

UNIVERSITY OF KWAZULU-NATAL

**AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE
NATIONAL HEALTH INSURANCE POLICY, ITS IMPLICATIONS FOR
IMPLEMENTATION IN HEALTHCARE FACILITIES IN THE ETHEKWINI
DISTRICT.**

BY

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DEDICATION

This study is dedicated to my late parents, Sikhosiphi and Khanyisiwe Mtshali, my late siblings Shiyinduku, Thabile and Hlangabeza, for the love and support we shared as a family.

I further dedicate this work to my late parents in law Gladstone and Beatrice Mthembu, my late brother in law Sikhumbuzo Mthembu for all the love they gave to me.

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ABSTRACT

Background: The government of South Africa has focused on Primary Health Care and implementation of the National Health Insurance (NHI) as part of the plan to reform the South African health care system. This is based on the principle of the right to healthcare and the right to access health care facilities.

Aim: The aim of this study was to analyse the Nurse Managers' interpretation of the National Health Insurance Policy and, its implications for implementation on their roles and responsibilities in health care facilities.

Methodology: The sequential mixed method approach was conducted. There was direct interaction (semi structured interviews) with the Nurse Managers as well as a survey (questionnaires) for both qualitative and quantitative phases. Qualitative data was collected and analysed first, and an instrument was developed based on the analysed data from the qualitative phase to collect quantitative data.

Setting: EThekwini district comprising of two district hospitals, three Community Health Centres (CHC) and four Private healthcare facilities were selected.

Participants: Nurse Managers in the public Primary Health Care facilities and private hospitals in the EThekwini district. These were Nurse Managers (top middle and lower levels) from the public healthcare facilities (district hospitals, Community

Health Centres, primary health clinics) middle and lower levels in the private facilities.

Data Analysis: A thematic analysis was used in the qualitative phase. Descriptive statistic was used in the quantitative phase to describe and synthesize data (Polit and Beck 2004) as well as inferential numeric analysis (Creswell 2009).

Findings: The findings in both the qualitative and quantitative data revealed that the participants demonstrated a general impression on the NHI rather than specific understanding; hence the researcher believes that there was more general than specific knowledge and interpretation of the NHI policy. The participants' display of lack of knowledge and understanding of the concept NHI and the implementation process was an indication that there was lack of personal development in relation to expectations from the nurse managers concerning NHI though there is a lot of publicity in this respect from the government and media. There are national policies and guidelines for all citizens to access.

Recommendations: The recommendations were made for sharing with the policy makers and seniors in the healthcare facilities in order to improve nursing management, nursing education and nursing research.

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LIST OF ACRONYMS

- ANC - African National Congress
- COSATU - Congress of South African Trade Unions
- DoH - Department of Health
- CEO - Chief Executive Officer
- CHC - Community Health Centre
- DA - Democratic Alliance
- HASA - Hospital Association of South Africa
- HOD - Head of Department
- JUDAS - Junior Doctors Association of South Africa
- KZN - Kwa –Zulu Natal
- NHI - National Health Insurance
- NHSI - National Health Insurance Scheme
- NHS - National Health Service
- PHC - Primary Health Care
- SANC - South African Nursing Council
- SPO - Structure Process Outcomes
- SPSS - Statistical Package for Social Services
- UK - United Kingdom

UKZN - University of Kwa-Zulu Natal

WHO - World Health Organization

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DECLARATION

I hereby declare that this research project entitled "**An analysis of the nurse managers' interpretation of the National Health Insurance policy, its implications for implementation in healthcare facilities in the eThekweni district**" is the researcher's original work, and the work used or cited has been acknowledged in the text and in the references.

Signature  _____

Date 26/02/13

Signature  _____

Date 26.02.13

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1. BACKGROUND TO THE STUDY

The healthcare system of South Africa prior to 1994 had many deficiencies and inadequacies, for example, it was fragmented along racial and socioeconomic lines (by government decision) into Own Affairs and Independent States including Self-Governing States. All had their own health departments. This warranted a well thought-out health reform and financial resources (Van Rensburg, 2008). The aim of the health reform was to unite these fragmented health services, reduce the disparities and inequalities in service delivery and health outcomes, and extend access to an improved health service, with the emphasis on Primary Health Care as key (Van Rensburg, 2008).

Post-1994, the African National Congress's (ANC) National Health Plan for South Africa examined the basis for the funding of healthcare. It contemplated introducing free healthcare and equity in health expenditure, and included the introduction of social health insurance to improve access to healthcare.

Dr Aaron Motsoaledi (Minister of Health in South Africa) was not happy with the existing healthcare system in South Africa, which he alleged was very expensive because it is predominantly curative (Bodibe, 2010). Since it was based on curative care as opposed to preventative care, especially in the private sector, it was therefore

unsustainable within the framework of South Africa's economic status. This led to a need for the adoption of the Primary Health Care concept.

The World Health Organization (WHO, 2008) identified five key elements for achieving the ultimate goal of better health for all which constitutes Primary Health Care. These were:

- Reducing exclusion and social disparities in health (universal coverage)
- Organising health services around people's needs and expectations (service delivery)
- Integrating health into all sectors (public policy)
- Pursuing collaborative models of policy dialogue (leadership)
- Increasing stakeholder participation (community involvement)

To achieve these elements, the member states of WHO aggregated all of the health care facilities at all levels, from Primary Health to Tertiary, into a comprehensive healthcare system. Van Rensburg (2010) stated that the comprehensive health care system advocated an equity-oriented approach to health care and preventive and promotive health. The Health Care System was defined as a complete network of agencies, facilities and all providers of health care in a specific geographic area (Mosby's Medical Dictionary, 2009). Van Rensburg (2008) defined the system as an institution of health service delivery for the promotion, protection or restoration of the health of individuals and populations. Van Rensburg further defined it as more than just

health services, since it also comprised those aspects surrounding and influencing actual or direct health services.

The key components of a well-functioning health care system include the following:

- Improvement of the health status of individuals, families and communities
- Defence of the population against what threatens its health
- Protection of the people against the financial consequences of ill-health
- Provision of equitable access to people-centered care
- Enabling people to participate in decisions affecting their health and the healthcare system (WHO, May 2010)

The health care system of South Africa is inequitable, with the privileged few having disproportionate access to health services. This system is neither rational nor fair (Government Gazette, 12 August 2011).

1.1.1 The challenges faced by the health care system of South Africa are as follows:

- Burden of disease –The country is plagued by four health problems which have been dubbed the quadruple diseases. These are HIV/AIDS and TB, maternal, infant and child mortality, non-communicable diseases and injury and violence. It is claimed that the burden of disease in South Africa is, on average, four times larger than that of developed countries, and almost double that of developing countries. The WHO (2004) study revealed that for every 100,000 of the

population, South Africa had 46,237 cases compared to Brazil with 20,112 cases and the United Kingdom with 11,012 cases of the quadruple diseases. According to the WHO, in South Africa, in 2009, the mortality rate was 496 for every 1,000 adults, higher than in most countries of the world.

- Quality of health care – There are quality problems cited and experienced by the South African public visiting public health care facilities. These include cleanliness, the safety and security of staff and patients, duration spent waiting for attention, attitudes of staff, infection control and drug stock shortage. This leads to the public preferring services in the private sector which are funded largely out of pocket and co-payments.
- Distribution of financial and human resources - The mal-distribution of health care resources in the public and private sectors leads to redistribution of health care professionals in favour of the private sector. The average doctor-to-population ratio in the private and public sector is 55 doctors per 100,000. This average in developed countries is 280:100,000. South Africa lags behind other middle-income countries like Brazil, where the ratio is 185:100,000. The World Health Organization aggregates for 230:100,000. To illustrate this point, two provinces in South Africa, namely Gauteng and Limpopo provinces, provide a true reflection of mal-distribution, one being an urban setting and the other rural. The ratio in Gauteng is 102:100,000 while in Limpopo it is 17: 100,000. The ratio of patients to health professionals is lower in the private than in the public sector. In 2009, the Department of Health records revealed that there were 42,373 nurses for a population of 49.3 million. The amount of money spent in the

private health sector in relation to the number of people covered defeats the principles of social justice and equity. Reports from the Department of Health state that 8.3% of the Gross Domestic Product (GDP) is spent on health. The private sector gets 4.1% from the Medical Aid Funds and out-of-pocket payments to cover only 16.2% of the population (8.2 million people), largely on medical schemes, while the public sector gets 4.2% to spend on 84% of the population (42 million people).

- High cost of health care –The high cost of private health care is out of control, and is at the expense of medical aid members. The cost of public health care is escalating at the expense of the fiscus; this means that health care is unaffordable for the poor (Government Gazette, 12 August 2011).

Furthermore, an additional challenge lies in the fact that the roots of health inequalities are embedded in social conditions outside the health system's control. These inequalities have to be addressed through cross-government action. A fundamental step that a country can take to promote health equity is to move towards universal coverage. This means universal access to the full range of personal and non-personal health services required with social health protection (World Health Report, 2008).

The arrangements for universal coverage can be tax-based or organised through social health insurance. The idea is to pool pre-paid contributions which are collected on the basis of a person's ability to pay, and to use the funds to ensure that services are available, accessible and produce quality care for those in need, without exposing them

to the risk of additional expenditure. The starting point should be to create or strengthen networks of accessible quality primary care services that rely on pooled pre-payment for their funding (World Health Report, 2008).

The current system of health care financing in South Africa is two-tiered. The private sector covers 16.2% of the population. A large proportion of its funding is acquired through medical schemes, various hospital plans and out-of-pocket payments. This funding provides cover to private patients who have purchased a benefit option linked to a scheme of their choice, or as a result of their conditions of employment. It benefits the employed, who are subsidised by their employers in the State and private sector (Government Gazette, 12 August 2011).

The public sector covers 84% of the population and is funded through the fiscus. This sector is under-resourced relative to the size of the population it serves and the burden of disease. It has less human resources than the private sector, yet it has to manage more patients (Government Gazette, 12 August 2011).

1.1.2 National Health Insurance as a solution

The South African Government thus needs to adopt an approach or strategy that will ensure universal access to healthcare. National Health Insurance is acknowledged as a Universal Coverage model by the World Health Organization. It is an approach to health system financing that is structured to ensure universal access to a defined,

comprehensive package of health services for all citizens, irrespective of their social, economic and/or any other consideration that affects their status. The ANC-led government thus proposed National Health Insurance for South Africa (ANC National Polokwane Conference, 2007).

In South Africa, National Health Insurance (NHI) is intended to ensure that all citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis. It aims to provide coverage to the whole population and minimise the burden carried by individuals of paying directly out of their pockets for health care services (Government Gazette, 12 August 2011).

Four key interventions needed to take place simultaneously, in order to successfully implement a healthcare financing mechanism that covers the whole South African population as the NHI, are as follows:

- A complete transformation of healthcare service provision and delivery
- The total overhaul of the entire healthcare system
- The radical change of administration and management
- The provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care plan (Government Gazette, 12, August 2011).

The South African Government's plan regarding the implementation of the NHI is to eliminate the current system where those with the greatest need have the least access and have poor health outcomes. This will therefore improve access to quality health

care services and provide financial risk protection against health-related expenditures for the entire population. The system will improve the overall health care by reducing the direct costs for health care, thus making households less likely to face impoverishing health care costs. Funding contributions would be linked to an individual's ability to pay and benefits from health services would be in line with an individual's need for care (Government Gazette, 12 August 2011).

The health care system under the NHI is based on a primary health care (PHC) approach. Its implementation is part of the Ten-Point Plan for health reform in South Africa (2010-2014). The strategic Ten-Point plan on the improvement of the health sector, as reaffirmed by the Minister of Health, includes overhauling the healthcare system and improving its management. It also includes improving human resources management, planning and development and improving the quality of health services (National Department of Health Strategic Plan, 2010/11-2012/13).

1.1.3 The principles that will guide the National Health Insurance are:

- The right of access to health care services.
- Social solidarity – the creation of financial risk protection for all, and subsidisation between rich and poor, healthy and sick.
- Effectiveness - better performance of the health care system, contributing to positive health outcomes and value for money.
- Appropriateness - new and innovative health service delivery models tailored to respond to local needs.

- Equity - those with the greatest health needs are provided with access to services without barriers, and inequalities are minimised.
- Affordability - services will be procured at reasonable costs.
- Efficiency of administrative structures to minimise or eliminate duplication across all spheres. Minimal resources to be spent on the administrative structures of the NHI and value for money achieved (Government Gazette, 12 August 2011).

1.1.5. The objectives of the National Health Insurance of South Africa are:

- To provide improved access to quality health services for all South Africans, irrespective of whether they are employed or not.
- To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.
- To procure services on behalf of the entire population, and to efficiently mobilise key financial resources.
- To strengthen the under-resourced and strained public sector so as to improve health systems performance (Government Gazette, 12 August 2011).

Dr Aaron Motsoaledi (Minister of Health) envisages a system where hospitals will be assessed and accredited before they are said to be ready to provide services under the NHI system. The Office of Health Standards Compliance has been established through an act of parliament. This office will inspect and ensure that the health facilities comply with the set standards and norms. These standards will deal with key quality principles that will improve safety and facilitate access (Government Gazette, 12 August 2011).

The healthcare facilities must meet the criteria set before they can be granted approval or accreditation and can be deemed suitable to operate under the National Health Insurance (Mkhwanazi, 2010). The six basic issues to be attended to as a matter of urgency are cleanliness, safety and security of staff and patients, duration spent waiting for attention, lack of drug stocks, staff attitudes and infection control (Government Gazette, 12 August 2011).

There have been discussions and debates between the political spheres, private hospitals, specialists and general practitioners as well as the private health insurance (medical aid) companies on the proposed implementation of the National Health Insurance. The issues that came up were the fact that the NHI would be too expensive for the country; it would cost tax-payers more, the fact that it has not worked in other countries prompting questions as to what would make it work in South Africa. One of the concerns raised was that the country would lose more of its skilled and knowledgeable health professionals as they would be compelled to leave the country to avoid paying too much tax.

The Junior Doctors' Association of South Africa (JUDASA) feels that poor management at public health institutions has resulted in the state that these institutions are in. JUDASA feels that with the type of management the hospitals have at present, the NHI will not work. They add that hospital managers must have basic training in health, as most managers are ignorant when it comes to issues of health (Bodibe, 2010).

According to a study conducted by Shisana, Rehle, Louw, Zungu, Dirwayi, Dana, Rispel (2006), a large percentage of the South African population feel that it is more important to provide improved health care coverage even if this means raising taxes. A small percentage thinks that it is better not to raise taxes despite the lack of access to health care.

Mclea and Davids (2011) reported that a discussion document on the NHI by the ANC put the cost of its implementation at R376 billion, if phased in over 14 years.

There are countries that have benefited from the implementation of the NHI, although they encountered some problems. Ghana, France, the United Kingdom, Rwanda and Brazil are some examples.

The implementation of quality improvement measures is important in order to ensure that facilities are ready for accreditation. This function/role rests squarely with the Nurse Managers. Nurse Managers must ensure that their facilities comply with the PHC principles and the accreditation standards set by the Office of Health Standard Compliance. They must ensure that the six basic issues of quality assurance are looked into as a matter of urgency (Government Gazette, 12 August 2011). Their perceived readiness and the support they have will determine the success or failure of the implementation of the NHI. The gaps they have identified in their readiness will have a negative impact on the implementation of the NHI policy in their facilities; however this may conscientise the powers that be to fill these gaps.

It is therefore interesting to investigate or understand how Nurse Managers interpret the NHI and its implication for implementation regarding their roles and responsibilities.

1.2. PROBLEM STATEMENT

The literature (Bodibe 2010; Engelbrecht and Crisp, 2010 and Thom, 2010) and the Minister of Health's speeches (4 August 2011; 11 October 2011) have asserted that poor management occurs in a number of public health care facilities in SA.

The Junior Doctors' Association of South Africa (JUDASA) has argued that the ills that afflict the public health system occur largely as a result of poor management. They add that, with the implementation of the National Health Insurance, the quality or calibre of managers will determine the success or failure of the health care system (Health –e news service, October 2010).

Dr Motsoaledi (August, 2011) in his speech at the Nurses' summit, alluded to a lack of management skills in the healthcare facilities. He stated that nurses should commit themselves to improving the way in which they deliver healthcare to all. Nurse Managers have been relieved of their positions as CEOs (top level Nurse Managers) in a number of public sector health facilities due to their lack of delivery and management skills.

The strategic Ten-Point Plan on the improvement of the health sector which was reaffirmed by the Minister of Health includes overhauling the health care system and

improving its management. It also includes improving human resources management, planning and development (National Department of Health Strategic Plan, 2010/11-2012/13). The quality problems of cleanliness; safety and security of staff and patients, staff attitudes and infection control commonly experienced by the members of the public indicate poor management in the health care facilities (Government Gazette, 12 August 2011).

The interpretation of the NHI policy by Nurse Managers could influence its implementation in all health care facilities in South Africa. The implementation of the NHI policy is one of the quality improvement strategies which the Minister of Health believes will improve health care in South Africa. The negative interpretation and understanding of the NHI policy by Nurse Managers will ensure the need for Management to communicate the purpose of improving health care delivery and empower staff. These Nurse Managers should also ensure that personnel have the necessary knowledge and skill to deliver health care to the population.

Although there could still be limitations since the policy has not yet been implemented, this study looked at the interpretation of the NHI by Nurse Managers, and the implications of the implementation of the policy on their roles and responsibilities. It is important to look into how Nurse Managers may interpret the NHI because this policy envisages the re-engineering of Primary Health Care. Nurses will play a major role, as they will provide the first level of care and ensure access to healthcare services that are

efficient and of good quality. As frontline workers, they will give the public the first impression of the Health Care System.

1.3 THE PURPOSE OF THE STUDY

The purpose of the study was to analyse how Nurse Managers interpreted the concept of National Health Insurance and the implications that the implementation thereof would have on their roles and responsibilities.

1.4. OBJECTIVES OF THE STUDY

- 1.4.1 Determine how Nurse Managers interpret the concept of the NHI.
- 1.4.2 Establish perceived readiness by Nurse Managers for the implementation of NHI.
- 1.4.3 Establish what Nurse Managers understand to be the implications of the implementation of the NHI on their roles and responsibilities.
- 1.4.4 Establish whether any strengths are possessed by Nurse Managers.
- 1.4.5 Determine whether there are any gaps in their readiness and understanding of the policy.

1.5 RESEARCH QUESTIONS

- 1.5.1 What do Nurse Managers understand about the NHI concept?
- 1.5.2 Do Nurse Managers perceive themselves as ready for the implementation of the NHI policy in their facilities?
- 1.5.3 Is there any evidence of their readiness?
- 1.5.4 How will the NHI policy affect the roles and responsibilities of Nurse Managers?
- 1.5.5 What support do the Nurse Managers have to help them to prepare themselves?
- 1.5.6 Are there any gaps in the readiness or understanding of the concept of NHI?

1.6. SIGNIFICANCE OF THE STUDY

The National Health Insurance implementation is a new phenomenon in South Africa. With the purpose of the study being to analyse the Nurse Managers' interpretation of the NHI and the implications of its implementation on their roles and responsibilities; this study is relevant to management, education and research in nursing as it will inform on the implementation of the policy.

Management:

The Nurse Managers' knowledge and understanding of the NHI policy will influence their interpretation which would, in turn, influence their perceptions of the implementation of this policy in their facilities. Nurse Managers are expected to ensure that their facilities comply with the accreditation standards set by the Office of Health Standard compliance. They are also expected to ensure that the basic issues of quality

assurance are attended to. Well qualified and skilled Nurse Managers who are knowledgeable regarding the NHI policy and its requirements, will be a cornerstone to efficient NHI policy implementation. The results of the study will identify gaps, and inform policy-makers as to the gaps in the Nurse Managers' understanding that need to be addressed before the policy is implemented. It will also inform the policy-makers on the preparedness of Nurse Managers for the implementation of the NHI.

Education:

Gaps in the interpretation of the implementation of the NHI could indicate a need for education to empower Nurse Managers as to their roles and responsibilities. Strengths identified can be capitalised on to ensure that they are sustained. There has been an outcry about the lack of managerial skills in health facilities by junior doctors (Bodibe, 2010) and the national Minister of Health's speech (4 August 2011) as cited in the Minister's speeches. This study will identify gaps in the understanding of the Nurse Managers regarding their expected roles and responsibilities, and highlight the areas in which support and training is needed. This information will be shared with the higher authorities in the District Health Office as well as senior management at the healthcare facilities, so that the appropriate action, such as the evidenced-based empowerment of nurses can be implemented.

Research:

Similar studies could be conducted in other contexts. The implementation process and outcomes could be evaluated in future research. This study could provide baseline data for some of the aspects of monitoring and evaluation of the outcomes of the NHI project.

1.7. THE THEORETICAL FRAMEWORK

The conceptual framework of the study is based on the structure/process/outcome (SPO) model of assessing healthcare quality (Burns, 1995) and reflects on systems. The model utilises three components namely Structure, Process, and Outcomes in analysing a system and assessing the quality of health care. Donabedian (1988) defines structure as professional and organizational resources associated with the provision of care. Process refers to the tasks carried out on and for the patient in the course of treatment, including nursing management (Gustafson and Hundt, 1995). Outcome measures are the desired states resulting from the care process. This framework was based on the organisational qualities required for the implementation of a project. For example, in this study, structure/input would include the Nurse Managers' understanding of the concept of the NHI policy, the strengths that they possess, the support that they have, their readiness for the implementation and the gaps that they identify. Process would include the NHI implications regarding their roles and responsibilities, for example, ensuring a conducive environment, preparation for the implementation of the NHI, ensuring compliance with the core standards and ensuring quality care. The outcomes would include the guiding principles to achieve as targets of the NHI, for example, ensuring access, affordability and equity. Figure 1.1 indicates the understanding of the NHI policy, the implications of its implementation and the targets as determinants of the structure process and outputs. These are in line with systems analysis and quality assessment in health care delivery.

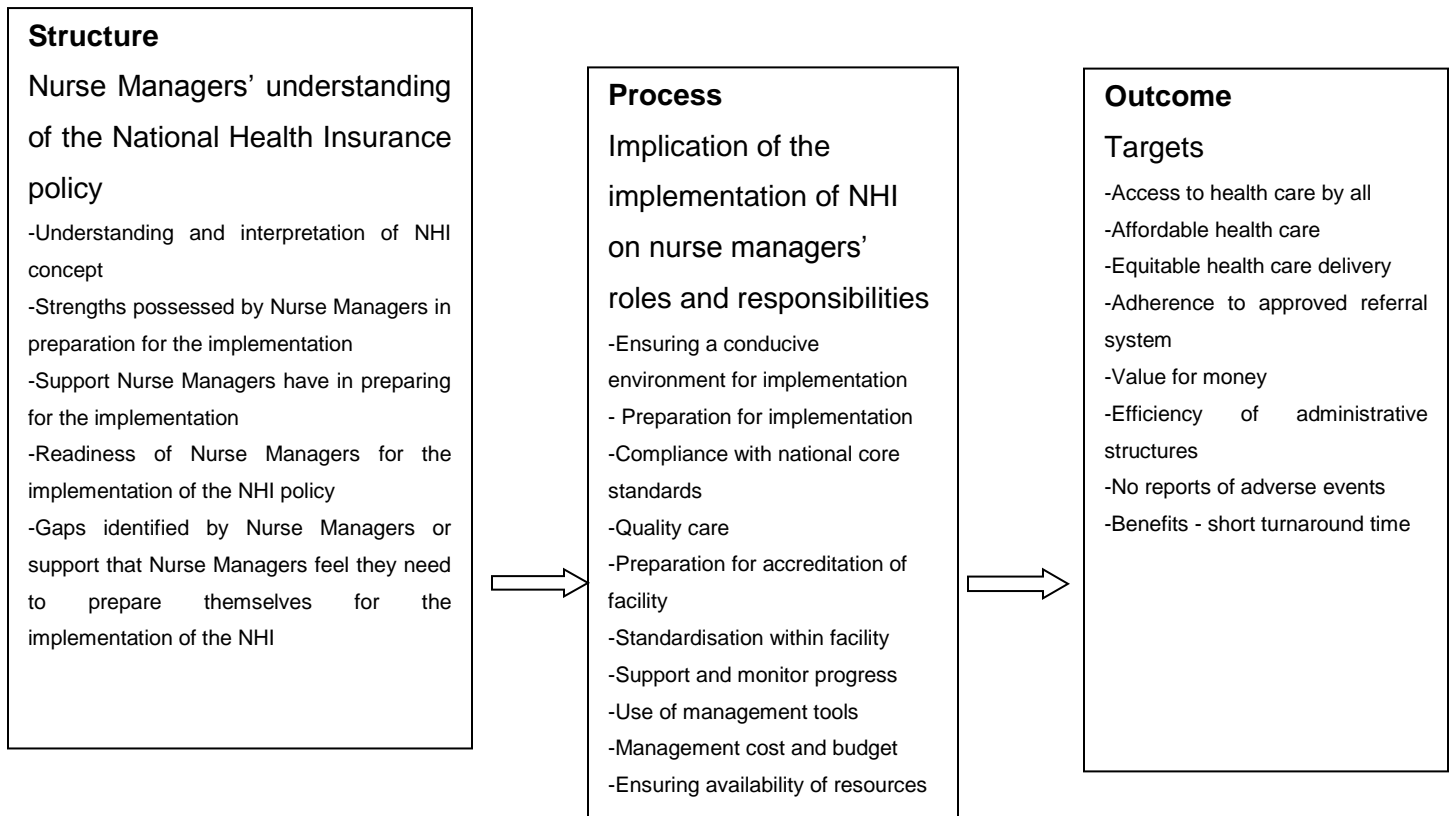


Figure 1.1 Conceptual Framework for the study adapted from Donabedian Quality Model (1988).

Structure

The study focused on the Nurse Managers' understanding of the concept of the NHI policy as well as their preparedness for the implementation of the NHI in terms of Quality Assurance skills.

Process

The study looked at the interpretation by Nurse Managers of the implications of the implementation of the NHI on their roles and responsibilities, and the tasks carried out by the Nurse Managers in preparation for the implementation of the NHI.

Outcome

Outcome looked at the Nurse Managers' knowledge of the targets of the implementation of the NHI policy. These included patients accessing the health care services, affordable health care, equitable health care delivery, value for money, efficiency of administrative structures, referral systems that were patient-friendly, the prevention of disease, and the benefits of a shortened turnaround time and less reports of adverse events.

1.8. DEFINITIONS

1.8.1. Interpretation

An explanation or conceptualisation by a critic of the literature or other piece of work. According to the Encarta Dictionary (2012), interpretation is the establishment of meaning or significance of something. In this study it means how Nurse Managers understand the meaning and the implications of implementing the NHI in health care facilities.

1.8.2. Implications

An indirect indication or a suggestion. The Free Online Dictionary (2013) states that implications are conclusions/consequences and results that can be drawn from something. In this study, it means the consequence of the implementation of the NHI in

their healthcare facilities on the roles and responsibilities of Nurse Managers as understood by Nurse Managers.

