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Strategic Recommendations to Improve South African Healthcare based on the Australian Health Model

By

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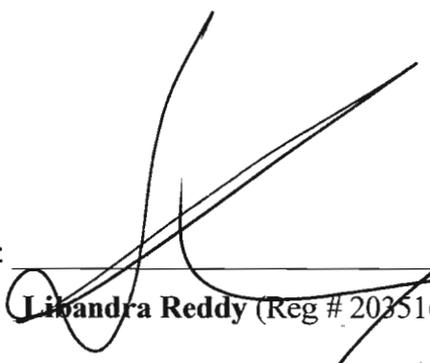
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(ii)

Declaration

This research has not been previously accepted for any Degree and is not being currently submitted in candidature for any Degree. I declare that this Dissertation contains my own work except where specifically acknowledged.

Signed:


Libandra Reddy (Reg # 203516778)

Date: 31 October 2005

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Executive Summary

Although strategic planning is widely used in industry and has been adopted by many not-for-profit organisations, the Department of Health has been slow to realise the relevance of a strategic approach. This thesis uses a strategic planning approach to assess the Department of Health by examining the three interacting factors which influence organisational outcome, namely the external environment, the internal structure of the organisation and the planning process itself. A composite model or template which incorporates several well-known strategic instruments is proposed as well as an overview of the Australian national health system and these are then used as part of the strategic assessment of the Department's vision and mission. The results and recommendations of the assessment are presented in the thesis.

Chapter One

Introduction

1.1 Introduction

South Africa is a huge, sprawling country at the foot of the African continent. It covers 1.2 million square kilometres with a population of 46.9 million, mostly urban based (Statistics South Africa, 2005). The healthcare industry is characterised by a huge division between the private and public sectors both in terms of facilities and funding. This grave disparity between the two sectors reflects South Africa's first world/third world dichotomy. Annually, government spends the equivalent of approximately R40 billion on 38 million people, while the private sector spends R60 billion on just 8 million citizens (www.doh.gov.za). The private healthcare system is highly rated, ranked within the top 40 nations for technological innovation and achievement by the United Nations (Bassett, 2003). In the public sector, pressing issues include lack of basic infrastructure and healthcare personnel, shortage of medication and poverty-related illnesses, including TB, malaria and cholera (Hooper, 2005). However, these inequalities are not unique and are seen in other countries. Healthcare across the world is under threat and is beset by numerous challenges, namely HIV/AIDS.

The mission of the Department of Health is a noble and selfless one:

- **Mission Statement**

To consolidate and build on the achievements of the past in improving access to healthcare for all and reducing inequity and to focus on working in partnership with other stakeholders to improve quality of care of all levels of the health system and to improve the overall efficiency of the healthcare delivery system (www.doh.gov.za).

- **The Vision**

A caring and humane society in which all South Africans have access to affordable, good quality healthcare (www.doh.gov.za).

Healthcare in South Africa

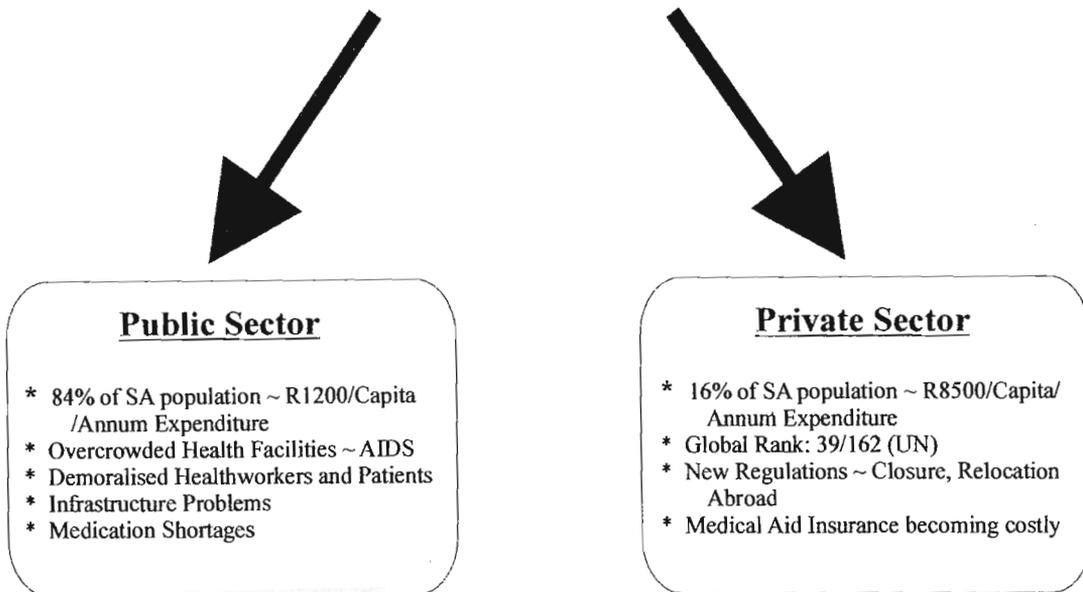


Figure 1.1: An adapted version of healthcare in South Africa (Source: www.doh.gov.za)

In order to sustain an industry that forms a basis of the South African economy, the question is – how does the country ensure a viable option for all stakeholders concerned? How does the private healthcare industry support the Department’s health principles of ‘affordability, sustainability, efficiency, access and quality’ (Keeton, 2004)?

The thesis uses the techniques of modern strategic planning to assess the current strategic position of the Department of Health and to suggest strategic responses to the challenges, based on the Australian healthcare model.

1.2.3 The Australian national health system

The Australian health system is widely regarded by the World Health Organisation (WHO) as being world class, in terms of its effectiveness and efficiency. The system is a mixture of public and private sector health service providers and a range of funding and regulatory mechanisms.

The health system is administered by the Health Insurance Commission ~ (HIC). HIC is a customer-focused service organisation delivering national health programmes to the Australian community and provides reliable, secure and innovative delivery of health claims, payments and information management (www.hic.gov.au).

The Australian Government's funding includes 3 major national subsidy schemes:

- Medicare
- The Pharmaceutical Benefit Scheme
- The 30% Private Health Insurance Rebate



Figure 1.2: Healthcare in Australia (Source: www.health.gov.au)

The aim of the Australian national health system is to give all Australians, regardless of their personal circumstances, access to healthcare at an affordable cost or at no cost, while allowing choice to individuals through substantial private sector involvement in delivery and financing (www.health.gov.au).

1.3 Motivation for the study

The policy of apartheid created a deep and lasting wound in South Africa. All citizens will spend many years, if not generations, recovering from that profound hurt. The country has achieved democracy but the truth is that the people of South Africa are not yet free; they have merely achieved the freedom to be free, the right not to be oppressed. South Africa must now take the next few steps on that longer and more difficult road.

Healthcare in South Africa is highly unequal. The ongoing inequity between those people with access to private medical care and those people dependent on the public sector remains one of the biggest challenges. Managed healthcare tools, systems and protocols still need to be improved. And who is suffering? It is the very same people who were oppressed in the days of apartheid. The Department of Health addresses the needs of 80% of the population. The demands are astronomical, resulting in poor health care delivery.

The desire to write a thesis on the strategic issues facing South African healthcare was born out of a wish to make sense of what is a frustratingly slow moving process. The motivation was also to try helping ease the problems.

1.4 Value of the study

The mission of the Department of Health is a noble and selfless one and if government fails in its mission, then civil society is much poorer for it. This study applies some of the theory of strategic planning to the Department of Health. The hope is that this thesis would be able to stimulate strategic thinking in the management of South African healthcare and help develop strategic responses to the healthcare challenges facing the country.

1.5 Problem statement

Although South Africa has the potential to be one of the leading healthcare providers in the world, the country seems to be in a perpetual state of health crisis. Questions can be asked as to whether the present direction offered by the Department of Health can achieve a better future. This thesis intends to assess the current position of the Department's vision and mission and to suggest possible strategic responses to the challenges prevailing in South African healthcare, based on the Australian national health system.

1.6 Objectives of the study

The study aims to:

- Evaluate the current strategic issues facing South African healthcare and the Department of Health.
- Determine possible responses to these issues, based on the Australian national health system.
- Establish an appropriate strategic response for the Department of Health.

1.7 Timeframe

The research proposal was submitted to the Graduate School of Business, University of KwaZulu-Natal on the 18th of October 2004. Having been approved by the Graduate School of Business, this study is intended to run from January 2005 to September 2005. This time period is allocated for data collection, analysis and reporting.

- Data collection and analysis: January – April 2005
- Reporting to supervisor: May 2005
- Draft revised as necessary: August 2005
- Submit: September 2005

All expenditure relating to this study will be borne by the researcher and Scriptnet Pharmaceuticals Pty (Ltd).

1.8 Structure of the study

- **Chapter Two – South African healthcare**

An overview of South African healthcare and the progress made by the Department of Health since the 1994 democratic elections will be presented in chapter two.

- **Chapter Three – Methodology**

Chapter three will provide the reader with an insight to the research methodology of the study. The methodology is shaped by the problem statement. Two methods of data collection will be employed: interviews and the techniques of a case study.

- **Chapter Four – The Australian national health system**

Chapter four will explore the Australian national health system. Aspects explored will include the key principles, logistics and benefits of the health system.

