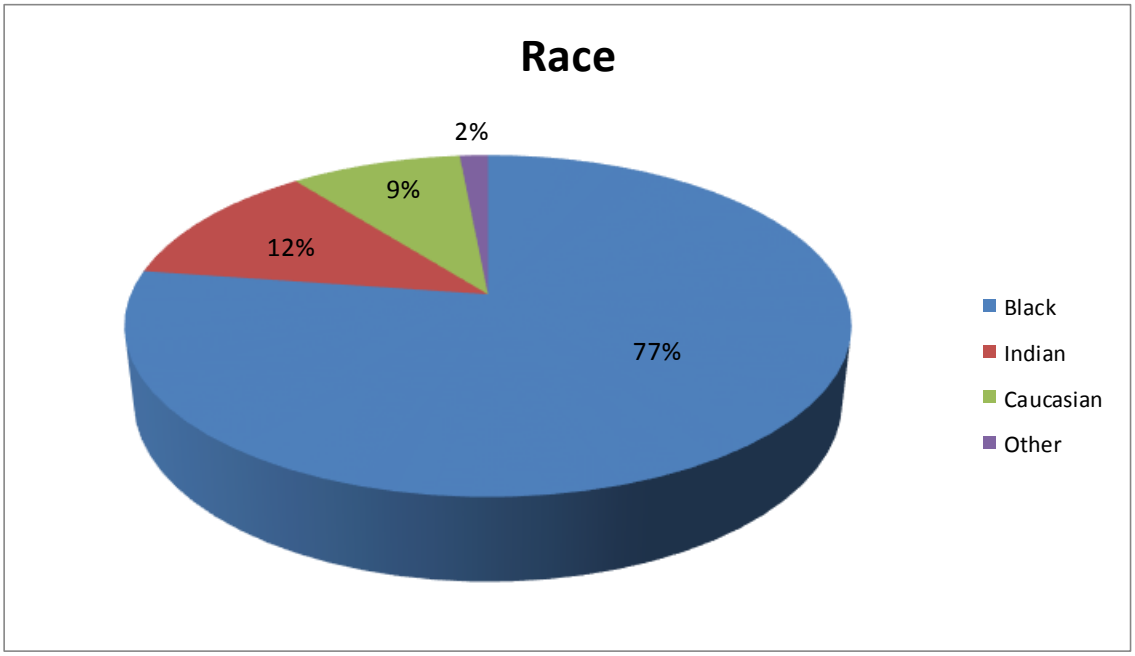


Chart 4. 2: Participation according to race
The 68 participants (according to race) comprised of 77.3% Black, 12.1% Indian, 9.1% Caucasian and 1.5% other participants.

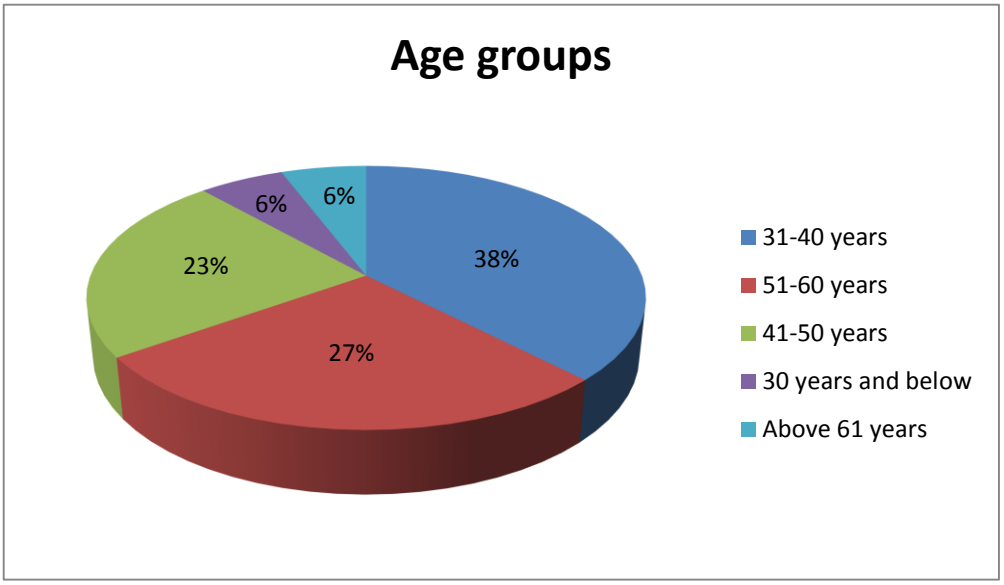


Chart 4. 3: Participation according to age group

The 68 participants were represented by: 37.7% (31-40yrs), 27.5% (51-60yrs), 23.2% (41- 50yrs), 5.8% (below 30yrs) and 5.8% (above 61yrs).

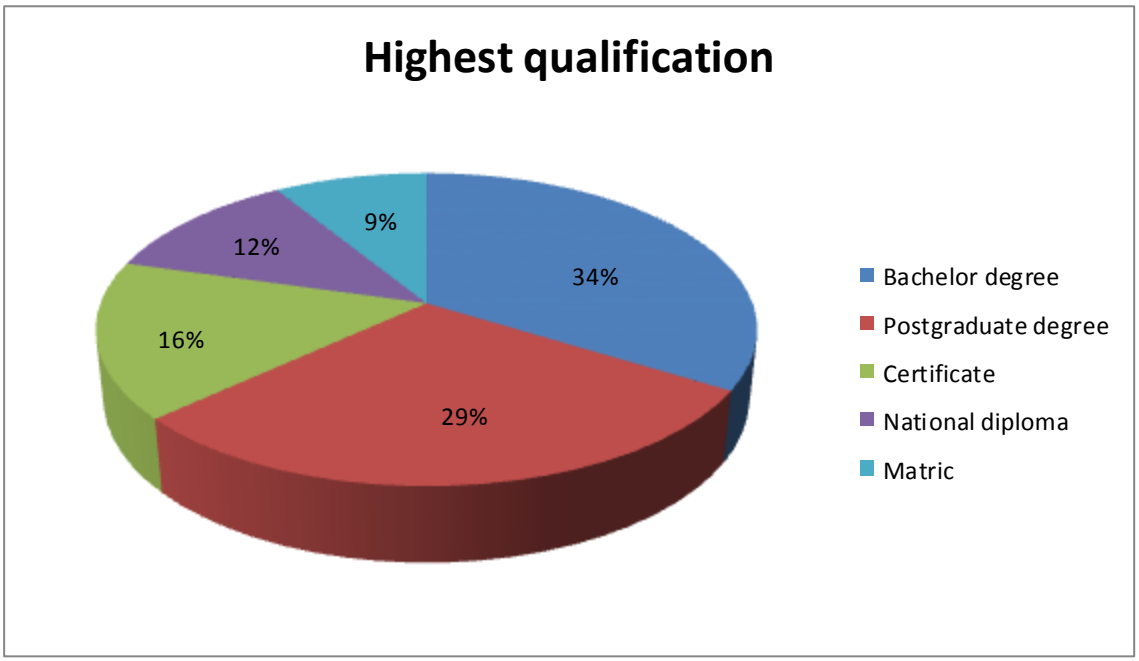


Chart 4. 4: Participation according to highest qualification

The 68 participants were grouped as: 33.8% (Bachelor degree), 29.4% (Postgraduate degree), 16.2% (Certificate), 11.8% (National Diploma) and 8.8% (Matric).

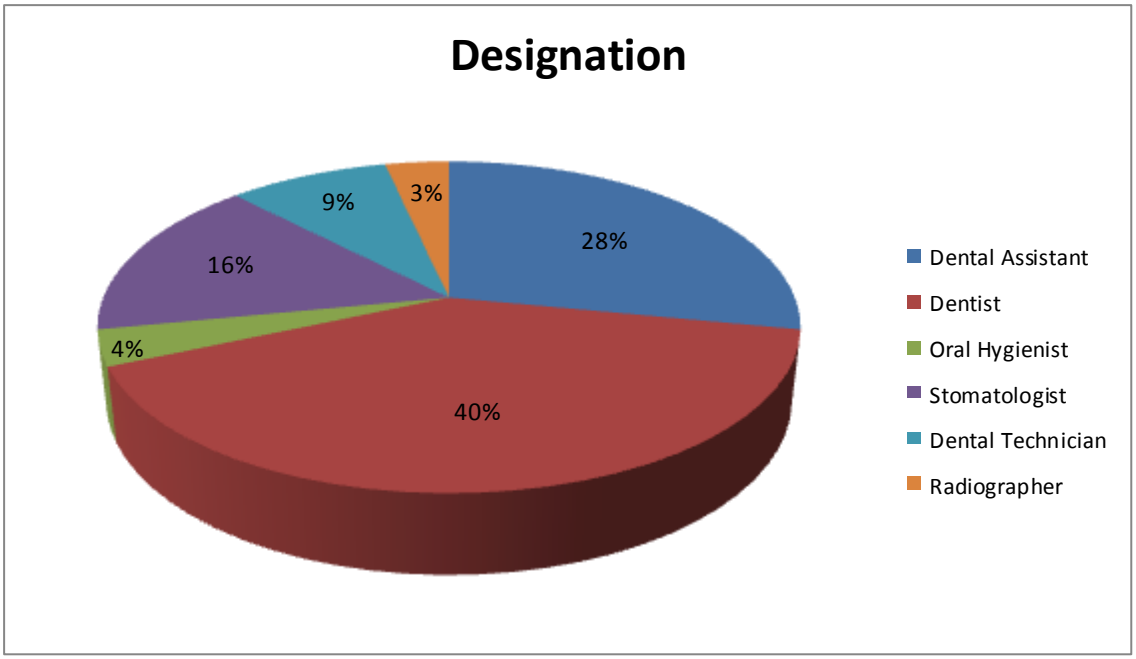


Chart 4. 5: Participation according to designation

The 68 participants were grouped as: 28.1% (dental assistants), 40.4% (dentists and dental therapists), 3.5% (oral hygienists), 15.8% (stomatologists), 8.8% (dental technicians) and 3.5% (radiographers).

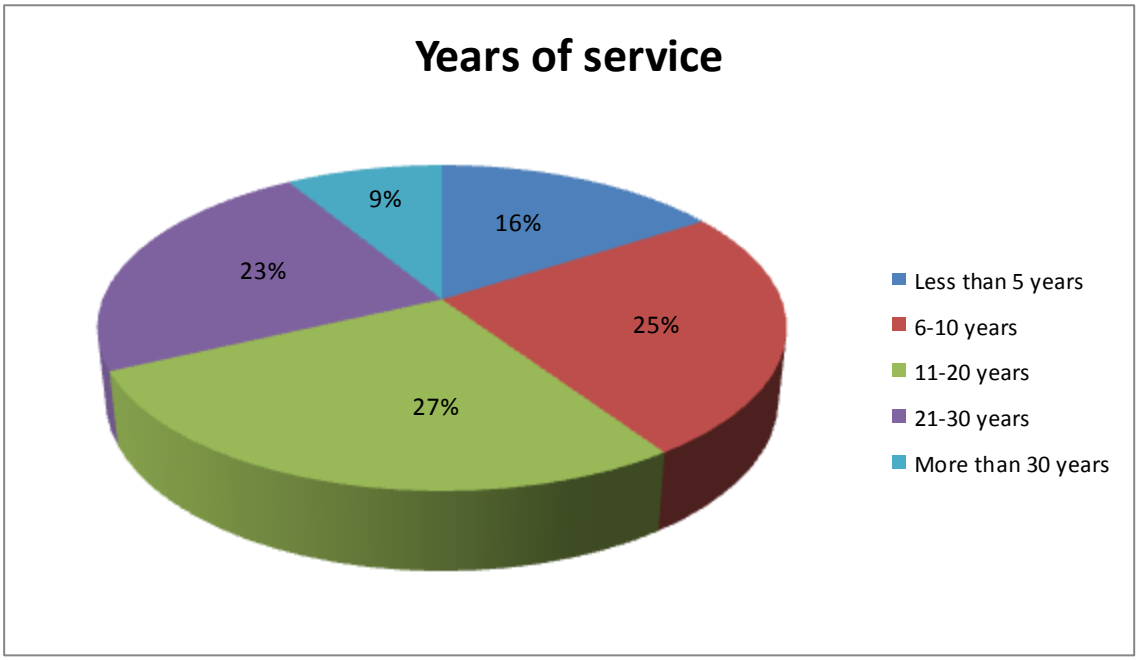


Chart 4. 6: Participation according to years of service

The 68 participants were grouped as: 15.9% (< 5yrs), 24.6% (6-10yrs), 27.5% (11-20yrs), 23.2% (21-30yrs) and 8.7% (>30yrs).