1.8.3. Perception

The process of interpreting sensation to produce a meaningful experience of the world. According to the English US Dictionary (2012), perception means a way of understanding or thinking about something. In the study, it means how Nurse Managers understand the meaning of the NHI in so far as their roles and responsibilities are concerned.

1.8.4. Private Hospital

A hospital owned by a for-profit company, privately funded by patients through their payment for service. In this study, there were four, from two different groups of private health care companies

1.8.5. Public Hospital

A hospital owned by the government which receives government funding and provides free medical care. This study was conducted in two eThekweni public hospitals.

1.8.6. Primary Health Care facilities

Health care facilities which provide healthcare based on practical, scientifically sound and socially acceptable methods and technology, which are universally accessible to all in the community through their full participation, and at an affordable cost (WHO & UNICEF, 1978). In this study, these included, District Hospitals, Community Health Centres, local health care clinics and private hospitals.

1.8.7. Primary Health Care Clinics

Health care clinics situated within easy access of the community. In the study these were local clinics.

1.8.8. District Hospital

The smallest type or lowest level of hospital which provides general medical services. It is limited to obstetrics and gynaecology, paediatrics and child health, general surgery and family medicine (Government Gazette, 12 August 2011). In the study, two District Hospitals in the eThekweni district participated.

1.8.9. Community Health Centre

The second step in the provision of health care which can also be used for first contact, this facility offers 24-hour maternity care, emergency and casualty facilities, as well as a short-stay ward. According to Health -e News Service (2006), this is defined as a facility that, in addition to a range of other PHC services, normally provides 24-hour maternity and accident and emergency services and up to 30 beds where patients can be observed for a maximum of 48 hours. There were three CHCs involved in the study.

1.8.10. Nurse Manager

A specialist in non-clinical nursing such as human resource and information management. In the study, this was the person responsible for ensuring that there was quality health care delivery by all health care workers, and that patients and staff were safe at all times. S/he will play a major role in the implementation of the NHI.

1.8.11. Top Level Manager

This person determines the objectives, policies and plans of the organisation, and requires more conceptual skills than technical skills

(www.managementstudyguide.com). A manager at this level is responsible for establishing organisational goals and strategic plans for the organisation (Sullivan and Garland, 2010). In this study, these are nurses who are Chief Executive Officers (CEOs) at District Hospitals and Community Health Centres. S/he will be responsible for the implementation of the NHI.

1.8.12. Middle Level Manager

The Head of the Department (HOD), who gives recommendations to top level management, then executes the implementation of policies and plans. This person requires more managerial and technical skills and less conceptual skills (www.managementstudyguide.com). Sullivan and Garland (2010) state that this manager is responsible for the people and activities within the directorates s/he supervises. In the study this is the Nursing Services Manager.

1.8.13. Lower Level Manager

The supervisor, who spends more time directing and controlling, the Lower-Level Manager is a link between senior management and the workers, and requires more conceptual skills than technical skills (www.managementstudyguide.com). In the study these will be Operational Managers/ Unit or Ward Managers.

1.9. COURSE OF THE STUDY

Chapter One presents the background to the study, the problem statement, the purpose of the study, the objectives of the study, research questions and the significance of the study, including the operational definitions of terms.

Chapter Two presents the literature review which supports the study and highlights what has been recommended or gaps identified in previous studies.

Chapter Three presents the methods and procedures followed to analyse how Nurse Managers interpret the National Health Insurance policy and the implications of its implementation in their facilities within the eThekweni district. The chapter further presents the design of the study, the setting of the study, the population under study, the sample size and method of sampling, the data collection technique and instrument, data analysis, ethical considerations and academic rigour.

Chapter Four presents the results of the study, firstly in the qualitative phase, and then in the quantitative phase. The development of the instrument is discussed in detail in Chapter Three (it is a phase in between the two previously mentioned phases).

Chapter Five is the discussion of the findings regarding the interpretation and understanding of the NHI by Nurse Managers and the implications of the

implementation of the NHI on Nurse Managers' roles and responsibilities. Recommendations are made in relation to findings and conclusions are drawn.

1.10. CONCLUSION

This chapter has presented the background to the study, highlighting the challenges faced by the country which led to the need for the health care system to be reformed. The problem statement, objectives, and the significance of the study on management, education and research are also presented. Chapter Two will present the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

Polit and Beck (2008) state that a literature review serves as an orientation to what is known and not known about an area of inquiry; while Neuman (2000) states that it is based on the premise that we learn and build on what others have accomplished. The literature studied was used to generate a better understanding of the phenomenon under study, namely the National Health Insurance.

This chapter gives an overview of the National Health Insurance as one of the WHO principles of health care services to ensure accessibility, affordability, equity and preventive and promotive health. The literature addresses the South African context, as well as that of other countries which have already implemented the NHI policy. This review analyses the present reformed health care system of South Africa, as well as the history of the old health care system in the public and private sectors.

2.2 LITERATURE SEARCH

In order to understand this study a search of the relevant literature was conducted.

Relevant literature was searched for, on the African National Congress (ANC) website, the Department of Health website, private hospitals' websites, in Medical Journals, on

the Universal Health Care website and in newspaper and magazine cuttings, on television and radio, while the Government Gazette; 12 August 2011 was also used. Search engines used were Google Scholar and EbscoHost. Key words used were NHI, ANC, and speeches of the Minister of Health, Department of Health, World Health Organization and private health care.

2.3 EVOLUTION OF HISTORY OF HEALTH CARE FINANCING REFORM IN

SOUTH AFRICA

The evolution and history of health care financing in S.A. dates back to more than 80 years ago.

- In 1928 a Commission on Old Age Pension and National Insurance recommended that a health insurance scheme be established to cover medical, maternity and funeral benefits for all low income employees in urban areas. The proposal was never taken forward.
- In 1935, a Committee of Enquiry into National Health Insurance recommended similar proposals to those made in 1928. This was also never taken forward.
- Between 1942 and 1944 a National Health Service Commission led by Dr. Henry Gluckman was set up. It recommended the implementation of a National Health Tax to ensure that health services could be provided free at the point of service for all South Africans. This was implemented partially for two years and was then reversed after the National Party came to power.

- In 1994 the Health Care Finance Committee recommended that all formally employed individuals and their immediate dependents should form the core membership of social health insurance arrangements, with a view to expand coverage to other groups over time. The state was, however, unable to finance the package of services.
- In 1995 the Committee of Inquiry on National Health Insurance supported the recommendations of the Health Finance Committee. The committee made a strong case for Primary Health Care services.
- In 1997, the Social Health Insurance Working Group developed the regulatory framework that resulted in the enactment of the Medical Scheme Act in 1998.
- In 2002, the Committee of Inquiry into a Comprehensive Social Security for South Africa recommended that there should be mandatory cover for all those in the formal sector earning above a given tax threshold, and that contributions should be income-related and collected as a dedicated tax for health.
- In 2002, the Ministerial Task Team on Social Health Insurance was established to draft an implementation plan with concrete proposals on how to move towards social health insurance, and how to create supporting legislative and institutional mechanisms that would result in the realisation of the National Health Insurance in South Africa.
- In 2009 the Advisory Committee on National Health Insurance was established. It was tasked with providing the Minister of Health and the Department of Health with recommendations on the health system reform and the design and rollout of the National Health Insurance (Government Gazette, 12 August 2011).

2.4. PRESENT HEALTH CARE FINANCING IN SOUTH AFRICA

Van Rensburg (2010) states that the four main sources of financing health care in South Africa are the government (largest contributor to health care finances), households' out-of-pocket and co-payments, employers' medical aid schemes and donors. The public sector funding is obtained through national taxes and donations from various sources, and the private sector funding is obtained through medical schemes (Botha, 2008). Social insurance through government-sponsored arrangements also funds health services, e.g. the Road Accident Fund. About 8% of South Africa's GDP is spent on health care, as opposed to 5% recommended by the WHO. Five percent of this 8% is spent in the private sector through medical schemes (Botha, 2008). Currently, the country spends about 11% of its total budget on health services, falling short of the 15% proposed for governments within the African Union (Abuja Declaration's proposal, 2001).

The public sector is overburdened; caters for 85% of the population on a budget of less than 44% of the total health expenditure. The public sector health expenditure is stagnant due to limited funding and a decline in budget allocations to provincial and local government departments (Botha, 2008). The public health care sector delivers free health care at the point of delivery for pregnant and lactating women; children under six years of age, and those who use the public primary health care system. Patients in the public sector pay for their examination and treatment in accordance with their income and number of dependents. The provincial government may partly, or entirely, finance

patients' treatment (address by former President Mandela, September, 1998). In the private sector, the hospital costs have increased over the years, leading to medical schemes increasing their premiums. Those who pay out of pocket, and those who cannot afford to pay are exposed to financial hardships, making it difficult for them to access health care. These patients are not covered by any form of health insurance, and it is for this reason that coverage should be extended to them (Government Gazette, 12 August 2011).

According to the Business Report of August 2, 2012, South African patients “cough up” far more for care. Prices in South Africa are higher than affordable, even if you adjust them to match the wealthiest in the country. Anban Pillay, the Head of Pricing at the DoH says that hospital services in the country do not fit the competitive market. He further says that costing information in the public sector should be used as the basis to reform pricing in the private sector (Business Report, 2 August 2012).

2.5. THE NHI PROPOSAL BY THE ANC

According to the World Health Report (2008), the member states that belong to the World Health Organization (WHO) agreed on organised health care systems with holistic health care services. The WHO principles of health care services include accessible, affordable, equitable, continuity on preventive and promotive health. Access is not only geographical, but includes financial consequences (World Health Report, 2008). Van Rensburg (2010) further states that access means the continuing and

organised supply of care that is geographically, financially and functionally within easy reach of the whole community. Geographical accessibility means the distance travelled, the time taken and the availability or means of transport used to access health care. Financial accessibility has to do with the methods of payment used to access health care. Functionally means organisational accessibility where there are proper referral systems, from the lowest level to the highest level of care, without any loss of valuable information about the health care needs of the individual.

In order to achieve these principles, in 1994 the South African government reformed its national health care system into one National Health system and adopted a Primary Health Care approach (Van Rensburg; 2010, Shisana, 2009). One of the projects to support this approach was the NHI which included universal coverage, but gave no room for voluntary insurance. In 2007, at the ANC Polokwane conference, a resolution was taken to resume the implementation of the National Health Insurance (Shisana, 2009). Shisana further states that the ANC agreed that the proposed NHI would pool mandatory contributions and public sector finances in order to purchase services from the accredited public and private sectors.

A ministerial advisory committee on the NHI was established in 2009 to advise the Minister on the development and implementation of the NHI policy. In 2010, the ANC's discussion document set out key elements of the NHI policy. This document suggested the phasing in of the NHI over a period of fourteen (14) years. The document further advised that the improvement of the health system run hand in hand with the

implementation of the NHI, and that the NHI be aimed at a revitalised and adequately financed district health system, the re-engineering of Primary Health Care and community-based health care teams (South African Health Review, 2010).

2.6 THE NATIONAL HEALTH INSURANCE

According to the Farlex Medical Dictionary (2012), the NHI is a health insurance program financed by taxes and administered by the government to provide comprehensive health care that is accessible to all citizens of the nation. The South African Department of Health defines the NHI as a financing system that will make sure that all citizens of SA and legal long-term residents are provided with essential health care, regardless of their employment status and ability to make monetary contributions to the NHI fund (www.doh.gov.za).

The rationale for introducing the NHI is based on factors such as the constitution in South Africa stipulating that health care is a human right which should not depend on how rich a person is or where she/he happens to live. A large number of South African people die prematurely and suffer unnecessarily from poor health. Conditions that are treatable are not being treated on time, and preventable diseases are not prevented. Such factors, together with the skewed health care financing system of the country, pose serious challenges. The NHI will assist in reducing the burden of disease in the country because the majority of the population suffers the greatest ill health and does

not have access to good quality health care (Government Gazette, 12 August 2011). For these reasons South Africa needs the NHI.

Financial risk protection against health-related expenditure will be provided for the whole population through the NHI. Funding contributions will be linked to the individual's ability to pay, and benefits from health services will be in line with the individual's need for care. Everyone will have access to a comprehensive package of healthcare services, provided through accredited public and private health care providers, with a strong focus on preventive and promotive health care (Government Gazette, 12 August 2011).

The following principles will guide the NHI:

- The right to access healthcare, as stated in the Bill of Rights, mandates the state to make reasonable legislation and other measures within its resources to ensure that these rights are realised. Health care reform has been one of the steps towards realising the right to access free health care at the point of use, and the benefit to health care will be according to the health profile.
- Social solidarity, where financial risk protection for the population is created. This will ensure sufficient cross-subsidisation between rich and poor as well as the healthy and sick. The costs of health care are spread over the life cycle of an individual: Pay when young and draw on later in life when sick.

- Effectiveness will be achieved through evidence-based interventions which will give rise to positive health outcomes resulting in the improved life expectancy of the population.
- Appropriateness means new service delivery models which look at the context and how it responds to the needs of the people. The model will be based on a well-structured referral system from primary health level to the relevant levels.
- Equity means that the health system must ensure that access to services is timely for all. There are no inequalities or barriers to health care for the vulnerable groups and areas such as rural areas. The Director-General of WHO sees equity as fairness even among countries of the world where there are differences in income levels, opportunities and health status (WHO, 2009).
- Affordability means that services are procured at reasonable costs for everyone, and that health is viewed as being a public good/in the interests of the public and not a commodity of trade. Health care delivery should not be looked at as a means of making money.
- Efficiency means the creation of administrative structures that will minimise or eliminate any duplication in the national, provincial and district health care spheres. Value for money must be achieved through quality health service delivery using appropriate resources (Government Gazette, 12 August 2011).

The process of implementation began with piloting in ten districts. In his speech in March 2012, Dr Motsoaledi announced that the NHI pilots would focus on the most

vulnerable sections of society across the country, to reduce high maternal and child mortality through district-based health interventions, and to strengthen the performance of the public health system in readiness for the full roll-out of the NHI. The pilots would further assess whether the health service package, Primary Healthcare (PHC) teams and strengthened referral system would improve access to quality health services, particularly in the rural areas and the previously disadvantaged areas of the country. The objectives of the pilots included, among other things, testing the ability of the districts to assume greater responsibilities under the NHI, to assess the utilisation patterns, and the costs and affordability of implementing a PHC service package. The selection criteria of these districts were outlined by the Minister of Health. There were 27 indicators, in 3 categories, used to summarise overall performance across the districts. These districts were ranked from best to worst performance for each indicator, and a score from 1 to 52 was given, 1 being the best performing district and 52 the worst performing. The selection was based on indicators including socio-economic, health service performance and financial and resource management (Minister of Health's speech, March 2012, cited in the Minister of Health speeches on the DoH website; www.doh.gov.za).

There were ten indicators considered under the socio-economic heading. These included the following: The amount of the population with private medical insurance, the unemployment rate, informal and traditional housing, no access to improved sanitation, no access to piped water, no access to refuse removal, no access to electricity for lighting, no income, or income less than R4 800, as well as a household head younger

than 19 years of age. Indicators under health service performance included, amongst others: HIV prevalence, TB cure rate, pneumonia and diarrhoea incidences, antenatal coverage and the number of deliveries in facilities. Indicators in the category of financial and resource management included PHC expenditure per capita, district expenditure, the percentage of under or over expenditure for PHC, as well as the percentage of under or over expenditure for these districts.

The Health Minister indicated that the financing of the pilots was part of on-going engagements between the Department and the National Treasury. He further indicated that R1 billion had been allocated by the National Treasury for the project. The Minister mentioned that the Department was ready for the roll-out of the pilots, and that he would be visiting all the identified districts to interact with stakeholders, including traditional leaders, church leaders, nurses and doctors, to explain more about the projects before the launch. The Minister also mentioned that he would hold meetings with the district medical practitioners to ask them to assist in the clinics for a few hours, adding that they would be paid for the services rendered (Minister of Health speech, March 2012).

The benefit of the NHI, amongst others, is that the health service package is available to all citizens. The package will contain health promotion, disease prevention, as well as curative and rehabilitative components. In his State of the Nation address (2012), President Zuma noted that the government has prioritised the NHI implementation through the critical social infrastructure projects. These include dedicating national efforts to the refurbishment of health care facilities and the re-engineering of the primary healthcare system, with the focus on health promotion and preventative care aspects.

This re-orientation of the healthcare system has the potential to significantly improve South Africa's national health status.

There are challenges that have been mentioned at various debates in the political sphere. It was stated that funding requirement estimates were inadequately explained and did not accommodate price inflation. The Congress of South African Trade Unions (COSATU) welcomed the NHI, but also openly expressed concern regarding the inclusion of medical schemes in a "multi-payer" system. Their concern was that this would sustain the inequitable service delivery and "undermine" the implementation of the NHI. The Democratic Alliance argued that the following were challenges posed by the implementation of NHI, *"We lack the human resources to implement NHI"; "NHI does not adequately attend to accountability and management structures" and "NHI eradicates freedom of choice for health care consumers"*

(www.consultancyafrica.com:Healthfinancing and the NHI in SA).

Another challenge suggested by Professor Alex van den Heever was that the establishment of a centralised fund might carry considerable risk and destabilise an already unsteady, under-performing public health sector. He then suggested that decentralisation of funding was critical to efficient functioning at a provincial level, and that political governance models might be insufficient to accommodate the administrative and procurement responsibilities central to an effectively implemented NHI (www.consultancyafrica.com:Health financing and the NHI in SA).

2.7. THE PRIVATE AND PUBLIC SECTOR PERCEPTIONS OF THE NEED FOR THE NHI

According to the Hospital Association of South Africa (HASA), the foundation of the NHI is the provision of access to health care services. There was a need to assess the framework legislation of health care in South Africa. This assessment was required to determine how best to align the legislation with the ultimate introduction of the NHI. Legislative amendments which changed certain aspects of access to health care were enacted. The Medical Scheme Act of 1967 was to remove risk-rating and provide a more equitable entry criteria for the admission of persons to medical schemes in order to increase the accessibility of private health care benefits. Further amendments to the Medical Schemes Act 1998 followed, aimed at introducing certain cost solutions for medical schemes, including the creation of designated service providers who may be nominated by a medical scheme to provide certain prescribed minimum benefits to the members of the medical scheme. This allowed the medical scheme to negotiate appropriate costs for services on behalf of its members. The introduction of fixed lists of medicines for members, and the prescribing of certain medical procedures covered by medical schemes, meant negotiating better and cheaper rates, thus making private health care affordable to more people. The Medical Scheme Act made provision for prescribed minimum benefits, and the Essential Drugs List recognised certain chronic conditions to be covered by medical schemes (Health Annals, 2009).

One of the private hospital groups (Netcare) offered to assist the government in improving health care before the implementation of the NHI. The chairperson of the

Netcare board stated that expenditure had to be allocated efficiently, that proper reporting mechanisms and sufficient financial oversight had to be developed, that the number of health care professionals had to be increased, and that the quality of service had to be improved (Khanyile, 2011).

Another private hospital group (Medi-clinic) and the Discovery Health medical aid scheme indicated that they were open to doing business with government in bringing in the NHI. The CEO for Discovery Health further stated that they had not been approached to assist with their expertise and assets, however they were eager to help the government implement the policy (Huisman, 2011). This could mean that consultation was not enough.

Professor Alex van den Heever from the Witwatersrand School of Public and Development Management said that taxpayers could end up contributing an additional 3% of the GDP for services they would not use and could still have to buy private insurance (Lombard, 2011). Dr Ken Grant from London wrote in the readers' views of the *Sunday Times* (August 21,2011) that, contrary to Professor Alex Van den Heever's claims, the United Kingdom had pooled over 90% of health funding and are able to share risk in a manner that medical aid schemes could never do. This is what, as he put it, the NHI aimed to do.

Women are said to be up against a brick wall in accessing health services. There are imbalances in the public and private sectors. Abortion services and contraceptives are

free in the public sector, but may not be readily available. The same services in the private sector may not be paid for by the medical aid as these are not covered by most medical aids (Stevens, 2009). Stevens further stated that the NHI is an opportunity to improve access to women's health services for rich and poor women alike.

2.8. THE RATIONALE FOR THE IMPLEMENTATION OF THE NHI OF SOUTH AFRICA AND ITS BENEFITS

At their 52ND National Conference in Polokwane (2007), the ANC established a committee on education and health that conducted an analysis of key challenges facing the health sectors in order to realise better health services to all. This was further realised through the 2009 ANC manifesto which outlined that the NHI would help reduce inequalities in the health system of South Africa. The manifesto further reported that the NHI would be publicly administered, and would uphold the right of all South Africans to access quality health care which would be free at the point of service. Thom (2010) stated that the National Minister of Health had said that South Africa's health system needed to move away from the dominant curative health system which is unstable and unaffordable, to a health system where prevention is the cornerstone.

The Minister of Health further stated that, at the heart of the National Health Insurance system, is the desire to afford all South Africans access to better quality health care, which seeks to move from the current health care model and employ one which will be based on the system of primary health care (Bodibe, 2010).

According to Olive Shisana (2009), the Chair of the ANC NHI task team, the National Health Insurance is a means to an end. It is a form of social security that would provide people with access to much needed quality health services.

At its National General Council, September, 2010, the ANC concluded that the reasoning behind introducing the NHI was that it would provide a mechanism for improving subsidisation in the overall health system, where funding contributions would be linked to an individual's ability to pay and benefits from health services. This would be in line with an individual's need for care and would be achieved through having a single funding pool.

The ANC Media Release of September, 2010 stated that there would be a publicly administered NHI fund which would operate like the South African Revenue Service (SARS), although it would fall within the Health Ministry. It would receive funds through a single-payer system. Health care funds would be received, and health care costs would be paid for all South African citizens through this single insurance pool. The fund would provide a comprehensive cover, though the core would be primary health care. It would be managed by a Chief Executive Officer who would report directly to the Minister of Health.

According to the Government Gazette, 12 August 2011, the fund would be advised by a technical advisory committee consisting of experts in health care financing, health economics, medical and nursing services, pharmaceutical services, public health

planning, research, monitoring and evaluation, public health law, labour, administration of public insurance schemes, information technology and communication.

2.9. HUMAN RESOURCE REQUIREMENTS FOR THE NHI

The need for and shortage of skilled health care personnel prompted the Health Minister to reaffirm his commitment to improving human resources through the following: Training of Primary Health Care personnel, re-opening of nursing schools and colleges, a new medical school in Limpopo, recruiting and retaining professionals, and included collaboration with countries that have an excess of these health professionals (National Department of Health Strategic Plan, 2010/11-2012/13). In his speech (October, 2011) launching the Human Resource for Health Strategy, the Minister of Health said that the health sector has to be staffed by an appropriately skilled workforce able to respond to the burden of disease and the citizens' expectations of quality service. He further mentioned the weak management skills in the public sector which aggravated the situation further. He also stated that the Department of Health had, however, partnered with local and international institutions to develop interventions to improve the management training and skills of managers at their healthcare facilities and at district level, to ensure that morale and productivity were improved, and that quality of care for patients was ensured. The lack of access to health care due to a shortage of staff not only affected people in the rural areas but also those in peri-urban areas as well.

The Minister said that in order for the plan to succeed there had to be improved coordination between health systems planning and health professionals' training and development. The country needs sufficient numbers and a fair and equitable distribution of health care workers. As a short-term solution, the Minister has recruited retired doctors and nurses to utilise their skills to fill in the gaps in the health care system (Department of Health, October, 2011).

The Health Minister further stated that there were people who wrongly believed that the government could implement the NHI without first addressing the human resources challenges. He revealed that, for the first time, the Department had a Human Development strategy which included plans to increase the number of doctors trained, to build a ninth medical school in Limpopo, to rebuild other medical training facilities and to increase the number of doctors trained in Cuba. The Minister aimed to increase the number of doctors trained in South Africa from 1,200 to 3,600 per year (Thom,2012).

2.10 LEGAL AND CIVIL SOCIETY CONSIDERATIONS

The Constitution is the highest law in the country and imposes obligations on the state to action the right of access to health care services. The Constitution (Act No 108 of 1996) states that the state must take reasonable legislative and other measures, within available resources, to achieve this. The NHI policy should be careful to address the short-, medium- and long-term needs of the people. The NHI policy should be budgeted for and accompanied by a detailed implementation plan. The Integrated Support Teams

(IST) were established by former Health Minister Barbara Hogan to investigate overspending and financial mismanagement in the provinces (Department of Health, 2009). The IST discovered inefficiencies in the system and recommended that the inefficiencies be addressed. The National Department of Health would have to fix these inefficiencies to enable implementation of the NHI.

The DoH has a lot of statutes which need to be reviewed in light of the NHI proposal, to check whether there are any inconsistencies or gaps between those laws and the proposed policy. The laws that govern medical schemes need to be considered; depending on the role for medical schemes envisaged by the NHI policy. The other laws that need to be reviewed are those in relation to the pricing of medicines, for example, the Public Finance Management Act (Act No 19 of 1999) and the Short Term Insurance Law (Act, No 53 of 1998). If these laws are not reviewed properly, the implementation could be disrupted or delayed due to legal challenges (Hassim, 2010).

Civil society groups have called on the government to speed up the implementation of the proposed NHI for the benefit of all South Africans who would receive equal and quality health care, thus closing the gap between private and public health care (Innovative Medicines South Africa, 2010).

2.11 HEALTH CARE SYSTEMS OF OTHER COUNTRIES USING THE NHI (BEST PRACTICE IN OTHER COUNTRIES)

In Brazil, everyone is provided with free health care through the government, and the employed are expected to pay into this system through taxes (Healthgov.net/brazil: 2008). Medical care is available to anyone who is legally in Brazil, this could include, a legal resident or any person visiting Brazil or living in Brazil legitimately. Those who cannot afford to pay for health care in Brazil use the government's free public national health system, mentioned above (Health care in Brazil).The drawback is the duration spent waiting for procedures and treatment because of easy access (World focus.org/blog/2009/01 health-care-brazil).

In France, all citizens have access to health care through the national insurance program funded by pay-roll and income taxes. Challenges faced are the rise in health care costs (Shapiro, 2008).

In the United Kingdom, the health care service is free to all residents, and is financed from mandatory National Insurance taxation paid by employees and an obligatory contribution from employers. Those with no income are exempted from contributing towards the National Insurance. The health service is publicly funded. The National Health Service (NHS) provides UK residents with medical care free of charge without them having to purchase health insurance. Those who earn money are charged taxes, with a percentage of these taxes going towards paying for the NHS. The unemployed,

young or elderly do not pay taxes but are still entitled to treatment. The taxes of those employed go towards covering the cost of treatment for all. Drawbacks for the UK are long waiting-lists and the high cost of running the health care services (www.dh.gov.uk).

In Taiwan, the NHI is run by the government and is financed through a mix of premiums and taxes. The NHI was incepted in 1995 and that led to the expansion of the health care systems. The government of Taiwan runs the NHI as the single payer through taxes and premiums (Cheng, 2003). The planning for the NHI took seven years under the KMT (National People's Party called Kuomintang) government. The people of Taiwan felt that the planning was too hasty and that this accounted for the problems experienced, though some felt that it was preferable not to prolong the planning as, in such a case, the NHI would likely never have come about. Problems encountered were rapid increases in the volumes of services (Chang, 2009).

