

Assessing the readiness to implement national health insurance at a clinic in Soweto

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Mini-dissertation submitted in partial fulfilment of the requirements
for the degree

Master of Business Administration

at the Potchefstroom Campus of the North-West University

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April 2015

PREFACE

I WOULD LIKE TO EXPRESS MY GRATITUDE TO:

- God Almighty, for carrying me through the studies and giving me the strength to complete them.
- My husband, Sefularo Mokoka, for his support, and motivation and for keeping the family together.
- My daughter, Lesedi, for her understanding and support.
- Mrs Susan Kekana, my Director, for her constant encouragement throughout my studies.
- Christine Bronkhorst at the NWU Library, for her assistance in finding the appropriate literature.
- Mr Theo Venter, my supervisor, for challenging me to work hard.
- Mrs Antoinette Bisschoff, for her work in editing the document and overall structural support in ensuring that I complete the dissertation.

ABSTRACT

The South African government intends to overhaul the entire public health system by introducing the National Health Insurance (NHI) system. The implementation of the NHI has created concerns amongst the majority of South African citizens who have a poor image of the quality of services provided by the public sector. One of the major questions that this study attempted to address was whether one of the largest clinics in Soweto could deliver quality healthcare in terms of the proposed NHI system.

The study conducted is quantitative in nature and two-pronged. The first part of the study involved a survey conducted amongst staff members at the Soweto clinic to determine their awareness of the National Health Insurance (NHI) and their knowledge of the National Core Standards (NCS). The second part of the study used an assessment questionnaire to determine compliance of the Soweto clinic to the six ministerial priority areas.

The results of the survey conducted among the Soweto clinic's staff members in all staff categories, showed that there is general awareness amongst staff members of National Health Insurance and they have some knowledge of the NCS; however, more education on NHI and NCS is needed for staff working in specialised or isolated departments who are unaware of NHI and have no knowledge of the NCS. The Soweto clinic showed some advancement with regard to the vital measures compliance scores compared to those of the rest of the Gauteng province in the three priority areas. The Soweto clinic has, however, failed to comply under the other four ministerial priority areas, with ratings of less than 80%. This study has shown a disconnect between knowledge of the NCS and the NCS's implementation by staff members, as staff members have failed to implement or comply with four of the ministerial priority areas, with sub-standard ratings of less than 80%. The Non-NHI clinic is still very far from ensuring the provision of basic quality health service for its clients and it is, thus, not ready to implement NHI.

Recommendations from the study:

- Managers must drive the quality improvement agenda for their facilities.

- Awareness campaigns and more knowledge on NHI and quality improvement (NCS) must be communicated to all staff categories in the health establishments to ensure a deeper understanding of these concepts.
- Workshops must be conducted for all staff members in the Soweto clinic, to support the creation of a culture of excellence, with emphasis in providing quality care to clients.

Similar future studies need to be conducted on a large scale such as in the whole of Gauteng to determine staff at health establishments' knowledge of the quality NCS.

Keywords: National Health Insurance, NHI, National Core Standards, NHI implementation Standards, South Africa Health Care System, Equitable Health System, Universal Health Coverage, Private and Private Health Care funding.

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CHAPTER 1: PROBLEM STATEMENT AND OBJECTIVES

1.1 INTRODUCTION

The majority of people in low income countries are unable to access the much needed health services as these are unaffordable to them (Harris et al., 2011). The World Health Organisation (WHO) member states committed in 2005 to develop their health systems so that all people have access to services and do not suffer financial hardships when they need them. The goal was defined as universal health coverage.

The Constitution of South Africa (SA, 1996) section 27 states that everyone has the right to access healthcare. While in theory, there is universal health coverage in the country, yet from a service delivery, resourcing and quality perspective there is no equitable access to healthcare services (Engelbrecht et al., 2010).

The current system of healthcare financing in South Africa is two-tiered, with a relatively large proportion of funding allocated through medical schemes and out of pocket payments. This funding arrangement provides cover to the employed, middle class and wealthy individuals who have purchased a benefit option with a medical aid scheme. The other portion is funded through taxes and is mainly for the majority of public sector users. This means that those with medical scheme cover have a choice of providers operating in the private sector which is not extended to the rest of the population (Human, 2010).

The public health sector is under-resourced and over-stretched. A large component of the financial and human resources necessary to provide quality healthcare are located in the private health sector that is serving a minority of the population. In proportion the public health sector has fewer human resources than the private health sector, yet it has to manage significantly higher patient numbers (Department of Health, 2011:4).

The World Health Organization recommends that countries spend at least 5% of their GDP on health care each year. South Africa already spends 8.3% of GDP on health which is higher than the WHO's recommendations and well above the majority of middle-income countries. Of the 8.3% of GDP spent on health care, only 4.2% is spent in the public sector which supports 84% of the population and 4.1% is spent in the private sector, serving 16.2% of population (Amado et al., 2012:6).

While access to health facilities has improved in the public sector, the quality of health care has deteriorated. The Department of Health (2011:6) states that large numbers of people continue to die prematurely and to suffer unnecessarily from poor health. Treatable conditions are not being dealt with timeously and preventable diseases are still highly prevalent in South Africa.

South Africa is plagued by four clear health problems that have been described in the Lancet Report (Coovadia et al., 2009:1) as the quadruple burden of disease,

- HIV, AIDS and TB;
- Maternal, infant and child mortality;
- Non-communicable diseases; and
- Injury and violence.

The South African government is responding to these challenges by introducing a reform plan to revitalise and restructure the health system, including:

- Moving towards a socialised model of health care delivery with the introduction of National Health Insurance (NHI) to help address the serious issue of equitable quality healthcare in SA;
- Strengthening the fight against HIV and TB, non-communicable diseases; and
- Increasing life expectancy from 56.5 years in 2009 to 58.5 years in 2014 (South Africa info, 2012).

The DOH believes that without NHI, the burden of disease in the country will not be reduced because the majority of the population and the section suffering the greatest ill health will not have access to quality health care. The NHI is a financing system that will ensure that all citizens of South Africa and legal long-term residents are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund (Department of Health, 2011:5).

1.2 PROBLEM STATEMENT

Significant improvements in health service coverage and access have increased in the South African public sector, but the quality of health care services has deteriorated or remained poor. The public health sector will have to be significantly transformed, in order to shed the image of poor quality services that have been shown to be a major barrier to access and utilisation (Bennett et al., 2001).

In 2011, South Africa launched the first cohort of 11 NHI pilot districts across the country's nine provinces, focusing on under-served communities (Ogunbanjo, 2013). It is expected that all public health establishments in South Africa be compliant with service quality standards that being National Core Standards and ultimately be in a position to provide services within the ambit of the National Health Insurance.

The following research hypotheses are being made:

1. There is no knowledge amongst staff members at a Soweto clinic about the quality standards that is, National Core Standards that need to be complied with to ensure acceptable standards at the public health establishments.
2. Little or no preparation in the public institutions has been conducted to address quality of service in readiness for NHI implementation.

Health establishments have to comply with all aspects of the National Core Standards; however, it is acknowledged that quality improvement is a process which does not happen overnight. Matsoso (2011:7) mentioned the six ministerial or priority quality problems or areas, which health establishments must improve within the shortest period: These six areas deal directly with patient experience, safety and dignity; – often cited by the public when they visit public health institutions:

1. Lack of cleanliness;
2. Safety and security concerns of staff and patients;
3. Long waiting times;
4. Bad staff attitudes;
5. Poor infection control, and
6. Inadequate medicine stocks.

This study intends to evaluate one of the Non-NHI pilot sites, namely, Soweto's largest clinic's readiness to implement NHI in compliance with the national core standards. Compliance to National Core Standards is used as one of the determinants for assessing a facility's readiness to deliver health care of acceptably high standards and even determine if that facility can be deemed ready to implement NHI.

1.3 PRIMARY OBJECTIVE

To evaluate staff's awareness of National Health Insurance (NHI) and knowledge of the National Core Standards (NCS) and their readiness to implement NHI in a large Soweto clinic.

1.4 SECONDARY OBJECTIVES

- To evaluate a Soweto clinic, a Non-NHI pilot site, in terms of its compliance with the six priority stipulations of the National Core Standards necessary to prepare it for NHI implementation;
- To assess the staff's awareness of the NHI and their knowledge of National Core Standards; and
- To determine the staff members' perceptions of the facility's readiness to roll out NHI.

1.5 RESEARCH QUESTIONS

- To what extent does the Soweto Clinic, a Non-NHI pilot site, comply with the six priority stipulations of the National Core Standards required to prepare it for NHI implementation?
- Are the staff members knowledgeable about the National Core Standards that their facility need to be complying with and are they aware of the National Health Insurance?
- What are the staff members' perceptions regarding the facility's readiness for NHI roll-out?

1.6 RATIONALE FOR THE STUDY

The National Health Insurance (NHI) implementation in all health facilities, involves overhauling the entire public health system while creating radical changes in the health

care system. The implementation of the NHI is likely to create concerns amongst most South African citizens who have a poor image of the quality of services provided by the public sector.

One of the major questions that this study attempts to address is whether one of the largest clinics in Soweto can deliver quality health care. The study will attempt to determine the readiness of a non-pilot site to roll out NHI.

1.7 SCOPE OF THE STUDY

Soweto is one of the most densely populated urban areas in South Africa located in the South-West of Johannesburg. Soweto has a population of 2 million people and has an HIV prevalence rate of 29.9% in antenatal clients (HST, 2014:114).

The study is conducted in one of Soweto's large public health, community health care centres (CHCs) serving a population of 113 750 people. The Soweto Clinic sees an average total head count of 26 189 Primary Health Care (PHC) patients per month.

The Soweto Clinic is one of the oldest clinics in the area, having been built in 1982 and the buildings are now 32 years old, where some departmental building structures are dilapidated. The health establishment provides a comprehensive range of services in line with its classification of being a community health centre (CHC). A CHC is defined as a facility which is open 24 hours a day, 7 days a week, at which a broad range of primary health care services are offered (DOH, 2012:46).

The services offered at the abovementioned CHC are TB preventative and curative, comprehensive management and treatment of HIV and AIDS (CCMT), a 24 hour maternity unit (MOU), male medical circumcision (MMC), pharmacy, antenatal, chronic, emergency, X-Ray, termination of pregnancy (TOP), mental health, oral health (dental), theatre, EPI, family planning and rehabilitation.

The facility manager is the overall manager of the Soweto Clinic; she has a deputy manager reporting to her who coordinates the activities of the 14 different heads of departments employed within the CHC as can be seen in Figure 1 below depicting the Soweto Clinic organogram.

The Soweto clinic was selected for the study because it was in line with the study profile of a non-NHI pilot site and this clinic has a management team who have worked at the clinic for over 10 years and are open to innovative ideas.