- **Chapter Five – Theory of strategic planning**

This chapter will review the theory of modern strategic planning as it applies both to for-profit and not-for profit organisations. Specific issues in the modern organisation such as the importance of strategic human resource planning and redesign of operations will be discussed. An attempt will be made to develop a composite model that can be applied to assess the progress of the Department.

- **Chapter Six – Research data and an assessment of the Department of Health**

Research data will be presented and a strategic assessment of the Department will be undertaken according to the composite model.

- **Chapter Seven – Recommendations and conclusion**

Chapter seven will conclude the study with a list of issues that need to be addressed by the Department of Health and a final list of five responses to these issues.

Chapter Two

South African Healthcare

2.1 Introduction

South Africa is a huge, sprawling country at the foot of the African continent. It covers 1.2 million square kilometres with a population of more than 46 million, mostly urban based (Statistics South Africa). The health of the nation is characterised by a quadruple burden of diseases, with the impact of HIV/AIDS added to the combination of a high injury burden, conditions related to underdeveloped nations and chronic diseases. The healthcare industry is characterised by a huge division between the private and public sectors both in terms of facilities and funding. Though first world facilities and care are available at a price, people in disadvantaged communities continue to die of preventable diseases because of the lack of public healthcare facilities. As a result of this inequality, South Africa rates badly in terms of the measure of health system performance, ranking 175th out of 197 countries in the 2000 survey (Bassett, 2003).

2.1.1 South Africa at a glance

- Mid-2005 population estimate – 46.9 million (Statistics South Africa)
- Average life expectancy at birth is 52 years in 2004 (Statistics South Africa)
- Mostly urbanised – many previously disadvantaged still in remote areas
- Unemployment 26.2% in 2004 (Bolowana, 2005)
- Health expenditure 8% of GDP in 2004/2005 (Shevel, 2005)

2.1.2 The South African health system – an overview

Healthcare in South Africa varies from the most basic primary healthcare offered free by the state, to highly specialised, hi-tech health services available in the private sector for those who can afford it.

The ongoing inequity between those South Africans with access to private medical care and those that dependant on the public sector remains one of the biggest challenges for government. Although in 2004 South Africa spent approximately 8% of GDP on

healthcare, most of this was in the private sector – R60 billion for healthcare for 8 million citizens while government's budget amounted to R42,8 billion for 38 million citizens (www.doh.gov.za). The public sector is responsible for 80% of the population and there is general concern that despite the funding available, and even with an increasing budget allocation, the public sector will not be able to keep up with the rising cost of healthcare.

Healthcare facilities need upgrading and renewal. In many instances, rural healthcare has been compromised by lack of infrastructure, including basic services such as roads, water and electricity. Finding funding for such activities is crucial. In addition to the actual facilities, maintaining a broad skill base is increasingly difficult for the public sector. Despite the fact that almost 75% of hospital funding are allocated to salaries (as opposed to 60% in the private sector), the level of skills varies considerably and the migration of health workers to the private sector and abroad is of particular concern (Health Systems Trust, 2004).

The biggest problem facing South Africa is the rising incidence of HIV/AIDS. The devastating impact of the epidemic has profoundly affected the health system. The care needs of patients suffering from HIV/AIDS have placed severe strain on services, often disproportionately on some of the most disadvantaged facilities. Health workers have been at risk of being overwhelmed with a sense of hopelessness, in the face of the disease.

Whilst the public sector is under-resourced and over-used, the mushrooming private sector caters to middle and high income earners who tend to be members of medical aids (just 20% of the population) and foreigners looking for top-quality surgical procedures at relatively affordable prices. The private sector also attracts most of the country's healthcare professionals (Health Systems Trust, 2004).

This gross inequity between the two sectors has led to the Minister of Health – Dr. Manto Tshabalala – Msimang enforcing healthcare regulations onto the private sector. The recent dispensing fee and dispensing licence regulations by the government have created trying times for private healthcare professionals. Presently the parties concerned find themselves deeper enmeshed in conflict.

2.2 Health of South Africans

This subsection provides a picture of the health of South Africans, both their wellbeing and their ill health. This section will focus on the health of the South African population as a whole.

2.2.1 Aspects of South African healthcare

South Africa has a population of 46.9 million. Life expectancy was estimated at 52 years in 2004. The HIV positive population in 2004 was 3.83 million, which relates to an HIV prevalence rate of 15.2% of the adult population. However some studies estimate that 24.5% of South Africa's population is infected with the virus (Reddy, 2005).

2.2.2 Disease prevalence in South Africa

South Africa has a very high disease burden, with a prevalence of diseases common to both developed and developing countries, including diabetes, hypertension, malaria, cholera, tuberculosis and HIV/AIDS.

2.2.2.1 Non-communicable diseases

Together with various stakeholders in the private and non-governmental sectors, government has conducted health screening mainly for hypertension, diabetes and Body Mass Index around the country. From the results done to date, it is clear that chronic diseases of lifestyle are a major problem (Health Budget 2005).

2.2.2.2 Communicable diseases

Malaria cases for 2004 decreased by 6%. Malaria deaths and case fatality rates however, have increased when compared to 2003 statistics. The increase in deaths and case fatality rates can be attributed to late presentation of malaria patients and health system failure (poor case management, late diagnosis and drug stock outs) (www.doh.gov.za).

The reported incidence of all tuberculosis (TB) cases for 2003 was 551/100 000 population. In terms of cases notified, this translates to more than 255 422 total TB cases in the country. Despite the high detection of cases (86%), the cure rates still remains low (54%). This indicates that the treatment programme is failing and therefore priority of this programme is essential (www.doh.gov.za).

Perhaps the biggest problem facing the public sector currently is the rising incidence of HIV/AIDS, which is and will continue to place considerable strain on the public health system. Current estimates are that 24.5% of the population is infected with the virus. South Africa's death rate, fuelled by AIDS has soared by 62% in the 5 years between 1997-2002 (272 221 – 441 029), yet government was woefully short of its own goal of treating 55% (53 000) of infected people by March 2005. The Department of Health announced this decision of rolling out antiretrovirals as part of a national plan on HIV/AIDS in September 2003 (Hooper, 2005; Reddy, 2005).

2.2.3 Causes of death

Whichever way one looks at it, the causes of death statistics released by Statistics South Africa indicate an extremely alarming picture of the health of South Africans.

Statistics South Africa figures show a 'bulge' in the number of deaths in the 20-44 age group as well as in death among children younger than 4. There was also a sharp increase in percentage deaths registered in the 30-34 age groups.

Tuberculosis (TB) emerges as the leading underlying cause of natural death followed by influenza and pneumonia – collectively accounting for 35% of natural deaths of South Africans in 2004. Next on the list are heart disease and related illnesses. These diseases are, however, killers of people globally. But that TB and influenza should be killing large numbers of South Africans, in this day and age is alarming.

In presenting the data, Statistics South Africa made it perfectly clear that these figures provided indirect evidence of the effect of the HIV epidemic – even though the cause of death data cannot give us accuracy on the full extent. Doctors who fill out the forms often may not know that the deceased is HIV positive. Even if they do – the stigma may prevent them listing it as a cause.

2.3 Healthcare resources

This subsection focuses on the financial and human resources South Africa uses and how they are allocated in achieving healthcare outcomes.

2.3.1 Funding of health expenditure

2.3.1.1 Private healthcare funding

Private medical aid fees are split 70/30 between employers and employees. However, faced with medical inflation on one hand and legislation to enforce solvency reserves on the other, medical aid plans are struggling. There have been spectacular collapses and many mergers. Some medical aids are insisting that members seek treatment in government hospitals. Managed healthcare has featured big, as have innovative savings schemes. Private patients now buy limited coverage and choose to pay for less severe ailments and save their medical aid contributions for severe ailments such as operations. Firms have cut costs by choosing lesser plans, leaving unwary employees to face unexpected healthcare bills, which often force them into the public sector (Naidoo, SN. 2005).

2.3.1.1.1 Scriptpharm

Scriptpharm Holdings is the Holding Company, of a dynamic entrepreneurial group of companies and together with its affiliation to companies within the healthcare industry, delivers healthcare solutions to a broad spectrum of the healthcare sector as well as providing accessible, affordable and quality healthcare to the South African nation.

The company's base comprises of 900 pharmacies and 800 medical practitioners working collectively in a unique environment and who adheres to all laws and ethics within the healthcare industry thus providing all South Africans with substantial cost savings on their healthcare needs without compromising on the quality of care.

This is in line with the objectives of the government to ensure an adequate and reliable supply of safe, cost-effective medicines of acceptable quality to all citizens of the country and the rationale use of medicines by doctors, pharmacists and patients (www.scriptpharm.co.za). The company:

- Makes medication easily accessible to medical scheme members via their national footprint of pharmacies as a result of being appointed as a Designated Service Provider by the various medical schemes and administrators. The company provides a controlled and managed environment which allows for outcomes to be easily measurable in terms of formulary compliance and saving to the medical aids, ensures medication integrity and eliminates incidences of fraud.
- Offers medical schemes a national doctor network, which will also enhance compliance to medical aid contracts and medicine formularies, thereby ensuring maximum savings to medical schemes and members (Cawood, 2005).