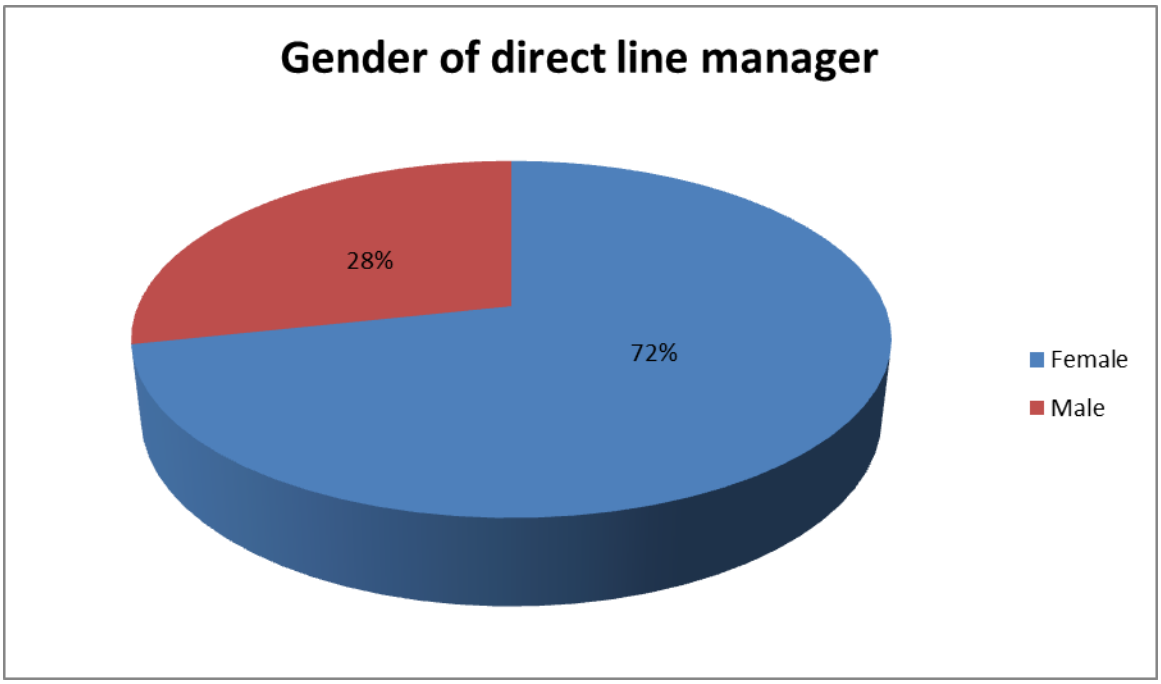


Chart 4. 7: Gender of direct line manager
It was determined that 28.4% of line managers were male and 71.6% female.

Section B is discussed next, however, data from section A has been incorporated to assist in reaching certain findings and conclusions.

4.2.1.1.2 Section B

Data obtained from section B of the questionnaire was grouped into four main categories and eleven sub-categories. The grouping of the relevant questions (as used in the questionnaire) is set out with the relevant sub- and super-themes created in an attempt to group together certain similar questions and dimensions:

1. MANAGEMENT AND COMMUNICATION

1.1 Management

Q1: I am satisfied with the way my line manager manages work and people related issues

Q3: My line manager respects and values my contribution at work

Q4: My line manager genuinely cares about employee needs

Q7: Management involves staff in decision making

Q13: My opinion is considered when there are changes that will affect my work

Q14: Communication in the hospital is open and clear and there is no need for gossip

Q38: I am able to discuss any difficulties I have managing my work with my manager

Q40: My manager values new ideas and implements them quickly

1.2 Hospitals and systems

Q15: The hospital has a system or process in place that encourages employees to offer feedback and ideas

Q16: Hospital policies and procedures are readily accessible to staff members

Q22: The hospital maintains a healthy and safe environment

Q30: The hospital's HR policies are communicated clearly to all employees

Q39: When problems emerge in our hospital, there is a willingness to fix them

Q41: People at the hospital are transparent (no hidden agendas) and communicate openly

1.3 Support and Human Resources

Q29: The support services departments respond promptly to my queries

Q31: The HR office is accessible to all employees

Q32: My personal HR queries are dealt with in confidentiality

1.4 Workplace vision, mission and expectations

Q2: I understand how my job aligns with the mission and vision of the hospital

Q6: I have a clear understanding of what is expected of me

2. WORK ENGAGEMENT

2.1 Support and compensation

Q5: I am paid fairly for the work that I do

Q19: Work is assigned equally and fairly to all members of my team

Q25: I am satisfied with the level of professionalism in service departments

Q33: I feel that benefits provided by the hospital meet my needs well

Q36: I receive adequate support in order to complete my work

Q49: I am highly motivated to do my job

2.2 Self-efficacy and fulfilment

Q26: My level of work stress is high

Q37: I am able to balance my work and personal life

Q45: At work, I have the opportunity to do what I do best every day

Q46: I feel that my work is meaningful

Q47: I have the skills I need to perform my work effectively

Q50: I find the content of my work interesting and stimulating

2.3 Colleagues

Q18: My colleagues are committed to doing quality work

Q20: I am able to consult colleagues when I am faced with a challenging situation

3. FUTURE PROSPECTS

3.1 Growth and development within the university

Q8: There are clear succession plans in place in my department

Q9: The hospital is able to retain its talented employees

Q11: Promotion processes are fair for all staff in the hospital

Q23: I would recommend the hospital as a suitable employer

Q24: The hospital makes me feel that I have an important role to play in its operations

Q43: People of all races have access to the same opportunities within my department

Q44: Women have the same opportunities as men in my department

3.2 Intent to leave

Q27: I am planning to leave the hospital in the next six months

Q34: The hospital is the best employer I have ever worked for

Q48: I have access to opportunities to grow and develop in the hospital

Q51: I am consistently looking for employment outside the university

4. STAFF SUPPORT AND MOTIVATION

4.1 Performance management and employee assistance

Q10: I am satisfied with the employee assistance program provided by the hospital

Q17: The telephone systems, personal computer support, email and mail distribution help me to do my work

Q55: The current PMDS performance management system is working sufficiently to motivate staff to perform

4.2 Morale /staff support management

Q52: Staff morale can be best improved by a well-defined employee wellness program that balances work and personal life

Q53: To maintain a high level of confidentiality, the employee wellness program must be outsourced

Q54: Staff morale can best be improved by regular team building activities

It should be noted that the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy as well as the Bartlett's test of Sphericity were performed on the four major categories above to ensure that the samples were adequate for factor analysis. Eigen values were extracted, percentage variation was determined, scree plotting was done, and component and structure matrices were constructed. In addition to the above, internal reliability needed to be established. To address this aspect, Cronbach's alpha was

determined for each of the 11 sub-categories. The values obtained are depicted in the following table:

Table 4. 1: Section B: Cronbach alpha and Kaiser-Meyer-Olkin values

	Cronbach alpha value	Kaiser-Meyer-Olkin (KMO)
1. Management and communication		0.869
1.1 Management	0.939	
1.2 Hospitals and systems	0.866	
1.3 Support and Human Resources	0.837	
1.4 Vision, mission and expectations	0.657	
2. Work engagement		0.663
2.1 Support and compensation	0.814	
2.2 Self-efficacy and fulfilment	0.647	
2.3 Colleagues	0.622	
3. Future prospects		0.834
3.1 Growth and development within the university	0.867	
3.2 Intent to leave	0.733	
4. Staff support and motivation		0.562
4.1 Performance management and employee assistance	0.715	
4.2 Morale/staff support management	0.762	

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy is used to compare the magnitudes of observed correlation coefficients in relation to the magnitudes of partial correlation coefficients. Large KMO values are preferred as it is indicative of correlation between two pairs of variables which can then be explained by the other variables. A KMO value of above 0.5 is preferred. If, however the KMO does not exceed 0.5 a factor analysis is not advised. From the above KMO values it is evident that factor analysis can indeed be done as all the obtained values exceed the minimum advised value of 0.5. Now, consider the Cronbach alpha values. We have discussed in Chapter 3 that an ideal Cronbach alpha value would be between 0.8 and 1 (ideally more than 0.9). Please refer to table 3.2 in Chapter 3 for a comprehensive lay-out. According to the table a value between 0.7 and 0.8 is acceptable, between 0.8 and 0.9 good and

between 0.9 and 1.0 excellent (Ellis & Steyn, 2003:53). From the above table, it is evident that 9 of the 11 values are acceptable to good whilst only two values (1.4 and 2.2) are questionable. Internal reliability and consistency has thus been confirmed and factor analysis can continue based on the KMO values. Returning to the grouping of similar fields as set out above, descriptive statistics were then utilised to evaluate the participants' responses in the questionnaire to the various categories and sub-categories. The table below depicts the response based on gender:

Table 4. 2: Group statistics of section B of questionnaire

Group Statistics						
		N	Mean	Std. Deviation	p-value	Effect sizes
General morale	Male	24	2.5217	0.97373	0.047	0.49
	Female	44	2.0419	0.76040		
Management and communication: Management	Male	24	3.1817	1.11523	0.008	0.69
	Female	44	2.4172	0.97626		
Management and communication: Hospital and systems	Male	24	2.6348	0.94449	0.051	0.50
	Female	44	2.1591	0.87748		
Management and communication: Support and Human Resources	Male	24	3.3913	0.74129	0.004	0.62
	Female	44	2.6984	1.12573		
Management and communication: Vision, mission and expectations	Male	24	4.0000	0.90453	0.310	0.26
	Female	44	3.7674	0.81904		
Work engagement: Support and compensation	Male	24	3.2101	0.83063	0.006	0.74
	Female	44	2.5936	0.82297		
Work engagement: Self-efficacy and fulfilment	Male	24	3.8696	0.50989	0.087	0.37
	Female	44	3.6045	0.72299		
Work engagement: Colleagues	Male	24	3.9783	0.79026	0.051	0.47
	Female	44	3.5465	0.91816		
Future prospects: Growth & Development within hospital	Male	24	2.9337	0.89396	0.036	0.54
	Female	44	2.4510	0.81261		
Future prospects: Intent to leave	Male	24	2.7826	0.98945	0.570	0.15
	Female	44	2.9280	0.98447		
Staff support and motivation: Performance management & employee assistance	Male	24	3.0145	0.86225	0.023	0.60
	Female	44	2.4962	0.83100		
Staff support and motivation: Morale / staff support management	Male	24	3.6957	0.89281	0.059	0.48
	Female	44	4.1240	0.77331		

The table is divided into seven columns where the first column depicts general morale, the four main categories and eleven sub-section under investigation. Column two and three indicates the number of participants based on gender. Column four is important as it depicts the mean (average) rating the participants of each gender scored each particular sub-section. As discussed in Chapter 3, p-values are not applicable here as this is a closed setting where generalisation is not indicated. However, for completeness p-values for each sub-section was included. Note that the blue highlighted blocks are indicative of p-values less than 0.5 which would indicate a statistically significant response. For the purpose of this study, the effect sizes which relate to practical significance and relevance were focused on.