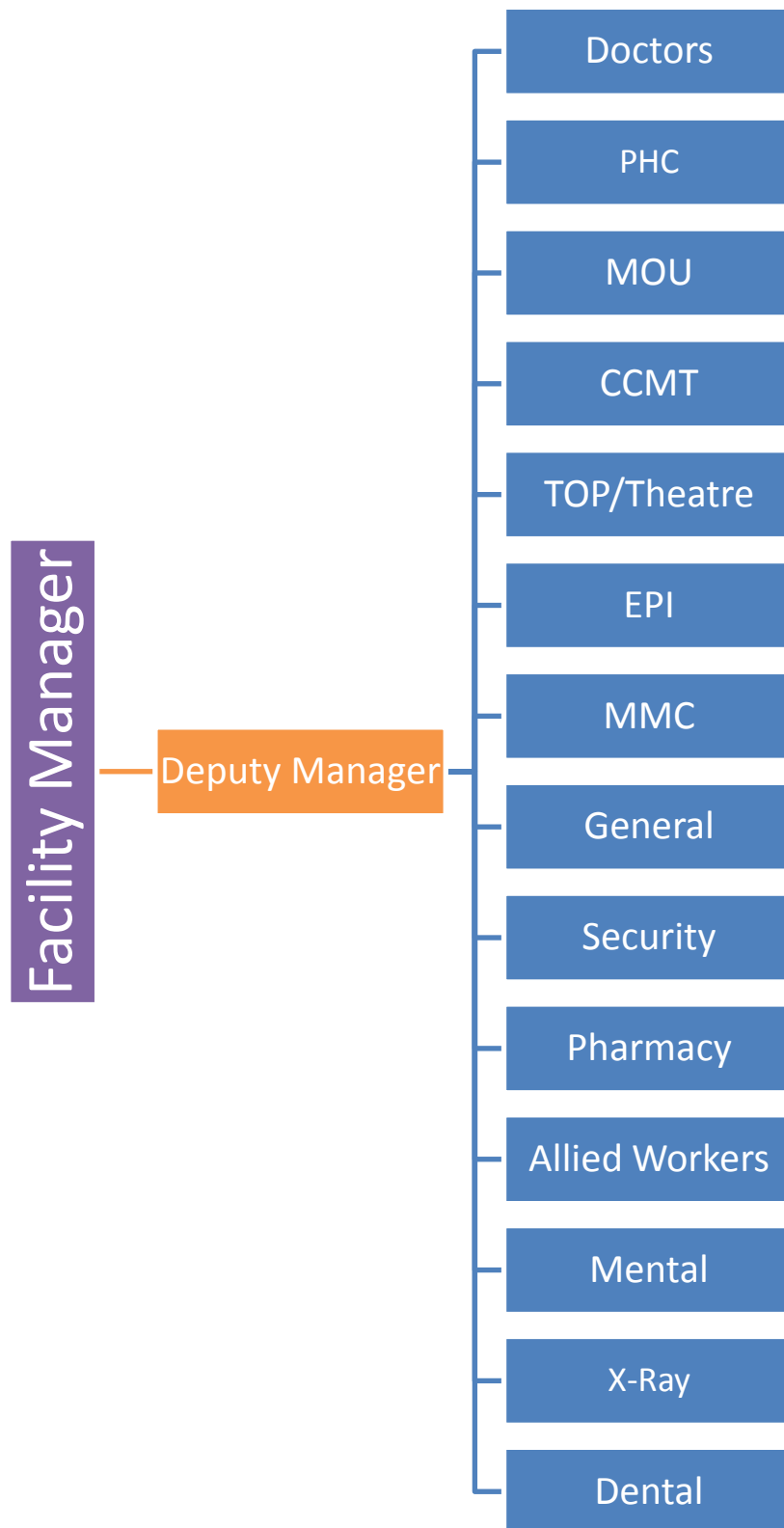


Figure 1: The Soweto Clinic Organogram (Zola Community Health Centre, 2014).

CHAPTER 2: LITERATURE REVIEW AND RESEARCH METHODOLOGY

2.1 Literature review

2.1.1 Introduction and Background

South Africa is in the process of overhauling its health system by introducing the National Health Insurance (NHI) to ensure equitable access to health care for all its citizens. The principles for developing the National Health Insurance (NHI) Scheme were described in the Green Paper as improving access to quality health services and providing financial risk protection against health-related catastrophic expenditures. (Matsoso & Fryatt, 2013). The NHI will be introduced over a 14-year period at pilot sites in the country's nine provinces. The selection of the pilot NHI districts was based on audit findings, which included the district's health profile, demographics, income levels and other social factors that impact on health, health delivery performance, management of health institutions and compliance with quality standards (Ogunbanjo, 2013).

Table 1 shows the NHI-Pilot districts.

The South African government intends modelling its NHI on the UK's National Health Service (NHS). Matsoso (2010:8) mentioned that the United Kingdom (UK) was "a good example of a country that has dealt successfully with problems of quality in the health care system". The UK implemented the NHS in 1948 and according to the NHS UK; the National Health Service was born out of a long held ideal that good health should be available to all, regardless of wealth. At the launch of the NHS by the then Minister of Health on 5 July 1948, the core values of the NHS were that:

- It meets the needs of everyone;
- It is free at the point of delivery; and
- It is based on the patient's clinical need, not his/her ability to pay.

National Health Insurance is an approach to health system financing that is structured to ensure that all South-Africans have access to a defined, comprehensive range of health services, irrespective of their social, economic and/or any other consideration that affect their status. South Africans have for too long tolerated a divided, inequitable and inefficient health system. There is a need for health system reform (McIntyre, 2010:10).

Table 1: NHI-Pilot districts (Matsoso, 2013)

District (population, 2012)	Province
OR Tambo (1 754 499)	Eastern Cape
Thabo Mofutsanyane (771 610)	Free State
City of Tshwane (2 520 435)	Gauteng
Amajuba (517 279)	KwaZulu-Natal
uMgungundlovu (1 071 606)	KwaZulu-Natal
Umzinyathi (517 806)	KwaZulu-Natal
Vhembe (1 312 197)	Limpopo
Gert Sibande (946 719)	Mpumalanga
Pixley ka Seme (192 572)	Northern Cape
Dr Kenneth Kaunda (905 675)	North West
Eden (567 993)	Western Cape

2.1.2 National Health Insurance (NHI)

The Declaration of Alma Ata (1978:1) expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

Chan (2010:4) mentioned that the Alma Ata declaration signatories recognised 30 years ago that health for all would contribute to a better quality of life and also global peace. In striving to attain the goal of universal health coverage, governments had to answer fundamental questions:

- How could they protect people from the financial consequences of ill-health and having to pay for health services?
- How could they encourage the optimum use of available resources?

Kutzin (2013) mentioned the three recommended dimensions of progressing towards universal health coverage highlighted in the World Health Report 2010; and these are depicted in the cube:

- *Breadth depicts* Population coverage i.e. the proportion of population that has access to the needed health services, including addressing physical, financial and access limitations.
- *Depth depicts* Service coverage i.e. the extent to which a range of services necessary to address health needs of the entire population are covered.
- *Height depicts* Financial Risk Protection i.e. the extent to which the population is protected from catastrophic health expenditure and avoiding waste. These include improvement of procurement and administrative efficiencies.

Figure 2 below shows the three dimensions towards universal health coverage.

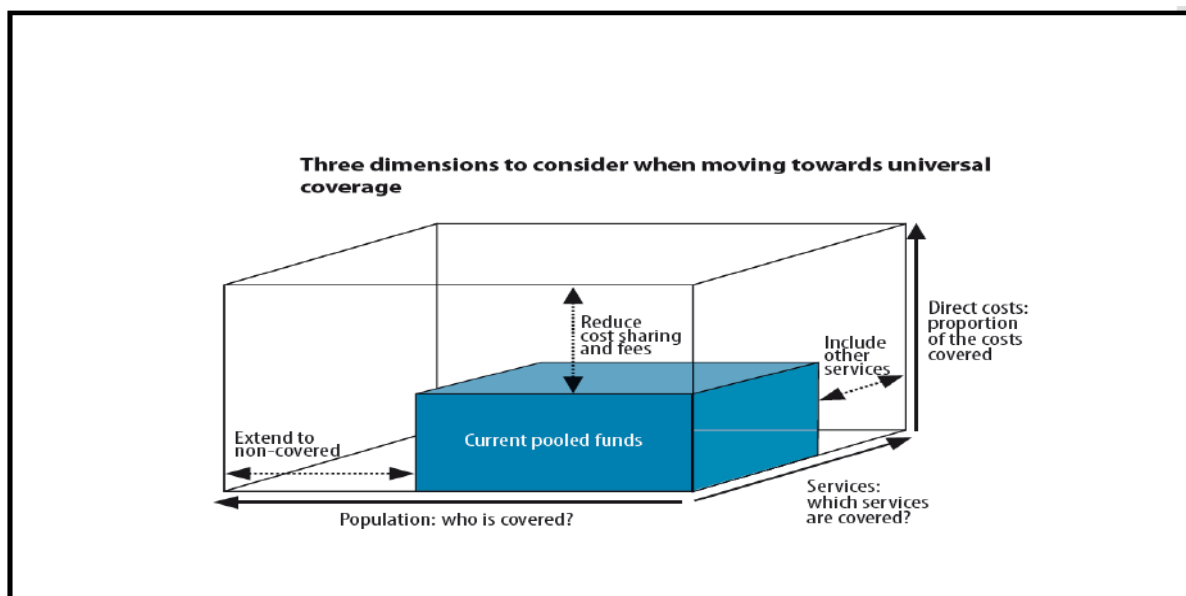


Figure 2: The three dimensions to consider when moving towards universal coverage (Kutzin, 2013)

South Africa's NHI is often compared with reforms undertaken by Brazil, Thailand and Rwanda. Their successes act as benchmarks against which the country may be measured. Rwanda, a genocide marred country, is said to have succeeded in doing what this country has been talking about for 18 years (Kardas-Nelson, 2013).

In Mexico, the basic capabilities of families living in extreme poverty were enhanced with the introduction of universal health coverage which was linked to innovative initiatives to tackle the burden of disease (Frenk, 2006).

DOH (2011:5), mentions that, to successfully implement a health care financing mechanism that covers the whole population, such as NHI, four key interventions need to happen simultaneously:

1. a complete transformation of healthcare service provision and delivery;
2. the total overhaul of the entire healthcare system;
3. the radical change of administration and management; and the
4. provision of a comprehensive package of care, underpinned by a re-engineered Primary Health Care programme.

During the first five years of piloting NHI, prior to full NHI roll-out, focus will be on improving some of the following areas:

1. Management of health care facilities and health districts;
2. Quality improvement;
3. Medical equipment and supplies, and
4. Human resource planning and development.

The pilot project focuses on improving district health systems and testing their ability to assume the greater responsibilities that will be required under NHI. As South Africa embarks on the implementation of the National Health Insurance, the continuous monitoring of the quality of care and health service delivery will be integral to informing health system strengthening strategies (DOH, 2011:7).

The 10-Point Plan of the Department of Health (DOH) 2009-2014 makes provision for the “establishment of a quality management and accreditation body” and “improving the quality of health services”, as is also reflected in the DOH’s Strategic Plan for 2009 to 2014.

2.1.3 National Core Standards (NCS)

To align to the DoH’s legislative and policy mandates, the Office of Health Standards Compliance was set up and it developed the National Core Standards (NCS) for Health Establishments in 2008, which were implemented in 2011. The NCS provide a benchmark of quality of care against which the delivery of health services can be monitored. The implementation of the NCS is based on the assessment of a health facility’s compliance to measurable service standards (DOH, 2012:4).

Motsoaledi (2011:5) mentioned that the NCS reflects a vision for South Africa’s health service rather than introducing a list of requirements. Managers of health establishments at all levels have to ensure that these standards are met. Motsoaledi states, “if quality is defined as getting the best possible results within available resources”, then the National Core Standards set out how best to achieve this.

The purpose of the National Core Standards for health establishments is to:

- Develop a common definition of quality of care which should be found in all health establishments in South Africa as a guide to patients and staff at all levels;
- Establish a benchmark against which health establishments can be assessed, gaps identified, strengths appraised, and quality improvement guided, and
- Provide for national certification of compliance of health establishments with mandatory standards.