Ghana embarked on a process of developing and implementing a National Health Insurance Scheme (NHIS) to replace out-of-pocket fees at the point of service in 2004. The public health care system of Ghana is operated through the National Health Insurance Scheme and took effect in 2005 (Ghana's health care system, 2010). A study conducted after the implementation showed that the provision of health care improved after the implementation of the NHIS. A problem was experienced with the enrolment into the insurance system of the large population in the informal sector, as well as problems with obtaining their ID cards even though they had registered early (Wahab, 2008).

Rwanda has a national health insurance which covers 92% of the entire nation. This has benefited those in rural communities and the informal sector as they have equitable access to quality services. No problems have been reported (Mc Neil, 2010).

2.12. IMPLEMENTATION OF THE NHI IN SOUTH AFRICA

In his speech on 11 August 2011, the Minister of Health stated that piloting of the NHI would commence in ten selected districts in 2012. The districts selected were OR Tambo, Gert Sibande, Vhembe, Pixley kaSeme, UMzinyathi, UMgungundlovu, Eden, Dr K Kaunda, Thabo Mofutsanyane and Tshwane. The Department of Health conducted audits of all the public health facilities throughout the country and the selection of the ten districts was based on the results of that audit. Consideration was given to factors like the district's health profile, demographics, income levels and other social factors impacting on health, health delivery performance, management of health institutions and compliance with quality standards (National Department of Health website on NHI piloting, 2012). The eThekweni district was initially one of the selected districts hence the study site, and it fitted some of the factors considered for selection.

Thom (2012) in his article entitled "*Five steps to better health care*" stated that the Health Minister had two preconditions for the implementation of the NHI with regard to which he refused to compromise. These were the overhauling of the quality of care in the public health system, and the regulation of the pricing of private health care. Thom (2012) further stated that the Health Ministry had identified five areas that were already

being worked on in the public sector. These were the infrastructure, human resources, the quality of the health care in the public sector, the re-engineering of the Primary Health Care system (called the heart-beat of the NHI) and the deployment of teams of specialists, including gynaecologists, paediatricians, family physicians, anaesthetists, midwives, paediatric nurses and primary health care nurses to the health districts to improve maternal and child health outcomes at the district level.

2.13 LEGISLATION THAT HAS AN EFFECT ON THE NHI POLICY IMPLEMENTATION

The constitution of the Republic of South Africa, No 108 of 1996 states:

- Everyone has the right to an environment that is not harmful to their health or well-being (Section 24 of the Bill of Rights).
- Everyone has the right to have access to health care services including reproductive health care (Section 27 of the Bill of Rights).

The National Health Act, 61 of 2003, provides a framework for a single health system for South Africa. This Act provides for a number of basic health care rights, including the right to emergency treatment, and the right to participate in decisions regarding one's health.

- The National Health Amendment Bill, 2010 ensures that all health establishments comply with minimum standards through an independent entity.

- The Medicines and Related Substances Amendment Act, 59 of 2002 makes drugs more affordable and provides for transparency in the pricing of medicines.
- The Medical Schemes Act, 1998 regulates the medical schemes' industry to prevent it from discriminating against "high risk" individuals like the aged and sick.
- The Nursing Act, 2005 provides for the introduction of mandatory community service for nurses.
- The Mental Healthcare Act, 2002 introduces a process to develop and redesign mental health services so as to grant basic rights to people with mental illnesses.
- The Pharmacy Amendment Act, 2000 allows non-pharmacists to own pharmacies with the aim of improving access to medicines. This was effective from May, 2003 (National Department of Health's website).

2.14 CONCLUSION

This chapter has presented the evolution of the health care financing reform in South Africa, the present health care financing, the NHI proposal by the ANC, reactions to the introduction of the NHI policy, the rationale for the implementation of the NHI, legal and civil society considerations, including legislation that affects the NHI, and best practice from other countries.

It seems like it has taken a long time to agree on the implementation of the NHI. This may have been due to the fact that it was not an easy task to reorganise the South

African health services into a single national Health System, because of the fragmentation of the services inherited from the apartheid government. The public and private health care dichotomy in the country is another issue.

The implementation of the NHI is therefore faced with a lot of controversy and harsh debates. This may have deprived this policy of adequate time for preparation in terms of gathering baseline data. In Taiwan, a preparation time of seven years was regarded as hasty and accounted for the problems encountered there (Chang, 2009).

Could this study contribute to some extent to evidence that can be used in some aspects of the projects like monitoring and evaluation? The next chapter presents the methodology used in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This section deals with the design of the study, population, sample and sampling strategy, data collection instrument and procedure, as well as analysis. The study was based on analysing the Nurse Managers' interpretation of the NHI policy. Emphasis was placed on how they interpreted the concept of the NHI and the implications of the implementation of the policy on their institutions and their roles and responsibilities. The data collection process is described according to the two phases, namely qualitative and quantitative approaches.

3.2. RESEARCH PARADIGM

Paradigms may be defined as worldviews or belief systems that guide researchers (Tashakkori and Teddlie, 1998). The paradigm that guided this study was pragmatism, since this emphasises the research problem and uses all approaches to understand the problem (Creswell, 2009). Pragmatically orientated theorists and researchers refer to methods which contain both elements of quantitative and qualitative approaches as mixed methods (Tashakkori and Teddlie, 1998). Pragmatism is not committed to any one system of philosophy and reality. Creswell (2009) states that pragmatism is open to different methods, different worldviews and assumptions, as well as to different forms of

data collection and analysis. Pragmatists believe that the truth is what works at the time based on the intended consequences rather than isolating reality from the mind. Pragmatists further argue that research occurs in social, historical, political and other contexts and influences social justice and political aims. The researcher contends that this study is placed within the combination of the above mentioned contexts, considering the motive of the NHI policy emanating from the past history of the country which influenced the social and political aims of redress in this country. The researcher chose this paradigm because of its use of a small qualitative and a large quantitative sample which will provide the best understanding of the research problem and use of the findings (Creswell, 2009).

3.3. RESEARCH APPROACH

A mixed method study involves the collection or analysis of both quantitative and qualitative data in a single study, in which the data are collected concurrently or sequentially, are given priority, and involve the integration of the data at one or more stages in the process of research (Cresswell, Plano Clark, Gutmann and Hanson in Tashakkori and Teddlie, 2003).

The mixed method approach was used for this study. It contains both elements of qualitative and quantitative research methods (Tashakkori and Teddlie, 1998). By using mixed methods, the researcher seeks to elaborate on or expand on the findings from one method with those of another method (Creswell, 2009). Tashakkori and Teddlie

(1998) assert that mixed methods present a practical and applied research philosophy, where the researcher studies what is of interest and value in different ways that can bring positive consequences within his/her value system. Considering that all methods have limitations, the pragmatists feel that biases inherent in any one method may be neutralised or offset by other methods, through, for example, triangulation (Lincoln and Guba, 1978, cited in Tashakkori and Teddlie, 2003). Onwuegbuzie and Johnson (2004), however, state that mixed method research also has limitations; for example, these authors state that mixed method research is expensive and time-consuming which may discourage many researchers. Bazeley (2004) further states that one of the main disadvantages of mixed method is that when “quantitising” qualitative data, it loses its flexibility and depth. This, as Bazeley states, is because qualitative codes are multidimensional, while quantitative codes are dimensional and fixed. According to Tashakkori and Teddlie (2003), some researchers believe that compatibility between quantitative and qualitative methods is not possible because the paradigms that underlie these methods are incompatible. The researcher conducted a qualitative study first, followed by a quantitative study.

3.4 RESEARCH DESIGN.

According to Babbie and Mouton (2002), a research design is a plan or structured framework of how the researcher intends to conduct the research process in order to pursue the research problem. A sequential exploratory design that used both qualitative and quantitative approaches was adopted for this study. The researcher conducted the

qualitative phase of the study first, followed by the quantitative phase. The sequential exploratory design allows for beginning with the qualitative interviews for exploratory purposes, since the NHI is a new concept or phenomenon in South Africa. This was followed with a quantitative survey method, with a larger sample, to enable the researcher to generalise the results to the target population and justify any intervention that might follow (Cresswell, 2009). Refer to Figure 3.1 below. Morse (1991), cited in Cresswell (2009), maintains that the sequential exploratory design can also be used to determine the distribution of a phenomenon within a chosen population, in this case, the understanding of the NHI and interpretation of the implications of its implementation on the Nurse Managers' roles and responsibilities. Furthermore, this design becomes the procedure of choice when a researcher needs to develop an instrument because of the unavailability of existing instruments (Cresswell, 2009). In this study, the themes that emerged from the qualitative data were utilised to develop a Likert scale instrument to determine the distribution of the phenomenon under study in quantitative form among the target population, and to justify the intervention that this study is expected to culminate in as a requirement for this level of study. A generalisable sample can also give more information that can be shared with policy-makers.

The quantitative approach was used in order to quantify data, thus allowing for a bigger generalisable representation. Cresswell (2009) suggests that a researcher should indicate whether the subsequent quantitative phase adopts the theme, multiple themes or comparisons among groups. This study used multiple themes from the qualitative data which were placed in the context of the Donabedian's SPO model to collect

quantitative data. Creswell (2009) further recommends a three-phase approach when embarking on a sequential exploratory design; hence this study first gathered qualitative data and analysed it as phase one, used the analysed data to develop the instrument as phase two, and then subsequently administered the instrument to the proposed sample of the population as phase three. When writing the report of the study, the three phases were presented as distinct phases with separate headings for each phase (Creswell, 2009). However, Tashakori and Teddie (2003) state that, in mixed methods, when two phases of data collection exist, the data collection and analysis may be reported separately in each phase and may be integrated in the discussion or conclusion of the study. They (Tashakori and Teddie, 2003) add that the analysis may be separate for both qualitative and quantitative phases and then information may be compared in the discussion stage of the research. This study thus integrates and compares the findings from the two phases in the discussion and conclusion stage. Figure 3.1 illustrates the sequence of the research process as followed in this study.

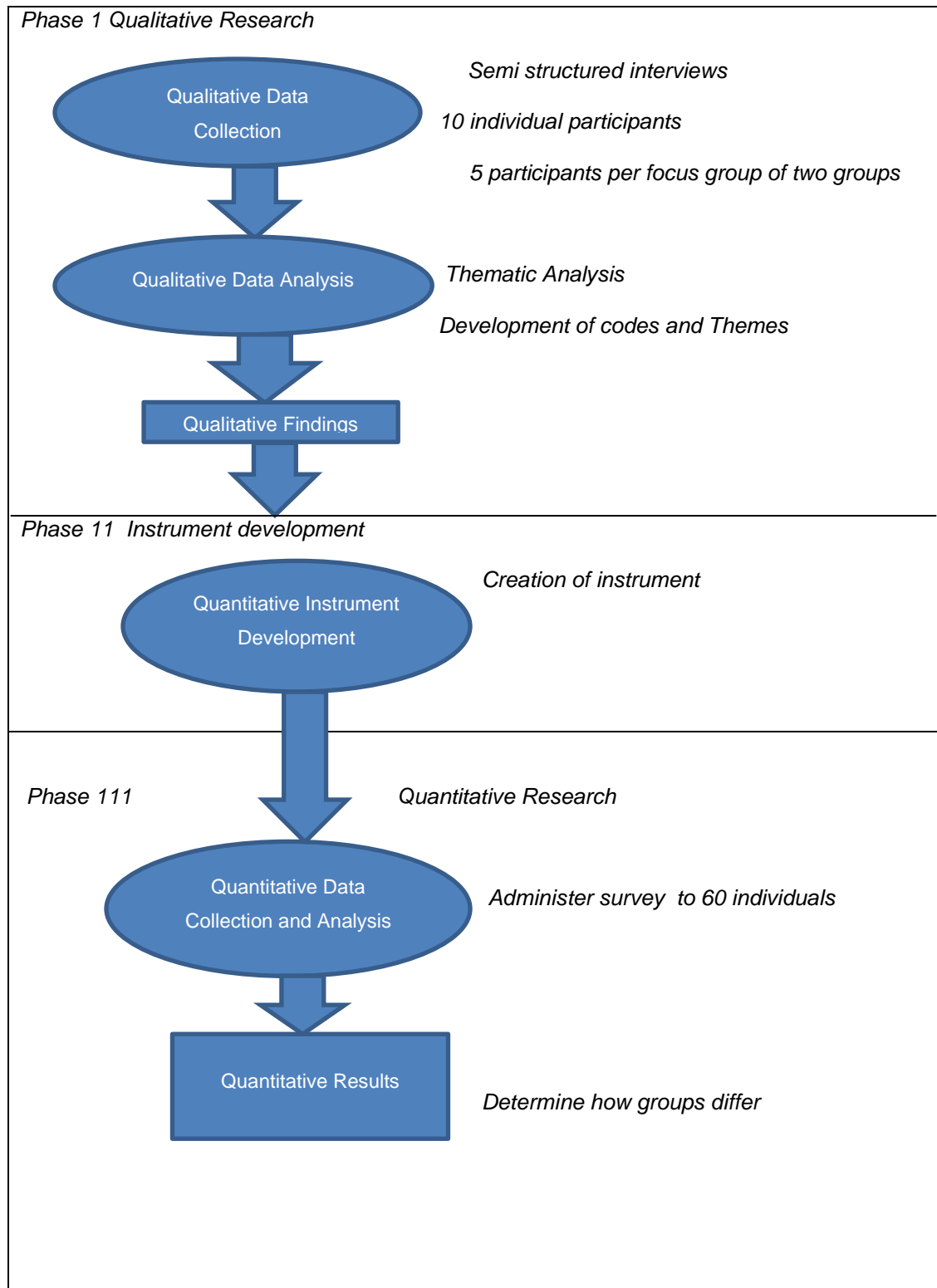


Figure 3.1 Sequential mixed method

3.4.1. Phase 1: Qualitative Survey

The study began with a qualitative approach which focused on an exploratory study (Creswell, 2009) since the NHI is a new concept in the country. The intent was to explore the topic or phenomenon with participants at the sites. Semi-structured interviews were conducted with a smaller sample which included top and middle level Nurse Managers at their facilities. The interviews were conducted with individual Nurse Managers as well as in focus groups. The researcher collected qualitative data and analysed it.

3.4.2 Phase 11: Instrument development

A quantitative instrument was then developed, based on the qualitative data findings. The instrument was used on the sample of the bigger population (Creswell and Plano Clark, 2007). A pilot study was conducted with a non-participating facility as well as with experts before it was used on the targeted sample. Generally, instruments are derived from clinical exposure, theory or prior research (Polit and Beck, 2008). However, since the NHI is a new concept, the aforementioned mechanisms of instrument development may not be helpful, more so because the NHI is in its infancy in the country and there is a paucity of studies from the countries that have introduced it. At the same time, these authors maintain that a researcher's knowledge base, no matter how rich, is subjective and limited. Thus pragmatists or mixed methodologists use sequential exploratory mixed methods starting with qualitative data to generate questions for quantitative

instruments. Such instruments, however, need to be subjected to rigorous testing (Polit and Beck, 2008).

The researcher initially did a literature review to understand the concept of the NHI and then developed qualitative open-ended questions based on the knowledge gained regarding the compiling of a semi-structured interview guide for individual and focus group interviews.

3.4.3. Phase 111: Quantitative Survey

A quantitative survey was subsequently done with a large sample. This allowed the researcher to generalise results (Creswell, 2009). The results from the bigger sample gave more information that will be shared with policy-makers and is to be used for further research or to generate a hypothesis (Polit and Beck, 2008). The quantitative structured instrument was developed after exploratory qualitative interviews had been analysed using multiple themes which emerged from the qualitative data (Tashakkori and Teddlie, 1998). The researcher based the enquiry on the assumption that collecting diverse types of data best provides an understanding of the research problem (Creswell, 2009). The quantitative approach was further used to quantify data. Researchers recommend the combination of quantitative and qualitative approaches. A quantitative approach may generate generalisable conclusions.

3.5. Research Setting

The study was conducted in the eThekweni district, one of the ten districts of the KwaZulu-Natal province. The researcher targeted the public Primary Health Care facilities as these exist to ensure basic provision of health care for all, according to the NHI policy (Government Gazette, 12 August 2011). These included Primary Health Clinics, both mobile and fixed, Community Health Centres, and District Hospitals because these were to be involved in the NHI implementation pilot and provided the first level of care. There are three hospitals which are both District and Regional in the eThekweni district. Permission was granted for these three to be part of the study, but Nurse Managers declined to be interviewed, stating that they were Regional as well. There are only two District Hospitals in the eThekweni district and both agreed to be part of the study. One is situated in an urban area and the other in a rural area. There are eight Community Health Centres in the eThekweni district. Three were chosen because they have top level Nurse Managers (CEOs), though the researcher discovered later that one of the three had been replaced by a non-nurse. Private hospitals were also targeted to ensure maximum variation. Two hospitals were chosen from two groups of private hospitals in the eThekweni district. These were suggested by their Head Offices when they gave the researcher permission to conduct the study. The pilot centres for the NHI were named by the Minister of Health on 22 March, 2012. UMzinyathi and uMgungundlovu were chosen in KwaZulu-Natal. These two were chosen because of their high population numbers and high burden of disease. Amajuba was added by the province as a third district, but will be using their own funds to carry out the pilot. As

eThekwini was initially one of the pilot districts, this study was based in this district (Preparing for NHI, National Department of Health, 2011).

3.6. POPULATION

According to Polit and Beck (2004), a population is the entire aggregate of cases in which a researcher is interested. The target population is further referred to by Polit and Beck (2004) as the aggregate of cases about which the researcher would like to make a generalisation. Williams (2004) describes population as a term that refers to a collection of persons, groups, events or things about which the researcher wishes to generalise. The researcher's target population in the study consisted of Nurse Managers in the public Primary Health Care facilities and private hospitals in the eThekwini district.

In the qualitative phase, the researcher used top and middle level Nurse Managers from the public health care facilities (District Hospitals, Community Health Centres and Primary Health Clinics) and middle level Nurse Managers from the private facilities. Low level Nurse Managers were, however, used in the focus groups. Nurse Managers should play an important role in the implementation of the NHI as they are responsible for the quality of care in the health care services. Primary Health Care will be the basic provision for all health care facilities (WHO, 2003). The choice of this population was based on the fact that Nurse Managers will be involved in ensuring that the health facilities meet with all of the requirements for accreditation before the implementation of

the NHI policy (Government Gazette, 12 August 2011). Refer to Table 3.1 below. In the quantitative phase, the researcher used middle and lower level Nurse Managers.

Table 3.1 Description of the context

Institution	Type of Facility	No of Beds	No of Nurses	Level of Nurse Manager
1	Community Health Centre	20	230	1.Top 2. Middle
2	Community Health Centre	21	124	1.Top 2. Middle
3	District Hospital	240	120	Top
4	Acute Private Hospital	180	250 including students	Middle
5	Private Hospital	270	350-380	Middle
6	Community Health Centre	30	115	Middle
7	District Hospital	217	±334	Middle Focus group: 1. Middle 2. Middle 3. Middle 4. Lower 5. Middle
8.	Private Health facility	163	220	Middle
9.	Private Hospital	454	789	Focus group: 1. Middle 2. Middle 3. Lower 4. Lower 5. Lower

3.7. SAMPLE AND SAMPLING

Sampling means the process of selecting a portion of the population in order for that portion to represent the entire population; while a sample is the subset of population elements.

3.7.1. Qualitative Phase

Purposive sampling was selected, as it is relevant when exploring people's behaviour or thinking. The researcher selected this sample because she believed that Nurse Managers are knowledgeable about the issue of NHI. This purposively selected sample of participants could provide data on the interpretation of the NHI policy.

Interviews were conducted with three top level managers from one District Hospital and two Community Health Centres. There were only three top level Nurse Managers in the population. The researcher included all three in the sample because they are at CEO level and are decision-makers at their facilities. It was important to understand how they interpreted the concept of NHI as key role-players. Seven middle level managers from five public hospitals and three private hospitals were also interviewed. The middle level Nurse Managers are at Nursing Services Management level. They are responsible for nursing services and for ensuring that quality nursing care is rendered. They were chosen together with the top level Nurse Managers at some institutions, so that the researcher could see if both had the same understanding. Two focus group interviews

were conducted, comprising five lower and middle level managers from both private and public sectors. The lower level Nurse Managers were included in the focus group because they are operational managers who will be dealing with the NHI principles firsthand, e.g. infection control and cleanliness. The focus group interviews were conducted to further strengthen the data, as focus groups provide rich information in an efficient manner (Polit and Beck, 2008). The management staffing the selected facilities varied between top and middle level management, with lower level providing quality assurance, hence the inclusion criterion was Nurse Manager at any of the three levels. The researcher felt that the participants would supply valuable information on how Nurse Managers understand and interpret the implementation of the NHI (Polit and Beck, 2008), since they had experience of the central phenomenon, namely managing health care facilities (Creswell, 2009). This is in accordance with Tashakkori and Teddlie (1998) who stated that the selected individuals must have information available about the central phenomenon, in this case, the management of quality health care in relation to the NHI.

In some facilities, two levels of Nurse Managers were chosen, and in others, all three levels, because there were only three top level Nurse Managers from that sample. The researcher used all three top level Nurse Managers for representation of top management. Interviews were conducted with all levels until there was no new data.

In the Primary Health Care Clinics, there was only one level of manager, namely lower level. In the private sector, there was no Nurse Manager corresponding with the top

level Nurse Managers in the public sector; however the researcher tried to match the middle and lower levels of management in both sectors. Facilities in the public sector included two District Hospitals and three Community Health Centres. The private sector facilities consisted of four hospitals. This allowed for maximum variation (Tashakkori and Teddlie, 1998).

The number of participants in this phase was determined by the saturation of data at all levels of Nurse Managers, hence the number of participants was realised by achieving saturation. The sample was realised once the researcher began receiving redundant data.

3.7.2. Quantitative Phase

The sample comprised middle and lower level Nurse Managers from District Hospitals and Community Health Centres and lower level Nurse Managers in Primary Health Care Clinics in the public sector. The same type of sample was used in the private sector. Purposive sampling was used. Samples were selected from the eThekweni district facilities. The three categories of health facilities, namely District Hospitals, Community Health Centres and Primary Health Care Clinics were used. In each facility, the two levels of Nurse Managers were chosen. Two District Hospitals, three Community Health Centres and two Primary Health Care Clinics were used in the public sector. The two District Hospitals were chosen because they were the only two in the eThekweni district. The three Community Health Centres were sampled for the qualitative phase as

well. In the private sector, two hospitals from the Netcare group and two from the Life health care group were used as advised by the groups' ethics committees. Based on the situational analysis, 10% of the 58 Primary Health Care Clinics were selected. Managers in the selected facilities were given questionnaires to respond to. These were all middle and lower level managers who were not involved in the qualitative phase. This enabled the researcher to gauge and determine gaps that needed to be addressed.

3.8. DATA COLLECTION TECHNIQUES

The researcher had to analyse the interpretation and understanding of the implications of the implementation of the NHI by Nurse Managers in the institutions. There was a need for direct interaction (interviews) with the Nurse Managers, as well as a survey (questionnaires). The results from the interviews helped identify questions to pose in the questionnaire (Tashakkori and Teddlie, 1998). Interviews were conducted with a small population until there was a redundancy of answers. The survey was then done on a bigger population, using questionnaires based on the results of the interviews. This gave a bigger representation of the Nurse Managers' population. The combination of the quantitative and qualitative research methods assisted in identifying gaps that need to be shared with policy-makers and be addressed by them and the researcher in the intervention (Creswell, 2009).

3.9. DATA COLLECTION INSTRUMENTS

The qualitative data collection instrument, interview guide included questions on the understanding of the concept of the NHI, the guiding principles of the NHI, the application of the guiding principles within the institutions, how the policy applies to the work environment, the implications of the implementation of NHI on roles and responsibilities, perceived readiness for implementation of the NHI and what, if any, support might be needed to prepare for the implementation of the NHI. Data analysis of the qualitative data then produced themes which were used to develop the quantitative instrument.

The quantitative instrument took the form of a Likert scale using the statements that emerged as themes. The rating of the statements was then allocated according to 'strongly disagree', 'disagree', 'don't know', 'agree' and 'strongly agree'. The instrument contained items which were categorised into: Understanding of the concept of the NHI, strength/support given for preparation, readiness for implementation, gaps identified implications of the implementation of the NHI on roles and responsibilities and guiding principles of the NHI as targets for the project.

The instrument was subsequently subjected to testing through a modified Nominal Group Technique. A Nominal Group Technique is a structure variation of a small group discussion to reach consensus, while allowing contributions from everyone without domination of the discussion by a single individual. This technique has the advantage of

immediate responses as opposed to the Delphi method which often has a low response rate by post (Campbell, Braspenning, Hutchinson and Marshall, 2003).

The process involved the preparation of a venue adequate for the group members, the provision of stationery, and the introductory session whereby the facilitator, or researcher in this case, welcomed the participants and explained the purpose of the meeting. In this study, the researcher invited a group of Nurse Managers, some of whom were students in the Nursing Management Programme. After the purpose of the meeting was explained, the information sheets and consent forms were distributed. The information sheets were read through with the participants, following which they were requested to sign and return the consent forms to the researcher who was also the facilitator. The researcher had extracted the questionnaire statements from the findings of the qualitative data, therefore the group participants were requested to read the questionnaire and comment on the statements in the questionnaire, per category, for example, the understanding of the concept of NHI. The participants were then asked to share their impressions about the statements with the person next to them. The pairs were allowed to jot down their comments.

A group discussion then followed whereby the participants were allowed to clarify and dispute the statements. Additional statements were welcomed. The researcher ended at this stage due to time limits, and the fact that the purpose of the meeting was questionnaire development rather than brainstorming ideas and the selection of quality indicators (Campbell, Braspenning, Hutchinson and Marshall, 2003).

The researcher then presented the instrument to the academics running the Nursing Management Programme in the school, as experts to review the tool. No major concerns were raised regarding the tool, therefore the tool was finalised and distributed in the same context of the study, but on a larger scale, that is, including lower level managers due to the small number of top and middle management managers. There was, in fact, often only one top or middle manager per institution.

3.9.1. Pilot Study

According to Polit and Beck (2008), a pilot study is a small-scale version or trial run of the major study. The purpose of the pilot study is to test protocols, data collection instruments, sample recruitment strategies and other aspects of a study in preparation for a larger study (Polit and Beck, 2008). In the study, the structured interview guide for the individuals and focus groups was pre-tested with Nursing Management experts and Nursing Management students from UKZN before it was used to collect data from the respondents.

The questionnaire was pre-tested so that the researcher could establish whether the respondents would understand the questions. Nurse Managers from an institution that was not part of the study responded to this instrument. There were no concerns regarding the tool and it was therefore finalised to be used on the sample.

3.10. DATA COLLECTION PROCESS

Data collection was conducted in two phases; the qualitative first and thereafter the quantitative phase.

3.10.1. Qualitative Phase

Ethics clearance by the University of KwaZulu-Natal (UKZN) was first obtained by the researcher (Appendix F).

Permission was sought from the private health care institutions' CEOs and from the eThekweni District Manager's office for the public health care facilities (Appendices H and I). After securing permission from the relevant key people in the institutions, an appointment was secured with hospital managers, and the research process as well as data collection was discussed. The researcher asked for a private room to conduct interviews without disturbance, and for the purpose of privacy.