2.3.1.2 Public healthcare funding

The public sector is funded at national (20%) and provincial (80%) levels. Public health consumes around 11% of the government's total budget, which is allocated and spent by the nine provinces. How these resources are allocated and the standard of healthcare delivered, varies from province to province, with less resources and more people, cash-strapped provinces like Eastern Cape face greater health challenges than the wealthier provinces like Gauteng and Western Cape (Health Systems Trust, 2004).

2.3.2 Healthcare workforce

There is approximately 137 000 medical doctors, pharmacists and nurses (Private – 95 000, Public – 42 000) in South Africa. In 2004, there were 310 health workers per 100 000 people in South Africa (Private) and 49 health workers per 100 000 in the public sector.

- In 2004, there were 3 864 private retail pharmacies and 11 109 pharmacists (Private – 8 331, Public 1 679, other – 1 099). The country provides a rate of 120 pharmacists per 100 000 population (n = 7 million - Private) and provides a rate of 5 pharmacists per 100 000 population (n = 35 million – Public) (South Africa Pharmacy Council Statistics)
- Last year, there were 32 068 (Private – 24 423, Public – 7 645) registered medical practitioners in the country. South Africa provides a rate of 350 doctors for every 100 000 population (Private) and a rate of 22 doctors per 100 000 (Public) – (South African Medical and Dental Council, Health Systems Trust)
- The shortage and sometimes, complete absence of medical doctors in under-served rural clinics implies that the role and distribution of nurses has become crucial to the functioning of the public system. Less than half of professional nurses registered with the South African Nursing Council, work in the public sector. Health Systems Trust data reveal that in 2004, 40% (41563) registered nurses were working in the public sector. This implies that 62345 (60%) work in the private sector or other. South Africa provides a rate of 462 nurses per 100 000 population (Private) and a rate of 119 nurses per 100 000 (Public) (Health Systems Trust, 2004).

2.4 Health services

This subsection describes the public and private healthcare services and the challenges facing each sector.

2.4.1 The South African public healthcare system

Although the state contributes about 40% of all expenditure on health, the public sector is under pressure to deliver service to about 80% of the population. Despite this, most resources are concentrated in the private health sector which sees to the health needs of the remaining 20% of the population (Health Systems Trust, 2004).

2.4.1.1 Challenges facing the public health system

2.4.1.1.1 Quality of care

In the public sector, standards vary according to location. Large, urban hospitals offer good, if clogged-up service. Despite a massive building programme, many rural facilities are run-down, with broken equipment, two patients per bed, long waiting queues and a shortage of medication. Ambulances are worn out. There is also a dire shortage of healthcare workers (Hernandez, 2005; Tselane, 2005).

2.4.1.1.2 Patients

Horror stories abound – patients wait for hours for treatment and medication, operating lists have been reduced and elective surgery is put on hold and patients having to bring their own implements and linen (Bassett, 2003; Clarke, 2004). The current concern among patients is that despite the Department's attempts to improve the general health of the country, their efforts could be submerged by the tidal wave of HIV/AIDS (Pillay, 2005).

2.4.1.1.3 Healthcare workers

The reasons for the shortage of healthcare professionals in the country are diverse (salary, poor working conditions, unsatisfactory management), but the absence of a comprehensive human resource plan for this sector has a part to play. Although the health minister promised that a national human resource plan to address the critical shortage of

health workers would be released by the end of March 2005, there is still no sign of it (Cullinan, 2005).

Figures from 2001 show that as many as 25 000 South African healthcare professionals work abroad. According to the 2003/04 South African Health Review, 31% of public health posts were vacant in this country (Blaine, 2004).

2.4.1.1.4 Mismanagement

The Auditor-general Shauket Fakie has highlighted financial irregularities in the Department of Health during the past financial year. He highlighted several flaws in the way the Department spent more than 90% of its budget. More than R100 million was spent on NGO's yet they were unable to give assurance of transparent financial management. In 18 instances, underspending of grants amounting to R279 million occurred in some of the provinces for various programmes such as HIV/AIDS and hospital revitalisation and quality improvement (Adams, 2004).

2.4.1.2 The Department's response to these challenges

2.4.1.2.1 Healthcare

On the plus side, more than 500 new clinics now stand in areas where formally people used to walk several hours for treatment. The national rail carrier, Transnet, operates a healthcare train that brings affordable healthcare to rural communities (Bassett 2003).

This year's budget (2005) sees government sustain its emphasis on social welfare spending, with a marked increase in provincial health budgets over the next three years. Consolidated provincial health expenditure is budgeted at R45.8 billion, rising to R49.9 billion in 2006-07 and R53.5 billion in 2007-08. This year's budget review highlights government's concerns with management capacity in the public healthcare sector (www.doh.gov.za).

An additional R600 million is allocated to the national health department over the next three years to improve its internal ability to manage the multibillion-rand hospital revitalisation programme, which is funded through conditional grants. The extra funds

are also to be used to strengthen health promotion programmes. A spotlight on the hospital revamp should come as no surprise as in November 2004; the treasury signalled its worries about the health Department's ability to manage the programme's planned funding increases (Kahn, 2005).

The initiative is intended to upgrade the national hospital stock by overhauling facilities and replacing those at the end of their life span. It began in 2002-03, with one facility in each province. Twenty-seven upgrades are under way, of which 10 will be completed by the end of 2005-06. Altogether 59 hospitals are to be re-vamped over the next three years. Hospital management is also given attention in the budget, with R150 million allocated to the hospital management and quality improvement grant, rising to R167 million in 2007-08. The treasury also sets aside R4.6 million for the health professions training and development grant. The six conditional grants administered by the national health department, which total R8.7 billion in 2005-06, are budgeted to increase to R9.9 billion by 2007-08. Almost half of this money goes to HIV/AIDS treatment and care.

The Gauteng government has already tabled a massive R8.7 billion budget to strengthen the provincial health system. Funds would be channelled to promote health, prevent and manage diseases, HIV/AIDS and improve healthcare resources. Ten new clinics will be built in the next five years bringing the total number of 277 clinics in the province. This will reduce the heavy burden on the provincial hospitals in the province (Kahn, 2005).

2.4.1.2.2 Health charter

The challenges in the public healthcare sector are enormous. Many facilities still lack equipment and medication, shortage of health workers and essentials like piped water, telephone access and reliable electricity supplies. To overcome these problems in the public healthcare sector, government is adopting healthcare policies to support a national medical insurance scheme. These policies will relieve some pressure on the public health infrastructure.

The Minister of Health has urged players from the public and private healthcare sectors to see government's planned healthcare charter as an opportunity to reconcile their differences and work more closely together. This will ensure the rationale use of resources and the provision of high quality care to the patient at the lowest possible cost. Consensus still has to be reached among the participants. If so, mutual understanding and respect among stakeholders will be improved. If not, they will have missed a once in a lifetime opportunity to rewrite the future of healthcare in South Africa (Bisseker, 2004).

2.4.1.2.3 Healthcare workers

In August 2004, the Minister of Health signed the National Health Act, which makes the registration of all public and private health facilities mandatory. This ensures equal distribution enabling equitable access to health service for all. The introduction of rural and scarce skill allowance designed to attract health professionals to the public sector is having moderate success in increasing the supply of personnel in underserved areas, (Blaine, 2004).

The government has entered into agreements with countries of strategic importance to South Africa. These agreements are aimed at improving cooperation and to advance the objectives of the Department of Health. Cooperation with Cuba includes recruitment of Cuban doctors who are specialists in their respective medical field and the training of entry level medical doctors within the public sector (Hernandez, 2005).

2.4.2 The South African private healthcare system

South Africa's private healthcare sector has emerged as the 4th best in the world in terms of quality, cost, efficiency and access, according to a global survey. Switzerland, the Netherlands and Belgium claimed the top three slots in the survey commissioned by Discovery Health. The results of the survey confirmed the ability of private healthcare facilities in the country to perform procedures such as coronary bypass surgery and renal transplantation more effectively than first world countries (Venter, 2005).

The private healthcare sector employs 60 000 individuals and treats more than two million patients annually. Annual reinvestment in healthcare technology by the private sector is estimated to be R8 billion with a further R120 million reinvested each year in training and skills development (Venter, 2005).

The gross inequity between the public and private healthcare sectors has led to the Minister of Health to enforce health regulations within the private sector. The aim is to redirect scarce health resources to areas of greatest need.

Between 4-8 million South Africans are employed but are not covered by medical schemes. It is government's priority to include them in a social health insurance system by 2006. This will then double the membership of schemes, which currently cover about 7 million people and relieve the pressure on the public health infrastructure (Pile, 2004).

The Department of Health, however, is concerned about the increase in medical inflation. Inflation continues to soar above headline inflation registering a 10.6% rate of increase in July 2003 (Taho, 2004). Over the past decade, the cost of medical cover has put ever-increasing pressure on the individuals' disposable income. Where members spent 2% of their pay on medical cover 10 years ago, they now spend a whopping 20%. With medical scheme increases of 9-18%, more haemorrhaging can be expected in the future forcing many private medical insurance patients to opt out (Pillay, 2005).

Government had thrown down the gauntlet to private medical practitioners and pharmacists, blaming their resistance to key healthcare sector reforms in the past on their desire to protect profit margins. Access to medicines was central to the well being of the nation and government was not going to abandon its attempt to bring down the price of healthcare (Ensor, 2004).