If one refers back to table 3.3 in Chapter 3 (effect sizes), it is stated that a value exceeding 0.5 poses a medium practical significance. Once the value increases to 0.8 the practical significance of the results is very important. The yellow highlighted blocks indicate sub-sections with effect values ranging close to 0.8 – indicative of a large practically important and significant result. In four sub-sections the responses of males versus females revealed practically significant results. Questions pertaining to management was met with neutrality by the male participants while the female participants responded negatively. Questions relating to Human Resources and the support they provide was met with an increased level of positivity by males, however females remained negative. Female participants also responded negatively to questions relating to support and compensation as well as performance management and employee assistance. In both the aforementioned sub-sections male participants remained neutral. Note that general morale as depicted in the top row of the table was determined at 2.04 for females and 2.5 for males - indicative of poor morale in general amongst participants.

When looking at the mean values obtained per gender for each sub-section, it is interesting to note that females in general responded more negatively than males. In general answers ranged in the mean (around 3) and poor (2 to 3) value ranges for the

majority of the questions. However, when considering specific individual sub-categories, certain interesting revelations can be noted. Males responded positively (mean value of 4) in terms of management and communication: vision, mission and expectations. This indicates that males share the vision, mission and expectations of management and feel positive about the future at the current workplace. Females however responded less optimistically (3.7).

Females felt negative about the hospital and its systems (2.15) as well as their growth and development prospects within the hospital (2.45). This poses a serious concern as it is indicative of an environment where preferential treatment of personnel based on gender might pose a problem. Note the high score of 4.1 (agree) among females for morale and staff support management. This indicates that females felt strong about having a support system in the workplace and that they would value efforts by management to provide staff support and motivation. However, from the results it is clear that female participants felt negative about the current employee assistance efforts. Females also had a higher intent to leave the organisation (2.9) compared to males (2.7). The results clearly indicate that female participants have a more negative perception and experience in the workplace compared to males who tend to remain neutral or lean towards positive perceptions and experiences of the workplace.

After comparing the responses of males versus females, the researcher set out to investigate the responses based on the demographic variables found in section A.

The following table is aimed at identifying possible correlations between the various age groups and the answers provided for each category and sub-section of answers:

Table 4. 3: Correlation between age groups and answers for each sub-section

Correlation with Q3: Age groups		N	Mean	Std. Deviation	p-value	Effect sizes			
						1 with	2 with	3 with	4 with
Management and communication: Management	30 yrs and less	4	2,3438	1,15188	0.164				
	31 - 40 years	26	3,0598	1,10703		0,62			
	41 - 50 years	16	2,4833	0,95245		0,12	0,52		
	51 - 60 years	18	2,3092	1,14819		0,03	0,65	0,15	
	61 yrs and above	4	2,9688	0,75260		0,54	0,08	0,51	0,57
	Total	68	2,6726	1,09422					
Management and communication: Hospital and systems	30 yrs and less	4	2,0417	1,23510	0,757				
	31 - 40 years	26	2,4615	0,74879		0,34			
	41 - 50 years	16	2,1875	1,03257		0,12	0,27		
	51 - 60 years	18	2,2105	1,02416		0,14	0,25	0,02	
	61 yrs and above	4	2,6083	1,03579		0,46	0,14	0,41	0,38
	Total	68	2,3130	0,92636					
Management and communication: Support and Human Resources	30 yrs and less	3	2,5556	1,53960	0,607				
	31 - 40 years	26	3,0321	0,91168		0,31			
	41 - 50 years	16	3,0521	1,25568		0,32	0,02		
	51 - 60 years	18	2,6111	1,14475		0,04	0,37	0,35	
	61 yrs and above	4	3,2500	0,31914		0,45	0,24	0,16	0,56
	Total	68	2,9154	1,06536					
Management and communication: Vision, mission and expectations	30 yrs and less	4	4,5000	0,40825	0,294				
	31 - 40 years	25	3,9200	0,71705		0,81			
	41 - 50 years	16	3,5313	1,04033		0,93	0,37		
	51 - 60 years	18	3,8158	0,90078		0,76	0,12	0,27	
	61 yrs and above	4	4,0000	0,40825		1,22	0,11	0,45	0,20
	Total	68	3,8382	0,84395					
Work engagement: Support and compensation	30 yrs and less	4	2,2500	1,19024	0,161				
	31 - 40 years	26	2,9756	0,79182		0,61			
	41 - 50 years	16	2,7917	0,94966		0,46	0,19		
	51 - 60 years	18	2,5219	0,92289		0,23	0,49	0,28	
	61 yrs and above	4	3,4583	0,34359		1,02	0,61	0,70	1,01
	Total	68	2,7940	0,89403					

Correlation with Q3: Age groups (continue)		N	Mean	Std. Deviation	p-value	Effect sizes			
						1 with	2 with	3 with	4 with
Work engagement: Self-efficacy and fulfilment	30 yrs and less	4	3,8333	0,56108	0,940				
	31 - 40 years	26	3,7436	0,48127		0,16			
	41 - 50 years	16	3,6125	0,61366		0,36	0,21		
	51 - 60 years	18	3,6088	0,98594		0,23	0,14	0,00	
	61 yrs and above	4	3,6667	0,27217		0,30	0,16	0,09	0,06
	Total	68	3,6768	0,66941					
Work engagement: Colleagues	30 yrs and less	4	4,3750	0,62915	0,016				
	31 - 40 years	25	3,7800	0,85489		0,70			
	41 - 50 years	16	3,1250	0,76376		1,64	0,77		
	51 - 60 years	18	4,0263	0,94976		0,37	0,26	0,95	
	61 yrs and above	4	3,6250	0,47871		1,19	0,18	0,65	0,42
Future prospects: Growth & development within hospital	30 yrs and less	4	2,5143	1,20294	0,231				
	31 - 40 years	26	2,9057	0,75828		0,33			
	41 - 50 years	16	2,4911	0,97306		0,02	0,43		
	51 - 60 years	18	2,3008	0,88435		0,18	0,68	0,20	
	61 yrs and above	4	2,6429	0,68512		0,11	0,35	0,16	0,39
	Total	68	2,6050	0,88084					
Future prospects: Intent to leave	30 yrs and less	4	3,1250	1,83144	0,911				
	31 - 40 years	26	2,9135	0,90538		0,12			
	41 - 50 years	16	2,7656	0,92407		0,20	0,16		
	51 - 60 years	18	2,9781	1,16562		0,08	0,06	0,18	
	61 yrs and above	4	2,5625	0,59073		0,31	0,39	0,22	0,36
	Total	68	2,8889	1,01406					
Staff support and motivation: Performance management and employee assistance	30 yrs and less	4	2,7083	1,30969	0,547				
	31 - 40 years	26	2,8494	0,79583		0,11			
	41 - 50 years	16	2,5625	1,07819		0,11	0,27		
	51 - 60 years	18	2,3947	0,80068		0,24	0,57	0,16	
	61 yrs and above	4	2,7500	0,45644		0,03	0,12	0,17	0,44
Staff support and motivation: Morale / staff support management	30 yrs and less	3	4,2222	0,83887	0,242				
	31 - 40 years	26	4,0513	0,87784		0,19			
	41 - 50 years	16	3,7083	0,76860		0,61	0,39		
	51 - 60 years	18	4,2632	0,75014		0,05	0,24	0,72	
	61 yrs and above	4	3,5000	1,13855		0,63	0,48	0,18	0,67
	Total	68	4,0049	0,84149					

Correlation with Q3: Age groups (continue)		N	Mean	Std. Deviation	p-value	Effect sizes			
						1 with	2 with	3 with	4 with
Morale	30 yrs and less	4	1,8500	0,77244	0,580				
	31 - 40 years	26	2,3769	0,82429		0,64			
	41 - 50 years	16	2,1125	0,98784		0,27	0,27		
	51 - 60 years	18	2,0444	0,85007		0,23	0,39	0,07	
	61 yrs and above	4	2,5000	0,95917		0,68	0,13	0,39	0,47
	Total	68	2,2029	0,86972					

The blocks highlighted in yellow indicate a strong correlation and practical significance in the answers provided by the indicated age groups. If one looks for example at morale, a strong correlation/similarity was noted between the answers provided by the less than 30-year olds, the 31- – 40-year olds and participants older than 60 years. Despite the correlation it is also important to note that the morale amongst participants younger than 30 years showed to be very poor as the mean value for this age group was only 1.85. Intent to leave amongst participants younger than 30 years were also the highest. In terms of growth and development within in the hospital, participants in the age groups 31-40 years and 51-60 years showed a strong correlation in the answers provided.

For the majority of questions mean values ranging between 2.2 and 2.9 (poor to neutral) were noted. However, on closer inspection values reaching as high as 4 was noted for self-efficacy and fulfilment, staff support management and collegial relations. This indicates that participants relied heavily on self-efficacy and self-actualisation, support from colleagues and the relationships they have in the workplace.

The following table illustrates the correlation between the highest level of qualification of the participants and the answers provided for each sub-section of the answers:

Table 4. 4: Correlation between highest level of qualification and sub-sections

Correlation with Q4: Highest level of qualification		N	Mean	p-value	Effect sizes			
					1 with	2 with	3 with	4 with
Management and communication: Management	Grade 12 / less	6	2,5000	0,067				
	Certificate	11	1,9205		0,48			
	Nat. Diploma	8	2,3281		0,14	0,32		
	Bachelor degree	23	2,9689		0,38	0,98	0,51	
	Postgrad degree	20	2,8938		0,32	0,98	0,45	0,07
	Total	68	2,6605					
Management and communication: Hospital and systems	Grade 12 / less	6	3,0833	0,232				
	Certificate	11	2,1364		0,68			
	Nat. Diploma	8	2,0000		0,78	0,13		
	Bachelor degree	23	2,3043		0,56	0,16	0,34	
	Postgrad degree	20	2,2500		0,60	0,11	0,28	0,07
	Total	68	2,2941					
Management and communication: Support and Human Resources	Grade 12 / less	5	3,3000	0,013				
	Certificate	11	2,1818		0,77			
	Nat. Diploma	8	2,2083		0,76	0,02		
	Bachelor degree	22	3,1136		0,13	0,73	0,85	
	Postgrad degree	20	3,2500		0,03	0,84	0,98	0,15
	Total	66	2,9040					
Management and communication: Vision, mission and expectations	Grade 12 / less	6	4,0833	0,228				
	Certificate	11	3,8182		0,23			
	Nat. Diploma	8	3,1875		1,01	0,55		
	Bachelor degree	22	3,8864		0,24	0,06	0,79	
	Postgrad degree	20	3,9500		0,18	0,12	0,86	0,08
	Total	67	3,8284					
Work engagement: Support and compensation	Grade 12 / less	6	2,8889	0,143				
	Certificate	11	2,2803		0,39			
	Nat. Diploma	8	2,4167		0,30	0,13		
	Bachelor degree	23	2,9058		0,01	0,68	0,46	
	Postgrad degree	20	3,0267		0,09	0,81	0,57	0,17
	Total	68	2,7811					
Work engagement: Self-efficacy and fulfilment	Grade 12 / less	6	3,9389	0,445				
	Certificate	11	3,4333		0,43			
	Nat. Diploma	8	3,4542		0,64	0,02		
	Bachelor degree	23	3,7681		0,23	0,29	0,42	
	Postgrad degree	20	3,7333		0,28	0,26	0,37	0,07
	Total	68	3,6819					