The researcher prepared a written guide of areas to cover with all participants (Polit and Beck, 2008). Data was collected through semi structured-interviews with all participants. Interviews were conducted with Nurse Managers, both as individuals and as focus groups. Where all three levels of Nurse Manager were present at a setting or facility, participants from all three levels were selected. Where only top and middle level managers were found, only those two levels of participants were selected. In the remaining settings, where only middle and lower level managers were present that

particular level of manager was selected. The researcher focused on the highest level of Nurse Manager per facility. The interviews were tape-recorded with permission from the participants, and notes were taken during the interview to ensure the highest possible credibility of data and to prevent a total loss of information (Polit and Beck, 2008). Nurse Managers were allowed to express their understanding and perceptions (interpretation) of the NHI, the guiding principles of the NHI, the implication of the implementation of the NHI on their roles and responsibilities, as well as to display their readiness for its implementation and any gaps in support that they could identify.

The focus groups' participants were from the middle and lower levels of Nurse Managers from both the public and private sectors. There were five participants from the public sector and five from the private sector. The same semi-structured interviews were used to collect the data. The interviews were tape-recorded and the researcher took notes during the interviews. The researcher had to first obtain written permission (Appendix D) from all the participants, after which information was given verbally and in written form (Appendix C).

3.10.2. Quantitative Phase

After the questionnaire was developed from the qualitative data, sampling of the health care facility was done. The sampled facility was approached for permission and an appointment for data collection was secured. Data collection was manual, and the researcher had to fetch all completed questionnaires. An appointment was made for

specific dates and times agreed upon with Nurse Managers depending on their schedules. On the day of collection of the data, the questionnaires were distributed to Nursing Services Managers and their assistants, as well as to the Operational Managers. Once the questionnaires were completed, the researcher collected them from a box that she had left to enable swift collection.

3.11. DATA ANALYSIS

Data was analysed in two phases; firstly in the qualitative phase, then in the quantitative phase.

3.11.1. Qualitative Data Analysis

Thematic analysis to compare or contrast similarities across cases (Polit and Beck, 2008) was conducted. According to Boyatzis (1998), thematic analysis is a process for encoding qualitative information. Boyatzis (1998) further maintains that thematic analysis can be used as a way of making sense out of seemingly unrelated material. Creation and application of codes to data took place. Coding means creation of categories in relation to data. It is the grouping together of different data under one group that can enable them to be regarded as of the same type (Gibson, 2006). Saldana (2013) states that a code in qualitative data analysis is a researcher-generated construct, that symbolises, and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorisation, theory building and other analytic processes. Data from the audiotape-recorder and the field notes were transcribed for analysis. The accuracy of transcripts was verified by the participants and

experts. Coding was initially done on raw data using different colours. Care was taken that the codes were allocated boundaries and meaning and were not redundant (Attride-Stirling, 2001). Examples of codes that were coloured were quality, standardisation, accreditation, access, equity, affordability, health care for all, resources - human and equipment, and education and training.

The themes were then extracted from the coded data. A theme is a pattern found in the information that, at minimum, describes and organises the possible observations, and at maximum, interprets aspects of the phenomenon (Boyatzis, 1998). This process was done with each institution. The researcher looked at the themes being specific and encapsulating ideas in more than one text. This assisted the researcher to reduce the data to make it more manageable and significant. Examples of emergent themes are:

- Coverage for all health care
- Not ready/ready for the implementation
- Training on the accreditation and implementation processes
- The need for resources
- Maintaining high quality of care
- Access to health care by all citizens

The themes were then arranged into groups of similarities which were allocated into categories. Themes will be discussed in detail in Chapter Four.

The categories were classified into the systems theory of SPO in order to organise and contextualise the subsequent quantitative data. "Structure/input" had all categories with

human and material resources needed to process outcomes. An example of this is the interpretation of the concept of NHI, strengths and support that Nurse Managers have, their readiness for implementation, and gaps identified by the participants. “Process” is the actual implementation of the NHI and its implication on the tasks carried out by participants, that is, the roles and responsibilities of the participants. The “Outcomes” are the targets of the implementation process of the NHI, for example, their knowledge of the guiding principles as targets.

The categories that were extracted from the interview guide included the following:

Structure/Input

- Interpretation of the concept of NHI
- Strengths and support given
- Readiness for implementation
- Support needed /Gaps identified

Process

- Implication of implementation on roles and responsibilities

Output/Outcome

- Guiding principles of the NHI as targets

Table 4.2 below summarises the categories and emerging themes

3.11.2. Quantitative Data Analysis

Quantitative data analysis used the Statistics Package of Social Sciences (SPSS) Version 19. Each response was entered into the computer after coding. Descriptive statistics were used by the researcher to describe and synthesise the data (Polit and Beck, 2004) and inferential numeric analysis was conducted (Creswell, 2009).

Descriptive method: Results were presented through simple statistics and graphic displays and tables. The objective was to provide a better understanding of the nature and distribution of variables and their relationships (Polit and Beck, 2008). Codes were allocated in the questionnaire. Descriptive analysis was carried out, including frequency, means and medians. Cross-tabulation of demographic data was done with interpretations, support, perceptions, the implication of implementation, readiness and gaps.

3.12. ACADEMIC RIGOUR

Academic rigour refers to the logical accuracy or trustworthiness of the research outcome, with respect to adherence to a philosophical perspective in the approach and thorough collection of data (Burns and Grove, 1995).

3.13. TRUSTWORTHINESS IN QUALITATIVE DATA

The researcher undertook measures to enhance the trustworthiness of the qualitative data. Miles and Huberman (1994) state that qualitative studies should be evaluated by using criteria that are developed for the qualitative paradigm. Four measures of trustworthiness were identified and applied to this study. These are credibility, dependability, confirmability and transferability.

Credibility is the truth value; the credibility of the study with regard to the people studied and to the readers. Miles and Huberman (1994) describe this as any sense on the findings, and Polit and Beck (2008) refer to this as the confidence in the truth of the data and interpretation by the researcher. It refers to the authentic quality of the data, and whether the data reveals what one is looking for. Babbie and Mouton (2002) state that credibility is achieved through prolonged engagement until data saturation occurs. The researcher spent time with the participants until there was saturation of data. The findings of the study were shared with Nurse Managers for comment and verification of the fact that this information constituted their true interpretation. Data was also presented to supervisory and academic colleagues to assess its credibility. The study was edited by two editors (Appendix: M)

Dependability, an equivalent of reliability in quantitative language, is whether the process of the study is consistent, reasonably stable over time, and across researchers and methods (Miles and Huberman, 1994). Dependability refers to the tractability of the

changes in data over time and conditions (Polit and Beck, 2008). Interviews were conducted until saturation was reached. Verification interviews were also conducted twice. Guba and Lincoln (1994), however, argue that there is no credibility without dependability, and therefore the existence of credibility is enough to establish the existence of dependability. This study undertook triangulation to demonstrate academic rigour and enhance the truthfulness of the data. Triangulation means gathering and analysing data from more than one source to gain a fuller understanding of the phenomenon under study. Silverman (2002) says that triangulation is an attempt to get a true fix of a situation by combining different ways of looking at it or different findings. The researcher used semi-structured interviews and questionnaires to collect data, in order to triangulate the qualitative data. The study employed two approaches, namely the qualitative and quantitative approaches. The researcher concluded the study by determining the distribution of responses in quantitative data which should demonstrate high agreement with the themes, considering the fact that the qualitative instrument was based on the Nurse Managers' data from the same context.

Confirmability asks if the conclusions depend on the subjects and conditions of the inquiry rather than on the inquirer (Miles and Huberman, 1994). Confirmability refers to the degree to which the study results and conclusions are derived from inquiry of the participants and the study context, and not from researcher biases (Polit and Beck, 2008). The researcher was explicit about any personal biases or assumptions and values that might have come into play in the study. Bracketing was done to identify the researcher's standpoint on the issue under study. Bracketing is discussed in detail on

page 81. Interviews were tape-recorded and transcribed verbatim by the researcher to ensure accuracy. Verification interviews were conducted with the participants to confirm that the information collected was the true reflection of their interpretations and perceptions. The supervisor verified the transcription of the data and the interpretation thereof.

Transferability is whether the conclusions of the study can be transferred to other contexts and whether they can be generalised (Miles and Hurberman, 1994). Polit and Beck (2008) describe this as the extent to which the findings of the study can be applied to other situations as the study is specific to a small pool of participants. This was ensured in the study by the fact that a bigger pool of participants was obtained through the quantitative method. This gave a bigger representation. It is not the aim of qualitative study to generalise, however, because this study aimed at informing policy-makers of any gaps, the researcher was compelled to follow with a quantitative phase which covered more participants for generalisation and implementation of the intervention. The researcher described the context of the study in detail to promote applicability to the study. A detailed research process and findings were presented to facilitate assessment for applicability by prospective researchers in other contexts.

3.14. VALIDITY AND RELIABILITY OF DATA

Validity is the degree to which an instrument measures what it is supposed to measure (Polit and Beck, 2004). Content validity was adopted, whereby the questions of the

qualitative instrument were compared to the objectives of the study (Table 3.2). In the study, the quantitative data collection instrument was constructed in relation to analysed data from the qualitative study. In this study, a facility not part of the study was chosen for the pilot study. Participants from the middle and lower level of Nurse Managers were chosen. No queries or major errors were identified, and the questionnaire was immediately used for collection of data for the main study.

TABLE 3.2: Content Validity of Data Collection Instrument

Objectives	Instrument Questions
To analyse the NHI policy with regards to its guiding principles in terms of inputs, process & expected outcomes	1. What are the guiding principles of the NHI policy?
To analyse how Nurse Managers interpret the concept of the NHI	2. What do you understand by NHI? 3. How does the NHI policy apply to your work environment as a Nurse Manager?
To analyse what nurse managers understand to be the implication of the implementation of the NHI on their roles and responsibilities.	4. What is the implication of the implementation of the NHI policy on your roles and responsibilities?
To identify any strengths the Nurse Managers possess.	5. How ready are you for the implementation of the NHI? 6. What support do you have which enables you to prepare yourself for the implementation of the NHI? 7. Do you need any further support? If yes, what support do you need?

Reliability is the degree of consistency or dependability with which an instrument measures the target attributes (Polit and Beck, 2004). A reliable measurement instrument should provide the same results over time, with a minimum error component (Polit and Beck, 2004).

In the study, questionnaires were pre-tested (pilot study) to check for understanding by participants, to ensure reliability. This was carried out in respect of a few participants possessing the same characteristics as the main study sample. A health care facility that was not part of the study was used for the pilot study. Pre-testing can also use discipline-specific participants in the same field, e.g. supervisors and Nursing Managers at various levels and the academics from UKZN. The quantitative instrument was subjected to further testing, as discussed under the data collection instrument.

3.15. DATA MANAGEMENT

The researcher will have to give feedback to the participants and the authorities in both the private and public sectors. The final report will be sent to the authorities who gave permission for the researcher to conduct the study.

Data will be stored in the supervisor's office under lock and key and in the computer with a password known only to the researcher. No names of the individuals or institutions will appear in the reports and publications. Destruction of data after five (5)

years will be through shredding and incineration. Electronic data will be deleted completely from the computer.

3.16 ETHICAL CONSIDERATIONS

The University of KwaZulu-Natal Ethics Committee approved the proposal before the study was conducted (Appendix: F).

Permission was secured to conduct the study from the following:

- The Research Committee of the KZN Department of Health (Appendix G)
- The eThekweni District Office (Appendix H)
- Hospital Managers in both the public and private sectors (Appendix I)
- The Netcare Research Committee (Appendix J)
- The Life Health Care Research Committee (Appendix K)

The researcher first provided information on the study. An information sheet was given to the participants to read (Appendix C). The collected data was treated with confidentiality. The participants were assured that the information that they gave was to be kept in strict confidence. An informed consent form was signed by all participants before the researcher conducted the interviews (Appendix D). The researcher ensured that participants were not coerced into participating in the study. The participants and their health facilities were kept anonymous. Numbers and codes were used for the

identification of the respondents and their facilities. This was shared beforehand with the Nurse Managers who participated in the study.

3.17. BRACKETING

According to Polit and Beck (2008), bracketing is the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study. The researcher's involvement with the phenomenon under study will be described so as to confront the data in pure form.

Personal

The researcher has a fair understanding of how rural and poor people do not have easy access to health care facilities. This is due to the fact that the researcher grew up in a rural area, which, to date, does not have easily accessible health care facilities. The demographics, as well as the lack of financial resources contribute to the problem of easy access.

Professional

The researcher has worked in public and private health care facilities. The researcher has a fair knowledge and understanding of how the private health care service deals with financing for health care. The researcher has been in a management position for seven years, and understands what roles and responsibilities a Nurse Manager has.

The fee for service in the private sector has resulted in the researcher seeing patients who do not receive care at their first entry into health care. The state of the public health care facilities has made the researcher aware of the need for reform. The duration spent waiting for attention and the lack of drugs was experienced first-hand by the researcher. The researcher's adult family member with tonsillitis was informed at a Primary Health Care Clinic that there were no drugs available, and was given a 50ml bottle of paediatric paracetamol syrup.

To quote a scenario that has remained in the researcher's mind; a nurse responded to a patient who was concerned about his long wait for medical attention as follows:

"I am still having my lunch; you will have to wait as I am all alone in that cubicle".

The nurse took that lunch break for as long as the researcher's stay at the facility which was close to two hours. It is no wonder that patients complain of the duration spent waiting for attention and the attitude of staff. Good management qualities and skills are needed to correct the wrongs experienced by patients at health care facilities.

The researcher supports the concept of the NHI as it will attend to those with the least access, thus improving their access to quality health care services, and will provide financial risk protection for the whole population. The researcher further supports Primary Health Care, where access to health care for all citizens, rich or poor, is important, as well as the prevention of illnesses and the promotion of health at the first level of care. The researcher also feels that skills development is vital so that the

country has skilled health care professionals attending to the health needs of the population accordingly.

3.18. CONCLUSION

The process undertaken to conduct this study was presented in this chapter. It was in keeping with the sequential exploratory research design. The samples selected for the study were discussed, and these consisted of Nurse Managers from primary health care facilities in both the public and private sectors. Data collection tools, collection and analysis of data were discussed. Ethical considerations and requirements before undertaking the study were also presented. Chapter Four presents the results or findings of the study.

CHAPTER 4

RESEARCH RESULTS

4.1. INTRODUCTION

This chapter will focus on the results which are based on the objectives and questions of the study. These detail how Nurse Managers interpret the concept of the NHI, the strengths that the Nurse Managers possess, the support that the Nurse Managers need/gaps that they identify in their readiness/preparedness, the implications of the implementation of the NHI on the Nurse Managers' roles and responsibilities and the guiding principles.

Qualitative data was analysed through thematic analysis, and results are presented in accordance with the responses obtained from the semi-structured individual and focus group interviews conducted with the Nurse Managers from the PHC facilities in the public sector. The respondents from the private sector were from the private hospitals. The quantitative data analysis used SPSS Version 19 software, and the results are in accordance with responses from the questionnaires completed and collected from Nurse Managers of the same health care facilities of the private and public sectors.

The qualitative data analysis and findings are presented in narratives and quotes for further clarity where applicable. Quantitative data analysis and findings are presented in a narrative format and are illustrated in tables and graphs.

In keeping with Creswell's three-phase approach for sequential exploratory mixed methods, this chapter presents data in three different phases. The first phase of the sequential mixed method employed in this study, which was qualitative, sought to explore the phenomenon under study, for example, the concept of the NHI and the implication of its implementation on the roles and responsibilities of Nurse Managers at various levels. Phase two presents the development of the instrument which was discussed in detail in Chapter Three. This was followed by the third phase of quantitative data, whereby the study sought to elaborate and expand upon the findings of the explorative phase by "quantitising" (Tashakori and Teddie, 2003) the exploratory data to enable the generalisation of data. Both the qualitative and the quantitative data can be connected by the qualitative data analysis and quantitative data collection. In Chapter Four, the data from the two phases are presented as two separate headings for each phase, as recommended by Cresswell (2009).

Morgan (1998), cited in Cresswell (2009), suggests that sequential exploratory strategy be used when testing elements of an emergent theory, however this study was assessing the elements of an emergent policy, such as the understanding of the concept of NHI and the interpretation and implications of the implementation of the NHI policy on the roles and responsibilities of Nurse Managers at different levels. The qualitative data was used to develop the instrument, while the quantitative data was used to determine the distribution of the understanding and interpretation of the phenomenon under study among the Nurse Managers.

4.2. QUALITATIVE PHASE

Phase one presents the qualitative data in the study.

4.2.1. Qualitative Demographic Data

Demographic data is used to describe the sample studied (Burns, Grove and Gray, 2013). This was analysed data collected from the top level, middle level and lower level (who were in the focus groups only) Nurse Managers from the Primary Health Care Centres, including the District Hospitals, Community Health Centres and Primary Health Care Clinics in the public sector. In the private sector, data was collected and analysed from the private hospitals.

A sample of Nurse Managers was realised after data saturation (individual interviews). They comprised three top level and seven middle level Nurse Managers. The lower level was not included in the individual interviews because the research was still in its exploratory stage. One was a male and nine were females. Seven participants were from the public sector and three from the private sector. Their experience as Nurse Managers ranged from five to fourteen years. Two focus group interviews were subsequently conducted by the researcher in order to access richer information. The groups consisted of five participants each, comprising middle and lower level managers. One focus group was comprised of public health care Nurse Managers and the other group was composed of Nurse Managers from the private health care sector. The

demographic data for the ten individually interviewed participants is summarised in Table 4.1.

Table 4.1 Individual Interview Participants' Demographic Data

Participant	Gender	Sector of Employment	Level of Manager	Experience as Nurse Manager
1	Female	Public	Top	10 years
2	Female	Public	Middle	5 years
3	Male	Public	Top	14 years
4	Female	Public	Middle	6 years
5	Female	Public	Top	7 years
6	Female	Private	Middle	5 years
7	Female	Private	Middle	10 years
8	Female	Public	Middle	7 years
9	Female	Public	Middle	7 years
10	Female	Private	Middle	8 years

4.2.2 Presentation of Qualitative Data

Nurse Managers were asked to express their understanding of the National Health Insurance policy. The researcher conducted interviews containing probing questions to

gain an in-depth understanding of the Nurse Managers' understanding of the NHI policy. From the transcribed interviews different themes emerged. The themes were generated from the raw information in order to access a wide variety of information on the phenomenon (Boyatzis, 1998). The themes that were relevant to the study objectives were grouped together, forming categories according to the objectives of the study (Polit and Beck, 2004). The themes were further grouped into a template/conceptual framework based on the SPO model which assesses health care quality (Donabedian, 1988).

The themes were grouped together into the following categories: **Structure/Input:** Interpretation of the concept of NHI; strength and support the Nurse Managers have to prepare for the implementation of the NHI; perceived readiness for the implementation of the NHI; the support that Nurse Managers need and gaps identified. **Process:** Implications of the implementation of the NHI on roles and responsibilities. **Output:** The guiding principles of the NHI as targets.

4.2.2.1 STRUCTURE/INPUT:

The structure included four categories with several themes discussed under each. Each theme is subsequently presented and illustrated with excerpts.

4.2.2.1 (a) Category A: Interpretation of the concept of NHI

The themes that emerged from the data in this category were as follows:

Theme 1... All health care funding into one basket and unification of health insurance...

Theme 2..."Make me look like a hospital" policy....

Theme 3... Unification of service delivery and coverage for all health care...

Theme 1.... All health care funding into one basket.....Unification of health insurance

The funding of health care was seen by some participants as a need to be fulfilled by the NHI. All health care funding should be sourced from one pool. All health care funding should be drawn from this fund, be it private or public. The following excerpt illustrates this further:

".... funding health care services by bringing together all health care funding into one basket...." TL2

"....A fund that has been made so that health care is available to everybody, the fund will be driven by the government...." FG1

Upon interview, most of the participants indicated that their understanding of the concept of NHI was that it was an insurance policy which would cover every citizen so that s/he could access health care. Every person in South Africa should be able to receive the health care s/he deserves without having to pay extra fees before s/he could receive such care. This was confirmed by the following excerpt:

'...Unification of insurance where everyone can access any health care in the public or private sector without extra payment...' FG2

Theme 2... "Make me look like a hospital" policy...

Some participants indicated that the policy introduced by the Department of Health should ensure that the conditions in the public health care facilities are improved, as these have an adverse effect on the provision of quality health care and the implementation of the NHI. One participant from the public sector was very critical of the conditions in the public health care facilities as evidenced by the following excerpt:

"...The "Make me look like a hospital" policy, where each and every one, each and every institution is expected to be clean. The attitude of staff is also expected to be good towards patients. The waiting times are expected to be acceptable. There must be availability of medication, safety and security. Every institution must promote safety and security...." ML2

Another participant from the public sector indicated that the policy has ensured that there are funds given to institutions by the Department of Health to improve conditions in their institutions as stated in this excerpt:

"...There are funds given for hospitals to "look like a hospital'...." TL3

Theme 3... Unification of service delivery... Coverage for health care...

Most of the participants understood the concept of the NHI to mean the unification of all activities and services in all health care facilities of both the public and the private sectors. The health care delivery must be same in all health care facilities as stated in these excerpts:

“...It is a system where the Department is trying to unify the service delivery in the public and private sectors...” ML2

“... Same service, and the standards to be the same in each and every health institution in our country, so that you don't have to go to a better institution if you have medical aid....” ML1

“... Public private integration of services and improvement of health care service to provide access to better health services for all communities...” ML5

A number of participants described the NHI as increasing coverage for all health care from PHC to the highest level of care, so that all South African citizens would be able to access health care facilities easily, as indicated in these excerpts:

“....coverage for health care from PHC to the highest level of care for everyone in the country....” TL1

“...to cover all the SA citizens so that they are able to access health care facilities at all levels ...” ML6

4.2.2.1. (b) Category B: Strengths and support the Nurse Managers have to enable them to prepare for the implementation of the NHI

The following themes emerged from the data in this category:

Theme 1 ... we have qualified nurses...

Theme 2... Department of Health support...

Theme 3 Institutional support....

Theme 4....Head Office support....

Theme 1... We have qualified health professionals...

Some of the participants indicated that they had received some form of support to help them prepare for the implementation of the NHI policy. The majority indicated that there was a lack of human resources, but the following excerpts indicate that not all participants agreed:

"...we have qualified professionals, especially in the Primary Health Care setting...." TL1

"...we have qualified nurses who are prepared to work so that NHI can be implemented..." TL1

Theme 2 ... Department of Health - National/Provincial/District support...

When interviewed, some participants from the public sector indicated that the Department of Health was supportive in preparing them for the implementation of the

NHI policy. They mentioned that the District Office was providing different forms of support to their institutions as indicated in the following excerpts:

‘...the Department of Health is very supportive...’ TL1

“...regular visits by coordinators from District Office.....” TL1

“...there is support from the District Office in terms of challenges...” TL2

“...we have support from National and Provincial Offices through in-service training or development...” ML2

Theme 3 ...Institutional support

Some participants indicated that there was support from personnel within their institution as evidenced in the excerpts below:

“...we have support institutionally for all the programs we have...” ML2

“... we have buy-in from managers within the institution...” FG2

“...we have support from the CEO and the Finance Manager....” ML6

“...we are going along supporting each other, the baseline has been set...” FG1

Theme 4Private sector Head Office/company support

The private sector participants indicated that their Head Offices were very supportive. They indicated that even though not much had been done with training and skills development for the implementation, they knew that their Head Offices were liaising

with the Department of Health and would give them all the support they would need for the implementation of the NHI policy. This is indicated in the following excerpts:

“...our management at Head Office decided long ago to be part of the NHI, we have their support ...” ML3

“...we will get a lot of support from my company with regards to implementation and accreditation process...” ML4

“...we will get direction from our company, so we have got support...” ML7

4.2.2.1. (c) Category C: Readiness for the implementation of the NHI

The themes that emerged from data in this category were as follows:

Theme 1... not ready/ready for the implementation...

Theme 2 ... working on being ready...

Theme 1 ... Not ready/ ready for the implementation

The majority of the participants stated that they didn't think that they were ready for the implementation of the NHI, as they stated that there were still areas that needed to be attended to, as shown by the excerpts below:

“...we are not ready; we are just not ready, we don't have resources...” ML1

“...not totally ready; as it is a 14-year-plan; the slow phasing-in will make us ready...” ML3

“... no, I don’t feel any one of us is ready for the implementation because there are so many unanswered questions...” ML4

“...I don’t think we are ready; we haven’t had the necessary information communicated or made ourselves ready...” ML5

“...not ready as there is a lot of work owing...” FG1

“...we are not ready; we still have a lot of gaps...” FG2

There were, however, some participants who indicated that they felt ready for the implementation of the NHI policy at their institutions, as they felt that they had met the requirements, although they still had a few concerns. Others, however, felt they were fully ready as evidenced in the following excerpts:

“...yes, I think we are ready, although not completely ready. ..” TL3

“...I would say the institution is ready, however there are certain prerequisites like the infrastructure that need to be sorted...” TL2

“...I really feel we are ready for it, judging from what we have at present in the institution...” TL1

“...yes, we are ready, because we have the knowledge of what the NHI is...” ML2

Theme 2...Working on being ready

There was a general feeling from most participants that they were still working towards being ready. This is reflected in the excerpts below:

“...don't think we are ready as an institution, but we are working towards being ready...” ML6

“ ... I see us being ready once we have finished the entire project...” FG2

Nurse Managers were still working towards meeting the set national core standards and hence they felt that they were not ready for the implementation of the NHI policy.

4.2.2.1. (d) Category D (a): Weaknesses of Nurse Managers

The themes that emerged from the data in this category were as follows:

Theme 1 ...Lack of knowledge and understanding...

Theme 2 ...Lack of skills...

Theme 1 ...Lack of knowledge and understanding ...

Some participants indicated that they had very little, or no knowledge at all, of the NHI policy as they had not yet been given any information (by their seniors) regarding it and how it would affect the private sector. The following quotes are indicative of this:

“.... I think there needs to be some involvement (with the implementation) from private, but to what extent I really have no idea whatsoever...” ML7

“...I am not quite sure where the private hospitals sit with this NHI; nothing definite has come out as to whether private hospitals are still going to exist in the country....” ML4

“...I am honestly not sure; I don’t know if they will allocate different hospitals for different levels; I am really not sure what the roll-out plan is...” ML7

“...I haven’t read much on the NHI, I must be honest I haven’t....” ML7

“...I don’t really know what is expected from the implementation....” ML7

‘...the insecurity around how it will affect us (implementation) is probably making me personally a bit more reluctant to be excited about it....’ ML4

“...we need to understand the process of accreditation and implementation....” ML4

Theme 2 ...Lack of skills...

Some of the nurse participants interviewed indicated that (some) nurses lacked certain skills. This would make them (nurses) unable to deliver quality health care and ensure a smooth implementation of the NHI.