The above information is essential to identify a health system’s strengths and gaps, to assess current and future needs and for planning investments and future services such as the National Health Insurance.

The National Core Standards are structured into seven cross-cutting domains (a domain is defined by the World Health Organization as an area where quality or safety might be at risk. The seven cross-cutting domains are Patient Rights, Patient Safety-Clinical Governance and Care, Clinical Support Services, Public Health, Leadership and Corporate Governance, Operational Management, Facilities and Infrastructure (See Figure 3).



Figure 3: Seven Domains of the National Core Standards (DOH, 2011:10)

The scope of each domain is outlined as below:

- **Patients' Rights:** these set out what a clinic must do to ensure that patients are respected and their rights are upheld, for example, attaining access to the needed care, to be respected, receive informed consent, diagnosis, advice or treatment in an acceptably hygienic environment in accordance with the Patients' Rights Charter.
- **Patients' Safety:** the Clinical Governance and Care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to patients in identified cases, prevent or manage adverse events, including health care-associated infections and support any affected patients or staff.
- **Clinical Support Services:** this domain covers specific essential services in the provision of clinical care and includes timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology.
- **Public Health:** this domain covers how health facilities should work with NGOs, the local communities and relevant sectors to promote health, prevent illness and further complications and ensure that integrated and quality care is provided for the whole community.
- **Leadership and Corporate Governance:** strategic direction must be provided by senior management through proactive leadership, planning and risk management. This domain includes the strategic functions of communication and leadership.
- **Operational Management:** this domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including the management of human resources, finances, assets, consumables and records.

- **Facilities and Infrastructure:** this domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and equipment) and functional well-managed clinic services and effective waste disposal.

A non-pilot site, the Soweto Clinic, will be evaluated during this study for compliance to the six priority quality problems or areas with which health establishments must comply, as part of the determinants used to assess this facility's readiness with acceptable quality standards.

2.1.4 National Healthcare Facilities Baseline Audits 2011 to 2012

From May 2011 to May 2012, an organisation, HST, contracted by the DoH, conducted National Healthcare facilities Baseline Audits in accordance with the National Core Standards tool-kit (DOH, 2012:1). All South African health establishments were audited for compliance in terms of the following aspects:

1. Priority areas of quality and function;
2. Infrastructure;
3. Classification of facilities;
4. Human resources, and
5. Range of and access to services offered.

Based on the NCS risk rating framework, measures are classified into three risk levels that form an integral part of a comprehensive quality health care system, namely:

- Vital measures are those that ensure that the safety of patients and staff are safely guarded so as to prevent unnecessary harm or death.
- Essential measures are those considered fundamental to the provision of safe, decent quality health care and are designed to provide an in-depth view of what is expected within the currently available resources.
- Developmental measures are those elements of quality care to which health managements should aspire to in order to achieve optimal levels of health care. (Figure 4 below depicts these three measures (DOH, 2012:14).



Figure 4: Continuous quality improvement and link to types of standards (DOH, 2011:14)

As a standard of practice, the government expects all health care facilities to attain a minimum of 80% compliance for the vital measures in each of the ministerial priority areas. The ability to achieve 100% compliance to the vital measures in each of the ministerial priority areas is what distinguishes a high-ranking facility (ideal facility) from a weak-ranking facility.

Results from audited facilities were aggregated according to sub-districts, districts and national averages. Under quality of service, public health services in South Africa collectively scored less than 50% compliance under two out of the six ministerial priority areas. Gauteng Province obtained the highest score on quality (69%) while the Northern Cape obtained the lowest score (40%). Figure 5 below delineates the results for Gauteng.

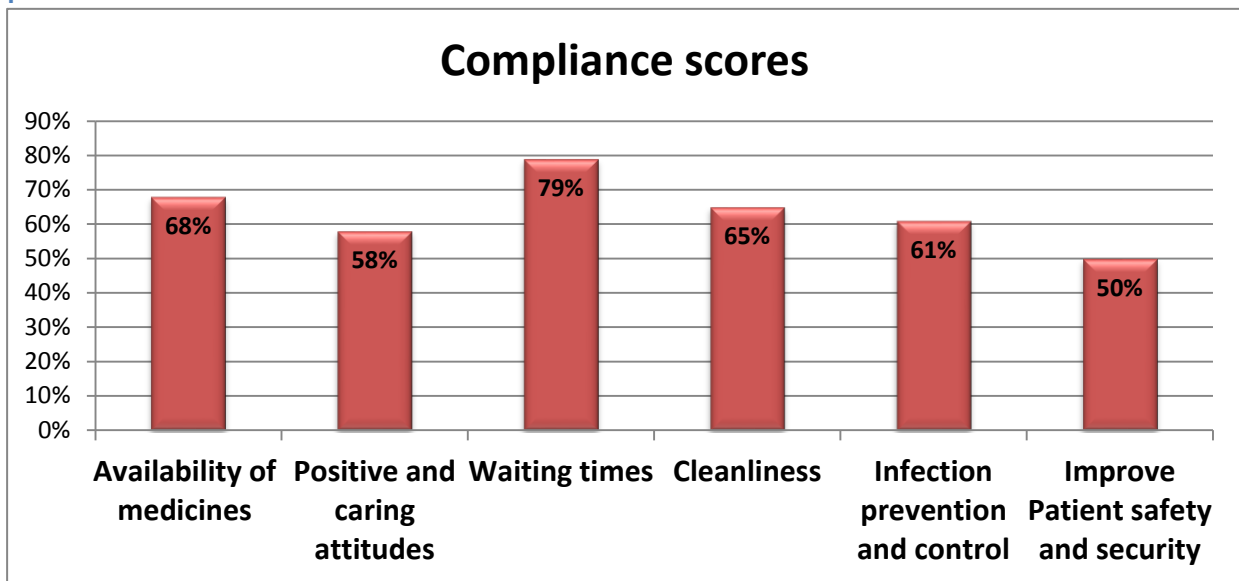


Figure 5: Graphical plot of the Gauteng compliance scores (DOH 2012:16)

As seen in Figure 5, Provincial (Gauteng) scores for all six priority areas were below 80%, which means that the province is not complying with the minimum standards as stipulated by the NCS and is, therefore, still far from being ready to roll out NHI.

2.2 RESEARCH METHODOLOGY

A survey was conducted at a Soweto clinic to assess staff's awareness of NHI and their knowledge of the NCS. The study evaluated the clinic's compliance to the National Core Standards and the clinic's results were compared with the provincial (Gauteng) results from the National Healthcare Baseline Audit conducted in 2011-2012 to determine whether the clinic's compliance showed more improvement than the baseline provincial results or not.

2.2.1 The use of a questionnaire as a measuring instrument

The first part of the study used a survey questionnaire as a measuring instrument, which aimed to determine the Soweto Clinic staff awareness of NHI and their knowledge of the NCS.

The second part of the study used an assessment questionnaire to determine compliance of the CHC or health establishment to the six ministerial priority areas. The questionnaire used, was the NCS tool developed by the Department of Health for assessing CHCs. This instrument was amended to only assess the facility's compliance to the vital measures of the six ministerial priority areas.

(See Appendix 2: Questionnaire on staff awareness of NHI and their knowledge of NCS at the Soweto clinic and Appendix 3 for vital measures to be assessed for the six priority areas.)

2.2.2 Ethical Considerations

The survey was conducted at one of the Public sector clinics or CHCs. All surveys conducted in public health care establishments have to be approved by the district research committee.

The Jo'burg District Research committee gave permission to conduct research at the Soweto Clinic and the dissertation was also registered with the NWU ethics committee. The letter of approval from the research committee was submitted to the facility manager of the Soweto Clinic. The researcher briefed the facility manager that participation of staff members in the study was voluntary and that their identity would be

kept anonymous. The outcome of the research will only be used for the purpose of the study. (See Appendix 4-7)

Appendix 4: Request from Researcher to Jo'burg District Health to conduct Survey

Appendix 5: Motivation from Supervisor to Jo'burg District Health

Appendix 6: Letter of Approval to conduct a study from Johannesburg Health District

Appendix 7: Student's statement on Ethics research

2.2.3 Contribution of the study

The findings of this study will be used to:

- Determine if there are any noticeable improvements at the clinic after baseline quality assessments had been completed.
- Inform evidence-based objectives and plans towards scaling up quality improvement strategies in Non-NHI pilot sites.
- Improve the current awareness and understanding of NCS and NHI in Soweto health care establishments.

2.2.4 Limitations of the study

The results of the study may not be generalised to all Community health care centres in the country but may be applicable to other clinics in the same area.

The survey did not probe deep into the knowledge of staff about NHI; it only aimed to determine their awareness on NHI.

Patient interviews were not part of the assessment procedure because their inclusion would have prolonged the process of approval to conduct the study by the district research committee. Results relating to some of the priority areas, for example, positive caring attitudes were limited to the perspectives of staff members and may not be indicative of the patients' perception of these attitudes.

CHAPTER 3: EMPIRICAL STUDY

3.1 INTRODUCTION

The study conducted aimed to respond to the research objectives. The study was two-pronged: the first part of the study involved a survey conducted amongst staff members at the Soweto Clinic to determine their awareness of the National Health Insurance (NHI) and their knowledge of the National Core Standards (NCS).

A study conducted by Bezuidenhout et al. (2014:1) assessed the health care workers' knowledge of NHI, having drawn its content from available publications on NHI. The current study's emphasis is to determine the staff's knowledge of the National Core Standards (NCS) that is the quality standards expected to be maintained by all public health establishments; however, this type of survey has not been explored. The study also aims to determine the staff's general awareness of NHI.

The second part of the study was an assessment conducted to determine if the Soweto Clinic complied with the National Core Standards in preparation for NHI. This part of the study used an assessment questionnaire that is, an NCS tool developed by the Department of Health to determine compliance of the CHC or health establishment to the six ministerial priority areas.

The assessment results of the Soweto Clinic were compared with the provincial (Gauteng) results from the National Healthcare Baseline survey conducted in 2011-2012.

3.2 METHODOLOGY

3.2.1 Research Design

The study is a cross-sectional study which aimed to determine different staff categories employed at the Soweto Clinic's staff awareness of NHI and their knowledge of NCS, at a certain point in time. Welman et al. (2005:95) defines a cross-sectional design as one in which the different groups, known as cohorts, are examined for one or more variables simultaneously.

The study is quantitative in nature and aims to use measuring instruments, viz evaluation assessments and questionnaires to determine the progress made by the

Soweto Clinic in improving the quality of service for its clients and also in its preparation for NHI.

Quantitative research is defined by Sage (2010) as explaining phenomena by collecting data and analysing it using mathematical or statistical methods.

3.2.2 The research instrument: The questionnaire

A self-constructed survey was deployed as the research instrument in order to determine the staff awareness of NHI and their knowledge of NCS at the Soweto Clinic. A survey is made up of questions that sampled individuals have to respond to by providing their preferences; a survey is said to be the most popular technique for collection of data (Kalof, et al., 2008).

The questionnaire was divided into two sections:

- The first section determined the demographic profile of the participants. The demographic profile of participants was collected to assist the researcher:
 1. In determining the non-identity personal details of the participants;
 2. In enabling the linking of these details to their responses which could then be grouped, and
 3. In validating the number of questionnaires received per department and per staff category.