Correlation with Q4: Highest level of qualification (continue)		n	Mean	p-value	Effect sizes			
					1 with	2 with	3 with	4 with
Work engagement: Colleagues	Grade 12 / less	6	3,3333	0,195				
	Certificate	11	4,1818		0,86			
	Nat. Diploma	8	3,7500		0,61	0,44		
	Bachelor degree	22	3,8182		0,47	0,35	0,07	
	Postgrad degree	20	3,4500		0,15	0,75	0,39	0,36
	Total	67	3,7164					
Future prospects: Growth & development in hospital	Grade 12 / less	6	2,6746	0,395				
	Certificate	11	2,3377		0,24			
	Nat. Diploma	8	2,1607		0,37	0,18		
	Bachelor degree	23	2,7882		0,08	0,60	0,63	
	Postgrad degree	20	2,6643		0,01	0,37	0,51	0,14
	Total	68	2,5950					
Future prospects: Intent to leave	Grade 12 / less	6	2,5139	0,547				
	Certificate	11	3,1364		0,43			
	Nat. Diploma	8	3,2813		0,71	0,10		
	Bachelor degree	23	2,7391		0,21	0,28	0,55	
	Postgrad degree	20	2,8750		0,34	0,18	0,47	0,14
	Total	68	2,8873					
Staff support and motivation: Performance management and employee assistance	Grade 12 / less	6	2,8472	0,040				
	Certificate	11	2,0227		0,68			
	Nat. Diploma	8	2,2188		0,51	0,16		
	Bachelor degree	23	2,8080		0,03	0,96	0,48	
	Postgrad degree	20	2,8750		0,02	1,22	0,54	0,08
	Total	68	2,6348					
Staff support and motivation: Morale / staff support management	Grade 12 / less	6	3,8889	0,646				
	Certificate	11	4,1818		0,30			
	Nat. Diploma	8	4,0833		0,25	0,10		
	Bachelor degree	22	4,1364		0,35	0,05	0,07	
	Postgrad degree	20	3,7833		0,10	0,38	0,29	0,34
	Total	67	4,0100					
General morale	Grade 12 / less	6	2,3000	0,977				
	Certificate	10	2,2600		0,03			
	Nat. Diploma	8	2,0250		0,17	0,25		
	Bachelor degree	23	2,1913		0,07	0,08	0,18	
	Postgrad degree	20	2,1600		0,09	0,12	0,15	0,04
	Total	67	2,1821					

The results from the above correlation proved to be extremely insightful. The results indicated that the morale was the lowest among participants with national diplomas - thus the dental assistants. It was also determined that the highest intent to leave was amongst dental assistants. Participants with certificates and national diplomas were the least satisfied with management, the hospital and its systems, human resources and compensation. They also felt negative about their future growth and development prospects in the hospital. Despite the above, participants in the above categories remained hopeful as they scored 4.0 and 4.1 respectively for morale and staff support management - indicative of the need amongst participants to have staff support systems in place in the workplace whilst indicating their positive association with the vision, mission and expectations of the organisation.

Participants with bachelor's degrees and postgraduate qualifications tended to have neutral responses. One result however stands out: general morale was very poor amongst all participants despite qualification and remuneration. Note the blue highlighted blocks which indicates statistically significant results (if generalisation was indicated).

The following table illustrates the correlation between the years of service of the participants and the answers provided for each sub-section of the answers:

Table 4. 5: Correlation between years of service and the sub-sections

Correlation with Q6: Years of service		Mean	p-value	Effect sizes			
				1 with	2 with	3 with	4 with
Management & communication: Management	5 yrs or less	2,7549	0,700				
	6-10 yrs	2,8529		0,08			
	11-20 yrs	2,7763		0,02	0,07		
	21-30 yrs	2,3348		0,34	0,42	0,36	
	30 yrs and more	2,5833		0,15	0,25	0,19	0,20
	Total	2,6726					

Correlation with Q6: Years of service (continue)		Mean	p-value	Effect sizes			
				1 with	2 with	3 with	4 with
Management & communication: Hospital and systems	5 yrs or less	2,5303	0,904				
	6-10 yrs	2,3039		0,19			
	11-20 yrs	2,3158		0,18	0,01		
	21-30 yrs	2,1563		0,32	0,15	0,16	
	30 yrs and more	2,3500		0,15	0,04	0,03	0,19
	Total	2,3130					
Management & communication: Support and Human Resources	5 yrs or less	3,0152	0,437				
	6-10 yrs	3,0417		0,02			
	11-20 yrs	3,1228		0,09	0,08		
	21-30 yrs	2,4556		0,44	0,46	0,52	
	30 yrs and more	2,8889		0,11	0,15	0,24	0,34
	Total	2,9154					
Management & communication: Vision, mission & expectations	5 yrs or less	3,7727	0,982				
	6-10 yrs	3,9375		0,16			
	11-20 yrs	3,7895		0,02	0,16		
	21-30 yrs	3,8125		0,04	0,13	0,02	
	30 yrs and more	3,9167		0,14	0,02	0,18	0,11
	Total	3,8382					
Work engagement: Support and compensation	5 yrs or less	2,7879	0,752				
	6-10 yrs	2,8725		0,07			
	11-20 yrs	2,9272		0,12	0,07		
	21-30 yrs	2,5313		0,23	0,34	0,40	
	30 yrs and more	2,8611		0,06	0,01	0,06	0,31
	Total	2,7940					
Work engagement: Self-efficacy and fulfilment	5 yrs or less	3,9394	0,720				
	6-10 yrs	3,5784		0,51			
	11-20 yrs	3,6474		0,41	0,14		
	21-30 yrs	3,6542		0,28	0,08	0,01	
	30 yrs and more	3,6278		0,44	0,08	0,03	0,03
	Total	3,6768					
Work engagement: Colleagues	5 yrs or less	4,0909	0,384				
	6-10 yrs	3,6250		0,70			
	11-20 yrs	3,5000		0,51	0,11		
	21-30 yrs	3,6875		0,44	0,07	0,16	
	30 yrs and more	4,0833		0,01	0,57	0,50	0,43

Correlation with Q6: Years of service (continue)		Mean	p-value	Effect sizes			
				1 with	2 with	3 with	4 with
Future prospects: Growth and development in hospital	5 yrs or less	2,6147	0,734				
	6-10 yrs	2,7681		0,14			
	11-20 yrs	2,6880		0,06	0,10		
	21-30 yrs	2,3571		0,23	0,47	0,38	
	30 yrs and more	2,5238		0,08	0,25	0,17	0,17
	Total	2,6050					
Future prospects: Intent to leave	5 yrs or less	3,4545	0,256				
	6-10 yrs	2,7206		0,64			
	11-20 yrs	2,6316		0,72	0,10		
	21-30 yrs	2,9115		0,46	0,16	0,24	
	30 yrs and more	3,0833		0,32	0,34	0,42	0,15
	Total	2,8889					
Staff support and motivation: Performance management and employee assistance	5 yrs or less	2,8258	0,851				
	6-10 yrs	2,6667		0,12			
	11-20 yrs	2,7105		0,09	0,05		
	21-30 yrs	2,5000		0,25	0,19	0,24	
	30 yrs and more	2,4167		0,32	0,32	0,36	0,10
	Total	2,6437					
Staff support and motivation: Morale / staff support management	5 yrs or less	4,0606	0,935				
	6-10 yrs	3,9167		0,16			
	11-20 yrs	4,1228		0,07	0,23		
	21-30 yrs	3,9792		0,09	0,07	0,16	
	30 yrs and more	3,8333		0,21	0,08	0,27	0,14
	Total	4,0049					
General Morale	5 yrs or less	2,3091	0,865				
	6-10 yrs	2,3412		0,03			
	11-20 yrs	2,0737		0,19	0,31		
	21-30 yrs	2,0933		0,18	0,29	0,02	
	30 yrs and more	2,3000		0,01	0,04	0,23	0,21
	Total	2,2029					

Correlating results were obtained from participants with less than five years, 6-10 years and 11-20 years' service based on their intent to leave the organisation. Participants with less than five years of service exhibited the highest intent amongst all participants

to leave the organisation. They also had the highest results in terms of self-efficacy and fulfilment. By correlating these findings, we can deduce that participants with less than 5 years' service still seek fulfilment and satisfaction from their employment. They are not ready to settle and accept their work situation. Therefore, they will seek greener pastures if the organisation fails to address their needs. All participants despite years of service felt negative about their growth and development prospects in the organisation. General morale was the lowest amongst participants with 11-20 years of service with the organisation. The following table illustrates the correlation between the gender of the direct line manager and the answers provided for each sub-section of the answers:

Table 4. 6: Correlation between gender of direct line manager and sub-sections

Correlation with Question 7: Gender of direct line manager		**N**	**Mean**	**Effect sizes**
General Morale	Male	19	2.2211	0.03
	Female	48	2.1917	
Management and communication: Management	Male	19	3.1645	0.60
	Female	48	2.5294	
Management and communication: Hospital and systems	Male	19	2.3246	0.02
	Female	48	2.3458	
Management and communication: Support and Human Resources	Male	19	3.4035	0.57
	Female	46	2.7754	
Management and communication: Vision, Mission and expectations	Male	19	4.0263	0.28
	Female	47	3.7766	
Work engagement: Support and compensation	Male	19	3.0526	0.34
	Female	48	2.7212	
Work engagement: Self-efficacy and fulfilment	Male	19	3.8333	0.35
	Female	48	3.5771	
Work engagement: Colleagues	Male	19	3.5526	0.22
	Female	47	3.7553	
Future prospects: Growth & development in hospital	Male	19	2.7669	0.22
	Female	48	2.5691	
Future prospects: Intent to leave	Male	19	2.7237	0.23
	Female	48	2.9549	
Staff support and motivation: Performance management & employee assistance	Male	19	3.0000	0.51
	Female	48	2.5451	
Staff support and motivation: Morale / staff support management	Male	19	3.9649	0.01
	Female	47	3.9787	

From the above results the researcher could identify three sub-sections where the gender of the direct line-manager played a practical significant role. As indicated earlier in this chapter, 71.6% of all line managers are female. From the results the researcher found that female employees respond more negative to a female line manager than their male counterparts. Female participants responded negatively in terms of performance management and employee assistance when their direct line manager was a female. Males responded neutral to positive to questions correlated to the gender of the direct line manager. Both male and female participants responded positively to questions related to colleagues, self-efficacy and the vision and mission of the organisation - irrespective of the gender of the direct line-manager.

4.2.1.1.3 Section C

Section C was an assessment of the level of staff morale at the time the research was conducted at the research site.

The Kaiser-Meyer-Olkin measure of sample adequacy was determined at 0.852. This value exceeds the advised baseline of 0.5. Factor analysis can thus be conducted. Communalities (initial and extraction) and Eigenvalues were determined followed by scree plotting. Cronbach's alpha was determined at 0.882 – indicative of good to excellent internal reliability results.

Descriptive statistics were used to determine the overall morale among participants. A mean value (for both male and female participants), were determined at 2.209 according to the Likert scale used during the research. A standard deviation of 0.87 was noted. As discussed in the previous section, the results obtained in this section confirms that employee morale in general is poor.

4.2.1.1.4 Section D

A total of 49 participants completed this section of the questionnaire which comprised of open ended questions. A response rate of 72% was noted. Although acceptable, the lower response rate can be attributable to participants fearing identification based on their handwriting. Nevertheless, the 49 completed section D's delivered truly valuable and remarkably similar responses. One-hundred percent of the participants indicated that the hospital has no program/system in place to address staff morale. A percentage of 87.3 of the participants indicated that staff morale is greatly affected by management as they feel that management is unapproachable. Descriptions such as transparency, victimisation, preferential treatment and inconsistency were used throughout. A percentage of 91,3 of the participants indicated that they feel excluded in the decision-making processes of the hospital - especially on aspects affecting them and their work situation. The need amongst participants to be included in decision making is clear as several responses included the description of desk dentists making decisions about clinical service delivery. Seventy-three percent of the participants indicated that career pathing and future prospects influenced morale negatively. Due to limited opportunities to grow and develop within the organisation, participants felt despondent and negative. The lack of incentives for work done well/exceptionally further contributes to the low morale levels - why work hard and go the extra mile of you will stay where you are, do the same thing day in and day out with no prospects of getting a promotion or a salary increase? Interestingly, several participants stated that verbal recognition of work done well was a foreign concept, yet they long for any form of recognition and praise.

Among dental assistants the need for further training and opportunities to enhance their skills were top priority. Equal distribution of responsibilities and accountability were noted in the response of 74,5% of the participating dental assistants.