“...we would like the four year curriculum for midwifery to be changed from six months to a year as they (newly-qualified midwives) lack good midwifery skills...” ML2

“...bridging courses should include midwifery so that they are skilled when they qualify, as there is a great need of midwifery skills at the first level of care....” ML2

“ ...to strengthen family planning by teaching the skill of inserting IUCD (Intra uterine contraceptive device) in the fourth year and bridging programs, in order to have more registered nurses skilled in IUCD insertion at the first

level of care...” ML2

4.2.2.1. (d) Category D (b): Support Nurse Managers need

The following themes emerged from the data in this category:

Theme 1...Training on the accreditation and implementation processes...

Theme 2 ...The need for resources...

Theme 3 ...Infrastructure improvement...

Theme 1 ...Training/ Education needs...

Some of the participants indicated that they needed training on the entire accreditation and implementation processes. They indicated that they lacked knowledge on the whole NHI process and needed to be trained on the process, as stated in the excerpts below:

“...there must be intense training on the accreditation and the implementation processes...” ML4

“... we do need a lot of training from the government on the NHI...” ML1

“...definitely, I think we need support with training on the whole process...” ML4

“...we need to be educated on the accreditation process...” FG2

Theme 2... The need for resources...

Most participants indicated that there was a need for human resources in all of their institutions in order for the NHI to be implemented successfully. The following excerpt is representative of all of the participants' views:

"...We need human resources because these programs take a very long time. We are practising a one-stop shop where the patient expects everything to be done, everything (by one nurse)... If you are consulting a patient you need to do it holistically, therefore we need more human resources for that..." ML2

Theme 3.... Infrastructure improvement...

All participants from the public sector indicated that there was great concern about the state of the infrastructure. Some of the buildings needed renovation or extension in order to accommodate the anticipated high number of patients. The state of the buildings had to meet set standards so that they could be accredited as NHI institutions.

The following excerpts indicate the general feeling of all public health care participants:

"...we need assistance from the infrastructure department so that our facility buildings can be improved to current norms and standards..." TL3

"...this place is very overcrowded; there were no plans for expansion..." ML5

"...our institution needs renovation..." ML1

“...our institution was built many years ago; there is so much that needs to be renovated...” FG2

4.2.2.2 PROCESS:

Only one category is presented in this section.

4.2.2.2. (a) Category E: Implications for the implementation of the NHI on roles and responsibilities

The themes that emerged from the data in this category were as follows:

Theme 1 ...preparation for the implementation of the NHI policy...

Theme 2 ... we have to request for new equipment...

Themes 3 ...managing the cost and budget...

Theme 4... maintaining high quality of care...

Theme 5 ...monitoring and evaluation...

Theme 1... Preparation for the implementation of the NHI Policy...

The majority of participants indicated that they needed to prepare for the implementation by ensuring that the environment was conducive to quality health care delivery as indicated in the following excerpts:

“...we are still preparing for it (implementation) ...” TL1

“...Working on preparation by attending discussions and workshops...” TL2

“...if we apply all the principles of NHI we will be on the right track...” ML2

“...everybody needs to have a mind-change as it is all about cost and quality...” ML4

“...there are many things that we need to fix in my institution before implementation...” ML6

“... we must meet the norms and standards for all health facilities in the country...” TL2

“... strengthen the policies, guidelines and protocols so that everybody in the institution will have direction as to what is expected of them...” ML2

“... developing institutional policies that are going to guide people in health delivery...” TL3

“...I am the one who has to make the environment conducive to implementation...” TL3

“...the one who must provide resources to implement the policy...” TL3

“... I would like to play an active role in the whole implementation process...” ML4

Theme 2 ...We have to request/buy new equipment

Most participants indicated that there was a great need for new equipment in order for them to be able to render efficient patient care, and for standards to be the same in both the public and private sectors. The following excerpts indicate that:

"... we have to request equipment..." ML1

"...we are going to buy equipment..." ML2

"...each and every department has got its relevant equipment needed ..." TL1

"...we have motivated for more equipment..." ML2

*"...buying state-of-the art equipment that is used in the private sector
in order to conform to the NHI requirements..." ML1*

Theme 3...Managing the cost and budget...

Some of the participants indicated that they had to manage the cost and budget of their institutions in order to ensure that quality health care was rendered without any compromise, as indicated in the excerpts below:

*"...make sure that we don't waste, that we use what we are supposed to use
effectively and efficiently, and try to keep the cost per event as low as possible
with the exact same outcomes..." ML3*

"...we will still manage the cost and budget in the units..." FG1

Theme 4... Maintaining a high quality of care...

Participants indicated that quality of care had to be high and needed to be maintained as such. They (participants) further stated that they needed to abide by the national norms and standards and be accredited. The following excerpts illustrate this theme:

"... maintaining the high quality of care within the institution through our quality assurance department..." TL1

"...ensuring quality nursing care will grow quite a bit... The quality responsibility of a nurse manager will get a bit bigger and heavier than current performance..." ML4

"...we must abide by the principles of high quality care to remain accredited..." TL1

"... maintain high standards so that we continue to hang on to our accreditation licence..." TL2

"...ensure sustainability of a high standard of care..." TL3

"...continue compliance with National core standards and the institution will subsequently be accredited..." TL2

The participants believed that maintaining the high quality of care and abiding by the national core standards would afford their facilities accreditation status after assessment, and allow them (facilities) to implement the NHI policy.

Theme 5 ...Monitoring and evaluation...

The excerpts below from some of the participants indicate that participants had to monitor and evaluate the implementation process as well as all other policies and guidelines pertaining to the NHI:

"...I must support, monitor and evaluate the whole process, ensuring that it is sustainable..." TL3

"... monitoring and evaluation after implementation of policies and guidelines..." TL3

'... I am the one who is going to be driving the whole process and monitor progress..." TL3

4.2.2.3 OUTCOME:

This section includes the category which would be used as targets for the NHI.

4.2.2.3 (a) Category F: Guiding principles as targets for the project of the NHI

The themes that emerged from the data in this category were as follows:

Theme 1...Application of guiding principles in institutions...

Theme 2...Access to health care by all citizens/ Ensuring health care delivery to all SA citizens...

Theme 3 ...Preventive care...

Theme 4 ...Follow approved referral system through various levels of care...

Theme 5 ...Affordable health care to all SA citizens...

Theme1... Application of guiding principles in institutions

The participants indicated that they needed to make sure that health care is delivered to all citizens by adhering to the norms, policies and guidelines as reported in the following excerpts:

“...we have policies, standards and norms which guide us according to the Department of Health requirements...” ML1

Theme 2 ...Access to health care by all citizens/Ensuring health care delivery to all SA citizens

Some participants indicated that there had to be equal access to health care for all citizens of the country as evidenced by the excerpts below:

“...everybody to access health care services, even the poorest of the poor...” ML7

“... access to better health services for all communities...” FG1

“...equal access to health care irrespective of their social status...” TL2

“...we are going to have more patients coming through to our institution...” FG1

Theme 3 ... Preventive care...

Participants stated that health care would be improved, with Primary Health Care as the first level of care, in which prevention would be key. This is highlighted by the excerpts below:

“... people will be treated early to prevent further complications...” TL2

“...health education on preventative measures at PHC level...” ML3

“...the community will utilise the local clinics or Community Health

Centres as first level instead of flocking to the next level...” ML5

Theme 4 ...Follow approved referral system through various levels of care

Some participants indicated that, for the implementation of the NHI policy to run smoothly, the approved referral system had to be followed. This is indicated by the following quote:

“...As health practitioners we need to be able to offer the necessary care at our level to satisfy the health needs of the community and refer patients accordingly...” ML3

Theme 5...Affordable health care to all SA citizens...

Some participants indicated that health care has to be affordable to all citizens of the country, irrespective of whether they have funds or not, as evidenced by the excerpts below:

“... health care accessible and affordable to all people living in South Africa...” ML3

“...making health care accessible, affordable and sustainable...” TL3

4.4.2.4 Summary: Qualitative data

The majority of participants had a general understanding of the NHI concept but were not specific. This was seen from the fact that the description of the NHI and the guiding principles was the same for some participants. There was a general mixing of the concept of the NHI with the principles of the NHI, as indicated in the following quote which describes the concept of the NHI.

“...The NHI will cater for everybody to access health care services even the poorest of the poor just to improve their conditions so everybody is going to access health services....”

4.3 INSTRUMENT DEVELOPMENT PHASE

Phase Two presents the instrument development which was discussed in detail in Chapter Three, Section 3.4.2 on page 56.

4.4 QUANTITATIVE PHASE

Phase Three presents the quantitative data in the study.

4.4.1 Quantitative Results:

Quantitative data constituted analysed data collected from the middle and lower level Nurse Managers from the public sector namely District Hospitals, Community Health Centres and the Primary Health care Clinics. In the private sector, it was from the private hospitals.

4.4.1.1 Demographic data

The characteristic of the sample of Nurse Managers involved in the study was as follows.

- Gender of respondents

There were forty-seven (47) respondents. Out of these 47 Nurse Managers, 94% (n=44) were females and 6% (n=3) were males. Refer to Figure 4.1 below. The respondents were chosen through availability and their willingness to participate.

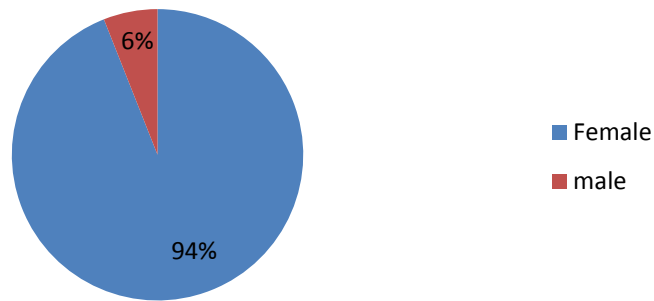


Figure 4.1 Gender of Nurse Managers (N=47)

- Age of respondents

The ages of the Nurse Managers (n=47) who participated, including 1 who did not state his/her age ranged from 30 to 63 years. The majority of these were in the 50 to 59 year age category [35%, (n=16)]. This was followed by 28% (n=13) for the 40-49 year age category. The 30-39 year age group followed with 24% (n=11) and the 60-63 group totalled 13 % (n= 6). Refer to Table 4.3

Table 4.3 Ages of Nurse Managers (N=47)

Age Category	Number of Respondents	Percentage
30-39	11	24%
40-49	13	28%
50-59	16	35%
60-63	6	13%
Missing	1	0%
TOTAL	47	100%

- Experience of respondents

The data in Figure 4.2 shows the number of years that the Nurse Managers had worked in their capacity as Nurse Managers. Out of the sample of 47 Nurse Managers, 40% (n=18) had been working for 5-10 years, 32% (n=14) for over 10 years and 28% (n=13) for less than 5 years.

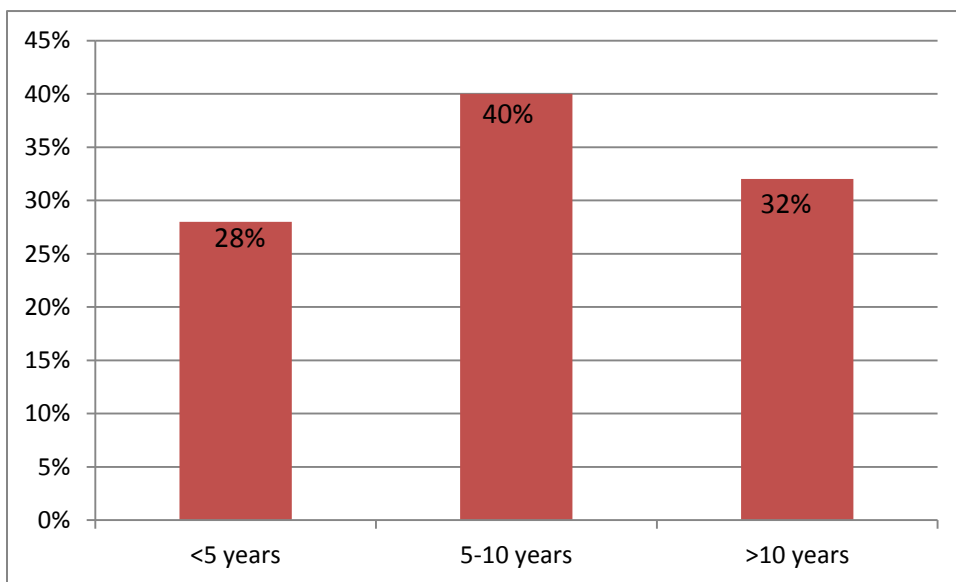


Figure 4.2 Working experience as Nurse Managers (N=47)

- Management level of the Nurse Managers

The data in Figure 4.3 shows which level of nurse management the respondents were in. Out of the sample of 47 Nurse Managers, 53% (n=25) were in the middle level and 47% (n=22) were in the lower management level. There were no top level managers in the sample as there were none in this population (top level Nurse Managers are CEOs of institutions and they are generally a small population).

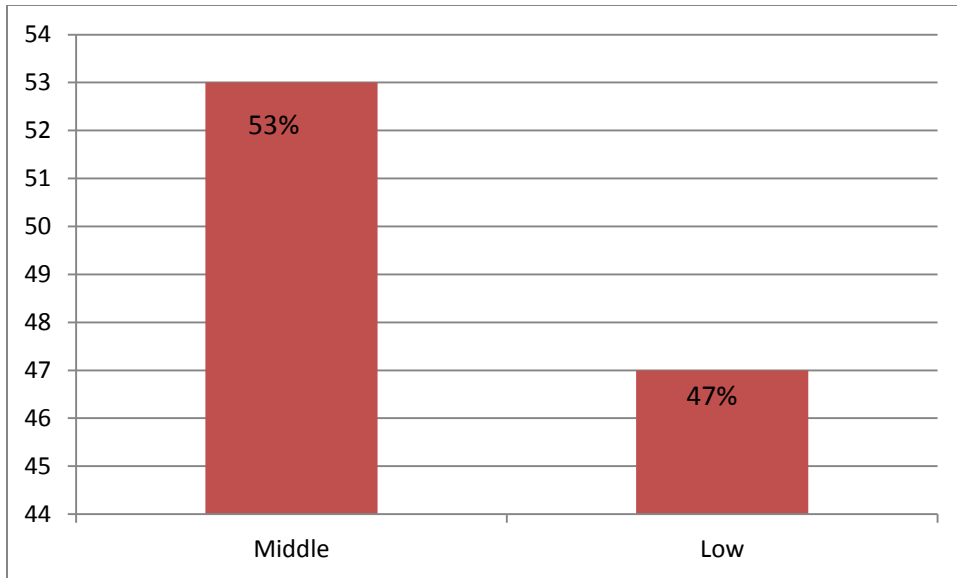


Figure 4.3 Level of Nurse Management (N=47)

- Sector of employment of respondents

According to the data in Figure 4.4 representing the sector of employment, of the 47 Nurse Managers, 60% (n=28) were from the public sector and 40% (n=19) were from the private sector.

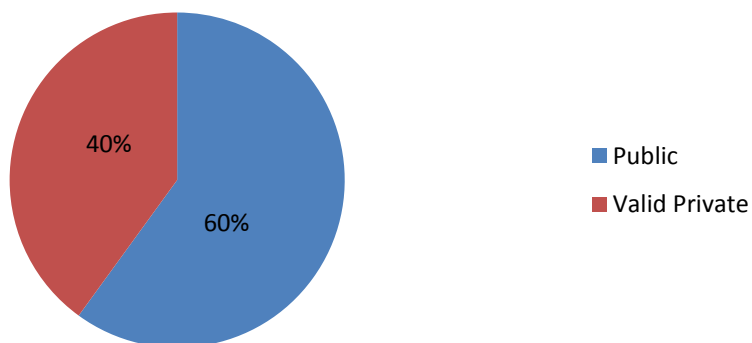


Figure 4.4 Employment sector of Nurse Managers (N=47)

4.4.1.2 Quantitative findings

Data was analysed using frequency tables and non-parametric tests. The study was aimed at identifying whether Nurse Managers understood the concept of the NHI and the implications of the implementation on their roles and responsibilities. It further aimed at identifying their readiness as well as their strengths and weaknesses.

The same sample institutions that were used for the qualitative data were used for the quantitative data, but were expanded to accommodate generalisation. The questionnaire was drawn up, based on the analysed data from the qualitative phase, following the SPO model and consisted of three sections as follows: **Structure-** Understanding/interpretation of the concept of the NHI, strength and support that the Nurse Managers have to prepare for the implementation of the NHI, readiness for the implementation of the NHI, the support Nurse Managers need/gaps identified. **Process-** Implications of the implementation on roles and responsibilities. **Outcome** -The guiding principles of the NHI as targets for the project,

Data was analysed using the SPSS Version 19 with the help of a statistician. Descriptive and non-parametric analysis was used.

4.4.1.2 (a) STRUCTURE/INPUT

The questionnaire was based on the interpretation of the concept of NHI, the strength and support, readiness for the implementation and support needed.

- **Interpretation of the concept of the NHI.**

In the study, Table 4.4 summarises findings with regard to how Nurse Managers understand the concept of the NHI. The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. The important note to make in this table is that there were questions in the questionnaire which were not answered by some of the Nurse Managers, for example, "same service in each and every institution". The results show that a large number of respondents, 78%, (n=36), strongly understand the concept of the NHI. A small number, 12%, (n=6) strongly do not understand the concept of NHI and some, 10%, (n=5) don't know about the NHI. Ninety-two percent (n=43) of the respondents strongly agreed that facilities are to be upgraded to prescribed standards after being assessed and accredited. Ninety-eight percent (n=46) believed that everybody would access health care, even the poorest of the poor. Another 98% of the respondents (n=46) strongly believed that there would be provision for access to better health services for all communities. Ninety-three percent (n=43) of the respondents strongly agreed that there would be public private integration of services to improve health care.

There were mixed feelings about the understanding of the NHI, as is evident from the following: Although 77% (n=36) agreed that there would be same service in each and every institution, 10.6% (n=5) indicated that they did not know, 6.4% (n=3) did not respond and another 6.4% (n=3) disagreed. There was a pattern of not knowing about the concept of same service in all institutions, for example, there was the same number of respondents, 10.6% (n=5) who didn't know that the service and standards in all institutions are to be the same, while 77% (n=36) agreed, 6.4% (n=3) did not respond and another 6.4% (n=3) disagreed. This response was further evident when 17% (n=8) of the respondents did not know that the level of service was to be the same for all, though 77% (n=36) agreed and 6.4% (n=3) disagreed. The respondents were not clear as to whether the patient would go straight to a specialist, as there were 47% (n=22) who disagreed, 32% (n=15) who didn't know, 15% (n=7) who agreed, while 6.4% (n=3) did not respond. Out of the 47 respondents, 21% (n=10) did not know whether the NHI would benefit those who had money or not; while there were a further 6.4% (n=3) of the respondents who did not respond; 38% (n=18) of the respondents who agreed that they would benefit and 34% (n=16) who disagreed with the concept of the NHI benefiting those who had money. Thirty percent (n=14) of the respondents did not know if the private sector would be a stand-alone, 43% (n=20) disagreed that it would and 27% (n=13) agreed. Refer to Table 4.4.

Table 4.4 Nurse Managers' understanding of the concept of NHI (N=47)

Data	Strongly disagree%	Disagree %	Don't know%	Agree %	Strongly Agree%	Missing %
Covering of all health care from PHC to highest level of health care	2	4	11	45	38	-
Facilities need to be upgraded to prescribed standards, assessed and accredited	-	2	6	21	70	-
Same service in each and every institution	2	4	11	28	49	6
Funding health care services by bringing together all health care funding into one basket	6	4	9	36	43	2
Policy laid down for the NHI, e.g. "make me look like a hospital"	-	4	13	26	55	2
Same service and the standards to be the same in each and every health institution in our country	2	4	11	28	49	6
This will benefit those who have some money	13	21	21	21	17	7
Affordable health care to all people living in SA	2		4	28	64	2
Public private integration of services to improve health care	-	4	4	43	49	-
Every person in SA will be entitled to medical care whether they have funds or they don't	-	4	7	30	59	-
Level of service received will be the same for all	-	6	17	40	36	-
The patient will be seen and treated at the first level of care	-	4	13	38	43	2
Stand-alone care for the private sector	17	26	30	17	10	-
The patient may go straight to a specialist	19	28	32	6	9	6

According to the data in Table 4.5 below, the highest rate of understanding in the public sector was 72% (n=28) and the lowest was 50%. The private sector had a 67% (n=19) highest rate and 48% was the lowest. The overall rate of understanding was 72% and the lowest rate was 48%.

The average understanding of the NHI concept was 64% in the public sector and 60% in the private sector. The understanding was more pronounced among the lower level of Nurse Managers though the margin was very low.

Table 4.5 Understanding of the NHI concept (N=47)

Sector of employment	N	Maximum	Minimum	Median
Public	28	72	50	64.0
Private	19	67	48	60.0
Total	47	72	48	62.0

- **Strengths possessed by Nurse Managers and support for the implementation of the NHI**

According to Table 4.6, there were widespread mixed responses in relation to this section of the questionnaire. The 'strongly agree' and 'agree' responses are grouped together and the same applies to the 'strongly disagree' and 'disagree' responses. The mixed responses were evident in the following: Some Nurse Managers [28% (n=13)] believed that the Department of Health is supportive and visits regularly, while 49% (n=23) disagreed, 21% (n=10) did not know and 2% (n=1) did not respond.

Support from Head Offices in both the public and private sectors was seen, as indicated by 28% (n=13) of the respondents, while 43% (n=20) felt that there was no support from Head Office, 25% (n=12) did not know if there was any support, and 4% (n=2) did not respond. The vast number of respondents [60% (n=28)] felt that they were supporting one another by assessing one another's departments, while 23% (n=11) disagreed, 12.8% (n=6) did not know, and 4.3% (n=2) did not respond. Senior management support was seen by 49% (n=23), 23% (n=11) of the respondents disagreed, 21% (n=1) did not know of any support and 6% (n=3) did not respond.

There was a clear majority of respondents [68% (n=32)] who believed that there were not enough human resources, while 11% (n=5) believed that there were enough human resources, 19.1% (n=9) didn't know, and 2.1% (n=1) did not respond to the question regarding human resources.

The availability of qualified nurses who are prepared to work as primary health care nurses was evidenced by 55% (n=26) who were agreeable to this, although 32% (n=15) did not agree, while 10.6% (n=5) did not know, and 2.1 % (n=1) did not respond. In addition to this, 32% (n=15) did not know if there were more posts created, 49% (n=23) disagreed, 13% (n=6) agreed and 6% (n=3) did not respond.

The availability of funds in the Department of Health's budget for the improvement of facilities and departments had widespread responses. There were 13% (n=7) who agreed that this was the case, while 55% (n=26) disagreed, 23% (n=11) did not know and 6% (n=3) did not respond.

Some Nurse Managers, 17%, (n=8), indicated that the District Office sends them to conferences and for in-service training, while 62% (n=29) disagreed, 19% (n=9) did not know and 2% (n=1) did not respond.

Supporting one another among departments was predominantly agreed to by 60% (n=28) of the respondents, while 23% (n=11) disagreed, 13% (n=6) did not know, and 4% (n=2) did not respond.

Table 4.6 Strength/Support given to Nurse Managers for the implementation of the NHI (N=47)

Data	Strongly Disagree %	Disagree %	Don't know %	Agree %	Strongly Agree %	Missing %
The Department of Health is very supportive we are visited regularly by the coordinators	28	21	21	19	9	2
We have support from Head Office	17	26	26	21	6	4
We have qualified nurses who are prepared to work	13	19	10	43	13	2
More posts have been created	28	21	32	11	2	6
We have enough human resources	32	36	19	7	4	2
We have been given a budget to improve our departments	23	30	30	13	-	4
The government is giving the budget to improve our facilities	34	21	23	13	2	7
We have the support from the doctors	21	34	19	17	9	-
We have support institutionally for all the programs	13	26	23	26	9	4
We have support from senior management	13	11	21	32	17	6
The District Office plans for in-service training. They send us for conferences and symposia	32	30	19	13	4	2
We support each other by assessing one another among departments	8	15	13	45	15	4

- **Perceived readiness for the implementation of the NHI**

According to Table 4.7, the respondents indicated whether or not they saw themselves as being ready for the implementation of the NHI in terms of the availability of resources. The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. There was no clear majority in all of the responses. Out of the 47 respondents, 51% (n= 24) did not feel ready judging by what they had available in their institutions, while 23% (n=11) agreed that they were ready. A further 19% (n=11) did not know if they were ready, and 6.4% (n=3) did not respond. Forty-nine percent (n=23) of the respondents felt that they were not completely ready. Forty-seven percent (n=22) of the respondents felt that they were not given the necessary information to make them ready, 40% (n=19) however, disagreed, 4% (n=2) did not know and 9% (n=4) did not respond. Fifty-five percent of the respondents agreed that they were working towards being ready, 28% (n=13) disagreed, 15% (n=7) did not know and 2.1 % (n=1) did not respond.

Table 4.7 Readiness for the implementation of the NHI (N=47)

Data	Strongly Disagree%	Disagree %	Don't Know%	Agree %	Strongly Agree%	Missing %
I feel ready judging from what we have in our institution	13	38	19	17	6	7
I don't think we are ready	15	17	11	32	19	6
We are ready though not completely ready	15	19	11	40	9	6
I don't think we had the necessary information communicated or made ready ourselves	9	32	4	28	19	8
We are working towards being ready	19	8	15	45	11	2

- Support needed/Gaps for the implementation of the NHI

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses.

In Table 4.8, of the 47 respondents, a good majority, 85%, (n=40) agreed that the infrastructure issues needed to be resolved before the implementation of the NHI. There was a further majority, 92% (n=43) of the respondents, who agreed that there

was a need for the facility buildings to be improved to meet the current norms and standards. According to 64% (n=30) of the Nurse Managers, there was a need to buy state-of-the art equipment in order to conform to the NHI policy requirements. According to more data in Table 4.7, there was a total of 85% (n=40) of the respondents who believed that there was a need for a lot of training and workshops on relevant policies by the government. There were mixed feelings about some of the responses, and the following examples illustrated this: 55% (n=26) of the respondents agreed that they were waiting for guidelines from Head Office, 19% (n=9) disagreed, and another 19% (n=9) did not know, while 7% (n=3) did not respond. Good leadership was identified as a need by a good majority of the respondents, 81% (n=38), while 4% (n=2) disagreed, 6 % (n=3) did not know, and 9 % (n=4) did not respond.

A need for more human resources to meet the prescribed standards was seen as necessary by the majority, 87% (n=41), of the respondents.

In addition to this, a good majority of the respondents, 83% (n=39), believed that somebody from the District Office had to come to the facilities more often.

The majority of the respondents, 85% (n=40), believed that there was a lack of understanding of the whole accreditation and implementation process. The same number of respondents, 85% (n=40), believed that they needed training on the accreditation and implementation process, while only 13% (n=6) disagreed, and 2% (n=6) did not respond. Findings further showed that in the public sector, on average,

lower level managers (20%) identified gaps more than the middle level managers (15%) did. In the private sector this was a little different, as, on average, middle level managers (22%) identified gaps more so than the lower level managers (18%).