On May 2, 2004 the Minister of Health, Dr. Manto Tshabalala – Msimang promulgated dispensing fee and dispensing licensing regulations, into effect. The main objectives of these interventions are to make healthcare more affordable and more accessible to the South African public.

These new private healthcare regulations dictate that:

- Dispensing doctors must complete a dispensing course and obtain a license to dispense medication
- All manufacturers of medicines had to set up a Single Exit Price (SEP) for medicines as from 2 June 2004. The SEP will be the price at which any person will buy a medicine. This price should be the same throughout the country. This price should include a logistics fee, which should cater for the expenses of transporting the medicine from the manufacturer to the health provider facilities.
- Health providers can add to the SEP a dispensing fee, capped at R26.00, for items on prescription. The fee can be added to medicines whose price is greater than R100.00. If the price is lower than R100.00, a maximum dispensing charge of 26% can be added. For items not on prescription, the dispensing fee is capped at R16.00 if the price is greater than R100.00 and 16% if lower than R100.00.

The R16.00 and 16% provision for all medicines is applicable to health personnel who are not pharmacists, but who have a dispensing licence. The R26.00 and 26% provision is applicable to pharmacists only. The dispensing fee provisions of R26.00, R16.00, 26% and 16% are maximum fees. The health providers can charge lower fees, but not higher (Zokufa, 2004).

The Department of Health's efforts to implement these regulations were opposed by the private health providers, who sought interim relief from the Cape High Court for dispensing fee and dispensing licensing regulations (Shevel, 2005a). The Cape High Court ruled in favour of the government and dismissed the case brought by the pharmacists and doctors. The pharmaceutical society thereafter applied directly to the Supreme Court of Appeal. In December 2004, the Supreme Court of Appeal overturned

the Department's disputed medicine-pricing regulations. The Department of Health has now appealed to the Constitutional Court and is awaiting the verdict.

2.5 Conclusion

The survey has shown several shortcomings with respect to the Department of Health's response to the healthcare challenges facing the country. The environment in which the Department functions has fundamentally changed. This means that the 'old solutions' and 'ways of doing things' may not be appropriate and a paradigm shift in the Department's approach is necessary. This work addresses the next logical step which is to find responses to these shortcomings. This must involve the development of a strategic mindset and the adoption of a number of strategic responses to meet these diverse challenges. Fresh approaches and solutions which draw on the fine traditions of the past but which are future oriented and progressive are needed. Government leadership is essential to provide this vision and direction and to facilitate the development of a new culture in South African healthcare that responds to ongoing change with strategic agility.

Chapter Three

Methodology

3.1 Introduction

Research is any organised inquiry carried out to provide information for solving problems and thereby increasing knowledge base (Cooper, 1998; Saunders et al, 2003). South Africa has the potential to be one of the leading healthcare providers in the world. However, the Department of Health seems to be in a perpetual state of health crises and questions arise as to where the Department is heading or how it can achieve this potential better future. The study undertaken intends to look at the strategic issues facing the Department of Health and attempts to craft a response to these issues.

Chapter Three will examine the research approach of the study. The need for a clear research approach and strategy is discussed and the implications of this for the credibility of the research data, findings and conclusion. The different methods of obtaining, collecting and analysing both secondary and primary data for the study will also be explored.

3.2 Research approach

On a daily basis, people reason with varying degrees of success and communicate their message, called meaning, in ordinary language or, in special cases, in symbolic, logical form. Meanings are conveyed through one of two types of discourse: exposition or argument. Exposition consists of descriptive statements that merely state or do not give reasons. Arguments allow one to explain, interpret, defend, challenge and explore meaning. Two types of argument of great importance to research are deduction and induction (Cooper, 1998). The deductive approach to a study is when a theory and hypothesis is developed and a research strategy is designed to test the hypothesis. The inductive approach to a study is when data is collected and a theory is developed as a result of the data analysis (Saunders et al, 2003).

The study undertaken will adopt an inductive research approach. To induce is to draw a conclusion from one or more particular facts or pieces of evidence. The conclusion explains the facts, and the facts explain the conclusion (Cooper, 1998).

To illustrate, South Africa rates badly in terms of the measure of health system performance. The country ranked 175th out of 197 countries in the 2000 survey (Bassett, 2003). The Department's unsatisfactory performance prompts the question to be asked – 'why is healthcare in the country faring so badly?' A researcher may conclude (hypothesise) that the Department of Health has a financial dilemma. Other hypotheses might also occur to the researcher on the basis of available evidence. Among them are the following: the Department has poor healthcare facilities and infrastructures, poor healthcare personnel and the mismanagement of healthcare funds.

All of the above hypotheses are inductions a researcher might base on the evidence of the Department's poor healthcare performance, plus some assumptions or belief the researcher holds about the Department. All the hypotheses have some chance of being true, but one would probably have more confidence in some than the others. All must be subject to further information before the researcher could hold any of them with much confidence. The task of research is largely to determine the nature of evidence needed and to design methods by which to discover and measure this other evidence. Hence the study to be conducted will adopt the inductive research approach.

3.3 Research design

There are many definitions of research design, but no one definition imparts the full range of important aspects. Several examples from leading authors can be cited:

The research design constitutes the blueprint for the collection, measurement and analysis of the data. It aids the scientist in the allocation of his limited resources by posing crucial choices: is the blueprint to include experiments, interviews, observations, the analysis of records, simulation, or some combination of these? Are the methods of data collection and the research situation to be highly structured? Is an intensive study of a small sample

more effective than a less intensive study of a large sample? Should the analysis be primarily quantitative or qualitative (Cooper, 1998)?

Research design is the plan and structure of investigation so conceived as to obtain answers to research questions. The plan is the overall scheme or programme of the research. It includes an outline of what the investigator will do from writing hypotheses and their operational implications to the final analysis of data. A structure is the framework, organisation, or configuration of ... the relations among variables of a study. A research design expresses both the structure of the research problem and the plan of investigation used to obtain empirical evidence on relations of the problem (Cooper, 1998).

These definitions differ in detail, but together they give the essentials of research design. First, the design is a plan for selecting the sources and type of information used to answer the research question. Second, it is a framework for specifying the relationships among the study's variables. Third, it is a blueprint that outlines each procedure from the hypotheses to the analysis of data. The design provides answers for such questions as these: what techniques will be used to gather data? What kind of sampling will be used? How will time and cost constraints be dealt with (Cooper, 1998)?

Early in any research study, one faces the task of selecting the specific research methods to use. A number of different research methods exist but the study believes the best way to handle the research statement is through interviews and a case study approach.

Robson (2002) defines case study as 'a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence'. Case studies place more emphasis on a full contextual analysis of fewer events or conditions and their interrelations. The case study strategy also has considerable ability to generate answers to the question 'why?' as well as 'what?' and 'how?' questions. The case study can be a very worthwhile way of exploring existing theory (Saunders et al, 2003).

The detailed emphasis placed on the case study approach will provide valuable insight to the Australian National Health System, the issues facing the South African Department of Health, the evaluation of these issues and the strategies recommended to improve the Department. The case study will allow information collected to be verified and will avoid missing data. In addition, adopting a case study type approach for the study will enable the researcher to challenge existing theory - that being the vision and mission of the Department of Health - and provide a source of new hypotheses.

3.4 Data collection

The data collection methods used in research may be various. They may include questionnaires, interviews, observations and documentary analysis (Saunders et al, 2003). Documentary analysis and interviews will be employed in the study to be conducted.

3.4.1 Documentary analysis (secondary data)

Secondary data is data already collected by others for some other purpose (Saunders et al, 2003). Secondary data for the study will be extracted from published literature, Internet information, journal articles and newspaper clippings.

Secondary data will be used in the study to serve three research purposes. First, secondary data will fill the need for specific reference or citation on some point – to demonstrate why the study fills a void in the South African healthcare knowledge base. Second, secondary data are an integral part of a larger research study or of a research report to justify having bypassed the costs and benefits of doing primary research. In essence, secondary data will be used in the study to try to keep from reinventing the wheel. Third, secondary data will be quicker and cheaper than certain primary data, especially when national and international statistics will be needed.

3.4.2 Interviews (primary data)

Primary data collection will be via one-to-one interviews, on a face-to-face basis. In particular circumstances, telephonic interviews will be conducted.

An interview is a purposeful discussion between two or more people. The use of interviews can help the researcher gather valid and reliable data that are relevant to the research question and objectives. Interviews may be highly formalised and structured using standardised questions for each respondent. A semi-structured interview is informal and is one where the researcher will have a list of themes and questions to be covered, although these may vary from interview to interview (Cooper, 1998). This means that the researcher may add or omit some questions in particular interviews, given the context that is encountered in relation to the research topic (Saunders et al, 2003).

Semi-structured interviews will be used in the study in order to conduct discussions, not only to reveal and understand what the strategic issues facing the Department are and how these issues impact on the Department, but also to place more emphasis on explaining why these issues are facing the Department of Health.

Semi-structured interviews will provide opportunities to ‘probe’ answers to the issues facing South African healthcare. Respondents will then explain and build on their responses. This is important for this particular study as these responses will add significance and depth to the data obtained. It may lead the discussion into areas that were not previously considered but are significant for understanding and will help address the research question and objectives.