A staggering 94,5% of all respondents indicated that team building, leadership workshops and developmental programs were needed, not only to improve clinical

skills, but to build staff relations and cohesiveness. The need to feel part of "the family" and not just a number was noted. A percentage of 86.5 of the respondents indicated that regular staff meetings where staff can voice their concerns are absent or merely "information sessions" from management. The opportunity to voice concerns without fear of victimisation and criticism was stated by several respondents. Staff shortages, high workloads and inefficient equipment to render comprehensive services were noted by 61.1% of the respondents. Healthier work conditions were top priority amongst 62.1% of the participants - stating that dirty bathrooms, poor ventilation, dripping water from the building and filthy windows were affecting staff morale negatively. Despite the above responses, 78,7% of the respondents felt hopeful.

4.2.2 Data obtained from patient satisfaction survey

A client satisfaction survey (CSS) was conducted at Medunsa Oral Health Centre during July 2017 by the client satisfaction survey Task Team. The aim of the survey was to assess the level of satisfaction experienced by clients (patients) after making use of the services of the institution. During this process, short-comings are identified and corrective steps are implemented to address them whilst best practices are acknowledged and maintained in view of future improvement of quality patient centred care. The CSS is based on Batho Pele principle compliance and all questions asked during the survey pertain to the eight principles as set out in Chapter 1.

Results obtained from the survey indicated that patients were generally satisfied with the quality of service rendering at the institution. The level of satisfaction experienced by patients regarding their privacy being respected was very good. Patients in general indicated that doctors were polite and explained what was wrong with them whilst dental assistants listed to their problems and assisted where needed. Pharmacy waiting times were not a concern and patients were satisfied with the quick service they received from the pharmacy. Tangibles such as benches in the waiting areas, the condition of the hospital, cleanliness of the facilities and the toilets were not raised as a concern during

the 2017 survey, although it has been a point of concern in previous years. Identified as an area of concern is the long waiting times before treatment can be received. This factor can however not be linked to staff morale alone as various external factors contribute to the situation. Patients dependent on hospital transport from various different provinces and districts are brought to the facility early in the morning as part of a group of patients attending the hospital. Further, due to the location of the dental hospital, patients coming from the various areas served by the hospital need to come earlier to avoid peak-time traffic. The processes followed from opening a file, going through diagnostics, radiographs and then reaching the area of treatment takes time as approximately 80-100 patients go through diagnostics on a daily basis. Appointments are given where indicated, however patients are under the perception that if they come earlier they will be seen earlier, which is not the case if they have a scheduled appointment.

4.3 SUMMARY

In an attempt to address the objectives of this study, data was collected, presented, analysed and interpreted. By utilising descriptive statistics, the researcher organised the data in a manner to give meaning to the objectives under investigation. Analyses of demographic data entailed the determination of frequencies, percentages, means and standard deviation which were conducted by the Statistical Consultation Services of the North-West University, Potchefstroom campus, using a software package called Statistical Analysis System (SAS). Internal reliability was determined by calculating Cronbach's alpha and effect sizes were determined for practical application. Correlations were drawn between questions and certain designated groups which revealed statistical (p-value) as well as practical significance (effect size), as can be seen from the tables presented above. In a closed setting such as the research site, where generalisation is not necessary, focus was placed on effect sizes whilst only reporting on p-values for the sake of completeness. Noteworthy results were obtained which indicated that management, human resources, support and compensation,

performance management and employee assistance had a practically significant effect on staff morale. Research also revealed a general low level of morale amongst participants with a mean value of 2.2 out of 5. Females had a lower morale than males (2.04 compared to 2.5). Another extremely interesting finding was that the majority of line managers were female as 71.6% of the participants responded as such. Furthermore, the correlation between the gender of the line manager (in this case thus female), is significant in terms of management, human resources, performance management and employee assistance and the low level of morale amongst participants. This signifies that participants had lower levels of morale when managed by female line managers. If one considers the answers provided in the open-ended questions and relate them to the above statistical results, various assumptions can be made in terms of preferential treatment of personnel, victimisation and lack of motivation amongst participants when subordinate to a female line manager.

The client satisfaction survey revealed that patients were satisfied with the service they had received from the dental professionals. The main concern raised was the long waiting times which could not be linked to staff morale directly as various external factors need to be taken into consideration before making such assumptions.

In Chapter 5, the researcher presents the conclusive findings and formulates recommendations.

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, the findings of the research were presented. In this chapter, the quantitative research results are discussed, conclusions are drawn from the findings and recommendations are made. A review of the research objectives forms the foundation of this chapter as the aim of this research was to address the objectives as set out in previous chapters.

5.2 DISCUSSION OF RESULTS

5.2.1 Research objectives review

The primary objectives of the research were to:

- Research objective 1: Identify and describe the factors influencing staff morale among public oral healthcare professionals
- Research objective 2: Describe the influence of staff morale on Batho Pele principle compliance

In the following section the findings related to the above objectives are presented. Based on the findings, relevant recommendations have then been made.

5.2.1.1 Research objective no 1: Identification and description of factors influencing staff morale among public oral healthcare professionals

Results indicated that management, human resources, support and compensation, performance management and employee assistance had a practically significant effect on staff morale. The morale amongst all participants was in general poor. Females also had a lower morale than males. As was determined in Chapter 4, 71.6% of line managers were female. Furthermore, the correlation between the gender of the line

manager (in this case thus female), is significant in terms of management, human resources, performance management and employee assistance and the low level of morale amongst participants. This signifies that participants had lower levels of morale when managed by female line managers. Performance management through PMDS (Performance Management Development System) also proved to cause unhappiness amongst participants. Preferential treatment and victimisation were mentioned in this regard.

Dental assistants proved to have the lowest morale and highest intent on leaving the organisation compared to other designated groups. Based on the feedback from the open-ended questions and correlation thereof with the above statistical results, preferential treatment of personnel, victimisation and lack of motivation amongst participants when subordinate to a female line manager were found. Participants also expressed their dismay with hospital management for excluding them in decision-making processes. Participants felt that they were merely spectators whilst management made decisions affecting them.

Resource related concerns were also voiced. Lack of equipment and consumables accompanied by a working environment which is not conductive further contributed to work related stress and decreased efficacy in service delivery.

It was also evident that participants shared the vision and mission of the institution and felt hopeful for the future despite their low morale and concerns as mentioned above.

5.2.1.2 Research objective no 2: The influence of staff morale on Batho Pele principle compliance

It is evident from the results that participants had certain definite concerns about management and their work-life environment. Work load, collegial conflict, lack of organisational support and resources and management not addressing personnel issues were some of the dimensions/factors highlighted by participants which implicated

management directly. By not addressing the contributing factors, management was directly involved in creating a stressful job environment due to the increase in job demands and lack of organisational support, which in the long run can result in burnout.

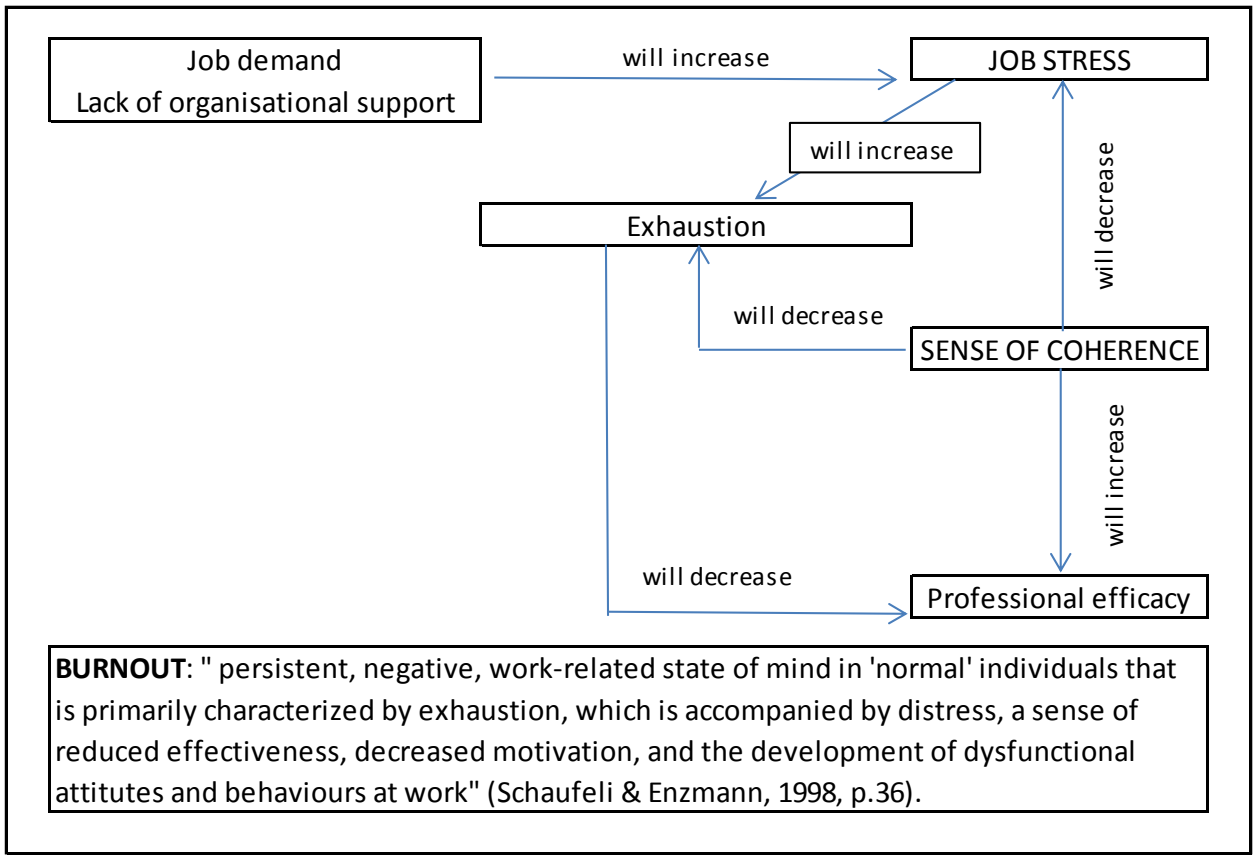
Recent studies conducted by Rothmann *et al*. in 2003 revealed that the higher the stress caused by job demand and lack of organisational support, the higher the level of exhaustion and the higher the sense of coherence, the lower the level of exhaustion and the higher the professional efficacy experienced by the individual in the workplace.

For an individual to function optimally in the workplace, he/she needs to feel joy and contentment. The individual needs to feel that he/she is making a valuable contribution and is valued as a team member. Management therefor plays a pivotal role in creating a conductive work environment for employees to ensure optimal functioning and flourishing as a sense of coherence mediates the effect of job stress on professional efficacy. In turn, higher levels of professional efficacy will coincide with lower levels of exhaustion and ultimately a lower prevalence of burnout in the workplace.

The crux of the matter is clear, certain factors in the workplace will affect employees either positively or negatively. Whichever the case, a chain reaction ensues. If an employee (and in this scenario an oral healthcare professional) feels that he/she is not receiving organisational support and the job is demanding, job stress will increase. Combining that with a lowered sense of coherence will result in reduced levels of professional efficacy, which in turn may influence the quality of his/her service.

The following simplified diagram illustrates the cross-functionality of the various factors as discussed above:

Diagram 5. 1: Cross-functionality of factors affecting professional efficacy (source: Rothmann *et al.*, 2003:57)



The client satisfaction survey (CSS) report for 2017 indicated that the overall experience of patients at Medunsa Oral Health Centre was positive and correlated with the Batho Pele principles of quality, patient centred service delivery. Based on the objectives of the study, it can be concluded that the morale of public oral healthcare professionals at Medunsa Oral Health Centre did not have a negative effect on the quality of service delivery at the institution.