Table 4.8 Gaps in the proposed implementation of the NHI (N=47)

Data	Strongly Disagree%	Disagree %	Don't Know%	Agree %	Strongly Agree%	Missing %
The infrastructure issues need to be resolved	4	2	9	17	68	-
There is a need for a lot of training and workshops on relevant policies from the government	*	6	5	32	53	4
We need more human resources in order to meet the prescribed standards	-	6	4	26	62	2
There is a need for the facility buildings to be improved to current norms and standards	-	6	2	22	70	-
There must be an increase of the budget in order to meet the national core standards	-	6	6	17	67	4
There must be more space for expansion of the facility	-	6	-	15	75	4
Waiting for the guidelines from Head Office	2	17	19	24	32	6
We need somebody from the District Office to come to the facilities more often	-	6	4	36	47	7
We need good leadership	2	2	6	17	64	9
We need understanding of the accreditation and implementation process	-	13	-	36	49	2

In Table 4.9, the analysed data shows that the lowest level of Nurse Managers identifying gaps was 9% (n=4), and the highest was 35% (n=16) in the public sector, with 11% (n=5) the lowest and 46% (n=21) the highest in the private sector. These were middle and lower level managers in both the public and private sectors.

Table 4.9 Gaps in the proposed implementation of the NHI (N=47)

Sector of employment	N	Maximum	Minimum	Median
Public	28	35	9	15.0
Private	18	46	11	18.5
Total	46	46	9	16.5

4.4.1.2. (b) PROCESS:

The process looked at how Nurse Managers viewed their roles and responsibilities with the implementation of the policy.

- **Implications of the implementation on the Nurse Managers' roles and responsibilities**

A. Ensuring quality of care

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. According to Table 4.10 (a) tabulating the Nurse Managers' understanding of the implications of the implementation of the NHI on their roles and responsibilities, it could be seen that the majority, 87% (n=41), agreed that they would have to maintain the high quality of care. A further clear majority, 96% (n=45), believed that they would have to sustain a high standard of care. Of the respondents, the majority, 81% (n=38), agreed that they needed to improve the level of care in order to be on par with other facilities, 11% (n=5) stated that they didn't know and 8% (n=4) disagreed that any improvement was needed.

Table 4.10(a) Implications of implementation on Nurse Managers' roles and responsibilities (N=47) - Quality of care

Data	Strongly Disagree%	Disagree%	Don't Know%	Agree %	Strongly Agree%	Missing %
Maintain high quality of care	-	2	4	32	55	7
Sustain high standard of care	-	2	2	34	62	-
Ensure sustainability of standards	-	2	2	38	58	-
Ensuring that quality nursing care grows	-	6	6	32	56	-
Improve the level of care to be on par with all other facilities	-	8	11	30	51	-

B. Compliance with core standards

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. In Table 4.10, (b), the majority of the respondents, 85% (n=40), agreed that they had to ensure continued compliance with national core standards, while 9% (n=4) did not know, 4% (n=2) disagreed and 2% (n=1) did not respond. The majority, 85% (n=40), further agreed that policies should be the same for health care facilities, 6% (n=3) disagreed and 9% (n=4) did not know. Seventy-five percent (n=35) of the respondents agreed that they had to maintain the

same standards at which institutions were accredited. There were, however, 17% (n=8) who didn't know and 8% (n=4) who disagreed.

Table 4.10(b) Implications of the implementation on Nurse Managers' roles and responsibilities (N=47) – Compliance with core standards and policies

Data	Strongly Disagree%	Disagree%	Don't Know%	Agree %	Strongly Agree%	Missing %
Continued compliance with National core standards	-	4	9	36	49	2
Maintain the same standards at which the institutions were accredited	-	8	17	28	47	-
Policies to be the same for health care facilities	-	6	9	40	45	-

C. Standardisation

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. The results in Table 4.10 (c) show that there was a clear majority of respondents, 87% (n=41), who agreed and strongly agreed, with the latter being more predominant [49% (n=22)], that they had to bring the level of care on par with all health care facilities. The statement that the implementation of the NHI was to be the same across the board was agreed to by the majority at 81%

(n=38), while 4% (n=2) disagreed and 13% (n=6) did not know. Standardisation of everything between private and public health care providers, including salaries, was agreed to by 79% (n=37), while 8% (n=4) disagreed and 13% (n=6) did not know.

Table 4.10(c) Implications of the implementation on Nurse Managers' roles and responsibilities (N=47) - Standardisation

Data	Strongly Disagree%	Disagree%	Don't Know%	Agree %	Strongly Agree%	Missing %
Private to be more integrated with government and standardise everything even salaries	2	6	13	32	47	-
Bring level of care on par with all other health care facilities	2	7	4	38	49	-
Implementation of NHI to be the same across the board	-	4	13	40	41	2

D. Provision of resources

The 'strongly agree' and 'agree' responses are again grouped together, as were the 'strongly disagree' and 'disagree' responses. According to Table 4.10 (d), the majority, 77% (n=36), agreed that they had to ensure that there were enough human resources for a successful implementation, while 13% (n=6) did not know and 8% (n=4) disagreed.

There were 2% (n=1) who did not respond. The request for relevant equipment for their departments and institutions was an issue that had widespread responses; 59% (n=28) of the respondents agreed that they had to do it, while 23% (n=11) disagreed and 13% (n=6) stated that they did not know. There were widespread responses to the question pertaining to the buying of new equipment, 28% (n=14) agreed, 21% (n=9) disagreed, and a remarkable 43% (n=14) did not know. There was a further clear majority, 83% (n=39), who agreed on the provision of resources for the implementation of the policy, 6.4% (n=3) who disagreed, 9% (n=4) who did not know and 2.1% (n=1) who failed to respond.

Table 4.10(d) Implications of the implementation on Nurse Managers' roles and responsibilities (N=47) – Provision of resources

Data	Strongly Disagree%	Disagree%	Don't Know%	Agree %	Strongly Agree%	Missing %
We have to request equipment	13	11	13	40	19	4
We have motivated for more equipment	11	8	21	43	11	6
We are going to buy equipment	11	10	43	26	2	8
Ensure there are adequate human resources	2	6	13	21	55	2
Provide resources for the implementation of the policy	2	4	9	28	55	2
We must use what we are supposed to use effectively	-	2	2	43	53	-
Efficiently keep the cost as low as possible with the same outcomes	2	11	17	32	38	-

E. Creating a conducive environment

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses. Data in Table 4.10 (e) shows that there was a clear majority of respondents [96% (n=45)] who agreed and strongly agreed, with the latter being more predominant [60% (n=30)], on the need to create a positive environment for the implementation of the NHI as part of their roles and responsibilities. Another clear majority [85% (n=40)] of the respondents believed that the role and responsibility of supporting and monitoring of staff was important in order to ensure that there was sustainability of care. A further 11% (n=5) did not know, and 4% (n=2) disagreed. Playing an active role in the whole accreditation process was seen by a clear majority of 92% (n=43) as having an impact on their roles and responsibilities, while 4% (n=2) disagreed and another 4% (n=2) did not know. A clear majority of 89% (n=42) of the respondents saw their role and responsibility as being the drivers of the implementation to ensure that it worked.

Table 4.10(e) Implications for implementation on Nurse Managers' roles and responsibilities (N=47) – Creating a conducive environment

Data	Strongly Disagree%	Disagree%	Don't Know%	Agree %	Strongly Agree%	Missing %
Create a positive environment for the implementation of NHI	-	2	2	36	60	-
Support and monitor staff to ensure sustainability of care	-	4	11	25	60	-
To play an active role in the whole accreditation process	-	4	4	32	60	-
As managers we must ensure that it works	-	4	6	28	62	-
Ensure people will be treated early to prevent further complications	-	2	6	32	60	-
It is a very good thing it's going to be implemented to ensure patients get the best	-	4	4	43	49	-

In Table 4.11, the results show the respondents' responses with regards to their sector of employment and how they view the implications of the implementation of NHI on their roles and responsibilities. The results of the information obtained from 28 respondents in the public sector ranged from 59% as the highest, to 22% as the lowest. The results of the information from the 19 respondents from the private sector ranged between 22% and 92%.

Table 4.11 Implication of the implementation (N=47)

Sector of employment	N	Maximum	Minimum	Median
Public	28	59	22	34.0
Private	19	92	22	40.0
Total	47	92	22	35.0

4.4.1.2. (c) OUTCOME:

The outcome looked at the guiding principles as targets of the process.

- Guiding principles of the NHI as targets

The target was to ensure accessibility, affordability, equitability, coverage (social solidarity) availability and value for money (Government Gazette, 12 August 2011).

The 'strongly agree' and 'agree' responses are grouped together, and the same applies to the 'strongly disagree' and 'disagree' responses.

There was a clear majority, where 94% (n=44) of the respondents agreed that services must be available to all. Another clear majority, 94% (n=44), agreed that health care must be available for all people of SA. There was another clear majority [80% (n=37)] of the responses who agreed that there must be preventive measures, where people will be treated early in order to prevent diseases and further complications.

There was a further clear majority [89% (n=42)] of the respondents who agreed that all citizens would have equal access to health care irrespective of their social status. The fact that the service rendered should be the same and of equal nature, irrespective of financial and social standing, was agreed upon by 87% (n=41) of the respondents. There was however a small number [9% (n=4)] who disagreed with this, while 2% (n=1) did not know and another 2% (n=1) did not respond. Health care services' affordability was a guiding principle acknowledged by 78% (n=37) of the respondents, although 11% (n=5) disagreed and a further 11% (n=5) did not know. There was a clear majority, 94% (n=44), who agreed that there must be availability of services to all. Refer to Table 4.12 below.

Table 4.12 The guiding principles as targets (N=47)

Data	Strongly Disagree %	Disagree %	Don't Know %	Agree %	Strongly Agree %	Missing %
Ensure health care for all people of SA	-	2	2	30	64	2
Service rendered must be equal irrespective of financial standing	2	7	2	21	66	2
All citizens to have equal access to health care irrespective of social status	-	4	4	28	62	2
Services are available to all	2	2	2	24	70	-
There will be a focus on preventive measures	-	4	7	36	53	-
Health care services will be affordable	-	11	10	30	49	-

4.5 CONCLUSION

An account of the findings from the analysed qualitative and quantitative data has been given in this chapter. The findings were presented in accordance with the SPO model of quality health care assessment.

Data was illustrated in terms of quotes/excerpts for the qualitative data, and as tables and graphs for the quantitative data. The participants demonstrated a general impression of the NHI, rather than a specific understanding.

The next chapter (Chapter 5) will discuss the qualitative and quantitative findings and the conclusions, as well as recommendations.

CHAPTER 5

5. DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The proposed NHI is a new concept in South Africa. An analysis of how Nurse Managers interpreted this concept, the implications of its implementation on their roles and responsibilities in their health care facilities and guiding principles were presented, directed by the structure/process/outcome model. This model assesses health care quality and reflects on systems.

This chapter's focus is on the discussion of the findings of the study, drawing conclusions, making recommendations and describing the limitations of the study. The findings are based on the five areas of data collection and the objectives of the study. These consisted of the interpretation of the NHI policy, support and strengths possessed by Nurse Managers, gaps identified or support needed by these managers and their staff, the implications of the implementation of the NHI on their roles and responsibilities as managers, and the guiding principles of the NHI.

The findings are discussed from both the qualitative and quantitative data. There is also the citation of related studies to support the evidence in the findings, to put the findings in context, and to ensure the confirmability of the findings. According to Tashakori and Teddlie (2003), in mixed methods, when two phases of data collection exist, the data

collection and analysis may be reported in each phase separately, and may be integrated in the discussion or conclusion of the study. Tashakori and Teddie (2003) state further that the comparison of information may be made in the discussion stage of the research. This part of the study has followed the above literature from Tashakori and Teddie (2003).

5.2 DISCUSSION OF MAJOR FINDINGS

This chapter discusses the findings, based on how the public and private sector Nurse Managers understand the proposed National Health Insurance policy. The major findings discussed are based on the SPO theory. These are as follows: **Structure:** The interpretation of the concept of NHI, strengths and support that Nurse Managers have to enable them to prepare for the implementation of the NHI, perceived readiness for the implementation of the NHI, and the support Nurse Managers needed or gaps identified. **Process:** Implications of the implementation of the NHI on Nurse Managers' roles and responsibilities. **Outcome:** The guiding principles as targets.

5.2.1 The demographics

The demographics included data from both public and private sector Nurse Managers on gender, age and their experience as Nurse Managers. In this study, there was a high majority of females; in the qualitative phase, there were 10 participants interviewed, with 9 being female and 1 male. The 2 focus groups of 5 had 1 male and 4 females in one

group. In the quantitative data, females comprised 94% (n=44) as opposed to 6% (n=3) who were male. This was in line with nursing being a female-dominated profession. A study conducted by Nkosi (2009) on the retention of professional nurses indicated the same, where 90% of the population was female and 10% male. The highest number of participants, 35%, was from the 50-59 year age group. The fact that the greater percentage of Nurse Managers are from the older generation is evidence of, among other things, the burden of disease; as younger Nurse Managers become sick or pass away mainly due to HIV-related conditions (Shisana, 2002). Another study conducted by Mokoka (2010) highlighted the age differences of Nurse Managers and their commitment to work. According to Mokoka, there was a distinct difference between older and younger nurses in terms of their commitment to work, hence older nurses ascended into management positions. The Peter Principle, which is based on the notion that employees will get promoted as long as they are competent and have long service (www.investopedia.com), results in older nurses being promoted, hence the majority of the participants consisted of older Nurse Managers. In terms of experience as Nurse Managers (number of years), 32% (n=14) had worked at that level for over 10 years. These results also highlighted the differences, since most of the Nurse Managers who had worked for longer than 10 years at that level belonged to the older age group. In this study, age and experience as Nurse Managers influenced the responses from interviews and questionnaires.

5.2.2. Structure: Interpretation of the concept of NHI

Interpretation of the concept of the NHI accommodates the meaning or definitions such as universal coverage, the pooling of pre-paid contributions, funding contributions linked to an individual's ability to pay, and benefits in line with an individual's need for care as described in the World Health Report, (2008). Furthermore, it is described as the provision of health, promotion and prevention services (Government Gazette, 12 August 2011), or health system financing that is structured to ensure universal access to a defined, comprehensive package of health services for all citizens, irrespective of their social, economic and/or any other consideration that affects their status (World Health Report, 2008).

In establishing the participants' understanding of the concept of NHI, they indicated a general knowledge, lacking in specifics. Nurse Managers, in general, could not describe the NHI concept as a financing system that would make sure that all citizens of South African and legal long-term residents would be provided with essential health care, regardless of whether they were employed or not (Government Gazette, 12 August 2011). They generally lacked the understanding of how and who would make monetary contributions to the NHI fund. There was a lot of mixing up of the concept of the NHI policy with the guiding principles of the NHI. For example, the guiding principles that were quoted as the concept of the NHI were access, equity, affordability and coverage.

The examples of how the participants understood the concept of the NHI that were quoted in the qualitative data were predominantly: The unification of service delivery,

the coverage for health care, the unification of health insurance, the “make me look like a hospital” policy, and all health care funding to be in one basket. There were two participants who mentioned the pooling of contributions into a single fund.

In the quantitative data, there was, however, a vast majority, 79% (n=37), who agreed and strongly agreed with bringing together all of the funding into one basket, although a large percentage strongly disagreed and disagreed, and there were even those who did not know. There was another large majority who strongly agreed and agreed that every person in South Africa would be entitled to receive medical care whether they had funds or not; there was a small number who did not know and even some who disagreed. Public private integration of services to improve health care was supported by a good majority, 92% (n=43), who agreed and strongly agreed that it (integration) would improve health care. This is supported by Global Health (2011, p.1), where they state that “Public-Private Integrated Partnerships are a novel way for resource-constrained governments in developing countries to simultaneously improve health infrastructure and health care service provision”.

The various summaries of the National Health Insurance concept are as follows:

The NHI is a health care financing system that ensures that every member of the population is covered to access quality health care services (Department of Health, Republic of South Africa, 2012). This is supported by an ANC Media release (2010) which states that one of the key proposals of the NHI is universal coverage and access to health care by all. Shisana (2009) also states that NHI is a form of social security that provides people with access to much needed and quality health services. Econex

(2009) indicates that the NHI is being proposed to expand health care coverage to the entire population of South Africa.

According to the WHO, the NHI provides universal coverage which is an essential and accepted objective for most countries. It is defined as access to key promotive, preventive, curative and rehabilitative health interventions, while guaranteeing adequate protection against financial risks (World Health Organization, 2005).

McIntyre (2010) summarises the proposed NHI in South Africa as a system of universal health care coverage where every citizen is covered, rich or poor, employed or unemployed, young or old, sick or very healthy, black or white.

The researcher in this study asserts that there was no specific knowledge and understanding of the concept of the NHI, but that there was a mixing of the concept with that of the guiding principles.

5.2.3 Structure: Strength and support that Nurse Managers have for the implementation of the NHI

With regards to structure, the framework used in this study relating to strengths possessed by and support for Nurse Managers towards the smooth implementation of the NHI policy included Head Office support, Department of Health support, human resources and institutional support. This is however different from what some of the

respondents were saying, namely that there was very little or no support with regard to preparation for the implementation.

In establishing the participants' views on the strengths and support they received for the implementation of the NHI, the participants indicated a generally low amount of strength possessed and little support for the implementation of the NHI policy in their respective institutions. This was seen from the fact that there were no clear majorities and that there were also widespread responses.

In the qualitative data, for example, the support that was quoted was support from the Department of Health, nationally, provincially and, in the district, institutional support, Head Office support (private), in order of popularity. Human resources support was mentioned by a few.

In the quantitative data there were mixed feelings between support and the lack thereof, with the Department of Health being supportive, institutional support, the allocation of funds in the budget to improve departments, and the presence of qualified nurses who were prepared to work. There was a majority of 62% (n=29) who strongly disagreed and disagreed that the District Office was supportive by sending them for conferences and by conducting in-service training, and that there were sufficient human resources. There was however a large number of respondents who did not know whether the District Office was supporting them and whether they had sufficient human resources. A majority of 60% (n=28) agreed and strongly agreed that they were supporting one

another among departments, although there was also a large number who disagreed with this, as well as those who did not know whether they were supporting one another among departments, thus spreading their responses widely.

The Ten-Point Plan summarises the support given to health care workers in preparation for, among other things, the implementation of the NHI policy. The Ten-Point Plan consists of the following priorities which give support to Nurse Managers for the implementation of the NHI policy for improved health outcomes.

- Improving the quality of health services by adhering to national core standards and having the facilities assessed and accredited as meeting these quality standards.
- Improving Human Resource Management, Planning and Development by ensuring that the staff is properly trained and skilled, especially in Primary Health Care.
- Revitalisation of infrastructure by being involved in public private partnerships to accelerate health care delivery (National Department of Health Strategic Plan, 2010/11-2012/13).

5.2.4 Structure: Perceived readiness for the implementation of the NHI

As far as the structure and perceived readiness for implementation is concerned, the framework used in the study accommodated the options of 'not ready', 'ready' and 'working on being ready' for the implementation of the NHI policy.

When establishing the participants' readiness for the implementation of the NHI, there was a general indication that they were not ready for the implementation of the NHI policy.

For example, in the qualitative data, the quotes of 'not being ready' were based on not having the resources to make themselves ready. Many questions were unanswered, and the lack of information about the NHI, and the presence of gaps in the support that the Nurse Managers needed for the implementation, were given as reasons for not being ready. Some of the participants indicated that they were not completely ready. There were participants who indicated that their institutions were ready judging from what they had, but that they needed to sort the infrastructure. Those who felt that they were ready indicated that their readiness was based on the fact that they had knowledge of what the NHI was about. There were only two participants who mentioned that they were working on being ready.

In the quantitative data, however, there was no clear majority. Although there was a bigger percentage, 51% (n=24), of those who strongly disagreed and disagreed that they felt ready, judging from what they had in their institutions, there were also several who did not know if they were ready for the implementation of the NHI policy or not. A large number of participants agreed and strongly agreed that they did not think that they were ready and were working towards being ready. There were, however, many respondents who did not know if they were ready and were working towards being ready. While participants predominantly claimed that they were not ready, existing

literature (www.kznhealth.gov.za) claims that the KwaZulu-Natal government has implemented a “make me look like a hospital” policy which provides guidelines on how to make the facilities ready for accreditation and the implementation of the NHI.

The office of Health Standards Compliance was established by an act of parliament to inspect and ensure that health facilities comply with set standards and norms that will improve health care and facilitate readiness and access (Government Gazette No. 34523, 12 August 2011). The health care facilities must meet the criteria set before they can be approved or accredited as suitable to run under the National Health Insurance (Mkhwanazi, 2010).

The above information on the available national core standards summarises and contradicts the participants' feelings of not being ready, as the policies and guidelines are available to enlighten them on the preparations for readiness. Working on being ready is a better response.

This is noted with concern, because there are policies already developed to inform participants in the pilot preparation for readiness for the implementation ‘make me look like a hospital’ policy. Perhaps the problem could be that the focus is on pilot areas which were not included in this study for the convenience of the researcher. In KwaZulu-Natal, the uMzinyathi and uMgungundlovu districts were selected because of the high population figures in the province (www.info.gov.za/speech).

5.2.5 Structure: Weaknesses of Nurse Managers

With regards to structure and weaknesses, in relation to knowledge and skills of human resources, equipment, infrastructure and anything else that needed to be ready for the implementation of the NHI, the framework used in the study accommodated a lack of knowledge and understanding, and a lack of skill for the implementation of the NHI policy.

In establishing the participants' weaknesses, they indicated a general lack of understanding of the NHI and the implications of its implementation for their different institutions.

The weaknesses identified in the qualitative data detailed having no idea whatsoever of what was expected for the implementation, nor of the requirements for the accreditation process. Skills in midwifery and family planning were predominantly lacking because nurses are primarily trained through the Bridging Program towards Professional Nurses due to numerous private schools running this program over and above the approved public institutions (www.sanc.co.za). There were participants who mentioned that they were unaware of how the implementation would affect the private sector. One of the participants admitted ignorance, as indicated in the quotes in Chapter Four, Section 4.2.2.1(d) page 96.

The quantitative data indicated a majority who strongly agreed that they needed to understand the accreditation and implementation processes.

The Department of Health has requested retired nurses with different skills to assist, especially in Primary Health Care (Minister of Health speech: The launch of the Human Resource for Health Strategy, 11 Oct 2011). The re-opening of nursing colleges in order to ensure the accelerated production of skilled nurses will also be given due attention (National Department of Health Strategic Plan, 2009-2014). This information explains the participants' admission to the lack of skills for the smooth implementation of the NHI policy, as these statements were made at almost the same time that the study was conducted.

5.2.6 Structure: The support Nurse Managers need/Gaps identified

With regard to the structure and support needed by Nurse Managers to successfully implement the NHI and the gaps they identified, the framework used in the study accommodated training on the accreditation and implementation processes, the need for resources and infrastructure improvement.

In establishing the participants' need for support in order to be able to implement the NHI policy, the participants' responses indicated that there was a general feeling of needing support within the identified gaps to enable the smooth implementation of the NHI at their institutions.

In the qualitative data, the area of support needed and the gaps that were identified were the improvement of the infrastructure to meet current norms and standards. The participants also expressed a need for human resources, namely the need for training on the accreditation and implementation processes, followed by training on the NHI as indicated in excerpts from public health care participants in Chapter Four, Section 4.2.2.1 (d) page 97.

In the quantitative data, there was a clear majority of 92% (n=43) who strongly agreed and agreed that facility buildings needed to be improved to current norms and standards, i.e. that the whole infrastructure needed to be resolved. They further expressed the need for more human resources in order to meet prescribed standards. There were, however, many respondents who did not know of infrastructure issues needing to be resolved. The need for an increase in the budget, more frequent site visits from somebody from the District Office, and the need for good leadership had the majority agreeing and strongly agreeing. There were, however, mixed feelings on waiting for guidelines; although a small number disagreed and strongly disagreed, and many did not know whether they were waiting for guidelines from Head Office. There was a widespread distribution of responses on the need for guidelines still to be supplied, though a sizeable number did not even know if they needed guidelines. This indicated mixed feelings about the NHI, its expectations or requirements.

The Ten-Point Programme of the Department of Health summarises and supports the above mentioned needs/gaps identified: “*Overhauling the health care system and improve its management*”. Regulations will include measures to standardise hospital

care across the country, and to ensure that managers of different categories of hospitals have specific skills, competencies and appropriate qualifications (Department of Health: NHI, 2011). This is supported by the study of Fushen, Marnoch and Marie Gray (2012) who state that challenges to the implementation of the NHI in Ghana were a lack of capacity development and managerial ability.

5.2.7 Process: Implications of the implementation of the NHI on Nurse Managers' roles and responsibilities

Regarding the process, the implications of the implementation of the NHI on the roles and responsibilities of Nurse Managers were considered. The framework used in the study accommodated preparation for the implementation of NHI policy, the request for new equipment, managing of costs and budget, maintaining a high quality of care and monitoring and evaluation.

In establishing the participants' understanding of the implications of the implementation of the NHI on their roles and responsibilities, they indicated a good knowledge of their roles and responsibilities towards preparation and the implementation of the NHI policy in their respective institutions.

In the qualitative data, for example, the participants indicated that their roles and responsibilities included predominantly preparing for the implementation, meeting the norms and standards, strengthening policies and protocols, making the environment conducive to the implementation, providing resources for the process, playing an active role in the implementation, requesting and buying state-of-the-art equipment, managing

the cost and their budget, and maintaining a high quality of care within the institutions. They further stated that they had to facilitate, monitor and evaluate the process to ensure that it was sustainable. This is evident in the quotes in Chapter Four, where some participants indicated what their roles were in preparing for the implementation.

In the quantitative data collected, there was a clear majority of 96% (n=45) who agreed and strongly agreed with creating a conducive environment for the implementation. A further 92% (n=43) indicated that they were to play an active role in the whole accreditation process. The sustaining of a high standard of quality care, continued compliance with National core standards, the effective use of resources and bringing the level of care on par with all other health care facilities also featured, in order of majority.

The provision of resources such as equipment and staff had mixed responses. A large number of participants did not know if they were going to buy equipment and whether they had motivated for more equipment. Another large number strongly disagreed that they had requested or motivated for more equipment, including intending to buy it.

The Department of Health supports the needs or gaps identified by the participants. It has processes in place for the first five years of NHI. The following summarises the intervention which will ensure that the implementation of the NHI is smooth:

- Management of health facilities and health districts
- Quality improvement

- Infrastructure development
- Medical devices including equipment
- Human Resources planning, development and management (DoH on NHI implementation, 2011)

5.2.8 Outcome: The guiding principles as targets for the process

As far as the outcomes are concerned, the framework used in this study accommodated availability, accessibility, affordability, equity, coverage and prevention as targets to demonstrate the smooth implementation of the NHI policy.

Van Rensburg (2010) defines the above in keeping with the Primary Health approach: The continuing and organised supply of care that is geographically, financially and functionally within easy access of the whole community. Geographical access refers to the distance to the health care facility, the time taken to get to the nearest health care facility, and the means of transport to get to the health care facility. Financial access means having finances to enable the individual to access health care, and the methods of payment for health care. Functional reach means the right kind of care available on a continuous basis, and the appropriate, well-structured referral system.