The demographic section consisted of seven questions, comprising six close-ended questions and one open-ended question. The seven questions aimed to determine the respondents' gender, age grouping, staff category, employment status, managerial status, the department they work in and number of years employed.

The second section of the questionnaire aimed to determine the staff's awareness of issues relating to the NHI and NCS. This section consisted of a list of 15 positively phrased questions, divided into five streams, viz A to E. Specific questions were linked to a certain stream, for example, question 1(Q1) and question 2(Q2) responded to stream A as can be seen in Table 2 below.

The questions were asked in a logical sequence to enable clarity amongst respondents of different educational levels.

Table 2: Staff awareness streams and linked questions

No	Staff awareness streams	Questions
A	Awareness of government's introduction of National Health Insurance (NHI)	Q 1, Q 2
B	Knowledge of National Core Standards (NCS)	Q 3, Q 4, Q5
C	Knowledge of the six ministerial priority areas (based on patients' complaints)	Q 6, Q7
D	Awareness of Quality Improvement activities in the clinic	Q 8, Q 9, Q 10, Q 11, Q 12, Q 13
E	Perception of the quality of service offered at the clinic	Q 14, Q 15

This section asked questions in accordance with a Likert scale. A Likert scale is defined by McLeod (2008) as a principle of measuring attitudes by asking people a series of statements about a topic, in terms of the extent to which they agree or disagree with them. Likert scales usually have five potential choices but may go up to ten.

In this study the scale was used as a measure to determine the degree to which the respondents agreed or disagreed with the statements:

- 1-Strongly disagree
- 2-Disagree
- 3-Neither Agree or Disagree
- 4-Agree and
- 5-Strongly Agree

The questionnaire was pilot tested among 3 NGO (Anova Health Institute) workers, who were requested to feedback on clarity of the questions and their understanding of them. Their feedback was then used to modify the final questionnaire.

3.2.3 Population and Sampling

3.2.3.1 Population

The Community Health care Centre (CHC) or Soweto Clinic employs an estimated population of 175 staff members in different departments. The inclusion criterion for the study was all staff members employed at the Soweto Clinic under study.

3.2.3.2 Sampling

A non-probability convenience sampling methodology was utilised for this research. Convenience sampling involves selecting sample units that are readily accessible to the researcher. It is a form of nonprobability sampling; that is, each member of a population has an unknown and unequal probability of being selected. The advantages of convenience samples are that they are relatively inexpensive and easy to access (Lewis-Beck et al., 2004). In order to obtain an acceptable sample size, the aim was to achieve an overall response rate of 30%.

At the Soweto Clinic's morning assembly, the facility manager and the deputy manager briefed staff members about the Study questionnaire on NHI and NCS to be completed by staff and they assured staff that their responses would be anonymous and kept confidential. The questionnaires were handed out to representatives of all departments and staff members were encouraged to complete the questionnaire and were told that the questionnaire would be collected later that day.

The completed questionnaires were later collected from the different departments by the deputy manager and the researcher. In the case of questionnaires which were not complete, staff members were encouraged to complete them and submit them at the facility manager's office.

3.2.4 Statistical Analysis

NWU Statistical Consultation Department used descriptive statistics to aid in the analysis of the questionnaires.

The statistical analysis was carried out by specialised statistical software programme, namely the Statistical Package for Social Sciences, Version 22 (SPSS, 2014).

3.2.5 Assumptions

- Respondents were able to read the questionnaire, understand it and write a response;
- Respondents would respond truthfully to the questions on the questionnaire, and
- The questionnaire was easy to understand.

3.3 RESULTS ON STAFF AWARENESS OF NHI AND KNOWLEDGE OF NCS

Questionnaires were completed by 104 employees, working in the various departments at the Soweto Clinic, as seen under Figure 6, translating to a response rate of 59%. The response rate of this study is measured as adequate to good. Vorster (2010: 48) mentions that, a 50% response rate is adequate, a 60% response rate is considered good, while a 70% response rate is considered very good.

The respondents covered all staff levels, namely management, support staff, administration staff, health care workers and health care professionals. For the purposes of the study, the staff categories stated above are classified under Table 3 below. Classification was done in accordance with the job role of the staff member viz:

- Management – staff who are involved in the management and/or, supervision of certain departments in the clinic.
- Support staff – employees whose services can be outsourced in other areas outside the health sector, namely security personnel, cleaners or general assistants.
- Administration staff – employees who maintain the clinical records of patients.
- Health care workers –staff members who are in contact with patients by providing direct clinical care. The World Health Report (2006:1) however defines health workers to be all people engaged in actions whose primary intent is to enhance health.

Table 3: Staff Classification and Staff titles

Staff Classification	Staff titles
Management	Heads of clinical departments, departmental managers and supervisors
Support staff	Security personnel, general assistants (cleaners)
Administration staff	Administrators, administration clerks, data capturers
Healthcare workers (HCWs)	Registered Nurses (RNs) as PHCs and RNs, Phlebotomists, enrolled nurses and enrolled nursing assistants, doctors, dentists, dental assistants, radiographers and darkroom assistants, pharmacists and pharmacist assistants, counsellors, health promoters, dieticians, social workers.

Figure 6 below indicates the number of respondents per staff classification.

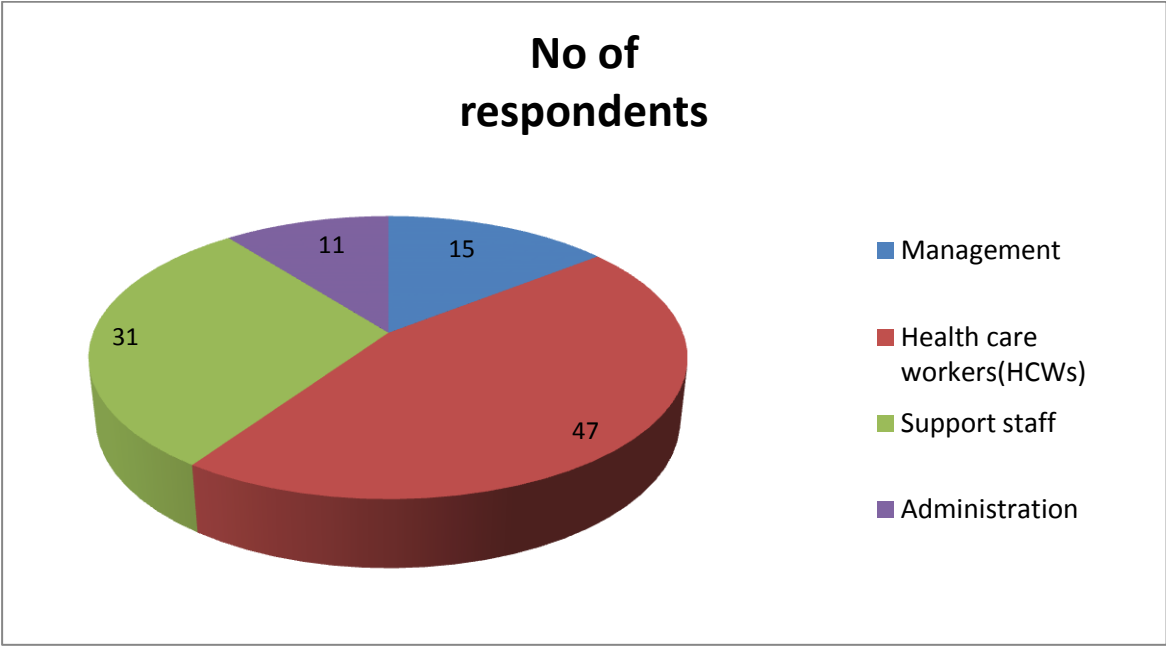


Figure 6: Number of respondents per staff classification

The health care workers' classification reflected the highest number of 47, followed by 31 support staff members.

Table 4: Demographic Analysis of respondents' Gender, Age and Number of years employed

1	Gender	30.8%	Male
		69.2%	Female
2	Age	4.9%	18-25 years
		23.5%	26-35 years
		30.4%	36-45 years
		30.4%	46-55 years
		10.8%	56-65 years
3	No. of years employed	15.7%	0 to 1 year
		22.5%	2 to 5 years
		16.7%	6 to 10 years
		10.8%	11 to 15 years
		34.3%	> 15 years

Table 4 represents the demographic analysis of the participants' gender, age and staff category. Participants comprised 32 males and 72 females, making a total of 104. The high percentage of 69% females as compared to 31% of their male counterparts is typical of staff establishments in the health sector. Studies by Naicker et al. (2009) and Bezuidenhout et al. (2014) justify the observation of the majority of health care workers being female. Of these 31% males, 16% were support staff (security personnel or cleaners), 8% health care workers were doctors and the remaining 7% were administrators.

60% of participants were aged between 36 and 55 years of age. 45% of respondents had been working at the clinic for more than 10 years. 65% of the managers or departmental heads, who responded, had been working at the clinic for more than 10 years.

Table 5: Demographic Analysis of Respondents' Employment and Management Status

4 Employment status	87.5%	Permanent
	1.0%	Part time
	6.3%	Contract
	5.2%	Other specify
5 Management Status	15.3%	Yes
	84.7%	No

Table 5 above represents the employment and management status of respondents. 15% of respondents were managers or departmental heads and more than 80% of the staff were employed on a permanent basis.

Table 6 follows on next page

Table 6: Demographic Analysis of Respondents - Staff Category and Department

6 Staff Category	2.9%	Counsellor/health promoter
	6.9%	Doctor
	21.6%	Registered Nurse
	15.7%	Enrolled Nurse
	1.0%	Data capturer
	1.0%	Pharmacist
	2.0%	Pharmacist Assistant
	16.7%	General Assistant
	8.8%	Administrator
	23.4%	Other specify
7 Department	5.8%	Labour Ward or Maternity
	4.8%	Pharmacy
	2.9%	ANC or Antenatal
	3.8%	TB
	6.7%	Clerical/Admin
	7.7%	CCMT
	9.6%	Chronic or PHC
	1.9%	Emergency
	1.9%	X-Ray
	1.4%	Termination Of Pregnancy(TOP),
	3.8%	Mental Health
	5.8%	Dental
	8.7%	Men's health (H4M)
	3.8%	Theatre
	2.9%	EPI and Family Planning(FP)
	8.7%	Security
	7.7%	Health
1.4%	Facility Manager	
10.7%	Other	

Table 6 represents the staff categories and the departments staff work in.

All the Soweto Clinic departments and staff categories were represented by the respondents, except for the rehabilitation department. The percentage of response rates varied depending on the size of the departments and the total number per staff category, for example, smaller departments and staff categories showed smaller percentages of the total response percentage. Staff categories under "other" included dental assistants, security officials, queue marshals.

Below are the responses for Section 2 of the questionnaire. They represent the overall results of all respondents regardless of occupational/staff classification.

The results indicated in Tables 7 to 11 were derived from descriptive statistics.

Table 7: Awareness of government’s introduction of National Health Insurance (NHI)

No	Question	Factor	Mean	Std. Deviation	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
1	I am aware that the Department of Health has decided to change the whole health system by introducing-National Health Insurance (NHI) to all health facilities	A	4.0	.828	2.9	6.7	2.9	74	13.5
2	The rolling out of NHI has started in other hospitals in the country	A	3.4	.868	1.9	14.4	26.9	51.9	4.9

A-A mean score of 4.0 for question 1, indicates that the majority of staff members were aware of the National Health Insurance (NHI) system that the DoH was intending to implement in all health facilities, with 88% of respondents agreeing to the statement. However, only 56.8% respondents knew about the NHI pilot currently operating in other hospitals.