5.3 CONCLUSION

The study succeeded in addressing the research objectives as set out in section 5.2.1 above. Factors affecting the morale of oral healthcare professionals employed at Medunsa Oral Health Centre were identified and the influence of the morale among oral healthcare professionals on the quality of service rendering and Batho Pele principle compliance was determined. Although the morale amongst public oral healthcare professionals at Medunsa Oral Health Centre was poor, it did not influence the quality of service delivery negatively. Patients were satisfied with the quality of service delivery and treatment at Medunsa Oral Health Centre.

5.4 LIMITATIONS OF THE RESEARCH

The findings of the research should be viewed in light of the limitations. The study was limited to Medunsa Oral Health Centre, Sefako Makgatho Health Sciences University. Generalisation of research findings to other public oral healthcare institutions or any other public oral healthcare setting can therefore not be permitted.

5.5 RECOMMENDATIONS

Management should tend to employees' sense of job stress, coherence and burnout. Management should also include employees in the decision-making process and thereby contribute positively to a sense of coherence. By enabling employees to see their role within the greater whole of the organisation, employees will comprehend their place and future within in the organisation. Employees should also be equipped with the necessary skills, knowledge, materials and equipment to perform their tasks to the best of their ability. Employees will then feel that work expectations are manageable and worthwhile. Job stressors such as a lack of opportunities for advancement, poor motivation among workers and colleagues not doing their work should be addressed.

From the open-ended questions, it was clear that participants felt management was not tending to their needs and concerns. Participants felt despondent and negative. Supervisors and management alike need to incorporate a new line of leadership in their strategy to inspire, nurture and guide employees. Transformational leadership is advised. Bass (1998:112) explained the concept of transformational leadership as the establishment of oneself as a role model by gaining the trust and confidence of followers. Eagly *et al.* (2003:573) added that such leaders state future goals and develop and implement plans to achieve them. Bass (1998:117) further went on to state that transformational leaders behave charismatically to inspire employees to identify with them. These leaders inspire followers to aim for higher goals, they challenge employees to seek new behaviours and they display individualised consideration for employees by showing concern for employee needs for growth and development.

Outsourcing of a personnel support initiative is advised, as well as team building activities to restore coherence amongst colleagues.

Identification of line managers who are guilty of victimisation and preferential treatment is indicated and corrective steps should be taken. Management training of all line managers is advised.

In terms of Batho Pele and patient management, the institution has proven to comply with the prescripts of the principles. The commitment to high quality service delivery will ensure that Medunsa Oral Health Centre continues conducting the CSS annually in view of strengthening the good practices already in place, however aiming to improve to a level of 100%.

REFERENCES

Aktouf, O. 1992. Management and theories of organisations in the 1990's: toward a critical radical humanism. *Academy of Management Review*, 17:407-431.

Al Jenaibi, B. 2011. Job satisfaction: comparisons among diverse public organisations in the UAE. *Management Science and Engineering*, 5(2):53-75.

Ang, S. & Van Dyne, L. 2008. Handbook of cultural intelligence. 1st ed. M.E. Sharpe: Armonk.

Anon. 2010. Health reform. https://econex.co.za/?s=health+reform Date of access: 29 Dec. 2016.

Antonovsky, A. 1987. Unravelling the mystery of health: how people manage stress and stay well. San Francisco: Jossey-Bass.

Armstrong, M. 2006. Management practice. 10th ed. London: Kogan Page.

Ashford, B.E. & Mael, F. 1989. Social identity and the organisation. *Academy of Management Review*, 14:20-39.

Balnaves, M. & Caputi, P. 2001. Introduction to qualitative research methods: an investigative approach. London: Sage.

Bass, B.M. 1998. Transformational leadership: Industry, military, and educational impact. Mahwah, NJ: Erlbaum.

Basson, M.J. & Rothmann, S. 2002. Sense of coherence, coping and burnout of pharmacists. *South African Journal of Economic and Management Sciences*, 5(1):35-62.

Batho Pele see South Africa.

Beatty, R.W. & Schneier, C.E. 1975. A case for positive reinforcement. *Business Horizons*, 18:57.

Borg, M.G. 1990. Occupational stress in British educational settings: A review. *Educational Psychology,* 10:103-126.

Bowles, D. & Cooper, C. 2009. Employee morale: driving performance in changing times. New York: Palgrave Macmillan.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2006. Fundamentals of research methodology for health care professionals. 2nd ed. Cape Town: Juta.

Brown, S.P. & Leigh, T.W. 1996. A new look at psychological climate and its relationship to job involvement, effort and performance. *Journal of Applied Psychology*, 81:358-368.

Bryman, A. & Bell, E. 2014. Research methodology. Business and management contexts. 1st ed. Cape Town: Oxford University Press.

Burns, N. & Grove, S.K. 2005. The practice of nursing research: conduct, critique and utilization. 5th ed. St. Louis: Elsevier Saunders.

Cameron, K., Mora, C., Leutscher, T. & Calarco, M. 2011. Effects of positive practices on organizational effectiveness. *The Journal of Applied Behavioural Science*, 47(3):266-308.

Cameron, K. & Wooten, L. 2009. Leading positively: strategies for extraordinary performance at a glance. Centre for positive Organizational Scholarship. Stephan M. Ross: School of Business, The Regents of the University of Michigan.

Chipeta, J. 2014. Factors that affect staff morale in tertiary hospitals in Malawi: a case study of Kamuzu Central Hospital. *Journal of Human Resources and Sustainability Studies*, 2:230-238.

Cicourel, A.V. 1982. Interview, surveys & the problem of ecological validity. *American Sociologist*, 17(1):11-20.

Clark, D. 2008. Creative ways to boost employee morale. www.deniseclarkinc. com/Denise/pdf/Creative%20Ways%20to%20Boost%20Morale.pdf Date of access: 25 Aug. 2016.

Coetsee, L.D. 2003. Peak performance and productivity. 2nd ed. Vanderbijlpark: Ons Drukkers.

Cohen, A. 1992. Antecedents of organisational commitment across occupational groups: a meta-analysis. *Journal of Organisational Behaviour,* 13(6): 539-558.

Crous, M. 2006. Quality service delivery through customer satisfaction. *Journal of Public Administration*, 41(22):397-407.

Daughtery, J. 2011. Twelve simple ways to improve employee morale. http://technorati.com/busiess/article/twelve-simple-ways-to-improve/employee/pdf Date of access: 27 Aug. 2016.

Deci, E.L. & Ryan, R.M. 2008. Facilitating optimal motivation and psychological well-being across life's domains. *Canadian Psychology*, 49:14-23.

Department of Health. ***see*** South Africa. Department of Health.

De Villiers, M.R. & De Villiers, P.J.R. 2004. Doctor's views of working conditions in rural hospitals in the Western Cape. *South African Family Practice*, 46(3):21-26.

De Vos, A.S. 2001. Research at grass roots: a primer for the caring professional. Pretoria: Van Schaik.

Eagly, A.H., Johannesen-Schmidt, M.C., & Van Engen, M.L. 2003. Transformational, transactional, and laissez-faire leadership styles: a meta-analysis comparing women and men. *Psychological Bulletin*, 129(4):569-591.

Ellis, S.M. & Steyn, H.S. 2003. Practical significance (effect sizes) versus or in combination with statistical significance (p-values), *Management Dynamics,* 12(4):51-53.

Essa, Z.I. 2010. Post-medical interns' reflection on medical internship in South African state training hospital. Johannesburg: University of Witwatersrand (Thesis - Master of Arts in community based counselling Psychology).

Fathaniy, A.Z. 2011. The role of HR practise, supervisory support and work-life balance policies on employee intention to stay: a study in oil and gas company. Graduate School of Business: University of Malaysia.

Fisher, I. 2015. Is talent management a golden egg? Talent management made easy. www.ingefisherconsulting.co.za Date of access: 4 Jan. 2017.

Fowler, A. 2015. A comparison of motivation theories 2. Safety and security 3. Belonging and social needs 4. Esteem and status needs 5. Self-actualization and fulfilment needs. http://www.slideplayer.com/slide/8992241/ Date of access: 07 Jan. 2017. [PowerPoint presentation]

Fredrickson, B.L. 2001. The role of positive emotions in positive psychology: the broaden-and-build theory of positive emotions. *American Psychology Journal*, 56(3):218-226.

Ghalia, A. & Rateb, J. 2010. The relationship between information technology adoption and job satisfaction in contracting companies in Jordan. *Journal of Information Technology in Construction*, 15:44-63.

Gillipsie, G. & Howarth, G. 2012. Counting the loss of litigation. *Casebook*, 20(1):14-15.

Goffman, E. 1959. The presentation of self in everyday life. New York: Doubleday Anchor.

Gray, A. & Vawda, Y. 2016. Health policy and legislation. South African Health Review 2016. http://www.health-e.org.za/wp-content/uploads/2016/05/Sout-African-Health_review-2016.pdf Date of access: 5 Jan. 2017.

Grimsley, S. 2014. Employee empowerment. http://study.com/academy/lesson/employee-empowerment-definition-advantages-disadvantages.html Date of access: 10 Sept. 2016.

Haddock, P. 2010. Importance of morale. http://www.ehow.com Date of access: 1 Sept. 2016.

Hames, J.M. 2011. Ten tips for boosting employee morale. http://www.inc.com/guides/2011/01/10-tips-for-boosting-employee-morale.html.pdf Date of access: 29 Aug. 2016.

Hemson, D. & Owusu-Ampomah, K. 2005. A better life for all? Service delivery and poverty alleviation. http://www.hrscpress.ac.za Date of access: 15 Aug. 2016.

Ibeziako, O.K., Chabikuli O.N. & Olorunju, S. 2013. Hospital reform and staff morale in South Africa: a case study of Dr Yusuf Dadoo Hospital. *Journal of South African Family Practice*, 55(2):180-185.

Kandpal, J. 2015. Equity theory of motivation. http://www.slideshare.net/ JyotiKandpal2/equity-theory-of-motivation-53432579 Date of access: 15 Jan. 2017.

Khan, W.A. 1990. Psychological conditions of personal engagement and disengagement at work. *Academy of Management Journal*, 33:692-724.

Khoza, V.L. & Du Toit, H.S. 2011. The Batho Pele principles in the health services. *Professional Nurses Today*, 15(3):8-9.

Khumalo, I.D. 2010. Compliance with the Batho Pele principles in a primary health context. Potchefstroom: NWU. (Dissertation – MCur).

Kinjerski, V. & Skrypnek, B.J. 2006. Creating organisational conditions that foster employee spirit at work. *Leadership and Organisation Development Journal*, 27(4): 280-295.

Kosteas, V.D. 2009. Job satisfaction and promotion. Available from: Social Sciences Network. http://ssrn.com/abstract=1361628 Date of access: 1 Aug. 2016.

Kreitner, R., Kinicki, A. & Buelens, M. 2002. Organizational behaviour. 2nd ed. Berkshire: Mc Graw-Hill.

Legodi, E.M. 2008. The perception of community members of the quality care rendered in Limpopo, in terms of Batho Pele principles. Pretoria: UNISA. (Dissertation – MA Health Studies).

Lemerle, K.A. 2005. Evaluating the impact of the school environment on teachers' health and job commitment: Is the health promoting school a healthier workplace? School of Public Health: Queensland University of Technology: Australia.

Linz, S.J., Good, L.K. & Huddleston, P. 2006. Worker morale in Russia: an exploratory study. *Journal of Managerial Psychology*, 21(5):415-437.

Lobiondo-Wood, G. & Haber, J. 2006. Nursing research: methods and critical appraisal for evidence-based practice. St. Louis: Mosby.

Locke, E.A. 1976. The nature and causes of job satisfaction. (*In* Dunnette, M.D., *ed*. Handbook of Industrial and organizational psychology. Chicago: Rand McNally. p. 1239-1349).

Luthans, F. 2011. Organisational behaviour. 11th ed. New York, NY: McGraw-Hill.

Lynch, M.F., La Guardia J.G., & Ryan, R.M. 2009. On being yourself in different cultures: ideal and actual self-concept, autonomy support, and well-being in China, Russia, and the United States. *The Journal of Positive Psychology*, 4(4):290-304.