In establishing the participants' understanding of the targets for the NHI project, they indicated a general knowledge/understanding of the guiding principles rather than specific details. As an example, the guiding principles that were quoted in the qualitative

data were predominantly access, equity and affordability, in order of popularity.

Coverage availability and preventive measures were mentioned by very few participants (1 or 2 for each).

However in the quantitative data, there was a clear majority who agreed and strongly agreed with coverage, availability, equity, preventive measures and affordability, in order of majority. There was, however, a relatively high number of participants who did not know of the proposed accessibility and affordability of services.

The respondents' views on the guiding principles and the preventive measures mentioned were supported by the fact that the ultimate goal of primary health care (prevention of disease and promotion of health) is better health for all (WHO, 2008). The WHO (2008) further states that primary health care brings promotion and prevention, cure and care together in a safe, effective and socially productive way.

Furthermore, the Constitution of the Republic of South Africa, (Act No. 108 of 1996) Chapter 2, Bill of Rights, asserts that everyone has the right to have access to health care services, including reproductive health care. This further supports the quotes of the participants where they said access is a guiding principle of the NHI.

The participants' views on guiding principles are further supported by the government gazette publication of the Green Paper which proposes seven guiding principles for the development, implementation and sustainability of a National Health Insurance (NHI)

policy as outcomes. These seven outcomes are the right of access to health care, social solidarity with the creation of financial risk protection for the whole population, effectiveness with evidence-based care, appropriateness with innovative health care delivery that responds to health care needs, equity where those with the greatest need for health care are provided for, affordability of health care which is procured at reasonable cost and efficiency where there will be elimination of duplicating administrative processes (Government Gazette No 34523, 12 August 2011).

Further to the South African perspective, the respondents' views on the guiding principles were supported by the following principles from different countries that have implemented the NHI, as well as shortfalls on their (respondents') views. The constitution of Brazil guarantees that everyone has access to medical care from the public national health system, from private providers subsidised by the federal government via the Social Security budget, or from the private sector via private insurance or employers' contributions (Health care in Brazil internationalliving.com). The NHI goal in Ghana is equitable and universal access to health care for all Ghanaians (Evaluation of NHI in Ghana, 2008). Furthermore, in Ghana, the contributions to the fund make it possible, in the event of illness, for the community to receive affordable health care (Ghana National Health Insurance, 2005). In 1995, Taiwan established universal insurance coverage to provide equal access to health care and improve the health of the population (Chen, 2006). In Rwanda, the same guiding principles were adopted. These basic principles adopted are equity and access to quality services (Rwanda National Health Insurance Policy, 2010).

5.3 CONCLUSIONS FROM THE FINDINGS

The findings in both the qualitative and quantitative data revealed that the participants demonstrated a general impression rather than a specific understanding of the NHI policy, indicating uncertainty concerning the implementation of the project. This could be an indication of a lack of personal development in relation to expectations from Nurse Managers concerning the NHI, though there is a lot of publicity in this respect. One may not exclude a lack of interest in the project.

There is a need for support from the national, provincial and institutional management in terms of infrastructure, equipment and human resources, including human resource development.

While there was so much uncertainty demonstrated by the participants regarding the NHI policy itself, they appeared to be clear about the implications of the implementation of the NHI policy on their roles and responsibilities. The examples of roles and responsibilities are: Creating a conducive environment, provision of resources, both human and material, ensuring quality of care within their institutions, standardisation and strengthening of Primary Health Care.

The data was from the same population in both the qualitative and quantitative phases, but there were negative responses, or non-responses, in the quantitative data. It is noted by the researcher that the qualitative data may have been from one participant, hence the differences in the quantitative responses.

While the instrument was generated from the same context, the responses in the quantitative data were not so much on the affirmation, though the researcher acknowledges the fact that the items in the qualitative data may have come from a few ambitious individuals.

5.4 RECOMMENDATIONS

The findings in the study showed that the Nurse Managers need more education and training in order to be sufficiently skilled and prepared for the implementation of the NHI policy. The following recommendations are made to nursing management, nursing education and nursing research:

5.4.1 Recommendations for nursing management

The implementation of the NHI exposes nurses to efficient practice to ensure that quality patient care is rendered at all levels of care. Readiness for the implementation of the NHI means that the facilities meet the prescribed national core standards. The needs or gaps identified by nurse managers indicated a need to be attended to before the policy is implemented, to allow evidenced-based empowerment for readiness to implement the NHI policy.

The need for resources emerged very high among the needs identified by Nurse Managers.

Resources were found to be lacking in both private and public health care. Human resources were a big concern. Skilled health professionals will be needed to ensure that the NHI is properly implemented, and this was indeed acknowledged by the national Minister of Health (August, 2011 media conference). There was a general concern that nurses will not be able to perform their duties effectively with the insufficient number of staff available at their institutions.

The researcher recommends that more posts be created when the budget allows for this. These posts must be advertised for younger, skilled, knowledgeable and more enthusiastic nurses, as older retired nurses may be placed at the health facilities for the sake of boosting staff numbers, without actually contributing to more efficient patient care if they lack the relevant knowledge and skill for that particular speciality or discipline. Concerns were raised (general discussion with non-participating Nurse Managers) that some of these older nurses have been out of the clinical environment for some time, and are unsure of themselves, having to ask the younger nurses for advice. The researcher, however, agrees with the concept suggested by some Nurse Managers, of using retired nurses in departments where they have the relevant knowledge and skill to contribute to the wellbeing of the patients. The other health care workers will also benefit from their vast knowledge and skill, and as such, they will be assets to the nursing profession.

There was a huge outcry that the infrastructure was not conducive to efficient patient care. This would affect the smooth implementation of the NHI as patients would not

receive quality patient care if the structure was not well built, and did not have everything necessary for the health care professionals to conduct their work accordingly.

The researcher recommends and encourages that attention be given to the old dilapidated buildings, and that more space be created in all facilities, as Nurse Managers expressed concerns about not being able to ensure privacy and confidentiality for their patients because of a lack of working space. The issue of infrastructure and renovations will affect the facilitation of quality patient care. Non-attendance to these gaps may affect the six basic quality issues to be attended to as a matter of urgency, namely cleanliness, the safety and security of staff and patients, duration of time spent waiting for attention, the lack of sufficient drug stocks, poor staff attitudes and inadequate infection control (Government Gazette, 12 August 2011).

Nurse Managers suggested the standardisation of all health care whether in the public or private sectors. The researcher agrees with this suggestion and recommends that nurses in the private sector be able to utilise their skills more in the absence of the doctor, and be able to nurse a patient holistically, as their patient, and not just as the doctor's patient.

Nurses do not have to phone for permission to attend to any health care needs, even those who are mandated by the SANC to perform. These are independent functions of a nurse (Nursing Act, 1978, Regulation 2598). The private sector Nurse Managers did

mention that they sometimes felt unable to take appropriate action as the patient belonged to the doctor.

The study revealed that the gaps identified or support needed were challenges faced by Nurse Managers and their staff in preparing and being ready for the implementation of the NHI in their facilities. It is important that these gaps be addressed in order to ensure that the nursing practice is not marginalised. The researcher therefore recommends that the Nurse Managers be supported by having the gaps identified attended to, so that they will be able to implement the NHI in their institutions. Training, monitoring and evaluation have to be maintained for the continuity of nursing care and for the implementation of the NHI.

Nurse Managers need to understand the concept of the NHI and be aware of the implications of the implementation of the NHI on their roles and responsibilities. This is in line with the recommendations by JUDASA which state that the ills that afflict the public health system are largely as a result of poor management. They further state that with the implementation of the National Health Insurance, the quality of managers will determine the success or failure of the health care system (Health –e News Service, October 2010). The role of the Nurse Managers of all health care facilities will be to ensure that primary health care is a strategy for achieving the health needs of all people.

The use of management tools (guidelines and policies) for the implementation of the NHI should be encouraged by all Nurse Managers from both the public and private sectors. Nurse Managers are expected to participate or engage in guideline development since their role is based on participating in policy development and ensuring that policies like the NHI policy are implemented (Beauman, 2006).

The researcher recommends that combined public and private sector management meetings be held, and advocates for effective public-private partnerships, where both parties will learn from each other and share ideas on how the implementation can work for them, based on the guidelines and policies laid down by the government.

There was a feeling of not being fully supported by the district office. Some of the public sector Nurse Managers felt that constant visits by the district office to check on how they are managing to meet the required norms and standards would assist in speeding up the process. The Nurse Managers felt that this would allow the district office to see first-hand where support was needed and ensure that it is given.

The private sector senior management is encouraged to send Nurse Managers from all levels to attend the workshops organised by the district or provincial offices on the implementation of the NHI policy. This will ensure a better understanding, as it was alluded to by some participants, that there is a negative attitude towards the NHI as a whole, in the private sector.

The researcher further recommends conducting a workshop to share with Nurse Managers the overview of the study report and to discuss the gaps identified. The rationale for the workshops is as follows:

Aim: To engage Nurse Managers from both the public and private sectors in discussing the identified gaps collectively.

Development: The researcher will approach senior management and request a slot in which to conduct the proposed workshop for all Nurse Managers. The researcher will suggest conducting the workshop during the Nurse Managers' meetings, as it is evident from the study that they (Nurse Managers) are always busy, and may not be able to set aside time in their busy schedules for this kind of workshop. The researcher will, however, be open to suggestions about the times that would best suit the target group. Nurse Managers in the pilot districts will be invited to share their experiences (positive and negative) as well as how they managed the negatives, if any. In the KZN province, the two pilot districts are uMzinyathi and uMgungundlovu. These workshops are intended to be conducted jointly for the public and private sectors if possible.

The researcher will look into the times given by the respective managements to conduct these workshops, however the researcher will request no less than two hours per session. There could be two sessions, the first being to identify the gaps and the second being how to address them. The Nurse Managers will be asked to share their impressions about the gaps with the person next to them or in small groups, depending on their numbers. They will be allowed to jot down their comments. A group discussion

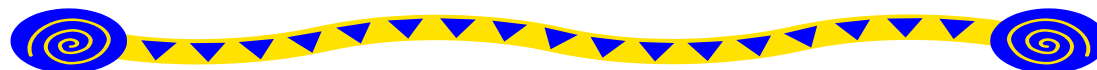
will then follow, whereby the participants will be allowed to clarify and dispute the gaps. Additional information or ideas about gaps will be welcomed, including those from the pilot districts. The researcher will use the same format to address the identified gaps institutionally, at district and provincial levels. The workshop will be ended with a summary of the discussion including action plans. Refer to Table 5.1 below for the recommended agenda of the workshop.

Table: 5.1 Proposed agenda for the workshop

**NURSE MANAGERS' WORKSHOP
NATIONAL HEALTH INSURANCE POLICY:
IMPLICATIONS OF THE IMPLEMENTATION**

AGENDA

<i>ITEM</i>	<i>RESPONSIBLEPERSON</i>
PROCESS ISSUES	
1.	Welcome remarks and introduction Head of school/Manager of Facility
2	Purpose and objectives of the workshop Facilitator
3	❖ Presentation of study Researcher
4	❖ Identification of gaps: Resources Infrastructure Support Group
MATTERS FOR DISCUSSION	
5.	Verification of gaps Group
6.	Presentation of experience from the pilot district (guest speaker) To be announced
7.	How do we address the identified gaps? ❖ Institutional ❖ District ❖ Provincial/ Hospital group Head Offices Group
8.	Summary and conclusion Facilitator



5.4.2 Recommendations for Nursing Education

The lack of knowledge and understanding of the NHI concept indicates a need for more training and education for both public and private Nurse Managers.

The provincial or district Department of Health is encouraged to run (budget allowing) more workshops aimed at all levels of health care professionals on the proposed NHI policy.

Nurse Managers indicated that they needed to be better informed about the assessment and accreditation process, as they needed to carry out the process with their subordinates. This was highlighted by a number of Nurse Managers from both the public and private sectors, as indicated in the quotes in Chapter Four, Section 2.4.2.1 (c) page 99.

The private health care Nurse Managers indicated a need for more workshops and in-service education regarding the objectives and principles of the NHI, in order to have a better understanding and to be able to implement the policy if and when the time arises. The admission of ignorance about the NHI concept by some Nurse Managers from the private sector in particular, raises a lot of concern regarding the success of NHI implementation. The researcher recommends that there be more training, workshops and in-service education at the private institutions to impart knowledge and to educate (upskill) all Nurse Managers about the proposed implementation of the NHI policy.

Generally, Nurse Managers had a lot of issues which proved that they are not ready for the implementation of the NHI in their facilities. For that reason, the researcher recommends more workshops, discussions and meetings between the policy-makers and the health professionals who will be involved in the implementation of the NHI. The Nurse Managers from both public and private health care facilities can preferably have these workshops together to promote sharing and standardisation in each and every facility.

In order to address the public sector's lack of skills required to deliver quality health care, it is advisable to ensure that as many nurses as the budget allows are sent for training and development, as an investment, and a promotion of efficient patient care, as the SANC advocates for self-development (Nursing Act, No 33 of 2005, Section 39).

The private sector is encouraged to send as many staff as possible to be trained in Primary Health Care (PHC) so that they will be sufficiently skilled to attend to patients at first level of entry and refer them accordingly. This recommendation is made as, in the private sector; there is more focus on curative as opposed to preventive care. Nurses in the private sector would thus be empowered to see patients at first level, treat them accordingly and then send them home, as opposed to sending all minor ailments to the doctor. This is in line with the objectives of the NHI. Medical Aid Schemes are encouraged to recognise prescriptions made by nurses trained in Primary Health Care, Advanced Midwifery and Advanced Mental Health.

5.4.3 Recommendations for Nursing Research

In this study, the Nurse Managers from the public and private sectors stated that there was a lack of knowledge and support regarding several issues. The lack of support made them feel ill-prepared for the implementation of the NHI policy in their institutions. Extending the study to other districts, especially pilot districts, will provide specific evidence which will, in turn, inform the policy-makers of the need to strengthen and focus training on specifics.

The researcher encourages monitoring and evaluation of the implementation process, sharing of the results of findings, and building on the positive results while improving on the negative results to ensure sustainability of this NHI project.

Monitoring and evaluation of the skills could be performed and outcomes evaluated in future research, to determine the success or failure of the implementation of the NHI policy, and to determine the possible causes of the failure or success and to build on the latter. The gaps are to be shared with Nurse Managers and policy-makers in order to be addressed accordingly. Research and evidence-based care could be encouraged in both public and private health care sectors, so that Nurse Managers and their staff can share ideas for quality patient care.

The researcher feels that it would be interesting to study further the effects of the implementation of the NHI on all of the ten districts that were involved in the piloting

exercise. It would be interesting to find out where the shortfalls and successes are, so that they can be dealt with in order to capitalise on them for success, once the NHI is rolled out to the entire country. An outcomes research could be conducted at the end of the pilot project to inform on the large-scale implications of the project, so that the project data is evidence-based.

A similar study can be repeated on a larger scale, in another context, to strengthen the results of the current study which is small-scale and limited.

5.5. LIMITATIONS OF THE STUDY

The researcher's study was limited by the following:

- The population in the study consisted of Nurse Managers in the public Primary Health Care facilities and private hospitals in the eThekweni district only. This was not a large enough sample to support generalisation. Nurse Managers constitute a small population in all health care facilities.
- The recruitment of participants focussed on those employed in Primary Health Care institutions, which include District Hospitals. Only a small number of managers acknowledged that they were from District Hospitals, while the others declined, and hence the random sampling became a problem.

- It was part of the researcher's plan to collect data from as many Nurse Managers as possible, from both the public and private primary health care sectors. A request for permission was submitted to a further two District Hospitals, but the Nurse Management declined to be part of the study.
- It was difficult to access as many respondents as the researcher would have liked. The reasons given by most were that they were very busy in their units and did not have time to fill in the questionnaires. Some mentioned experiencing a lack of human resources which resulted in them having to do all the work, so they could thus not spare any time for the completion of the questionnaires.
- Some Nurse Managers declined to be interviewed; some mentioned that they did not know anything about the NHI, while others refused to give appointments for the interview. The researcher had to respect their feelings to avoid coercing them, and concentrate on those participating of their own free will in accordance with the ethical principles of research.
- The fact that the concept of NHI is new to South Africa, and the two-tier (public and private) health system of South Africa (Van Rensburg, 2010) has created a lot of negativity about the NHI which made some respondents express this, saying that it will never work as it has never worked anywhere else in the world. This was found to be a limitation by the researcher, as those respondents

already viewed this as a threat and could not give objective responses during their interviews.

- The NHI policy was not implemented at the time of the study when the researcher was looking for their (Nurse Managers') understanding of the concept of NHI.
- The study was chosen because the EThekweni district was listed among the pilot areas but was subsequently withdrawn, and by that time, the researcher was well underway with the process, and, as a student it was not easy to restart the process.
- Therefore many factors work against the generalisation of this study, hence the strong recommendation for further study as presented in the previous session.

5.6. CONCLUSION OF THE STUDY

The researcher studied how all levels of Nurse Managers from the private and public sectors understood the concept of the NHI policy. The researcher further studied how they viewed the implementation of the NHI policy having implications on their roles and responsibilities; their perceived readiness for the implementation, as well as any support

they needed and any gaps they saw which would impinge upon the success of the implementation.

The study showed that there were a number of Nurse Managers who felt that they were not ready for the implementation as they still needed training on the assessment and accreditation process, as well as the implementation process of the NHI policy. They (nurse managers) were however aware of the implications of the implementation of the NHI policy on their roles and responsibilities.

The level of understanding was different in the two sectors. Nurses in the public sector seemed to have a better understanding of what the NHI was all about, but they felt less ready for its implementation than the Nurse Managers in the private sector. This was largely due to the fact that those in the private sector felt that they knew that their Head Offices were dealing with the government regarding this matter, and would fully support them once the NHI policy was implemented in the private sector. The public sector however cited the lack of resources as the main reason for them not being ready, and not getting the full support they felt they should be getting.

The framework used for the study was based on the structure/process/outcome (SPO) model of assessing health care quality. In the study, the structure was the understanding of the National Health Insurance (NHI) policy, process was the implementation of the NHI policy and outcome was the targets of the NHI policy.

The researcher's recommendations are based on the need for efficient patient care, where quality health care has to be upheld at all times in all health care facilities generally, thus improving nursing practice, nursing management, nursing education and nursing research.

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APPENDIX: A.

TOPIC GUIDE FOR THE INTERVIEWS

1. Demographics questions.

1.1 What type of health facility is your institution?

1.2 How many beds in the facility

1.3 How many nurses work in your health care facility?

1.4 In which level of nurse management are you?

1.5 How long have you been working as a nurse manager?

2. What do you understand by NHI?

3. What are the guiding principles of the National Health Insurance?

4. How are you going to apply them in your institution?

5. How does the NHI policy apply to your work environment?

6. What are the implications of the implementation of the NHI on your role and responsibility?

7. Do you think you are ready for the implementation of the NHI policy? If yes how ready are you?

8. What support do you have to prepare yourself for the implementation of the NHI policy?

9. Do you need any further support?

APPENDIX: B

Letter requesting for permission to conduct research at health care facilities in the eThekweni district of the province of Kwa -Zulu Natal.

Athlone Park,

649A Kingsway Road,

4126

1st November 2011

Head of Departments

Kwa-Zulu Natal Public and Private Health care

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

TITLE: AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE NATIONAL HEALTH INSURANCE POLICY, ITS IMPLICATIONS FOR IMPLEMENTATION IN HEALTH CARE FACILITIES IN THE ETHEKWINI DISTRICT.

RESEARCHER: NOZIPHO MTHEMBU

SUPERVISOR: PROF B.R. BHENGU

I hereby request for permission to conduct a study at some of your district hospitals, Community Health Centres and Primary Health Care institutions. The study will be conducted as a requirement for a Masters Degree in Nursing Science.

The purpose of this study is to analyse how nurse managers interpret and understand the implications of the implementation of the National Health Insurance (NHI) policy on their institutions and their role and responsibility.

The EThekweni district will benefit from the study as identified gaps will be shared with the policy makers.

The interpretation and understanding of the NHI by nurse managers will influence its implementation (positively or negatively) in the health care facilities.

Thank You

N. MTHEMBU (MRS)

CONTACT DETAILS: 031-2601210/ 0824307566

SUPERVISOR: PROF. B.R. BHENGU

CONTACT DETAILS: 031-2601134

APPENDIX: C

INFORMATION TO PARTICIPANTS

Dear Nurse Manager,

I am a Masters student in Nursing Research at the University of Kwa-Zulu Natal.

I am conducting a study on how nurse managers interpret the National Health Insurance policy and what implications it will have on their institutions and their role and responsibility. The study will be conducted at private and public health care institutions in the EThekweni district of Kwa-Zulu Natal.

If you are willing to participate in this research study, I request to have an interview with you at your convenient time. The interview will take about 30-45 minutes and will be tape recorded and notes taken with your permission.

The questions asked in the interview will include your knowledge and understanding of the National Health Insurance policy and its proposed implementation in our country South Africa.

Participation is voluntary, and you may withdraw from the study at any time if you so wish, with no adverse consequences.

You may contact me or my supervisor if you require more information or have any concerns or suggestions.

My contact details are as follows: 031-2601210 (C) 0824307566.

My supervisor's details are as follows: 031-2601134.

You may also contact Mr Sugen Reddy from faculty office if you are not happy about anything.

His contact details are as follows: 031-2607209

If you are happy to participate in the study, kindly sign the attached informed consent form.

Thank You,

NOZIPHO MTHEMBU (MRS)

APPENDIX: D

INFORMED CONSENT

An Analysis of the nurse managers' interpretation of the National Health Insurance policy, its implications for implementation on their institutions and their role and responsibility in private and public health care facilities in the eThekweni district.

I _____(Full Name) have been informed by Nozipho Mthembu about the above named study to be conducted at private and public health care institutions in the eThekweni district of the province of KwaZulu - Natal.

Please circle the appropriate answer

- | | |
|--|----------------|
| 1. I understand the purpose and procedure of the study. | YES/ NO |
| 2. I have been given an opportunity to ask questions about the study. | YES/ NO |
| 3. I received satisfactory answers. | YES/ NO |
| 4. I declare that my participation in the study is voluntary. | YES/ NO |
| 5. I understand that I may withdraw at any time without any adverse Consequences | YES/ NO |
| 6. I understand that I may contact the researcher/ supervisor on queries about The study | YES/ NO |
| 7. I have read the participant's information sheet. | YES/ NO |
| 8. I have been informed that the information I give will be confidential. | YES/ NO |

RESERCHER: Mrs. N. Mthembu Tel: 031-2601210 (C) 0824307566

SUPERVISOR: Prof. B.R. Bhengu Tel: 031-2601134

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF WITNESS

DATE

APPENDIX: E

Research Title: An analysis of the nurse managers' interpretation of the National Health Insurance policy, its implications for implementation in health care facilities in the eThekweni district.

SECTION A

Instructions: Please answer the following questions by making a cross (X) in the appropriate box.

1. Demographic Data

- What is your gender?

1	Female	
2	Male	

- What is your actual age?

- How long have you worked as a nurse manager?

1	< 5 years	
2	5 -10 years	
3	>10 years	

- In which level of nurse management are you?

1	Top	
2	Middle	
3	Low	

- In which sector are you employed?

1	Public	
2	Private	

SECTION B

Instructions: Please answer the following questions by making a cross (X) in the box that best describes your views about the proposed National Health Insurance policy.

Directions:

1= Strongly Disagree

2= Disagree

3= Don't know

4= Agree

5=Strongly Agree

1. INTERPRETATION OF THE CONCEPT NHI

ITEM	1	2	3	4	5
Covering of all health care from PHC to highest level of health care					
Facilities need to be upgraded to a prescribed standard and be assessed and accredited					
Same service in each and every institution					
Funding health care services by bringing together all health care funding into one basket					
Everybody to access health care services, even the poorest of the poor.					
Provide access to better health services for all communities					
Delivery or ensuring health care to all people of SA					
This will benefit those who have some money					
Affordable health care to all people living in SA					
Public private integration of services to improve health care					
Every person in SA will be entitled to medical care whether they have funds or they don't.					
Level of service received will be the same for all					
The patient will be seen and treated at the first level of care.					
Stand-alone care for the private sector					
The patient may go straight to a specialist					

2. STRENGTH YOU POSSESS AS A NURSE MANAGER-SUPPORT AND READINESS FOR IMPLEMENTAION

ITEM	1	2	3	4	5
I feel ready judging from what we have in our institution					
Idon't think we are ready					
We are ready though not completely ready					
I don't think we had the necessary information communicated or made ready ourselves.					
We are working towards being ready.					
Each and every department has got its relevant equipment needed.					
We have to request for equipment					
We have motivated for more equipment.					
We are going to buy equipment					
The department of health is very much supportive, we get regular visits by coordinators from the district office					
We have support from head office					
We have qualified nurses who are prepared to work					
More posts have been created					
We have enough human resources					
We have been given a budget to improve our departments.					
The government is giving the budget to improve our facilities					
We have the support from the doctors					
We have support institutionally for all the programs					
We have support from senior management.					
The district office plans for in-service training. They send us for conferences and symposia					
We are constantly applying for more staff to be trained to accommodate for the implementation					
We support each other by assessing one another among the departments.					

3. GAPS

ITEM	1	2	3	4	5
The infrastructure issues need to be resolved					
Waiting for the guidelines from head office.					
There is a need to buy state of the art equipment in order for us to conform to the NHI,					
There is a need for a lot of training and workshops on relevant policies from the government.					
We need training on the accreditation and implementation process.					
We need more human resources in order to meet the prescribed standards					
There is a need for the facility buildings to be improved to current norms and standards.					
There must be an increase of the budget in order to meet the national core standards.					
There must be more space for expansion of the facility					
We need somebody from the district office to come to the facilities more often.					
We need good leadership.					
Alignment of training of nurses with the same curriculum for both public and private.					

4. IMPLICATIONS OF IMPLEMENTATION OF NHI POLICY TO YOUR ROLES ANSD RESPONSIBILITIES

ITEM	1	2	3	4	5
Maintain high quality of care within the institution through quality assurance.					
Sustain high standards of care					
Ensure sustainability of standards					
Ensuring that quality nursing care grows quite a bit.					
Improve the level of care to be on par with all other facilities					
Continued compliance with National core standards					

Maintain the same standards at which the institutions were accredited					
Implementation of NHI to be the same across the board					
Policies to be the same for health care facility					
Bring level of care on par with all other health care facilities,					
Ensure you have enough human resources, because of the number of programs to run					
Provide resources for the implementation of the policy.					
Support and monitor to ensure sustainability of care					
To play an active role in the whole accreditation process					
Create a positive environment for the implementation					
We must look at how we are going to send our patients home and the follow up care					
Sell the idea to the community to utilize the clinics or CHC at first level.					
We must use what we are supposed to use effectively. and					
Efficiently keep the cost as low as possible with the exact same outcomes.					
Ensure that all people will be treated early to prevent further complications					
It's a very good thing that it's going to be implemented because it's for the patient, ensuring that we give them the best					
As managers we are the drivers of this and we must ensure that it works.					
Private should be more integrated with government, and standardize everything even salaries.					