Due to the diverse nature of the topic, respondents are likely to agree to be interviewed, rather than complete a questionnaire. The interview will provide these healthcare stakeholders with an opportunity to reflect on events without the interviewee needing to write anything down. The interview will also provide the opportunity for interviewees to receive feedback and personal assurance about the way in which the information will be used.

The interview method of primary data collection will undoubtedly be the most advantageous for the study as the questions to be answered are complex and open ended and where the order and logic of the questions may need to be varied.

3.4.2.1 Sampling

Input and opinions from South African healthcare stakeholders will be sought and analysed in light of the strategic analysis. Much folklore surrounds the question of sample size. In a study conducted, a sample of more than two million voters failed to predict correctly a presidential election. Sample size is only one aspect of representativeness. A sample of more than two million can be misleading while a sample of 1000 drawn in a proper manner can be more than adequate (Cooper, 1988). The sample size for the study is thirty three ($n = 33$) (Appendix One). The sample size chosen was shaped by the work limitation on the study and the timeframe. This point is taken up under limitations in chapter seven. The study sample does however, provide for an equal representation of the public and private healthcare sectors in South Africa:

- 13 key gate keepers in South African healthcare (seven public and six private healthcare sector management and healthcare workers).
- 10 public service patients at a local provincial hospital along the North Coast.
- 10 private healthcare patients at a private healthcare facility along the North Coast.

The thirteen key gate keepers were chosen to identify the issues facing the Department of Health, stimulate strategic thinking and help develop responses to the challenges facing the Department (Appendix Two). This could be seen as a purposive sampling sample as put forward by Welman and Kruger, 1999.

The twenty public and private patients chosen for the study were asked to reflect on how these issues and challenges facing the Department have affected them on a personal level and as clients of the Department (Appendix Three). Convenience sampling will be the sampling technique of choice for these patients. Researchers who adopt convenience

sampling have the freedom to choose whomever they find. The choice of sample is likely to have biased the sample, meaning that subsequent generalisations are likely to be at best flawed (Cooper, 1998; Saunders et al, 2003). While a convenience sample has no controls to ensure precision, it is a useful procedure for the study to be conducted. The problems experienced using this technique in the study is less important as there is less variation in the population chosen and the general South African population.

3.5 Data analysis

A strategic management assessment of the Department of Health will be undertaken according to the composite model that has been developed in Chapter Five. Primary and secondary data collected during the study will be analysed in light of this assessment.

3.6 Conclusion

The study will adopt a qualitative type approach using the techniques of interviews and a case study. The study entails an overview of South African healthcare and a documentary analysis of the Australian national health system. An academic review of the principles behind strategic planning is presented, out of which a composite strategic model is developed. The strategic model as well as documentary analysis of the Australian national health system will be used to assess the strategic situation of the Department and develop strategic responses to the current challenges. Information will be extracted from published literature, Internet information, journal articles and newspaper clippings. Input and opinion from key decision gatekeepers in South African healthcare and the public and private healthcare sectors will be sought and analysed in light of the strategic assessment.

Chapter Four

The Australian national health system

4.1 Introduction

Almost sixty years ago the World Health Organisation (WHO) described health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO, 1946). Australians are generally healthy and their health and wellbeing is likely to improve. Australians are gaining a better understanding of their own health and how to maintain it. The science and practice of prevention and treatment is continually advancing and most Australians have very good access to health services (Visick, 2005).

4.2 Australia at a glance

- Population of 20 million, including about 460 000 Indigenous Australians.
- Average life expectancy at birth is 80 years.
- Highly urbanised; most people live in south-east seaboard region.
- Unemployment under 6% in early 2004.
- Health expenditure 9.3% of GDP in 2001-02 (www.health.gov.au).

4.3 The Australian health system – an overview

The Australian health system is world-class in both its effectiveness and efficiency - Australia consistently ranks in the best performing group of countries for healthy life expectancy and health expenditure per person (WHO, 2003).

These achievements are largely the result of partnerships between individual Australians and health care professionals. People’s decisions about lifestyle, self-care, and seeking and acting on professional help, and their participation in the development of public policy at many levels, all contribute to shaping the Australian health system (Sheridan, 2005).

The health system is complex, with many types and providers of services and a range of funding and regulatory mechanisms. Those who provide services include medical - practitioners, other health professionals, hospitals and other government and non-governmental agencies. The Australian government, state and territory governments, health insurers, individual Australians and a range of other sources provide funding (www.health.gov.au).

The health system is administered by the Health Insurance Commission ~ (HIC). HIC is a customer-focused service organisation delivering national health programmes to the Australian community and provides reliable, secure and innovative delivery of health claims, payments and information management. HIC processes more than 400 million transactions annually. There are almost 4 500 staff, supporting service through a network of Medicare offices, easy claim facilities in pharmacies and rural transaction centres, national telephone claiming and online services (www.hic.gov.au).

Patients admitted to a public hospital can choose to be treated as public or private patients. Public patients receive treatment from doctors and specialists nominated by the hospital, but are not charged for their care and treatment. Patients treated in a private hospital or as a private patient in a public hospital, can select their treating specialist, but charges then apply for all of the hospital's services (such as accommodation and surgical supplies) (www.health.gov.au).

The aim of the Australian national health system is to give all Australians, regardless of their personal circumstances, access to affordable health care at an affordable cost or at no cost, while allowing choice individuals through substantial private sector involvement in delivery and financing (Sheridan, 2005).

4.4 Australian healthcare statistics

- Total health expenditure for the period 2001-02 was \$66 million.
- Health expenditure per person was \$3 292 for the period 2001-02.
- In 2001, there were 2 322 healthcare workers for every 100 000 Australians
- 52% of Australians with HIV/AIDS were receiving anti-retroviral treatment in 2002.
- In 2002, there were 4 926 approved pharmacies in Australia (1 pharmacy per 4 060 Australians) (www.health.gov.au).

4.5 Funding of health expenditure

4.5.1 Public healthcare

Funding for health services comes from both government and non-government sources. The major levels of government - the Australian government, and the state and territory government - provide funding for health services from their respective revenue sources. Local governments are also involved in the funding of health services (www.health.gov.au).

4.5.2 Private health insurance

All Australians are eligible to receive public hospital treatment at no direct personal cost. Private health insurers provide cover for people who choose to be treated by doctors of their choice in hospitals. They also provide a range of other benefits to insured people (Sheridan, 2005).

4.5.2.1 30% rebate on private health insurance

Many Australians purchase private health insurance, with around 49% of the population covered for hospital and/or ancillary benefits in early 2004. Unlike other countries, such as the United States of America and South Africa, there are virtually no employer-based health insurance schemes in Australia. In response to a significant decline in health insurance membership towards the end of the last century, the Australian government introduced various incentives to encourage uptake and retention of private health insurance—notably a 30% rebate on membership fees (Sheridan, 2005).

Families and individuals that pay private health insurance premiums are eligible for the Federal Government 30% Rebate. The rebate is not means tested. It does not matter how much an Australian earns or the level of their family income. If the individual has hospital and/or ancillary private health insurance with a registered health fund, he/she can claim the Federal Government 30% Rebate. This incentive supports people's choices to take up and retain private health insurance (www.hic.gov.au).

4.5.2.2 Medicare

Medicare, Australia's universal health insurance scheme, came into operation in 1984. Administered by the Health Insurance Commission (HIC), the scheme provides free or subsidised treatment by medical practitioners, participating optometrists and for certain services provided by other health professionals. All Australian residents are eligible for Medicare (www.health.gov.au).

The term Medicare is also often used to refer to arrangements whereby people can access free public hospital outpatient and emergency department treatment, and admitted patient care as public (Medicare) patients in hospitals. These arrangements are agreed by the Australian Government and the state and territory governments under the Australian Health Care Agreements. Under them, doctors appointed by the hospitals provide medical care for public patients (at no cost to the patient). Patients who choose to be treated as private patients in public or private hospitals are liable for hospital accommodation and other charges, and for medical fees charged by private practitioners. Private health insurance can be purchased to cover these private hospitalisation costs (www.hic.gov.au).

4.5.2.3 The Pharmaceutical Benefits Scheme

Through the Pharmaceutical Benefits Scheme (PBS), the Australian Government makes a range of necessary prescription medicines available at affordable prices to all Australian's and those overseas visitors eligible under Australia's reciprocal healthcare agreements (Visick, 2005).

Under the scheme, HIC makes payments to pharmacists to subsidise medicines on the Pharmaceutical Benefits Schedule. HIC also makes payments to pharmacists for other PBS related issues including payments in support of rural or remote pharmacies. Authority prescription approvals are administered by HIC for prescriptions for which the Pharmaceutical Benefits Advisory Committee limits supply in specified circumstances. HIC administers the approval of pharmacists to supply medicines under the PBS, the approval of health care providers in rural areas where there are no adequate pharmacy services and the approval of hospitals to supply PBS medicines to their patients (www.hic.gov.au).

4.6 Conclusion

The Australian national health system is indeed world-class in both its ‘effectiveness’ and ‘efficiency’. The country ranks in the best performing group of nations for healthy life and healthy expenditure per person.