Some of the respondents, who indicated their lack of awareness of the NHI implementation, were support staff and health care workers (doctors and an enrolled nurse).

Table 8: Knowledge of National Core Standards (NCS)

No	Question	Factor	Mean	Std. Deviation	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
3	I am aware of the National Core Standards (NCS) that clinics must comply with to improve the quality of service for patients in preparation for NHI roll-out.	B	3.7	.929	2.9	9.6	16.3	58.7	12.5
4	I have attended a meeting or workshop where NCS was discussed.	B	2.6	1.241	18.3	37.5	10.6	26.9	6.7
5	I have seen NCS materials such as assessment tools, Quality Improvement(QI) guides.	B	2.8	1.256	17.0	30.0	13.0	33.0	7.0

B-A mean score of 3.7 is close to 4 for question 3, which indicates that staff members generally had knowledge of the National Core Standards (NCS) that the facilities had to comply with to improve the quality of services at clinics. Whereas 71% of respondents agreed to having known about the National Core Standards (NCS), only 34% respondents agreed to having attended a meeting or workshop where NCS were discussed and only 40% respondents have seen some form of documentation on NCS.

The 12.5% of staff members who said that they did not know about NCS were 7.5% GA support staff, 3% dental health care workers, 1% MMC Manager and 1% administrator.

Table 9: Knowledge of the six priority areas

No	Question	Factor	Mean	Std. Deviation	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
6	I am aware of the general six priority areas that most patients complain about, which are prioritised by the Health Department for quality improvement.	C	3.8	1.116	7.8	5.8	12.6	50.5	23.3
7	Three of the six priority areas include cleanliness, infection control, and positive staff attitudes.	C	4.1	.943	3.0	4.0	9.9	46.5	36.6

C- A mean score of 3.8 for question 6, which translates to 74% of the respondents, indicates that staff knew of the six priority areas, which formed part of patients' complaints and are the focus areas for quality improvement for health care facilities.

The 14% staff members who mentioned that they did not know or were uncertain about the six priority areas, were 4% support staff, 3% dental HCWs, 1% dental manager, 4% CCMT&TB HCWs and 2% Theatre HCWs.

Table 10: Awareness of Quality Improvement Activities in the Clinic

No	Question	Factor	Mean	Std. Deviation	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
8	Assessments on NCS were conducted in my clinic or department	D	3.3	1.111	10.8	9.8	28.4	42.2	8.8
9	NCS assessments in my clinic were conducted by external Department of Health officials	D	3.2	1.102	10.6	12.5	26	44.2	6.7
10	Self-Assessments on NCS were conducted by our clinic personnel or QI official	D	3.3	1.221	14.4	9.6	24.1	40.4	11.5
11	There is a Quality Improvement(QI) Official and QI teams in my clinic	D	3.8	.971	4.8	3.8	15.4	54.8	21.2
12	I am a member of the QI team in my clinic	D	2.4	1.139	15.4	53.8	9.6	13.5	7.7
13	Quality Improvement plans are available for my clinic	D	3.5	1.106	4.8	18.3	17.3	44.2	15.4

D- For question 11, a mean score of 3.8, which is closer to a mean of 4, indicates that staff knew of the Quality Improvement Official and QI Teams that existed in the clinic.

60% of respondents agreed to have knowledge of the existence of QI plans for the clinic.

A mean of 3.3 and 3.2 for questions 8 and 9 respectively, indicates that the respondents were unsure or did not know if NCS assessments were conducted at the clinic by internal or external auditors.

The respondents, who did not know of if NCS audits were conducted at the clinic, included all staff categories, namely support staff, HCWs in MMC, TB, CCMT,

emergency, dental, theatre departments, dental managers, social workers and administrators.

Table 11: Perception of the quality of service offered at the clinic

No	Question	Factor	Mean	Std. Deviation	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
14	The current quality of service offered in the clinic makes it ready to implement NHI.	E	2.6	.987	12.5	50.4	29.8	4.4	2.9
15	The quality of service offered in the clinic is similar to that offered in clinics in the private sector.	E	2.1	.917	26.5	46.1	20.6	4.8	2.0

E-A mean score of 2.1 for question 15 indicates that the employees perceive the quality of service offered at the Soweto Clinic to be different or even inferior to that offered at private sector clinics.

Some 73% of respondents perceived the quality of service offered at their clinic to be of inferior quality while 20% respondents were neutral about the situation. The 7% of clients who agreed that the quality of service offered at the clinic was similar to that offered by the private sector, were staff members from the Male Medical Circumcision (MMC) department (a doctor, support staff members) and Comprehensive Management and Treatment of HIV (CCMT) department (social worker). The responses of the 9% respondents were true for the MMC and CCMT departments, not necessarily for the whole clinic, in that the quality of service offered by these two departments mimics that of private sector clinics.

3.4 DISCUSSION

While there seems to be a general awareness by the majority of staff members on NHI, NCS and the six ministerial priority areas there are still staff members who are unaware of the NCS and NHI. Staff that are the most unaware of NHI and NCS are employed in the specialised or isolated departments, those being dental, security, MMC, CCMT, TB and Theatre departments.

An average of only 34% respondents agreed to having attended a workshop on NCS or having seen any NCS documentation. This translates to a majority of respondents, who had not received any formal training or presentation on NCS.

The respondents were mostly aware of the presence of the Quality Improvement (QI) official and QI committee within the clinic even though only 51% agreed to having seen QI assessments being conducted by internal and external auditors at the clinic.

While 73% of the respondents perceived the quality of service offered at the Soweto Clinic to be inferior to that offered in the private sector, respondents from the MMC and CCMT departments believed that the MMC and CCMT units offered services similar to that available in the private sector. On observation and from the evaluation, the researcher noted that these two units or departments showed compliance to standards in all areas assessed and did not share the same results as the rest of the CHC and seemed to be privately run.

3.5 THE RESEARCH INSTRUMENT: NCS ASSESSMENT TOOL

An amended NCS assessment tool or questionnaire for CHCs was used for the purposes of collecting data for this study. Its criteria were broken down into measures specific for a CHC and only standards needed to assess the clinic's compliance to the vital measures of the six ministerial priority areas were included for assessment. The NCS assessment tool was phrased positively and the types of assessment methods varied from:

1. Observational: directly observing staff carrying out certain functions;
2. Document review: checking the availability of a document (policies, SOPs) and/or reviewing its contents;
3. Staff interviews: conducting one-on-one interviews with a staff member, and
4. Patient record assessment: reviewing the contents of patients' records.

The vital measures assessments were conducted by the researcher over a period of two days, for four hours each day. In accordance with the requirements of the assessment tool, different departments, for example, the labour ward, emergency, administration, chronics, TB, CCMT, MMC, theatre and main pharmacy were assessed to determine the compliance of these departments to the vital measures of the six ministerial priority areas.

The assessment tool enabled the generation of reports on compliance and a percentage score per domain. The Risk Rating informs how the compliance standards were scored and reported, thus the weighting of results is in accordance with the impact on patient care and safety. A similar rating was used for the National Healthcare facilities Baseline Audits where the National Core Standards tool-kit (DOH, 2012:1) was used.

3.5.1 Analysis of the results

Results were analysed using Microsoft Excel and the National Core Standards Risk Rating Framework. The National Core Standards Risk Rating Framework provides scoring of the vital measures from 0% to 100%, in which:

A vital area is made up of a list of questions, where some of the questions have specific checklists to be assessed separately. The results from the assessments would then be aggregated as percentage to respond to the main question.

- A score of 0% represented a total lack of compliance.
- A score of 100% indicates full compliance.
- Increased percentages were allocated depending on the degree of compliance for a vital area.

3.6 RESULTS FOR COMPLIANCE TO NCS

3.6.1 Priority area 1: Availability of medicines

- One of the six building blocks of health systems is access to essential medicinal products and vaccines. Availability of medicines and supplies is also one of the six ministerial priorities within the NCS (WHO, 2010: iv).
- The main pharmacy at the Soweto Clinic was assessed to determine the availability of essential medicines which are needed for the treatment of patients. The pharmacy had 33 out of the 36 required medicines.
- A sample of 10 patients' prescriptions were reviewed to determine if patients received all prescribed medication and the results showed that all patients had all the items on the prescription dispensed to them.
- Upon document review, to determine schedule 5 and 6 medicine(s) standard operating procedure (SOPs), it was found that these were not compiled separately.
- The vital measures under the availability of medicines' priority area, resulted in an overall score of 91%.

3.6.2 Priority area 2: Cleanliness

- Key areas were assessed for cleanliness. While the Soweto Clinic seemed generally clean, departments with high volumes of patient traffic (such as the chronics department) when assessed, the patients' toilets were found to be dirty and the taps were dripping water.
- It must be noted that the labour ward was an exceptionally clean department.
- Most of the cleaning materials were available and kept at a central place.
- The aggregated score allocated for cleanliness was 63%.

3.6.3 Priority area 3: Reduced waiting times

- There are widespread media reports about poor service delivery at health facilities, for example, long queues, rude staff members, dirty facilities and medicine stock outs. Mahlangu (2014) from Health e-news reported an alleged death of an elderly man while he queued at a clinic outside Johannesburg and this incident sparked a protest at the clinic. Mahlangu reported that as part of national facilities audits, clinics and hospitals are evaluated on waiting times. In 2011, facilities scored an average of 68 percent when evaluated on the criteria including whether or not queue marshals were present.
- In the study, to assess waiting time, an observation was made to determine if there was a health care worker responsible for reviewing or assessing and channelling patients – and it was found that a queue marshal or counsellor were present in certain departments to channel patients. It was also noted that the waiting times of patients were monitored in the key departments.
- A score of 80% was attained for this priority area.

3.6.4 Priority area 4: Positive staff attitudes

- A vital measure to assess if staff showed a positive caring attitude towards patients was conducted through a review of records in the facility manager's office to determine the recording of incidents of patients' abuse by staff. It was found that records were available but there were no incidents of such abuse reported in the last year.
- The files of two patients recently discharged were reviewed and these showed that a comprehensive clinical assessment and diagnosis had been carried out, even though filing of documents was not adequate and there were loose pieces of paper containing relevant information.
- The aggregated score for positive staff attitudes was 68%.

3.6.5 Priority area 5: Patient safety

- It was observed that there were adequate security measures in place to safeguard new-borns and unaccompanied children, including restricted access and exit monitoring in the labour ward.
- The Soweto Clinic is old and needs investment in infrastructure upgrading. In certain departments, the ceilings are falling down, walls are cracked and pipes are leaking. The quality of infrastructure has a major impact on the functioning of the health care service and clients' satisfaction with this service. (Department of Health, 2012:46). The dilapidated infrastructure is a health hazard and poses a serious risk to the safety of staff and patients. Some of the equipment is old and/or broken and needs replacing.

Figure 7 below shows a flooded room caused by a leaking pipe.



Figure 7: Flooding of the room resulting from a leaking pipe (Zola CHC, 2014)

For safe assessment and accurate diagnosis of patients there needs to be functional equipment available in good working order appropriate for the level of care needed at a CHC.

Table 12 below indicates the availability of functional equipment and its maintenance schedule.