5. GUIDING PRINCIPLES OF THE NHI

ITEM	1	2	3	4	5
Ensure health care for all people of SA					
Health care facilities must comply with National core standards.					
Facilities will be assessed and accredited to be allocated the status for NHI.					
NHI will afford facilities to learn from each other					
Standardization of nursing care.					
Management tools will be standardized in all health care facilities					
Policies laid down for the NHI e.g. Make me look like a hospital					
Service rendered must be equal irrespective of financial standing					
Services are available to all					
All citizens have an equal access to health care irrespective of social status.					
There will be focus on preventive measures					
Health care services will be affordable.					
NHI will allocate people according to zones.					
Services will be standardized					

APPENDIX: F



Research Office, Govan Mbeki Centre
Waverille Campus
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 9387
Fax No: +27 31 260 4609
ximbagg@ukzn.ac.za

2 February 2012

Mrs Nodipo Mthembu (211553499)
School of Nursing

Dear Mrs Mthembu

PROTOCOL REFERENCE NUMBER: HSS/0033/012M

PROJECT TITLE: An Analysis of the Nurse Managers' Interpretation of the National Health Insurance policy, its implications for implementation in healthcare facilities in the eThekweni District.

In response to your application dated 1 February 2012, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



Professor Steven Collings (Chair)
Humanities & Social Science Research Ethics Committee

cc Supervisor Professor B R Bhengu
cc Ms P Nene



health

Department
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalala Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

APPENDIX: G

Reference : HRKM21/12
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

06 February 2012

Dear Ms N Mthembu

Subject: Approval of a Research Proposal

1. The research proposal titled 'An analysis of the nurse managers' interpretation of the National Health Insurance Policy, its implications for implementation in healthcare facilities in the eThekweni district' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at selected PHCs and CHCs at eThekweni District.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

KwaZulu-Natal Department of Health

Date: 10/01/2012

uMnyango Wezempilo, Departemen van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX: H



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54316 Durban 4000
es: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel. 031 2406308; Fax: 031 2405500
Email: nan.boosain@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Ms TP Dladla
Date : 6 February 2012

Mrs N Mthembu
School of Nursing
University of Kwa-Zulu Natal

REQUEST TO CONDUCT RESEARCH:

An Analysis of the Nurse Managers' Interpretation of the National Health Insurance Policy, its Implications for Implementation in Health Care Facilities in the eThekweni District

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on the above research study.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.


Ms TP Dladla
Acting District Manager
eThekweni
Telephone: 031 2405308
Fax : 031 2405500
Email : nan.boosain@kznhealth.gov.za

uMnyango Wezampilo - Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

WENTWORTH HOSPITAL

Private Bag, Jacobs 4026
1 Boston Road, Jacobs 4026
Tel.: 031-460 5000, Fax.: 031-4689654
Email:
www.kznhealth.gov.za

APPENDIX: I (a)

Reference : Research Protocol
Your Ref : Research
Enquiries : Dr. S.B. Kader
Telephone : 031-460 5001
E Mail : Suriya.kader@kznhealth.gov.za
Date : 9th March 2012

Ms. Nozipho Mthembu
Mthembun3@ukzn.ac.za
School of Nursing and Public Health
5th Floor Desmond Clarence Building
Howard College Campus
University of KwaZulu Natal

Dear Ms. Mthembu,

RE: **PERMISSION TO CONDUCT RESEARCH AT WENTWORTH HOSPITAL**
'AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE NHI
POLICY, ITS IMPLICATIONS FOR IMPLEMENTATION IN HEALTHCARE FACILITIES
IN THE ETHEKWINI DISTRICT'

I have a pleasure in informing you that permission has been granted to you to conduct research on:
**"AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE NHI POLICY, ITS
IMPLICATIONS FOR IMPLEMENTATION IN HEALTHCARE FACILITIES IN THE ETHEKWINI
DISTRICT"**

Kindly take note of the following information before you continue:-

1. Please adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KwaZulu Natal Department of Health.
3. Kindly ensure that this office is informed before you commence your research.
4. The hospital will not provide any resources for this research.
5. You will be expected to provide feedback once your research is complete to the Chief Executive Officer.

Yours faithfully

DR. S.B. KADER
HOSPITAL MANAGER

uMnyango Wezampilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



APPENDIX: 1 (b)

ADDINGTON HOSPITAL
OFFICE OF THE HOSPITAL MANAGER
Postal Address: P.O. Box 977, DURBAN, 4000
Physical Address: 16 Etokina Terrace, South Beach
Tel.: (031) 327-2870, Fax: (031) 368-3300
Email: addington.management@kznhealth.gov.za
www.kznhealth.gov.za

AD/923/R

Enquiries: Dr R N Mokoena
Extension: 2970/2568

8th March 2012

Principal Investigators:
> Ms N. Mthembu

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE NATIONAL HEALTH INSURANCE POLICY, ITS IMPLICATIONS FOR IMPLEMENTATION IN THE HEALTHCARE FACILITIES IN THE ETHEKWINI DISTRICT"

I have pleasure in informing you that permission has been granted to you by Addington Management to conduct research on "An analysis of the nurse managers' interpretation of the National Health Insurance Policy, its implications for implementation in healthcare facilities in the eThekweni District".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.


HOSPITAL MANAGER
DR RN MOKOENA
ADDINGTON HOSPITAL

uMnyango Wezempho . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



APPENDIX: 1 (c)

Netcare St Augustine's Hospital

Tel: +27 (0) 31 268 5000
Fax: +27 (0) 31 201 4506
127 J.B. Marks Road, Durban, 4001, South Africa
PO Box 30105, Mayville, 4068, South Africa
www.netcare.co.za

8th February 2012

NOZIPHO MTHEMBU
Member@stakz1.ac.za

LETTER OF PROVISIONAL PERMISSION TO CONDUCT RESEARCH IN A NETCARE FACILITY

Dear Ms Mthembu:

It is with pleasure that we inform you that your application to conduct research on AN ANALYSIS OF THE NURSING MANAGERS' INTERPRETATION OF THE NATIONAL HEALTH INSURANCE POLICY, ITS IMPLICATIONS FOR IMPLEMENTATION IN HEALTHCARE FACILITIES IN THE ETHERKWINI DISTRICT at St Augustine's Hospital has been approved in principle, subject to the following:

- i) Approval by the Research Committee
- ii) All information with regards to Netcare will be treated as confidential.
- iii) Netcare's name will not be mentioned without written consent from the Academic Board of Netcare.
- iv) Where Netcare's name is mentioned, the research will not be published without written consent from the Academic Board of Netcare.
- v) A copy of the research will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.
- vi) All legal requirements with regards to patient rights and confidentiality will be complied with.

The Netcare Research Committee can be contacted as below:

Dr CW Fölscher
Project Manager: Bursaries & Research
Netcare

Telephone number: 083 201 1871

Email address: research@netcare.co.za

Courier address: 657 Mirage Street, Etardepark, Pretoria

(Please phone to arrange for recipient at this address at estimated time of delivery).

We wish you success in your research.

Yours faithfully

AUGUSTA DORNING
General Manager

JENNIFER PIETERSE
Nursing Manager

Netcare Hospitals (Pty) Ltd T/A Netcare St Augustine's Hospital
Directors:
J Du Plessis, R H Fölscher, I Searles
Company Secretary: L Bagwandeen Reg. No: 1999/00351/07

APPENDIX: J



Netcare Limited

Tel: +27 (0)11 991 0000
Fax Corporate +27 (0)11 201 0488
75 Maude Street, Corner West Street, Sandton, South Africa
Private Bag X24, Berea, 2012, South Africa

RESEARCH COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2012-0008

Ms Nozpho Mthembu

E mail: mthembu3@ukzn.ac.za

Dear Ms. Mthembu

RE: AN ANALYSIS OF THE NURSE MANAGERS' INTERPRETATION OF THE NATIONAL HEALTH INSURANCE POLICY, ITS IMPLICATIONS FOR IMPLEMENTATION IN HEALTH CARE FACILITIES IN THE ETHERWINI DISTRICT

The above-mentioned research was reviewed by the Research Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Netcare Kingway & St. Augustine's Hospitals, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Academic Board of Netcare (Research Committee).
- ii) All information with regards to Netcare will be treated as confidential.
- iii) Netcare's name will not be mentioned without written consent from the Academic Board of Netcare (Research Committee).
- iv) All legal requirements with regards to patient rights and confidentiality will be complied with.
- v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability
- vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)
- viii) Netcare must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from Academic Board of Netcare (Research Committee) as well as a FINAL REPORT with reference

Executive Directors: R.H. Fikile (CEO), V.B. Fimber (CFO), V.L.J. Luthi (General Manager)

Non-Executive Directors: S.J. Viljoen (Chairman), I. Brewer, A.P.H. Jammitso, J.M. Kahn, M.J. Kuscu, H.R. Lavan, K.D. Moolbe, M. Seck, N. Williams

Company Secretary: I. Mtshwane (Reg. No. 1996/0081500)

- to intention to publish and probable journals for publication, on completion of the study.
- b) A copy of the research report will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.
 - x) Netcare has the right to implement any Best Practice recommendations from the research.
 - xd) Netcare reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully,



Prof Dion du Toit
Full member Research Committee & Medical Practitioner evaluating research applications as per
Management and Governance Policy
Date:

Sharon Nell
Chairperson Research Committee
Network Healthcare Holdings Limited (Netcare)
Date: 23/2/2012



APPENDIX: K



Life Healthcare (South Africa)
Central Manor, 21 Church Road, Roseville
Pretoria 0001, South Africa
Telephone: +27 11 218 2000
Toll-free: +27 11 218 2001
www.lifehealthcare.co.za

15 February 2012

Attention: Nozipho Mthembu

APPROVAL FOR RESEARCH STUDY

Our previous correspondence refers.

The Research Committee of the Life Healthcare College of Learning has granted permission for your study entitled:
'An analysis of the Nurse Managers' Interpretation of the National Health Insurance policy, its implications for implementation in healthcare facilities in the eThekweni District.'

We look forward to seeing the results of your research once it is completed.

Yours sincerely

A handwritten signature in cursive script, appearing to read "Anne Roodt".

Anne Roodt
Nursing Education Specialist

APPENDIX: L

TRANSCRIBED INTERVIEWS:

INTERVIEW WITH A TOP LEVEL NURSE MANAGER

R: What type of health facility is your institution?

N.M: Well our facility is ,A is A community centre in fact is a community health centre and which is a second level in terms of e you know health care service delivery levels and PHC and e ja

R: How many beds in the facility

N.M: Ja we have, we have 21 beds and those beds are located in maternity and also in MOPD you know receiver of the short stay

R: How many nurses work in your health facility?

N.M: E...e 124

R: In which level of nurse management are you?

N.M: OK I am actually the head of the institution and the CEO

R: How long have you been working as a nurse manager?

N.M: As a nurse manager I have been a nurse manager since 1996 to 2003.In fact as a nurse manager since 1996 to 2003. And as CEO from 2005 1st of December 2005 until to date because the period in between 2003- and Dec 2005 I was out eh.. I was overseas

R: What do you understand by NHI?

N.M: I think the National Health care Insurance is actually e it is a strategy of funding health care services by bringing together all health care funding into one basket and then actually allocate into all services that actually deliver services. At the moment it's not you have the public service are funded separately the private sector is funded separately. Somewhere along the way you may find some NGO also providing health care service and they are funded differently

R: What are the guiding principles of the National Health Insurance?

N.M: I think one of them is to ensure that all the citizens have an equal access you know to health care irrespective of their social status or their earnings and also e..it's also to ensure that the choice in terms of receiving health care still lies with the individual you can actually have a choice of either going to any institution in SA whether its private or public but still be funded equally

R: How are you going to apply them in your institution?

N.M:I think in PHC e I think there is e the current provisions in PHC services are free for everybody except for certain categories e.g. those on medical aid and those who actually sustain injuries you know in terms of the workman's compensation act and also those who sustain injuries in terms of the road accident fund who actually who get funds through the road accident fund and also those who are brought in like your awaiting trial prisoners you through the SAPS and those are the ones who are actually expected to pay in the system but the rest the services are actually free and therefore in terms of the NHI those will be the ones targeted except the medical aid because medical aid will change completely. The status of the medical aid will change completely so those you know, we will still continue to provide free service because in terms of the.. the health care insurance PHC has to be available in all health care facilities including the private sector because that will be gateway of access at the moment in the private sector they don't have PHC so for us instead we will actually benefit in terms of being strengthened in delivering PHC in terms of funding so that the standard e we meet the standard which are expected in terms of norms and standard s for all health facilities in the RSA

R: How does the NHI apply to your work environment?

N.M: At the moment I must admit because there has been discussions, conferences I attended it is not clear cut in terms of application in PHC but I think as it jells it is going to give us a picture in terms of how in terms of expectations but I think because we are a gateway to the health system as PHC so therefore everybody has to go through PHC to facilitate referral to higher level of care I think therefore those expected norms and

standards have to be strictly adhered to ensure that the service actually gives value for money. Ja

R: What are the implications of the implementation of the NHI on your role and responsibility?

N.M: I think one of them is actually to ensure that we conform to the national norms, the national core standards and being fully compliant with the national core standards therefore the institution will subsequently get accredited and be licenced to operate without which the institution can easily be closed down if it doesn't conform to national core standards if it fails to comply with national core standards and therefore that has serious implications for senior management of every facility to ensure that those national core standards are continually complied with and we maintain high standards so that we continue to hang on to our licence which will be validated on goingly and ja.

R: Do you think you are ready for the implementation of the NHI policy? If yes how ready are you?

N.M: (Laughter) I would say the institution is ready. However there are certain prerequisites that have to be sorted out first these actually relate to infrastructural issues which are key in ensuring that we conform to national core standards. Infrastructural challenges which have to be resolved. For instance you know our institution like most of CHC were previously large clinics that were commissioned as CHC so the infrastructure in fact ,they were not they were not refurbished and therefore with the type of service that we are providing some of them that have been strengthened now we are having challenges in terms of space. This goes right throughout the clinical its occurring both in clinical and in non-clinical areas. So those are the challenges that have to be resolved because at the same time when you have to be accredited in terms of national core standards you find that there are issues which you still have to comply with. And those issues impinge on the infrastructural issues especially the one for instance clinically issues of space actually talk to the issues of privacy and confidentiality and ja those are very very key.

R: What support do you have to prepare yourself for the implementation of the NHI policy?

N.M: I think the support is actually there its forthcoming from the district office especially in terms of some of the challenges they have actually been very supportive and helpful in terms of addressing issues of maintenance for instance and also I think head office the support is also there also from head office but I think the load I think unfortunately for head office I think the load for them is big because we are not the only institutions and it's the PHC ,the CHC have these challenges it's not only mine there is a number of them and also there are hospitals which I know actually are in desperate need of upliftment in terms of infrastructure

R: Do you need any further support?

N.M: No I don't think so, I don't think so except perhaps for now in preparation, issues that need to be looked at in addition to that I think addressing the issues of human resources would also need to be supported through funding. Because for one to meet those national core standards I think besides infrastructure there is an issue of human resources so I think that support is required I think that support is right at the door of the provincial head office. Especially that there are key posts which are vacant and a number of them are at senior management.

INTERVIEW WITH A MIDDLE LEVEL NURSE MANAGER

R: What type of health facility is your institution?

N.M: District Hospital

R: How many beds in the facility

N.M: At the moment 217. It's allocated for 300 but we are using 217 at the moment

R: How many nurses work in your health facility?

N.M: There are ±334 nurses

R: In which level of nurse management are you?

N.M: That is e..e, My tile is deputy nurse manager that is my title, from 2007 we were given those tiles because there was a belief that there would be nurse manager

employed in head office so we are considered as deputy nurse managers all of us except X. X, she is a nurse manager. We others are deputy nurse managers

R: How long have you been working as a nurse manager

N.M: Since March 2005

R: What do you understand by NHI?

N.M: The little that I know about the NHI is that the aim of the government of the day is to cover everybody all the citizens SA citizens so that they are able to access health care facilities easily. What we were told is that each and every family will have a card NHI card where they will be allocated which hospital they can use the card in the card and which clinic and the GPs around the area they can use. They will also be able to access some services of the private hospitals the government will fund the whole process within their demarcated area. It is said that initially but as the time goes on I believe that it will be funded by the public. Somehow tax will be increased in one way or another and we were told that because of NHI the facilities need to be upgraded to a prescribed standard of which it has started because we have been assessed as W hospital we were assessed in December and the assessment outcome was that we were compliant we were compliant we were A compliant with some vital criteria that we didn't meet so we are working on them so that we are ready to be reassessed so that we can be accredited

R: What are the guiding principles of the National Health Insurance?

N.M: Guiding principles I will be lying if I say I know them .Accessibility, affordability. I would say the facility must meet a certain criteria of standards you must be accredited so that you as a facility can be allocated the status for NHI clients to access let me put it like that so you need to be accredited. Then what is the other thing the principles that there will be demarcation, if you live in this area these are the facilities that you can access how they will demarcate them I don't know but there will be demarcation of the areas whether it will be done according to the present catchment areas or it will be redemarcated I don't know. And the other principle is that the facilities even the public service ,the public institution can have the private wards for those people who want to

stay there I believe that it can only be used by private clients if our standards is acceptable.

R: How are you going to apply them in your institution?

N.M: At the moment we try to reach the required standards we are busy upgrading the institution especially the wards. I believe for us to really render quality patient care we need to have acceptable numbers of the nurses of which we have started employing more nurses. I am still going to employ more I have already requested to employ more. I am in the process of employing more with the hope that I will have the correct ratios. The nurse patient ratios though we don't even know the nurse patient ratios. There are no prescribed nurse patient ratios in the service, we just have to thumb suck you just look around and say I think this is enough for nurses to render quality patient care. Now and again we meet with the quality assurance manager to looking at what we not meet. We have developed QIPS from the projects because we want to meet those criteria with the hope that we will come to the required standards, but we have done a lot, we have really done a lot to upgrade the facility and to sort of improve the nursing care. There are many projects that we are busy with.

R: How does the NHI apply to your work environment?

N.M: My work environment, to tell you the honest truth at the moment because of the NHI there is a lot of work that we are doing because there are so many things that we need to fix sort of. To us I think it will come with some relief because if you as a family you have this NHI card I believe you will be told to go to these facilities.so that I hope we will not receive people from the Eastern Cape as we are currently receiving if it's going to work like the province you need to stick to your area because these are the facilities you must access with your card.If the card does not say that I don't see any change. We will still get the influx from the Eastern Cape.

R: What are the implications of the implementation of the NHI on your role and responsibility?

N.M: It will mean with the implementation of the NHI all the citizens will be able to access quality patient care at their earliest possible moment. They will not have to walk long distances because they will know that if I live here these are the doctors and clinics

and hospital I can access including private. So the people will be treated early to prevent further complications

R: Do you think you are ready for the implementation of the NHI policy? If yes how ready are you?

N.M: I don't think we are ready as an institution but we are working towards being ready. I am sure you have seen that there are so many things that are happening especially the upgrading of the facility. We are not yet ready but we will be assessed for accreditation second quarter, second quarter is from April to June. We were told that we need to choose a date in the second quarter for people to come and assess us toward accreditation. That will be a deciding factor. These are the people who will measure if we are ready or we are near being ready or we are still far from being ready. From my side we are not yet ready although there are so many things that we have done. Can't say that tomorrow, but I see us being ready once we have finished the entire project because we have worked very hard to achieve them.

R: What support do you have to prepare yourself for the implementation of the NHI policy?

N.M: We have got the district support. We have support from our CEO and the finance manager because whatever we request we tell them it's a requirement for the national standards so they are trying to give us although the budget is limited, there is no budget set aside for the national core standards we are using the normal budget but we are trying to stretch it further to the national core standards. I am so happy this morning because I am getting a report from the matrons; one area that we failed was the resuscitation trolleys because with us we were using the normal utility trollys as resus put everything on there now they were delivered yesterday we had to fight please this is a requirement they were ordered for all the wards.

R: Do you need any further support?

N.M: I think from the budget side it would be nice if they increase the budget because the budget that is currently allocated didn't cater for the national core standards for upgrading of the facility to the prescribed standards and of course to have more human

resources. (Phone rings) We need more budgets which will make it possible to meet the national core standards.

INTERVIEW WITH FOCUS GROUP INCLUDING LOWLEVEL NURSE MANAGERS

R: What type of health facility is your institution?

N.M: It's a private health facility

R: How many beds in the facility

N.M: 454

R: How many nurses work in your health facility?

N.M: 789

R: In which level of nurse management are you?

- N.M: 1. Middle level-senior management
2. Middle level- senior management
3. Lower level-unit manager
4. Lower level –unit manager
5. Lower level –unit manager

R: How long have you been working as a nurse manager

- N.M: 1. - 7 years
2. - 3 years
3. -2 years
4. - 12 years
5. -1 year

R: What do you understand by NHI?

N.M: Basically a fund that has been made so that health care is available to everybody and affordable to everybody. Looking at the millennium development goals, goal health for all where they are bringing in the NHI .It is a fund which will be driven by the government. If you look at SA we have a dual health system Public and Private. The public sector serves a large population whereas the private serves 18% of the population. It's more for those people who can afford the out of pocket expense. It is

very disproportionate. Trying to alien it so that every person has an equal and fair opportunity to get the health care that they deserve, from which institution I am not sure. The policy on the white paper looks nice.

R: What are the guiding principles of the National Health Insurance?

N.M: To make sure that everyone has equal opportunities in terms of health care and making health care affordable, sustainable it has to be accessible. Looking at provincial institutions lots of patients get turned away I mean some patients for dialysis get turned away because they think their quality of life is not going to mean anything. I think they must make health care accessible think another thing is quality, everything in line with government sector. I think we are going to learn from each other going forward. Standardization, where we are going to use and do the same and to learn from each other. I think what we understand is that hospitals will be accessed through speciality. Looking at catchment perspective. They will look at catchment areas in terms of service delivery to the catchment areas.

R: How are you going to apply them in your institution?

N.M: We have started already. We already are seeing patients who belong to the Germs medical aid. Cost effect. We have gone through all the things that WHO has put down for all hospitals being private or provincial. We have seen those patients already. We have started standardization already. We have completed verification for the core standards, on the audit tool. We started implementation. In terms of the results we have obtained I think everybody has put in a fair share towards achieving those results.

R: How does the NHI apply to your work environment?

N.M: I don't think it's going to have a lot of difference. A patient is a patient whether it's a government or a private patient, the principles are going to be the same. The occupancy is very high already. I don't see us being any quieter its going to be the same.

R: What are the implications of the implementation of the NHI on your role and responsibility?

N.M: As unit managers it is not going to have an effect at all because we will still manage the cost and budget but when it comes to patient care there is going to be a difference. We are presently busy with change champions. We have to facilitate change with the staff. I think it's a change of a mind-set. There has been a lot of negativity with the NHI I think that's where the change champions will come into effect. Because at this stage we think we are going to be paying towards the medical aid and also pay for the NHI already there is negativity among professional people, so that is where the change is going to be. People leading their teams as well they have to remain positive. You have to remain positive and inform the staff that these are the benefits. It's going to assist more people. However the doctors have also a role to play and the hospital is gearing itself towards that direction and the doctors are lacking behind. These are going to be challenges for us as managers. We must stay positive but there are things that are dragging us down and how are we going to make it work The discharge plan is going to be important for us, what happens to a patient when he goes home. There is a huge role to be played by a nurse there. If the patient is ready to go home we will have to I think everybody must know what is happening. The patient will now have to go to primary health. If everybody knows it will be easy to understand what needs to be done. The people are not going to make a decision; people are not going to change unless it's there. I think it will have an impact on the hospital we will be diver sing ourselves more. At the moment from Monday to Friday we work on 100% occupancy. I can guarantee you that we are going to have more patients coming through on a Saturday and Sunday. The doctors have revenue to be generated. It's going to be a strain to the doctors as occupancy will be 100% all the time. From my side as well I think that it will be a strain on resources in the sense that we are extending our services to the community. Medical insurance is very expensive. It is much more rewarding to extend your services to somebody who previously could not afford it. At the same time we have to be positive, will it work, do we have the resources, do we have the finance to manage this. What is Netcare's role with the government to say this is how we are going to implement. I have got this feeling that for something to happen at a government institution I may have to get permission from the minister whereas here I can say let's try this to make a change. I would live it to kick off but given the history of the NHI. This

has been implemented in the states and the UK and has failed dismally. As managers we are the drivers of this and we must ensure that it works. Also for us as managers there are huge challenges on the nursing side. The work load that we are going to be having on weekends as well. We are already feeling the pressure. I think that will add a lot of pressure. I think for us as managers we have to find more staff which goes down to resources. At the moment we are looking at organization fit, job fit or job is going to be vast, from recruitment to selection. We have to extend our teaching role. Our clinical facilitation department will have to be involved. There is a lot that will need to be done. Government must look at what they are doing and align themselves with what private is doing. There have some resources that are supposed to be used and are not used. Another thing is salaries because at this stage we loose staff because you can't compete with the high salaries. It is an issue; we should be more integrated with government. To standardize everything even salaries.

R: Do you think you are ready for the implementation of the NHI policy? If yes how ready are you?

N.M: No, there is a lot of work owing. An audit is something, where you have a check list to check how compliant you are. When you are in it and go through the process and when you do the post mortem of it and check where you faulted It is very difficult to gauge at the moment. From a private institution doctors, in the public institution the good thing is you have a lot of doctor driven activities, here you don't. The hospital manager and the nursing services manager have a lot to do and everybody else fits into it. One of the requirements is patient confidentiality and obtaining consent from the patient .It is the doctors' responsibility to ensure that the patient has signed for a correct procedure. It's going to be a huge change for management in terms of getting doctors on board and to say we are on the same level now.

R: What support do you have to prepare yourself for the implementation of the NHI policy?

N.M: We have each other. The information is there. We are going along supporting each other. The baseline has been set. The national core standards have been rolled to every X hospital. In terms of the NHI distribution it will be divided among institutions .That is why all institutions must be aware of what government wants us to do. We are

getting support from head office in the sense that we received core standards from them to work on. It's still new to them. It's still going to come back to us but it's still new

R: Do you need any further support?

N.M: We went through an accreditation process about seven years ago. We found that the whole process was not communicated to us nicely .We all learnt a hard way. With NHI we need to get it right from the word go. We need to establish a strong nursing roll out. Every ward has to be standardized; everything has to be the same. The standardization of all 20 units is important here at this hospital. On the nursing side we need to standardise everything to be in line with government. That is where we need good leadership. The core standards are a guideline. Support from government is also important and we need it. Will they be willing to take suggestions from us. There is best of both public and private. To be compliant with the core standards you need to have met certain requirements. The issue of policies must be done, the government must state what needs to be done .Over the top is documentation. Alignment of training of nurses with the same curriculum for both public and private.Standardization of training where private and public nursing schools are taught the same. I think having group meetings with government unit managers. Government support, Professional bodies, SANC , HPCSA. If you employ somebody from government, they are taught differently. We need to learn from government as its new to them. The government must stipulate what they want as the NHI is their baby and they must drive it. The minister of finance must also stipulate how much he is prepared to put down as this is very expensive.