Health systems do not operate in a vacuum. Trends in the health outcomes of Australian’s, reflect the country’s socio-economic patterns and are linked inextricably with other factors such as opportunities for education and employment.

The success of the Australian national health system lies in the country’s health policy that healthcare is a human right and just not a service. South Africa can learn from this (Visick, 2005).

Chapter Five

Theory of Strategic Planning

5.1 An introduction to modern strategic planning

The purpose of strategic planning is to use a formal planning system for the development and implementation of the strategies related to the mission and objectives of the organisation (Lynch, 2000). The concept of strategic planning has its origins in military thinking, where strategy is the science and art of planning and directing large-scale operations, of manoeuvring forces into the most advantageous position prior to engaging the enemy and is designed to bring overwhelming force to bear upon the enemy (Clarke, 2004). In the business world, strategy aims to develop a so called sustainable competitive advantage and must answer these questions:

- | | |
|--|-----------------------|
| • What future do we want for our organisation? | Vision |
| • Where is our organisation now? | Analysis |
| • How do we achieve this potential future? | Synthesis |
| • How do we put our plans into action? | Implementation |

Importantly, strategic planning is no substitute for strategic thinking; it merely formalises the strategy process in the organisation. More specifically, the plan will integrate the activities of the organisation and specify the timetable for the completion of each stage (Lynch, 2000).

Strategic planning remains an art form that needs to be practised repeatedly. Whilst strategic planning as a concept has become firmly entrenched, the approach to or the philosophy behind the process has undergone marked evolution.

5.2 The basic approaches to strategic planning

In the past, there have been three basic approaches to strategic planning in organisations:

- Top down. Planning is initiated and conducted primarily by the centre of the organisation.
- Bottom up. Planning is the responsibility of the individual parts such as divisions. Simple guidance is given by the centre as to what is required. The centre then sits in judgement on the plans provided.
- Integrated. There is continuing discussion involving both the centre (top) and the individual parts (bottom) of the organisation (Lynch, 2000).

In the 1990's, many organisations chose the Integrated approach. However, where the diversity of the company was large, there was a clear argument for the Bottom-up approach (Lynch, 2000).

In undertaking the strategic planning process, many organisations believe that it is important to establish first the background assumptions and the basis on which business is conducted, including key factors for success. Following this, the organisation will then explore its long-term vision and broad strategic direction: these might be only achieved over a number of years and would be expected to include the input of new technologies and ideas. A medium-term plan can then be developed for the next two or three years, where the environment is sufficiently stable. Short-term annual plans and budgets consistent with the medium term are then developed. It is important to see this process as not just happening in sequence but involving much iteration and revisiting before each stage is finalised (Lynch, 2000).

Sometimes such a cycle is repeated by the organisation every year. However, because of the potential complexity and length of such investigations, it would be most unusual if every aspect of the business was reviewed every year from a long-term perspective. Product groups, special topics, core competencies are often chosen as starting points for exploring strategic issues and fed into the long-term review (Lynch, 2000).

5.3 The changing status of strategic planning

The approach to strategic planning adopted by a particular organisation today will depend on the historical situation, the culture of the organisation, the nature of the organisation's leadership, the complexity of the environment and the expertise and philosophy of the planners. The nature of the participants in the strategic planning process may significantly affect the approach to strategic planning. Detailed-orientated people may prefer a linear, top-down, general-to-specific approach to planning, whereas artistic and highly reflective people may favour a divergent organic approach to planning. The goals-based approach focuses on the organisation's mission. It identifies goals and devises strategies to achieve these goals and then allocates tasks based on these objectives. The resource-based approach focuses on the internal aspects of the organisation and attempts to ensure alignment between an organisation's capabilities and its strategy. Issues-based strategic planning often starts by examining issues facing the organisation, strategies to address those issues, and action plans (Clarke, 2004).

Although an organisation's approach to the strategic planning process will depend on numerous specific factors in the environment and the organisation, it is possible to sketch the broad outlines of the process.

5.4 The process of strategic planning: an outline

It is possible to develop an eclectic strategy model representative of the foremost thought in the strategic management area because of the similarity among the general models of the strategic management process. The strategic planning process should begin by identifying the organisation's vision and mission. The situational analysis follows this and looks at the external environment to identify threats and opportunities. The process then has an inward focus and assesses the organisation's resources and capabilities. This facilitates a strategic response that matches the response with organisational capabilities. From the overall strategic plan will be derived the smaller strategic goals with action plans and tactics. The organisation will need to periodically re-evaluate its strategy and tactic in light of ongoing environmental changes. This may result in the adoption of emergent strategies. The ultimate goal of strategic planning processes is to create a

paradigm shift in the organisation, which institutionalises the strategic approach throughout the organisation. The following guideline proposes a template for an organisation embarking on the strategic planning process (Clarke, 2004; Pearce and Robinson, 2003).

5.5 Vision and mission

Identification of the organisation's vision and mission is the first step of any strategic planning process. Whether an organisation is developing a new business or reformulating direction for an ongoing business, it must determine the basic goals and philosophies that will shape its strategic posture. This fundamental purpose that sets an organisation apart from other organisations of its type and identifies the scope of its operations in product, service and market terms is defined as the company mission. The company mission is a broadly framed but enduring statement of the organisation's intent. It embodies the business philosophy of the organisation's strategic decision makers, implies the image the organisation seeks to project, reflects the organisation's self-concept and indicates the organisation's principle product or service areas and the primary customer needs the organisation will attempt to satisfy (Lynch, 2000; Pearce and Robinson, 2003).

Whereas the mission statement expresses an answer to the question 'what business are we in?' a company vision statement identifies a potential future more 'ideal' state that the organisation aims to achieve. A vision statement presents the organisation's strategic intent that focuses the energies and resources of the organisation on achieving a desirable future. The vision essentially is 'where we want to get to' while the mission is 'what we do' (Clarke, 2004; Pearce and Robinson, 2003).

Understanding one's mission is the essence of effective strategy. An effective mission statement must give people a clear, compelling, and motivating reason for the organisation's existence (Pearce and Robinson, 2003). An excellent example is the mission statement of the International Red Cross, which reads 'to serve the most vulnerable'. The vision and mission must be based on an organisation's core values and core competencies. A core value is something on which the organisation will not

compromise even if it incurs penalties for this. In the Department of Health, core values would include ethical treatment of patients without regard to race, creed, culture or ability to pay (Clarke, 2004).

5.6 Situational analysis

Once the vision and mission are clearly identified, the organisation must analyse its external and internal environment. The environmental scan identifies factors in the external environment (economic, social, demographic, political, legal, technological and international factors), and highlights internal strengths and weaknesses that will impact on the organisation's functioning. Measuring and comparing an organisation's performance against the practices and performance of another organisation, which is regarded as being the industry leader quantifies the gap between the present reality and the future strategic objectives. This process is referred to as benchmarking. An ongoing benchmarking process will establish a reference point for the setting of realistic targets. A variety of models have evolved which help the planning process by providing a framework to analyse the information generated by the external and internal analyses (Clarke, 2004).

5.7 Strategic models

The strategic planning process may generate a vast quantity of data. Raw data may be overwhelming and is simple noise. A strategic model is a tool to assist with the understanding and interpretation of events in the environment. A good model will convert this noise to information which can be acted upon (Clarke, 2004; Pearce and Robinson, 2003).

Many of the available strategic models are generic and apply to many diverse organisations. Each strategist should try and understand the organisation or industry he/she is analysing and adapt the generic models to produce unique models for the industry under scrutiny.

5.8 SWOT

As a starting point for the development of strategic options, Professor Kenneth Andrews first identified the importance of connecting the organisation's mission and objectives with its strategic options and subsequent activities. 'The interdependence of purposes, policies, and organised action is crucial to the particularity of an individual strategy and its opportunity to identify competitive advantage.' He went on to argue persuasively that the rational analysis of the possibilities open to organisations was an essential part of strategy development (Lynch, 2000). A SWOT analysis of the organisation - its Strengths, Weaknesses, Opportunities and Threats - is a useful way of summarising the current status of the organisation. From SWOT, the strategist is able to identify an organisation's unique competencies and generate a strategy with good alignment between the external forces and internal resources (Ambrosini, 1998).

Figure 5.1 illustrates how SWOT aids strategic analysis. Key external opportunities and threats are systematically compared with internal resources and competencies - that is, strengths and weaknesses - in a structured approach. The objective is one of four distinct patterns in the match between the organisation's internal resources and external situation. Cell 1 is the most favourable situation; the organisation faces several environmental opportunities and has numerous strengths that encourage pursuit of those opportunities. This situation suggests growth-orientated strategies to exploit the favourable match. Cell 4 is the least favourable situation, with the organisation facing major environmental threats from a weak resource position. The situation clearly calls for strategies that reduce or redirect involvement in the products, services or markets examined by means of SWOT analysis. In Cell 2, an organisation faces an unfavourable environment despite numerous internal strengths. In this situation, strategies would seek to redeploy those strong resources and competencies to build long-term opportunities in more opportunistic product or service markets. An organisation in Cell 3 faces impressive market opportunity but is constrained by weak internal resources. The focus of strategy for such an organisation is eliminating the internal weaknesses as to more effectively pursue the market opportunity (Pearce and Robinson, 2003).