Table 12: Percentage compliance on equipment

Question No	Vital Measure	Compliance
3.4.1.1.1	CHECKLIST - Functional essential medical equipment as listed in the checklist is available in the Trauma/Accident and Emergency units	88%
3.4.1.1.4	CHECKLIST - Functional essential equipment as listed in the checklist is available in the Maternity ward	75%
3.4.1.1.5	CHECKLIST - Functional essential equipment as listed in the checklist is available in the Theatre	53%
3.4.3.1.1	CHECKLIST – Up-to-date records for the last six months show that the equipment listed has been maintained according to a planned schedule	0%
3.4.3.1.2	There is a system in place to monitor that items requiring replacement or ordering are received within three months and action is taken if this is not done	0%
3.4.3.1.3	An up-to-date report for the last 12 months shows that adverse events involving medical equipment are reported and actions necessary for preventing a recurrence have been implemented	0%

- The table indicates that the trauma or the emergency unit is the only department which is compliant to the NCS vital measures since its percentage of functional equipment available is more than 80%, sitting at 88%. The theatre unit only has 53% functional equipment available.
- The Soweto Clinic does not have any equipment maintenance records or a system to monitor outstanding orders of equipment and the equipment that has to be replaced. There are also no records or reports showing adverse events caused by equipment failure or an intended plan of action for equipment maintenance and replacement.
- On assessment, it was noted that the turnaround time for laboratory results could range from 48 hours to weeks, depending on the type of results required. The department which showed a delay in results was the Expanded Programme on Immunisation (EPI) which is part of the Babies Unit with PCR results being delayed for up to six weeks or even missing altogether. The department also had difficulty filing results correctly when they came back from the laboratory.

- Wellness (VCT), Theatre and Male medical circumcision (MMC) departments were assessed to determine if their informed consent forms were completed correctly by the health workers. In all three departments the consent forms were completed correctly except for one non-compliance deviation due to the fact that it had only been signed by one witness instead of by two witnesses. It was also noted that there was no filing system for the forms in the theatre unit.
- Audit reports were available to indicate that the Soweto Clinic conducts audits of priority programmes, such as TB, PMTCT, STI and CCMT. However, there was no evidence to indicate that review meetings were held to discuss maternal and perinatal morbidity.
- The aggregated score of the Patient Safety priority area was 60%.

3.6.6 Priority area 6: Infection Control

- The vital measures for infection control assessment, audited the TB Department and its policies for the sterilisation of equipment amongst others.
- There was a separate TB Department for managing TB patients; in which windows were kept open for cross airflow. An observation was made to determine if staff members were provided with appropriate masks and FDA approved respirators – and it was found that all staff working in the TB department possessed an N95 mask to prevent them contracting TB.
- There was a policy in place for the handling of needles or sharps and evidence that these were handled correctly. Records of needle stick injuries showed that those staff involved had received post exposure prophylaxis although there was no evidence of re-testing.
- There was no evidence that the sterilisation equipment was validated/licensed and maintained according to a planned schedule since the autoclave (sterilising) machine was broken. As a result sterilisation of some theatre equipment had to be conducted at a tertiary hospital.
- The aggregated score of infection control priority area was 57%.

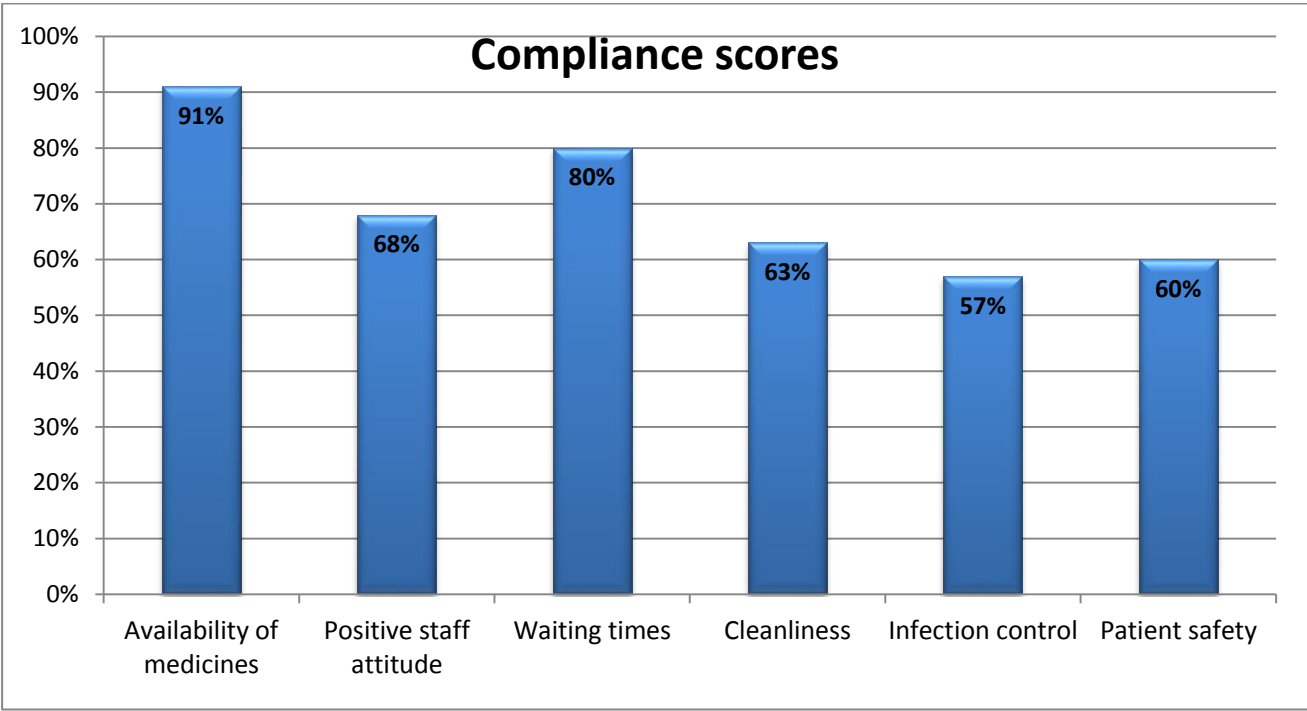


Figure 8: Compliance scores of the Soweto clinic to the six ministerial priority areas

CHAPTER 4: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter will provide a general summary of the results of the study, a conclusion and recommendations for future studies.

4.2 DISCUSSION ON NHI AWARENESS AND NCS KNOWLEDGE

Two research hypotheses were stated for the study, the first hypothesis stated that, “There is no knowledge amongst staff members at a Soweto clinic about the quality standards i.e. National Core Standards that need to be complied with to ensure acceptable standards at public health establishments”. The hypothesis is aligned with the first part of the primary objective which aimed to evaluate the staff’s awareness of the National Health Insurance (NHI) and their knowledge of the National Core Standards (NCS).

The study proved this hypothesis to be false as it showed that in fact 88% respondents were aware of the NHI and 71% respondents had knowledge of the quality standards i.e. the NCS health facilities needed to comply with to ensure acceptable standards. The results of this study are consistent with the observations made in the studies of Bezuidenhout et al. (2014:1) and that of Setswe et al. (2014:1) who also found that health care workers and the public, respectively, were generally aware of the National Health Insurance.

10% to 15% of staff members, who were unaware of the NHI and had no knowledge of the NCS, were employed in the specialised or isolated departments, i.e. dental, security, MMC, CCMT, TB and Theatre departments. More work needs to be done to integrate these staff members with the rest of the clinic and create awareness on NHI and NCS.

To respond to the secondary objective, which aimed to determine the staff members’ perceptions of the facility’s readiness to roll out NHI, only 7% respondents agreed that their facility was ready to roll out NHI, 63% respondents disagreed and 30% respondents were neutral. 73% of respondents perceived the quality of service offered at their clinic to be of inferior quality as compared to the private sector while 20% respondents were neutral about the situation. The 7% of clients who agreed that the quality of service offered at the clinic was similar to that offered by the private sector,

were staff members who worked at the Male Medical Circumcision (MMC) department and Comprehensive Management and Treatment of HIV (CCMT) department. The responses of the 7% respondents were specifically true for the MMC and CCMT departments, not necessarily for the whole clinic, in that the quality of service offered by these two departments mimics that of private sector clinics. On observation and from the evaluation, the researcher noted that these two units or departments showed compliance to standards in all areas assessed and did not share the same results as the rest of the CHC and seemed to be privately run.

MMC and CCMT departments have the following similarities:-

1. The departments had been renovated and kept clean;
2. Staff members are positive and friendly;
3. They offer specialised services;
4. They see many patients but work on a booking system; therefore, patients do not have to wait for long for diagnosis and treatment, and
5. They use electronic management of records.

4.3 RECOMMENDATION

Awareness campaigns and more knowledge on NHI and quality improvement (NCS) must be communicated to all staff categories in the health establishments to ensure a deeper understanding of these concepts.

4.4 DISCUSSION ON THE SOWETO CLINIC'S EVALUATION ON THE SIX VITAL OR PRIORITY MEASURES

On evaluation of the Soweto Clinic for the six vital areas that form the basis of many patients' complaints, the clinic scored 80% or more in only two vital areas those being availability of medicines and supplies which scored 91% and patient waiting times which scored 80%.

Infection control vital area for the clinic had an aggregated low score of 57% since the equipment sterilising unit was broken and not maintained, exposing most equipment to

infectious organisms. The clinic's equipment had to then be taken to the referral hospital for sterilising. Infection control is thus compromised since non-sterile equipment can be used on patients. Poor infection control practices expose patients to nosocomial infections. Nosocomial infections are defined by McQuoid-Mason (2012:353) as infections that are acquired in healthcare settings by patients admitted for reasons unrelated to the infection or not previously infected when admitted to the facility. He says that healthcare facility administrators may be held directly liable for not introducing or implementing best practice infection control measures, resulting in harm to patients.

The aggregated score for positive staff attitudes was 68% and there were generally no incidents reported on patient abuse by staff. This observation did not however investigate the patient views.

The aggregated score allocated for cleanliness vital area was 63%. The Soweto Clinic was generally clean; however, the departments with high volumes of patients (such as the chronics department) when assessed, the patients' toilets were found to be dirty and the taps dripping of water.

The aggregated score of the Patient safety priority area was 60%. In this vital area there was general compliance in the following measures:

- Adequate security measures in place to safeguard new-borns and unaccompanied children;
- Complete records kept for consent forms;
- Audit reports available for key programmes for example, TB, PMTCT, CCMT and STI; and
- More than 80% availability of functional equipment in the emergency, trauma and labour ward departments.

Gross non-compliance for this vital area was found in the unavailability of equipment maintenance records or a system to monitor outstanding orders of equipment and the equipment that has to be replaced. There were also no records or reports showing adverse events caused by equipment failure or an intended plan of action for equipment maintenance and replacement. Non-compliance for this vital measure somehow resulted in a situation as evidenced in the theatre department where there were falling

ceilings, leaking pipes and only 58% functional equipment. The situation in the theatre department was a health hazard and needed to be attended to urgently.

All health systems everywhere could make better use of resources, whether through better procurement practices or other measures (Chan, 2010:vi). Poor quality raises costs through inefficiencies, prolonging the need for care, and requiring remedial treatments (Kirby, 2011).

Motsoaledi (2011:5) stresses that health care staff must be reminded of their basic duties and cognisance must be taken of factors that contribute to the current situation of poor health outcomes and poor quality of services, viz

1. Delayed response to quality improvement requirements;
2. Unsatisfactory maintenance and repair services;
3. Poor supply chain or procurement management;
4. Poor disciplinary procedures; and
5. Failure to act on identified deficiencies.