Makawatsakul, B. & Kleiner, B.H. 2003. The effect of downsizing on morale and attrition. *Management Research News*, 26(2), 52-62.

Maloka, S. 2012. A comparative study of job satisfaction and motivation in the private and public health sectors of South Africa. Potchefstroom: NWU. (Dissertation - MBA).

Martineau, T. & Lehman, U. 2006. Factors affecting retention of different groups of rural health workers in Malawi and Eastern Cape Province, South Africa. http://www.who.int/hrh/migration/background_paper.pdf Date of access: 20 Sept. 2016.

Maslach, C., & Jackson, S.E. 1986. The Maslach burnout inventory. 2nd ed. Palo Alto, CA: Consulting Psychologists Press.

Mbanga, S.L. 2006. An evaluation of the implementation status of the Batho Pele principles, general perceptions, attitudes and challenges in selected departments in the Eastern Cape. Port Elizabeth: Nelson Mandela Metropolitan University. (Dissertation – MA Public Administration).

Meyer, D. 2006. Technology, job satisfaction and retention: rural mental health practitioners. *The Journal of Rural Health*, 22(2):158-163.

Mouton, J. 2006. How to succeed in your masters and doctoral studies: a South African guide and a resource book. Pretoria: Van Schaik Publishers.

Mullins, L.J. 2010. Management and organisational behaviour. 9th ed. London: Pearson.

Ngambi, H.C. 2011. Relationship between leadership and employee morale in Higher Education. *African Journal of Business Management*: 5(3), 762-776.

O'Maolalaidh, E. 2000. Obtaining morale in an Irish retail company through a combination of open communications, appropriate leadership style, job design and an effective rewards system. Dublin: National College of Ireland. (Thesis - undergrad).

Oxford Advanced Learner's Dictionary of current English. 2006. Morale. http://www.oxforddictionaries.com/definition/learner/morale Date of access: 20 Feb. 2016.

Patient's rights charter. ***see*** South Africa.

Pepper, M.S. & Slabbert, N.M. 2011. South Africa on the verge of a malpractice litigation storm? *South African Journal of Bioethics and Law*, 4(1):29-35.

Piko, B.F. 2003. Burnout, role conflict, job satisfaction and psychosocial health among Hungarian healthcare staff: a questionnaire survey. *International Journal of Nursing Studies,* 43:311-318.

Polit, D.F., Beck, C.T. & Hungler, B.P. 2001. Essentials of nursing research: methods, appraisal and utilization. 5th ed. Philadelphia: Lippincot.

Quick, J.C., Wright, T.A., Adkins, J.A., Nelson, D.I., & Quick, J.D. 2016. Occupational stress: preventing suffering, enhancing wellbeing. *International Journal of Environmental Research and Public Health*, 13(5):459.

Ramasodi, J.M.B. 2010. Factors influencing job satisfaction among healthcare professionals at South Rand Hospital. Pretoria: University of Limpopo. (Dissertation – MPH).

Rautenbach, C., & Rothmann, S. Flourishing at work: the psychometric properties of a multidimensional scale (In press).Rich, B., Lepine, J.A. & Crawford, E.R. 2010. Job engagement: antecedents and effects on job performance. *Academy of Management Journal,* 53(3):617-635.

Rispel, L. 2016. Analysing the progress and fault lines of health sector transformation in South Africa. South African Health Review 2016. http:///www.health-e.org.za/wp-content/uploads/2016/05/South-African_Health-Review-2016.pdf Date of access: 5 Jan. 2017.

Rossouw, D. 2005. Intellectual tools: skills for human sciences. 2nd ed. Pretoria: Van Schaik Publishers.

Rothmann, S. 2013. Flourishing at work: a Southern African perspective. (*In* Wissing, M.P. *ed*., Cross-cultural advancements in positive psychology. New York, NY: Springer-Verlag. p. 123-151).

Rothmann, S., Jackson, L.T.B., & Kruger, M.M. 2003. Burnout and job stress in a local government: The moderating effect of sense of coherence. *Journal of Industrial Psychology*, 29(4):52-60.

SA ***see*** South Africa

Saari, L.M. & Judge, T.A. 2004. Employee attitudes and job satisfaction. *Human Resource Management*, 43(3):395-407.

Shaefeli, W.B. & Enzmann, D. 1998. The burnout companion to study and practice: a critical analysis. London: Taylor & Francis.

Shaughnessy, J.J., & Zechmeister, E.B. 1997. Research methods in psychology. 4th ed. New York: Mc Graw Hill.

South Africa. 1997. White paper on Transforming Public Service Delivery (Batho Pele White Paper), 1997. (Notice 1459). *Government Gazette*, 18340:1-40, 1Oct.

South Africa. 1999. Health sector strategic framework, 1999-2004. http://www.gov.za/docs/policy/framewrk 99-04.htm Date of access: 17 Jul. 2016.

South Africa. 2015. Department of Health. Annual performance plan. 2015/16-2017/18. Pretoria.

South Africa. KwaZulu-Natal Provincial Treasury. 2010b. Stringent cost cutting measures: Circular PT (6) of 2010/2011. Pietermaritzburg.

Skosana, I. 2016. Better health for all, not just the rich. *Service delivery Review*, 11(2). http://www.dpsa.gov.za/dpsa2g/documents/service-delivery-review/SDR_Vol_11_No_2_of_2016.pdf Date of access: 4 Jan. 2017.

Strachan, B., Zabow T. & Van Der Spuy, Z. 2011. More doctors and dentists are needed in South Africa. *South African Medical Journal*, 101(8):525-526.

Struwig, F.W. & Stead, G.B. 2004. Planning, designing and reporting research. 3rd ed. Cape Town: Hanli Venter.

Swart, J.P. 2012. Antecedents and outcome of happiness of managers in the agricultural sector in South Africa. Unpublished doctoral thesis, North West University, Vanderbijlpark, South Africa.

Thomas, D.C. & Kerr, I. 2004. Cultural intelligence people skills for global business. New York: Berret-Koehler.

Thomas, L.S. & Valli, A. 2006. Levels of occupational stress in doctors working in a South African public sector hospital. *South African Medical Journal*, 96:1162-1168.

Van der Walt, C. & Van Rensburg, G. 2006. Fundamentals of research methodology for health care professionals. 2nd ed. Cape Town: Juta.

Williams, S., Rothman, S. & Temane, Q.M. 2010. Self-efficacy, work, and psychological outcomes in a public service context. *Journal of Psychology in Africa,* 20(1): 43-52.

Woods, S.A. & West, M.A. 2014. The psychology of work and organizations. 2nd ed. Hampshire, UK: Cengage Learning.

World Health Organisation. 2012. World health statistics. A snapshot of global health. www.who.int/gho/publications/world_health_statistics/2012/en/WHO Date of access: 20 Aug. 2016.

Zweni, T. 2004. An assessment of the impact of the organizational restructuring on the morale of employees at a selected final institution. Nelson Mandela Metropolitan University: SA.

ANNEXURE A: REQUEST TO CONDUCT RESEARCH: MEDUNSA ORAL HEALTH CENTRE

Department of Operative Dentistry
Molotlegi Street, Ga-Rankuwa, 0208
***Telephone:** (012) 521 4886*
***Email:** Suretha.Griesel@smu.ac.za*

13 February 2017

For attention: Prof L. Ayu-Yusuf
Dean: School of Oral Health Sciences
Medunsa Oral Health Centre

Re: Request for study site approval

Good morning Professor,

My name is Dr. Suretha Griesel. I am a dentist employed in the Department of Operative Dentistry, Medunsa Oral Health Centre, Sefako Makgatho Health Sciences University. I am currently registered with the School of Business and Governance, North West University (NWU) to complete my final year of the postgraduate Master's degree in Business Administration - also known as an MBA.
As prerequisite for the successful completion of the degree, a mini-dissertation pertaining to the student's field of study and interest is to be submitted.

As medical professional, I aim to conduct my research in the healthcare environment among medical professionals, in particular oral healthcare professionals. The title of my dissertation is as follows:

"Investigating staff morale and Batho Pele compliance of public oral healthcare professionals"

The study aims to identify factors influencing and contributing to staff morale, flourishing in the workplace and motivation, and how the quality of service rendered to patients dependent on the public healthcare sector is influenced by these factors.

My protocol has been approved by the North West University and a temporary ethical clearance number has been issued to me so that I can continue with the research as soon as possible after obtaining permission from Sefako Makgatho University Research Ethics Committee.

The ethical clearance number is **TEMPPBS09/02/17-01/01.**

I trust that you will consider my request favorably.
Please do not hesitate to contact me if you require any further information or clarity.

Kind regards
Dr. S Griesel
Department of Operative Dentistry

ANNEXURE B: REQUEST TO CONDUCT RESEARCH: SMUREC

Department of Operative Dentistry
Molotlegi Street, Ga-Rankuwa, 0208
***Telephone:** (012) 521 4886*
***Email:** Suretha.Griesel@smu.ac.za*

13 February 2017

For attention: Prof GA Ogunbanjo
Chairperson: Sefako Makgatho University Research Ethics Committee
PO Box 163
Medunsa
0204

Re: Request for study site approval

Good morning Professor,

My name is Dr. Suretha Griesel. I am a dentist employed in the Department of Operative Dentistry, Medunsa Oral Health Centre, Sefako Makgatho Health Sciences University. I am currently registered with the School of Business and Governance, North West University (NWU) to complete my final year of the postgraduate Master's degree in Business Administration - also known as an MBA.
As prerequisite for the successful completion of the degree, a mini-dissertation pertaining to the student's field of study and interest is to be submitted.

As medical professional, I aim to conduct my research in the healthcare environment among medical professionals, in particular oral healthcare professionals. The title of my dissertation is as follows:

"Investigating staff morale and Batho Pele compliance of public oral healthcare professionals"

The study aims to identify factors influencing and contributing to staff morale, flourishing in the workplace and motivation, and how the quality of service rendered to patients dependent on the public healthcare sector is influenced by these factors.

My protocol has been approved by the North West University and a temporary ethical clearance number has been issued to me so that I can continue with the research as soon as possible after obtaining permission from Sefako Makgatho University Research Ethics Committee.

The temporary ethical clearance number is **TEMPPBS09/02/17-01/01.**

Please refer to the attached ethical clearance document from the North West School of Business and Governance as well as a copy of the approved protocol. The ethical clearance is attached as Appendix C in the approved protocol document.

It is with the above background given, that I would like to request approval from the Sefako Makgatho University Research and Ethics committee to conduct my research at the School of Oral Health Sciences, Sefako Makgatho Health Sciences University.

I have discussed my proposed research with Prof Ayu-Yusuf, the Director of the School of Oral Health Sciences and he is familiar with the content of the questionnaires I aim to make use of during the research project. He did not voice any concerns or objections. I will obtain a formal letter of approval from Prof Ayu-Yusuf upon receiving the requested study site approval which I will then forward to you for your record purposes.

I trust that you will consider my request favorably.
Please do not hesitate to contact me if you require any further information or clarity.

Kind regards

Dr. S Griesel
BChD (UP)
Department of Operative Dentistry
Medunsa Oral Health Centre

ANNEXURE C: REQUEST APPROVAL: MEDUNSA ORAL HEALTH CENTRE

DIRECTOR: SCHOOL OF ORAL HEALTH SCIENCES
Molotlegi Street, Ga-Rankuwa, Gauteng, 0208
Telephone: (012) 521 4800| Fax: (012) 521 4102
Email: pagollang.motloba@smu.ac.za
PO BOX D12, MEDUNSA, 0204

13 March 2017

Dr S Griesel

Department of Operative Dentistry

Sefako Makgatho Health Sciences

Dear Dr Griesel

RE: Permission to conduct study

I hereby give you permission to conduct research for MBA in the prospective study titled:

Investigating staff morale and Batho Pele compliance of public oral healthcare professionals

Kindly ensure you provide a copy of your report to this office. I wish you all the best with your research.