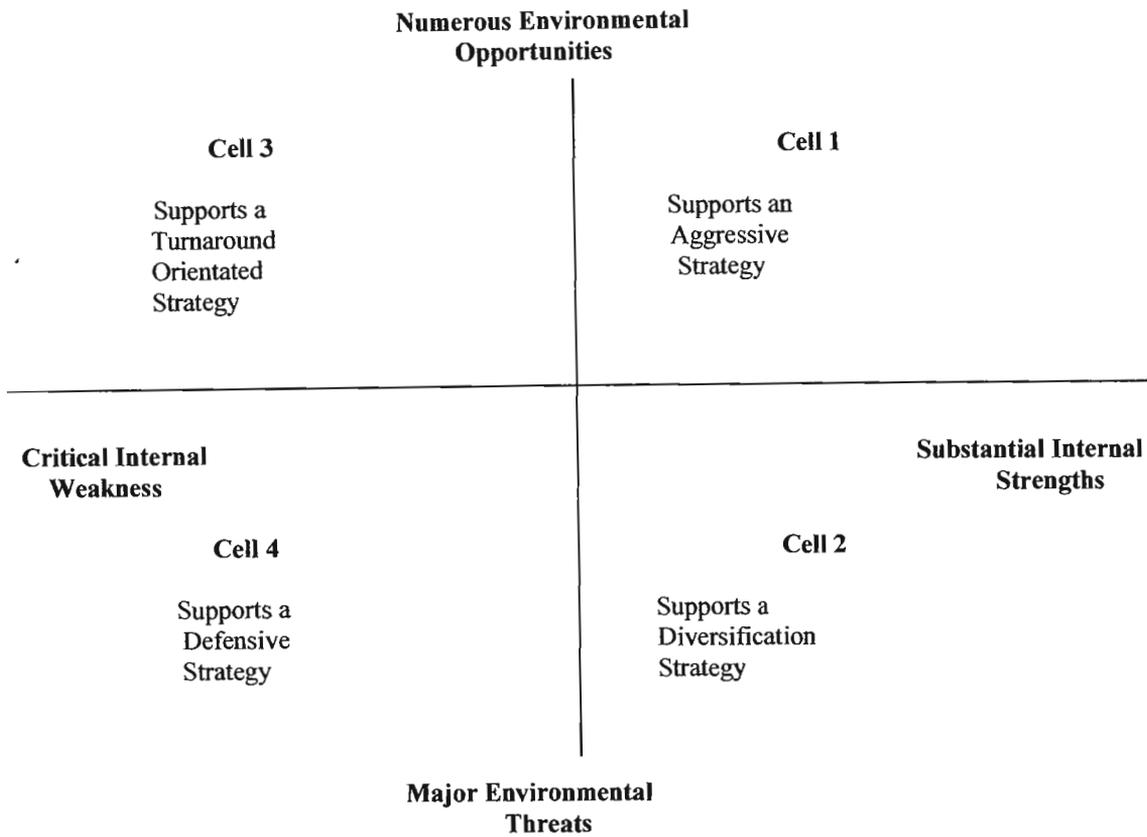


Figure 5.1: SWOT Analysis (Source: Bensoussan, 2003)

5.9 Strategic drift and gap analysis

Strategic drift or gap analysis (Figure 5.2) is the difference between expected outcome and actual outcome. Final outcome is a result of four factors, namely the environment over which we have very little control, the plan itself, the organisational leadership and the organisational culture. Leadership and culture are closely related to organisational structure and organisational power. The model is presented in this thesis to help identify the reason for the strategic gap by focusing on four possible sources of drift namely the planning process itself, the changing environment or inherent organisational problems such as structure, culture and leadership. Strategic drift is experienced due to unexpected environmental developments or due to unexpected resilience on the part of competitors.

If this is the situation, the ongoing strategic process needs to detect this and suggest steps to deal with this new environmental threat or opportunity. Unfortunately very often it is an imbalance in the three controllable factors that leads to this drift. If strategic drift is a result of one of these factors, then the solution must be an internal one and this may be extremely difficult to achieve. The gap analysis can be used during analysis and the implementation phases (Clarke, 2004).

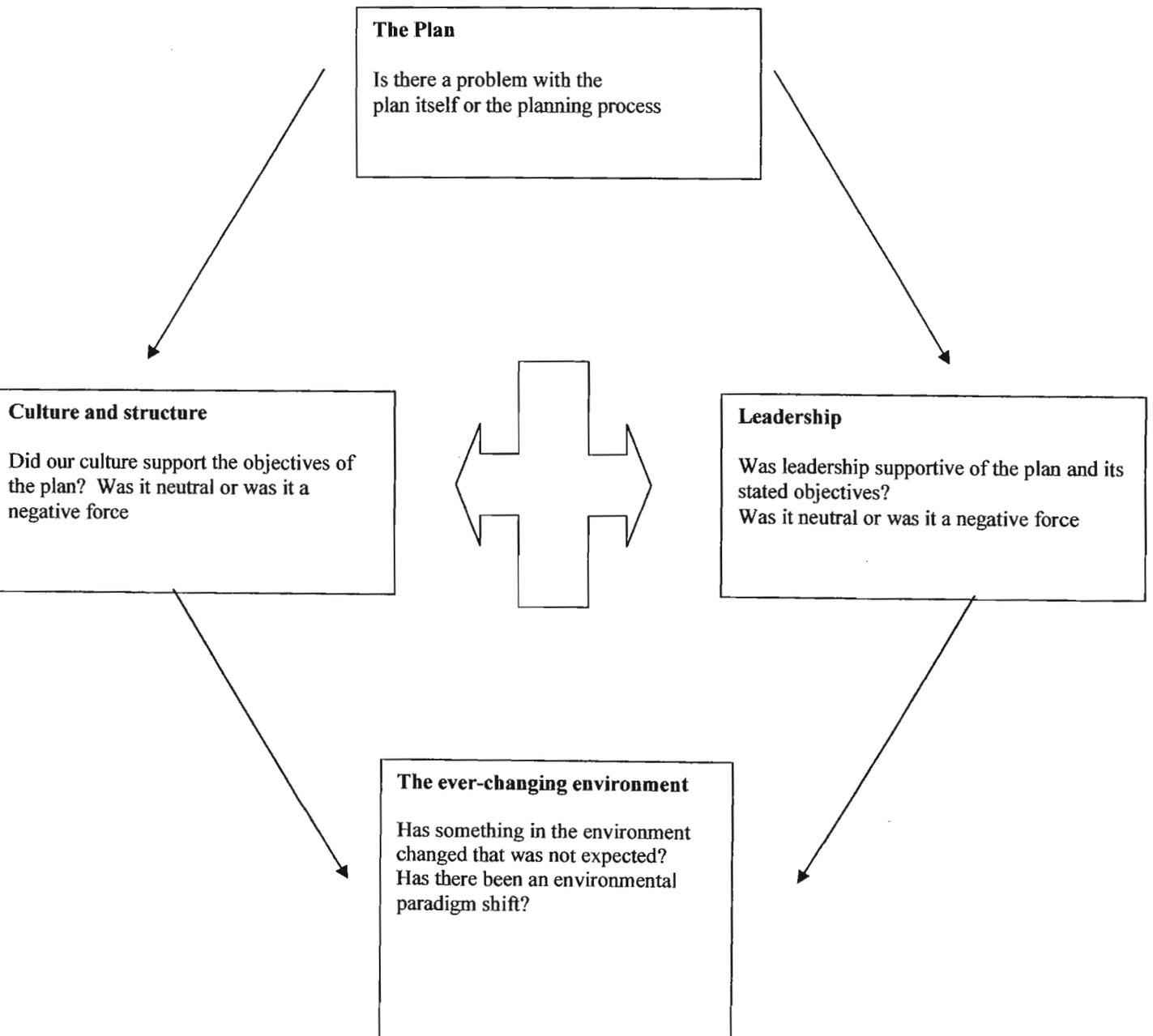


Figure 5.2 Strategic Drift/Gap Model (The Imbalance) (Source: Clarke, 2004)

5.10 Branding of an organisation

The issues surrounding brand development and support have become important in business. A brand is a collection of images and feelings, which a customer has when they think about a product and is regarded as part of the intellectual capital of an organisation. A strong and healthy brand is a barrier to entry and ignoring the issue of branding may allow new entrants such to penetrate a market-place (Pearce and Robinson, 2003). Once the models have been applied, the analytic process ends and the process must now turn to synthesis by drawing up a list of objectives and proposed strategic tactics to achieve these objectives (Clarke, 2004).

5.11 Strategic objectives and tactics

Objectives are practical real world goals, which are distilled from the above process. Strategic goals must be specific, measurable, realistic and achievable within budgetary and time constraints. Once the planners have decided on the strategic objectives, they must turn their attention to drawing up action plans and devising tactics. An action plan attempts to define how we get to where we want to go and the steps required to reach the strategic goals. Tactics are specific actions used to achieve the strategic goals and implement the strategic plans. These tactics must then be implemented with constant monitoring to ensure effectiveness (Clarke 2004; Lynch, 2000).

5.12 Evaluation and review of the strategy

Periodic evaluation of strategy, tactics and action programmes on at least an annual basis is essential. The organisation should measure current performance against previously set expectations, and consider any changes or events that may have impacted the desired course of actions. Unexpected events and situations arise which will demand a response. The plan may need to be revised in light of these unexpected events (Lynch, 2000).