The second research hypothesis stated that, “Little or no preparation in the public institutions had been conducted to address quality of service in readiness for NHI implementation”. The study proved this hypothesis to be true as the evaluation of the Soweto Clinic for the six priority or vital areas gave scores of much less than 80% for the four priority or vital areas, indicating little preparedness by the Soweto Clinic to address quality of service challenges.

4.5 SOWETO CLINIC VERSUS GAUTENG PROVINCE AGGREGATED VITAL MEASURE SCORES

When the Soweto Clinic’s evaluation results are compared to the Gauteng Province’s scores, the clinic showed some improvement in three priority areas, viz

1. Availability of medicines and supplies;
2. Positive and caring attitudes, and
3. Waiting times.

Table 13 below compares the clinic's vital measures scores with that of the Gauteng province. The only two areas which were deemed compliant by vital measure standards were the waiting times and availability of medicines, both of which had scores of 80% and above.

Table 13: Comparison of Clinic Vital Measures scores to Gauteng scores

Six Ministerial Priority Areas	Clinic Compliance score	Gauteng Compliance score	% Increase or Decrease
Availability of medicines and supplies	91%	68%	23%
Positive and caring attitudes	68%	58%	10%
Waiting times	80%	79%	1%
Cleanliness	63%	65%	-2%
Infection prevention and control	57%	61%	-4%
Improve patient safety and security	60%	50%	10%

4.6 RECOMMENDATION

Leadership is essential for quality improvement initiatives to succeed. The Soweto Clinic leaders, that is the facility manager and her heads of departments, play a key role to ensure that a culture of quality improvement is created.

The World Health Organization sets out steps for quality improvement which are:

- i. **Setting Priorities to identify specific areas for improvement:** Focus for improvement at the clinic must start with areas that showed non-compliance.
- ii. **Define a performance measurement method for the improvement project and use existing data, to monitor progress:** The NCS toolkit must be used to conduct self-audits and the results of this study to serve as baseline data for improvement.
- iii. **An improvement team to be established:** The Soweto Clinic has a Quality Improvement team and a leader and these need to be strengthened.
- iv. **Understand the processes of the underlying system of care so that improvements can be implemented to effectively address problems.**
- v. **Make changes to improve care, and continually measure whether those changes actually produce the improvements in service delivery that you wish to achieve.**

4.7 RECOMMENDATION FOR FUTURE RESEARCH

I believe that this dissertation builds on the current body of knowledge on surveys conducted on staff members to determine their knowledge of the National Core Standards and to evaluate the level of quality at the Clinic, in accordance with the NCS 's priority areas to deem it ready to implement NHI. Studies have been conducted to determine the community and staff's knowledge, understanding and perception or acceptance of the NHI, but there are no studies available to determine staff knowledge of the quality National Core Standards expected to be complied with by all health facilities. Similar future studies need to be conducted on a large scale, for example, in the whole of Gauteng to determine staff knowledge of the quality NCS standards and continue assessments using the NCS tool-kit to determine the quality service levels at health establishments.

4.8 CONCLUSION

Concerns about quality of service at public sector facilities, cause the public to prefer services in the private sector which are largely funded by the clients themselves. The majority of people cannot afford these out-of-pocket payments. The quality of service has to be aggressively improved in the public health sector to make it acceptable to the general population (DOH, 2011:9).

The main aim of this study was to determine if a Soweto clinic offered acceptable quality standards to its patients as determined by the compliance of the specific clinic to the basic quality measures , i.e. the NCS “ministerial priority areas or vital areas to deem it ready to roll out NHI”. Vital measures are minimal quality standards that the Soweto Clinic must meet to ensure that the patients and staff are safeguarded from unnecessary harm or death.

The evaluation of the Soweto Clinic for the six priority or vital areas gave scores of much less than 80% for the four priority or vital areas, indicating little preparedness by the Soweto Clinic to address quality of service challenges. The non-NHI pilot Soweto Clinic studied is still very far from ensuring the provision of basic quality service for its clients and it is thus not ready to implement NHI.

A survey conducted among the Soweto Clinic staff members in all staff categories, concluded that there is general awareness amongst staff members of National Health Insurance and they have some knowledge of the NCS; however, more education on NHI and NCS is needed for staff working in specialised or isolated departments who are unaware of NHI and have no knowledge of the NCS. This study has shown a disconnect between knowledge of the NCS and the NCS’s implementation by staff members, as staff members have failed to implement or comply with four of the ministerial priority areas, with sub-standard ratings of less than 80%.

Workshops must be conducted for all staff members in the Soweto Clinic, to support the creation of a culture of excellence, with emphasis in providing quality care to clients.

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Appendix 1: Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-retroviral therapy
CCMT	Comprehensive care management and treatment of HIV & AIDS
CHC	Community Health Care Centre
DOH	Department of Health
EN	Enrolled Nurse
ENA	Enrolled Nursing Assistant
EPI	Expanded Programme on Immunisation
GA	General Assistant
HIV	Human Immunodeficiency Virus
MMC	Male Medical Circumcision
MOU	Maternal Obstetric Unit
NCS	National Core Standard
NHI	National Health Insurance
PA	Pharmacist Assistant
PHC	Primary Health Care
QI	Quality Improvement
RN	Registered Nurse
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
WHO	World Health Organization

Appendix 2: Questionnaire: staff awareness of NHI and knowledge of NCS at the clinic

DEMOGRAPHICAL INFORMATION: Please indicate with an (X) the most appropriate answer:

Gender	Male			Female	
Age	18 - 25	26 - 35	36 - 45	46 - 55	56 - 65
Staff category	Counsellor/ health promoter	Doctor	Registered Nurse	Enrolled Nurse	Data capturer
	Pharmacist	Pharmacist assistant	General Assistant	Administrator	Other specify
Employment status	Permanent	Part time	Contract	Other specify	
Are you a Manager or head of department?	Yes			No	
Which department do you work in?					
Number of years working at the clinic	0 to 1 year	2 to 5 years	6 to 10 years	11 to 15 years	More than 15 years

For each statement below, write the number that best describes how much you agree or disagree with each statement. 1=Disagree strongly 5 = AGREE strongly

	1	2	3	4	5
	Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly
<i>Awareness of government's introduction of National health insurance (NHI) in all health facilities</i>					
1	I am aware that the Department of Health has decided to change the whole health system by introducing National Health Insurance (NHI) to all health facilities in the country.				
2	The rolling out of NHI has started in other hospitals in the country.				
<i>Knowledge of National core standards (NCS) needed for compliance to improve quality of service.</i>					
3	I am aware of the National Core Standards (NCS) that clinics must comply with to improve the quality service for patients in preparation for NHI roll out.				
4	I have attended a meeting or workshop where NCS was discussed.				
5	I have seen NCS materials such as assessment tools, Quality Improvement(QI) guides				
<i>Knowledge of the six priority areas (based on patients' complaints) which are a focus for quality</i>					

<i>improvement</i>		
6	I am aware of the general six Priority areas that most patients complain about, which are prioritised by the department for quality improvement.	
7	Three of the six priority areas include cleanliness, infection control, and positive staff attitudes.	
<i>Awareness of Quality Improvement(QI) activities in the clinic</i>		
8	Assessments on NCS were conducted in my clinic or department	
9	NCS assessments in my clinic were conducted by external department of health officials	
10	Self-Assessments on NCS were conducted by our clinic personnel or QI official	
11	There is a Quality Improvement(QI) official and QI teams in my clinic	
12	I am a member of the QI team in my clinic	
13	Quality Improvement plans are available for my clinic	
<i>Perception of the quality of service offered at the clinic making it ready to implement NHI</i>		
14	The current quality of service offered in the clinic makes it ready to implement NHI.	
15	The quality of service offered in the clinic is similar to that offered in clinics in the private sector	

Appendix 3: Vital Measures by Priority Area

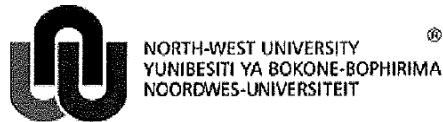
a) Availability of Medicines		
Number	Measure	Score
3.1.2.1.1	CHECKLIST Tracer medicines as per applicable Essential Drugs List or formulary are available in the pharmacy/medicine room	
3.1.3.3.1(CHC)	An SOP is available which indicates how S5 and S6 medicines are stored/controlled/distributed in accordance with Medicines Act 101 of 1965	
1.5.1.3.1	10 random selected scripts in the pharmacy are correlated with medication dispensed to ensure that all medication was dispensed	
b) Cleanliness		
Number	Measure	Score
1.1.3.1.2	CHECKLIST 5 chosen areas are checked for the state of cleanliness	
7.4.1.1.1	Records show that daily inspections of cleanliness are carried out	
7.4.1.1.2	Sample of 5 ward toilets and bathrooms are clean both on the floor and above the floor/door handles/countertops/toilets	
7.4.1.2.1	Cleaning materials cloths / dusters / scourers and chemicals and equipment are available and stored in an appropriate safe lockable area / with clear labels for equipment used internally and externally	
7.4.1.2.4	Cleaning staff wear protective clothing while carrying out their duties	
7.4.1.3.1	Records show that Pest Control is done monthly in all areas	
7.5.4.1.1	The outside bin/waste container section is well maintained and poses no health risk	
c) Positive & Caring Attitude		
Number	Measure	Score
1.1.1.1.3	Recent records show what actions have been taken in the event of an incident of staff abuse on a patient	
2.1.1.1.1	CHECKLIST The files of three patients recently discharged show that a comprehensive clinical assessment and diagnosis has been done.	
d) Waiting times		
Number	Measure	Score

1.5.1.4.1	There is a health care professional responsible for reviewing or assessing and channelling patients or clients	
e) Infection Control		
Number	Measure	Score
2.6.1.4.3	Statistics on common health care associated infections demonstrate that they are in line with acceptable benchmarks	
2.6.2.1.2	The health establishment provides appropriate types of masks and FDA approved respirators which are fit tested for all staff who are at risk of contracting TB or for all staff exposed to serious contagious respiratory infections	
2.6.2.2.1	The establishment 's rooms to be used for confirmed infectious TB patients are separated by means of adequate physical barriers from Non-TB patients	
2.6.3.1.2	The establishment has a reporting system for needle stick injuries or other incidents related to failure of standard precautions	
2.6.3.2.1	CHECKLIST A random selection of 5 clinical areas show that sharps are safely managed and disposed of.	
2.6.3.4.2	CHECKLIST Appropriate isolation accommodation exists for patients with communicable diseases -as a minimum for hazardous diarrheal diseases	
3.5.1.1.2	CHECKLIST Staff are able to explain the procedure by which dirty instruments are sterilised from start to finish	
3.5.1.4.2	All sterilisation equipment is validated / licensed and maintained according to a planned schedule	
3.5.1.5.1	There is a system in place to monitor all incidents of sterilisation failure whereby failures are documented with a detailed action plan and outcomes of those actions taken are recorded	
6.2.2.4.2	Records of needle stick injuries show that those staff have received post exposure prophylaxis and have been re-tested	
7.5.2.3.2	Records show that the waste manager monitors and manages the service level agreements for waste removal and disposal	
7.6.1.2.2	Areas for receiving soiled linen are separated from areas of clean linen	

f) Improve Patient Safety		
Number	Measure	Score
1.2.1.2.2	CHECKLIST Forms used for informed consent are completed correctly by the health professionals	
1.6.1.1.1	CHECKLIST Patient records demonstrate that the correct handover procedure was followed	
1.6.1.2.1	CHECKLIST 5 patients records or files indicate that the guidelines regarding examination and stabilisation have been adhered to	
2.1.1.2.1	There is evidence that the health establishment conducts monthly maternal and perinatal morbidity and mortality meetings	
2.2.1.2.1	CHECKLIST. The establishment conducts clinical audits of each priority programme/health initiative Review the clinical audit reports	
2.2.1.3.2	The health initiatives outcome report shows that quality improvement plan has been implemented to address shortcomings and improve outcomes	
2.3.1.2.1	Healthcare professionals specifically doctors and nurses indicate that they have access to adequate supervision (excluding doctors for private sector)	
2.4.2.5.1	CHECKLIST - The initial assessment of high risk maternity patients reflects the identification and implementation of specific plans to ensure safety	
2.4.2.6.1	Security measures are adequate to safeguard new-borns and unaccompanied children including restricted access and exit monitoring in wards identification of new-born/children and their parents	
2.4.3.2.1	CHECKLIST - Patients` peri-operative documents demonstrate that safety checks have been conducted during and after surgery	
2.4.3.3.1	CHECKLIST - The establishment has a formal policy for handling emergency resuscitations	
2.4.3.3.3	The recent minutes within 6 months of the committee reviewing resuscitations indicates that resuscitations are regularly discussed /analysed and actions taken to reduce risk	
2.4.3.3.5	CHECKLIST VITALS - Emergency trolleys are standardised as far as practical appropriately stocked and regularly checked	
2.4.3.4.1	A protocol regarding the safe administration of medicines to patients is available including a protocol for the safe administration of medicines to children	
2.4.3.4.2	CHECKLIST - Observation of patient receiving medication confirms that patients` safety is assured	