Yours Sincerely

DR DP MOTLOBA, BDS, MPH, M Dent ,MBL
SCHOOL DIRECTOR/DEAN

ANNEXURE D: REQUEST APPROVAL: SMUREC

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)

Molotlegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 163 Medunsa 0204

Dr SM Griesel
Department of Operative Dentistry
P.O Box D18
Medusna
0204

RE: DR SM GRIESEL – REQUEST FOR STUDY SITE APPROVAL

SMUREC **NOTED** a letter dated 13 February 2017 requesting permission to collect data at Sefako Makgatho Health Sciences University (SMU).

SMUREC **NOTED** that the researcher received approval of proposal from University of North West Ethics Committee

Study Title:	Investigating staff morale and Batho Pele compliance of public oral healthcare professionals
Researcher:	Dr SM Griesel
Supervisor:	Ms K Nell
University:	University of North West
Research Type:	MBA
Ethical Clearance Number:	TEMPPBS09/02/17-01/01
Approval letter date:	09 February 2017

SMUREC **NOTED** and **GRANTED** the researcher permission to conduct a research study at Sefako Makgatho Health Sciences University.

SMUREC **NOTED** a letter dated 2 June 2017 indicating approval of a title change for the study from North-West University (Potchefstroon Campus). The request was received to update the new title in the approval to collect data at Sefako Makgatho Health Sciences University (SMU). The new title is reflected in the site approval.

Yours Sincerely,

PROF C BAKER
DEPUTY CHAIRPERSON SMUREC

28 June 2017

SEFAKO MAKGATHO
HEALTH SCIENCES UNIVERSITY
SMU Research Ethics Committee
Chairperson
Date: 28/06/2017

ANNEXURE E: ETHICAL CLEARANCE

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

NWU School of Business & Governance
North-West University
Private Bag X6001, Potchefstroom
South Africa 2520
Prof CJ Botha
Tel: (018) 299 1672
Email: christoff.botha@nwu.ac.za

10 March 2017

23293454
GRIESEL, SM DR
sue.griesel@gmail.com

ETHICAL CLEARANCE

This letter serves to confirm that the research project of **GRIESEL, SM** has undergone ethical review. The proposal was presented at a Faculty Research Meeting and accepted. The Faculty Research Meeting assigned the project number **EMSPBS17/03/06-01/04**. This acceptance deems the proposed research as being of minimal risk, granted that all requirements of anonymity, confidentiality and informed consent are met. This letter should form part or your dissertation manuscript submitted for examination purposes.

Yours sincerely

Prof CJ Botha

Manager: Research - NWU Potchefstroom Business School

Original details: Wilma Pretorius(12090298) C:\Documents and Settings\Administrator\My Documents\Briewe MBA\2017\

1

ANNEXURE F: QUESTIONNAIRE

QUESTIONNAIRE

TO BE COMPLETED BY PUBLIC ORAL HEALTHCARE PROFESSIONALS EMPLOYED AT MEDUNSA ORAL HEALTH CENTRE (MOHC)

Guidelines for completion of the questionnaire:

1. Participation is completely voluntary.
2. Participants will remain anonymous and all completed questionnaires will be treated with confidentiality.
3. Participants to remain objective and answer all questions to their best possible knowledge.

Please do not write your name on the questionnaire

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION:

Mark the applicable block with a cross (X). Complete all questions.			
Q1:	Gender:	1. Male	2. Female

Q2:	Race:	1. Black	2. Coloured	3. Indian	4. White	5. Other

Q3:	Age group:	1. 30 years and less	2. 31-40 years	3. 41-50 years	4. 51-60 years	5. 61 years and above

Q4:	Highest level of qualification:	1. Grade 12 or less	2. Certificate	3. National Diploma	4. Bachelor's Degree	5. Postgraduate degree
Q5::	Designation:	1. Dental Assistant	2. Dentist/ Dental Therapist	3. Oral Hygiene	4. Specialist / Stomatologist	5. Dental technician 6. Radiography
Q6:	Years of service:	1. 5 years or less	2. 6-10 years	3. 11-20 years	4. 21 -30 years	5. 31 years and above

Q7:	What is the gender of your direct higher report / manager?	1. Male	2. Female

SECTION B:

1. Carefully read through each statement before deciding on an answer
2. Please mark an "X" in the appropriate block which corresponds with your decision
3. Please be honest when deciding on your opinion
4. Please do not discuss your answers or the statements with fellow participants
5. Please return the completed questionnaire as indicated
6. Thank you for your cooperation!

Example:	**STRONGLY DISAGREE**	**DISAGREE**	**NEUTRAL**	**AGREE**	**STRONGLY AGREE**
I have access to opportunities to grow and develop in the Hospital			X		

QUESTIONS:	**STRONGLY DISAGREE**	**DISAGREE**	**NEUTRAL**	**AGREE**	**STRONGLY AGREE**
1. I am satisfied with the way my line manager manages work and people related issues.					
2. I understand how my job aligns with the mission and vision of the hospital.					
3. My line manager respects and values my contribution at work.					
4. My line manager genuinely cares about employee needs.					
5. I am paid fairly for the work that I do.					
6. I have a clear understanding of what is expected of me.					
7. Management involves staff in decision making.					
8. There are clear succession plans in place in my department.					
9. The hospital is able to retain its talented employees.					
10. I am satisfied with the employee assistance program provided by the hospital.					
11. Promotion processes are fair for all staff in the hospital.					
12. I am satisfied with the conditions of service in the hospital.					

QUESTIONS:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
13.My opinion is considered when there are changes that will affect my work.					
14.Communication in the hospital is open and clear and there is no need for gossip.					
15.The hospital has a system or process in place that encourages employees to offer feedback and ideas.					
16.Hospital policies and procedures are readily accessible to staff members.					
17.The telephone systems, personal computer support, email and mail distribution help me to do my work.					
18.My colleagues are committed to doing quality work.					
19.Work is assigned equally and fairly to all members of my team.					
20.I am able to consult colleagues when I am faced with an unexpected or challenging situation.					
21.I feel safe at work during the day.					
22.The hospital maintains a healthy and safe environment.					
23.I would recommend the hospital as a suitable employer.					
24.The hospital makes me feel that I have an important role to play in its operations.					
25.I am satisfied with the level of professionalism in service departments.					
26.My level of work stress is high.					
27.I am planning to leave the hospital in the next six (6) months.					

QUESTIONS:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
28.I Have a measure of control and influence over how my work is completed.					
29.The support services departments respond promptly to my queries.					
30.The hospital's HR policies are communicated clearly to all employees.					
31.The HR office is accessible to all employees.					
32.My personal HR queries are dealt with in confidentiality.					
33.I feel that benefits provided by the hospital meet my needs well.					
34.The hospital is the best employer I have ever worked for.					
35.I work with unreasonable deadlines and heavy workloads.					
36.I receive adequate support in order to complete my work effectively.					
37.I am able to balance my work and personal life.					
38.I am able to discuss any difficulties that I have managing my work with my manager.					
39.When problems emerge in our hospital, there is a willing-ness to fix them.					
40.My manager values new ideas and implements them quickly.					
41.People at the hospital are transparent (no hidden agendas) and communicate openly.					
42.My Department contributes to the unity of different cultures and religions.					

QUESTIONS:	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
43.People of all races have access to the same opportunities within my Department.					
44.Women have the same opportunities as men in my Department.					
45.At work, I have the opportunity to do what I do best every day.					
46.I feel that my work is meaningful.					
47.I have the skills I need to perform my work effectively.					
48.I have access to opportunities to grow and develop in the hospital.					
49.I am highly motivated to do my job.					
50.I find the content of my work interesting and stimulating.					
51.I am consistently looking for employment outside the hospital.					
52.Staff morale can be best improved by a well-defined employee wellness program that balances work and personal life.					
53.To maintain a high level of confidentiality, the employee wellness program must be outsourced.					
54.Staff morale can best be improved regular team building activities.					
55.The current PMDS performance management system is working sufficiently to motivate staff to perform.					

SECTION C: **OVERALL SCALE**

HOW DO YOU RATE THE FOLLOWING?	1 VERY POOR	2 POOR	3 NEUTRAL	4 GOOD	5 EXCELLENT
1. How would you rate the staff morale level at the Hospital?					
2. Overall, how would you rate the Hospital's attempts to involve all employees in decision making?					
3. How would you rate the Hospital Management's attention to staff needs?					
4. How do you rate overall staff retention at the Hospital?					
5. How would you rate support services' willingness and ability to address staff queries?					

SECTION D: **OPEN-ENDED QUESTIONS**

1) Are there any programs provided by the hospital which address morale?

YES	
NO	

If "YES", please elaborate:

_____

_____

_____

2) Which programs, in your opinion, should the hospital implement in order to uplift staff morale?

_____

_____

_____

3) How can the program/s suggested above improve work performance of employees at the hospital?

_____

_____

_____

_____

~ THANK YOU FOR YOUR PARTICIPATION ~

ANNEXURE G: INFORMED CONSENT FORM

INFORMED CONSENT FOR ORAL HEALTHCARE PERSONNEL

Enquiries: Dr. SM Griesel
Tel: [redacted]
Cell: [redacted]
Email: [redacted]

CONSENT TO PARTICIPATE IN A NON-EXPERIMENTAL RESEARCH PROJECT

TITLE OF STUDY: Investigating staff morale and Batho Pele compliance of public oral healthcare professionals

PURPOSE AND BACKGROUND OF THE PROPOSED STUDY:

I, Dr. SM Griesel, am conducting research through the North West University Business School as partial completion of my MBA (Masters in Business Administration) degree. Your participation is cordially requested in this research project as your input will be of great value in achieving the objectives of the study as explained hereafter.
The overall purpose of this research project is to identify the factors influencing staff morale in your current work setting and the influence this has on the quality of service rendered to patients attending the hospital.
The objectives of the study are as follow:

- To identify and describe the factors influencing staff morale among Public Oral Healthcare Professionals
- To describe the influence of staff morale on Batho Pele Principle compliance and the subsequent effect on the quality of patient care.

Your participation will entail completing a structured questionnaire that consist of four sections with 63 questions which the researcher will provide. It will take approximately 10 minutes to complete the questionnaire. The data gathered from the participants will be code protected. The data-analysis will also be closely monitored by the Statistical Services of the North West University (NWU), Potchefstroom Campus.

CONFIDENTIALITY:

The data provided to the researcher will remain confidential as no other person beside the researcher and members of the research team will have access to the provided data. Anonymity is ensured as no names will be used during data collection, analysis and dissemination of the results of this study.

RISKS TO THE PARTICIPANT:

Participants can be assured that no risk will be involved with participation. As participants will not be identified, there can be no connection to whom answered which questionnaire. Management approved the research study, therefore participants should not fear victimization of any kind.

BENEFITS:

Participants will benefit by forming part of a team that contributed to identifying possible factors in their workplace which can influence employee morale and ultimately the quality of service rendered to patients. By identifying these factors, management can address it accordingly- which in turn will benefit the participants.

COSTS AND PAYMENT INVOLVED:

- No costs are involved for you as participant in this study.
- No payment will be made to you as participant in this research project.

PARTICIPATION IS VOLUNTARY:

Participation is voluntary. Participants are free to withdraw from the research at any time or to decline participation in this research project.

Participant Name (please print): _____

Participant signature: _____ Date: _____

Researcher Name (please print): _____

Researcher Signature: _____ Date: _____

ANNEXURE H: DECLARATION BY LANGUAGE AND TECHNICAL EDITOR

DECLARATION

I, C Vorster (ID: 710924 0034 084), Language editor and Translator, and member of the South African Translators' Institute (SATI member number 1003172), herewith declare that I did the language editing of a mini-dissertation written by SM Griesel from the North-West University (student number: 23293454).

Title of the mini-dissertation: Investigating staff morale and Batho Pele compliance of public oral healthcare professionals

C Vorster 12 October 2017

_____ _____

C Vorster Date