2.5.1.1.2	CHECKLIST - three adverse event reports reflect that Immediate actions are taken at the time of incident to address harm and adverse events are analysed to identify underlying causes and contributory factors	
f) Improve Patient Safety (continued)		
3.2.2.1.6	CHECKLIST - Radiology results requested are available in the patient`s file or nursing unit	
3.4.1.1.1	CHECKLIST - Functional essential medical equipment as listed in the checklist is available in the Trauma/Accident and Emergency	
3.4.1.1.4	CHECKLIST - Functional essential equipment as listed in the checklist is available in the Maternity ward	
3.4.1.1.5	CHECKLIST - Functional essential equipment as listed in the checklist is available in the Theatre	
3.4.3.1.1	CHECKLIST - Up to date records the last 6 months show that the equipment listed has been maintained according to a planned schedule	
3.4.3.1.2	There is a system in place to monitor that items requiring replacement or ordering are received within 3 months and action is taken if this is not done	
3.4.3.1.3	An up to date report the last 12 months shows that adverse events involving medical equipment are reported and actions taken to prevent recurrence have been implemented	
7.1.4.1.2	No obvious safety hazards are observed during the visit such as loose electrical wiring / collapsing ceilings / unstable walls / leaking water	
7.2.1.2.2	There is a system to provide emergency power for all strategic areas such as Operating Theatres / ICUs/ clinical care and emergency of lighting of grounds/passages	
7.2.1.3.1	Maintenance record reflects that emergency generator is functional and maintained and that the generator is started and run for five minutes a week	
7.3.1.2.1	Security systems are positioned at vulnerable patient areas such as maternity / paediatric and psychiatric units	

Appendix 4: Request from Student to Jo'burg Health District to conduct Survey



To : Chief Director (Jo'burg Metro district)
Date : 10 August 2014
Subject : Request permission to conduct a NCS survey at a Soweto CHC

Purpose

I hereby request permission to conduct a survey at a Soweto Community Health Care (CHC) centre as part of fulfilling my research module requirement for Master's degree.

Background

- The University of North-West has accepted my research proposal for a Master's in Business Administration degree. The purpose of the study is to evaluate a Community health care's compliance to national core standards (NCS) to determine its readiness for NHI.
- A compliance assessment will be done by the researcher using the NCS assessment questionnaire.
- The second type of questionnaire, aims to determine staff's awareness of the NCS and NHI. The staff will be informed about the purpose of the survey and then requested to participate in the survey. Participants will be assured that all information collected during the survey will be kept anonymous and only used for the purpose of the study.

On completion of the survey, the results and recommendations will be shared with the clinic and district. Interventions will be planned collectively with stakeholders.

The survey is only conducted for the purpose of the research module, quality improvement purposes at the clinic and not for publication.

Your positive response will be highly appreciated.

Yours Sincerely,

Phethogo Madisha | Phethogo.madisha1@gmail.com

Mobile +27 71 885 0474 | Fax +27 11 482 1116

Signed.....

Appendix 5: Motivation from supervisor to Jo'burg Health District

From: Theo Venter [<mailto:Theo.Venter@nwu.ac.za>]

Sent: 15 September 2014 12:26 AM

To: phethogo.madisha1@gmail.com

Subject: Re: FW: Research

Dear Phethogo,

WHOM IT MAY CONCERN

I have studied and read the research application form issued by the Johannesburg Health District and confirm herewith that I am the study leader of Ms Phethogo Madisha in completing her dissertation for MBA at the North West University.

Ms Madisha is far advanced with her theoretical work for the dissertation and needs approval urgently to do research in one of the facilities of the Johannesburg Health District.

Ms Madisha is a very good student and it is my hope that approval for her research will be done with urgency.

Sincerely yours

Theo Venter

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Appendix 6: Approval to conduct a study letter from Johannesburg health district



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

JOHANNESBURG HEALTH DISTRICT

Enquiries:
Hillbrow CHC
Private Bag X21, JHB, 2001
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Johannesburg.research@gmail.com

08 October 2014

Phethogo Madisha
ANOVA Health Institute

Email: madisha@anovahealth.co.za

Dear Ms Madisha,

Re: Research protocol titled '*An Evaluation of the readiness to implement the national health insurance of a clinic in Soweto*'

Your application dated 19 September 2014 refers. The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project, subject to following conditions:

- The facility to be visited: Zola CHC
- This facility will be visited from 15 October 2014 to 31 March 2015.
- You will report to the Facility managers of the CHC/ Clinic before initiating the study.
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee. Your supervisor and University of the Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above.

Please feel free to contact us, if you have any further queries. On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

Ms M Morewane
Chief Director
Johannesburg Health District

Appendix 7: Student Statement on Ethics Research



FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

Student Statement on Research Ethics *(to be completed as part of the Proposal Colloquium)*

Name and Phethogo Madisha

Surname:

Student number: 2394 7969

Please answer each question by ticking the appropriate box¹:

1. Does the study involve participants who are particularly vulnerable² or unable to give informed consent? (e.g. children, people with learning or other mental or physical disabilities, people who are incarcerated, unemployed or otherwise compromised in responding to your questions)
2. Will it be necessary for participants to take part in the study without their knowledge and consent at the time? (e.g. covert observation of people)
3. Will the study involve discussion of, or questions about, a sensitive topic? (e.g. sexual activity, drug use, crime, harassment, violence)
4. Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind or any physical, psychological or socio-economic intervention?
5. Will blood or tissue samples be obtained from participants?

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

¹ Adapted from Economic and Social Research Council (2005). Research Ethics Framework (REF). www.esrcsocietytoday.ac.uk

² **Vulnerable groups** raise special issues of informed consent and potential risk. "Vulnerable" participants are not clearly described, but have been noted to include "...children, prisoners, pregnant women, mentally disabled persons, economically or educationally disadvantaged persons" (Common Federal Policy, 1991). Weijer and Emanuel (2000) consider participants to be vulnerable if they are not in a position to provide informed consent, due to their position (such as being in prison), or not possessing adequate intellectual faculty (such as children or the mentally ill). "Children" here are defined as participants younger than 18 years of age.

6. Could the study induce physical, psychological or social stress or anxiety or cause harm or negative consequences beyond the risks³ encountered in normal life?
7. Will the study require the personal identification of individuals for follow-up evaluation? (i.e. through names and surnames, identification or staff numbers)
8. Will financial inducements (other than reasonable expenses and compensation for time) or inducements of any other kind be offered to participants?
9. Could the image of the NWU, the relevant academic department, your employer, or any other institution however affected by/involved in the project be negatively affected by this research or put in a bad light?

In answering the following 2 questions; consider the classification of the research also as being of *no, low, medium or high risk*, according to NWU guidelines. Attach documentation in which you outline/describe your motivation for this classification.

10. Are you planning on making use of NWU students and/or direct and/or secondary/contracted staff members as research subjects in this research? Also please indicate anticipated *level* of risk:

No risk	Low risk	Medium risk	High risk
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11. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (e.g. students at school, members of self-help groups, residents of a nursing home, the Minister of Education, a tribal chief or village elder). Also please indicate anticipated *level* of risk:

No risk	Low risk	Medium risk	High risk
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If you answered **yes** to any of the above questions, you will need to describe more fully how you plan to deal with the ethical issues raised by your proposal. ***This does not mean that you cannot do the research, only that your proposal will need to be approved by the Faculty***

³ **Risk:** These possible risks are described as an "...invasion of privacy, loss of confidentiality, psychological trauma, indirect physical harm, embarrassment, stigma, and group stereotyping" (Oakes, 2002: 449), and also risks posed to. "...a subject's personal standing, privacy, personal values and beliefs, their links to family and the wider community, and their position within occupational settings, as well as the adverse effects of revealing information that relates to illegal, sexual or deviant behaviour" (Economic and Social Research Council (ESRC), 2005: 21). Minimal risk may be defined as where "...the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life" (Code of Federal Regulations, 2005).

Research Ethics Committee. Attach a full description of the specific issues to this declaration, for discussion by the panel at the Proposal Colloquium. Also, outline/describe your motivation for the classification of the research as being of low, medium or high risk (Please refer to the attached NWU Ethical risk level descriptors).

Please note that it is your responsibility to follow NWU's *Guidelines for Ethical Research* as set out in the *Manual for Postgraduate studies* and any other relevant academic or professional guidelines in the conduct of your study. **This includes providing appropriate information sheets and consent forms, and ensuring the confidentiality in the storage and use of data, and anonymity of participants.** Any significant change in the question, design or conduct over the course of the research should be notified to the Study Leader and may require a new application for ethics approval.

Candidate

Students should retain a copy of this form and submit it with their dissertation/thesis.

I have read the NWU's Manual for Postgraduate Studies and am familiar with the Guidelines for Research Ethics contained therein⁴.

<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N
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I have familiarised myself with the NWU Policy on Plagiarism and Academic Misconduct, and submit myself thereto.

<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N
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Name and Surname: **Phethogo Madisha**

Signature:

Supervisor/Promoter

Name and Surname: **Mr Theo Venter**

Signature:

Chair: Research Colloquium:

Name and Surname:

Signature:

Date:

Approved at level:

Faculty	Institutional (Refer for full review)
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⁴ <http://www.nwu.ac.za/sites/www.nwu.ac.za/files/files/i-research-support/ResearchLinkdocs/EnglishPDFs/PGManual.pdf>

Appendix 8: Letter from language editor

May 5, 2015



TO WHOM IT MAY CONCERN

Re: Letter of confirmation of language editing

The dissertation "An evaluation of the readiness to implement the National Health Insurance at a clinic in Soweto" by PM Madisha (23947969) was language, technically and typographically edited. The sources and referencing technique applied was checked to comply with the specific Harvard technique as per North-West University prescriptions. Final corrections as suggested remain the responsibility of the student.

Antoinette Bisschoff

Officially approved language editor of the NWU since 1998
Member of SA Translators Institute (no. 100181)