5.13 Organisational culture

Organisational culture is the set of important assumptions (often unstated) that members of an organisation share in common. Every organisation has its own culture. An organisation's culture is similar to an individual's personality; an intangible yet ever present theme that provides meaning, direction, and the basis for action. In much the same way as personality influences the behaviour of an individual, the shared assumptions (beliefs and values) among an organisation's members influence and opinions and actions within that organisation (Pearce and Robinson, 2003). Organisational culture may forge unity of purpose and allow the individual to submerge himself/herself in the greater cause. However entrenched culture may be an obstacle to progress, especially if the paradigm in which the organisation operates were to change (Clarke, 2004).

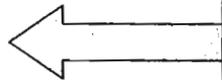
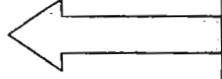
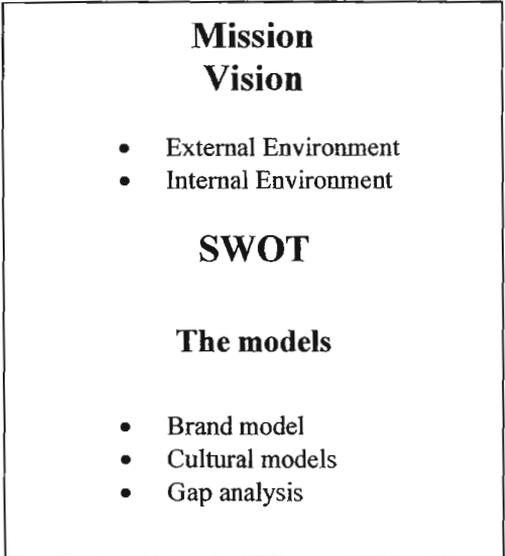
5.14 Strategic planning in the not-for-profit organisation

The previous review of the strategic planning process is predominately associated with traditional for profit organisations. However, there are numerous organisations throughout the world whose mission is not to make profit, but rather to provide a service to society. Not-for-profit-organisations have increasingly had to respond to new and emerging challenges. Differences in the strategic planning process are usually more a matter of the size of the organisation than it is for profit/non-profit status. Small not-for-profit and small for-profit organisations tend to conduct somewhat similar planning processes. On the other hand, large not-for-profit and large-for profit organisations tend to conduct somewhat similar planning activities that are different from those conducted in small organisations. However, the focus of the planning activities is often different between for-profits and nonprofits. Not-for-profit organisations tend to focus on development, fundraising and volunteer management whereas for-profit organisations focus on activities that maximise profit (Clarke, 2004).

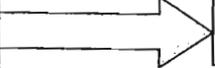
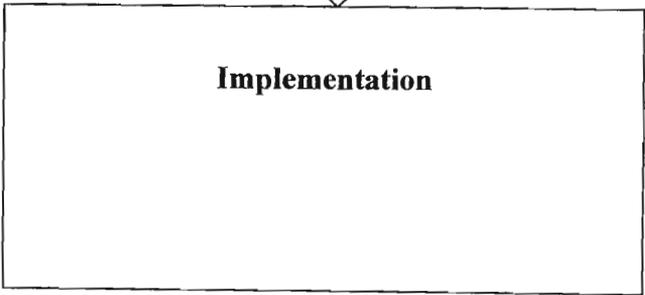
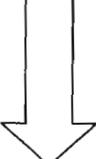
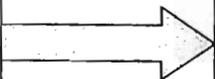
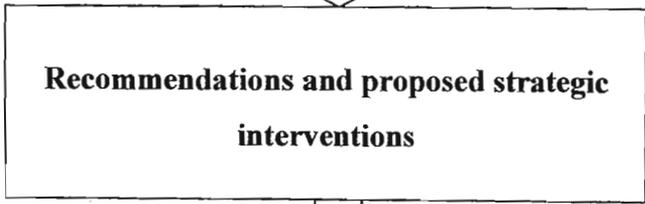
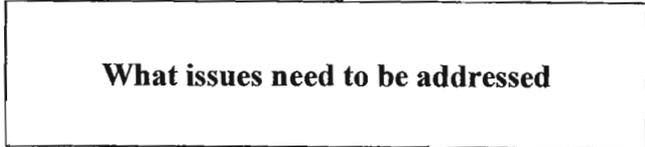
5.15 A composite model

Figure 5.3 attempts to incorporate all the above planning issues into a single composite model that is applicable for the strategic assessment of the Department of Health. The composite model of strategic planning is circular with ongoing feedback and consists of three phases namely analysis, synthesis and implementation. Analysis begins by elucidating the organisational mission and vision. The mission will identify customers, core competencies and core values, the vision will set the long term strategic objective. The analysis continues by examining the external and internal milieu of the organisation and distilling this information into a SWOT diagram. The strategic models are now applied as strategic planning tools. These include the state of the organisation's brand, cultural mapping and gap analysis. The gap analysis attempts to identify the reasons for the gap between the organisation's current reality and its potential future. Strategic synthesis follows once the process of analysis has been completed. The process involves the formal enunciating of all the strategic issues faced by the organisation followed by formal recommendations designed to address each of these issues. These objectives and action plans must have inbuilt evaluation systems and this is where the gap analysis model is invaluable as it provides the metrics which are directly relevant to the chosen strategies.

Analysis



Synthesis



Evaluation

Figure 5.3 The composite model (Source: Clarke, 2004)

Chapter Six

Research data and an assessment of the Department of Health

6.1 Introduction

The promotion of equity in health is one of the basic ideologies underlying South African health policy. Therefore, it is befitting after 11 years of democracy to gauge how far the country's healthcare system has moved towards providing equitable services to all citizens is concerned.

The aim of analysing the Department of Health is to assess whether or not the Department is 'performing' to an 'acceptable' standard and the requirements needed to improve the nation's health status. The following research data and strategic tools will be used to measure and assess the healthcare and wellbeing of South Africans:

6.2 The Mission and Vision statements – Department of Health

These statements are a useful starting point to this study. As a theoretical piece, these statements position the Department of Health firmly in the new South Africa whilst at the same time committing itself to maintaining healthcare excellence. In reality, these statements are being restricted to fine sentiments in the government gazettes and on posters decorating health facilities.

6.2.1 Research findings on the Department of Health

Thirty three (n = 33) stakeholders in South African healthcare were interviewed (February – August 2005) for the study. All respondents (n = 33) perceived healthcare to be in a state of crisis and felt that it was imperative for government and the private healthcare sector to meet the healthcare challenges facing the country as soon as possible.

6.2.1.1 Tension between the Department and healthcare stakeholders

The ongoing source of tension between the Department and stakeholders (private sector) tends to limit the degree of team work in the country. Collaboration and co-operation is almost existent. The recent court battle is the obvious source of discontent.

- **Arguments by independent pharmacists**

A report, which formed part of the application brought before the High Court, found that the proposed dispensing fee by the Department would not cover pharmacies operating costs and the regulations would lead to closure of many pharmacies. This would then increase unemployment in the pharmacy industry. In June 2004, South Africa had 3 988 registered pharmacies, about 11 130 registered pharmacists and about 40 000 persons employed directly in the retail pharmacy industry. Pharmacists argued that unemployment in the industry would result in a large number of similarly qualified pharmacy employees searching for employment in an increasingly shrinking industry. Chances of getting re-employed would be slim and this would not augur well for the economy (Cawood, 2005).

The most devastating effects would be on patients. As non-viable pharmacies are forced to close down, a related effect would be a reduction in the availability of, and access to, pharmaceutical products. The effect on rural areas would be especially dramatic, and patients who are in dire need of dispensed medicines would be forced to go without, or to travel considerable distances to find medication they need. This would then place an increased demand on the already strained state facilities in such areas. The consequences for patients who are vitally dependent on the delivery of these medicines by courier pharmacies would be obvious (Naidoo, R. 2004).

- **Arguments by dispensing doctors**

Government's controversial licensing regulations would hurt the very people that they were trying to protect – the poor. For example, among the private patients were domestic helpers and gardeners who were charged reduced fees because doctors could buy cheaper drugs for them. Dispensing doctors would receive drug samples from pharmaceutical companies and hand them to these patients at no cost. When samples were outlawed, medication was bought near the expiry date, as they were cheaper. Consumers were therefore not paying as little for their drugs as promised by government.

Some of these previous dispensing doctors, who are no longer allowed to dispense, are now seeking greener pastures abroad. Private practise is just not viable for these independent medical practitioners (Mudaly, 2004).

6.2.1.2 Health workers

Health personnel cite low levels of job satisfaction, poor working conditions, despondency in the face of the HIV/AIDS epidemic and unsatisfactory management, as well as inadequate salaries, as underlying their dissatisfaction with working in the public sector (Naidoo, S. 2005).

Dr. Ernesto Hernandez, a medical manager at Umpumulo Hospital, described the lack of accommodation and equipment in rural public health institutions as a 'crisis' which needed urgent attention. Health workers were using toilet taps to wash dishes and that some workers were even sharing rooms because of the shortage. Dr. Hernandez said that workers were even using candles because the accommodation they were given did not have electricity.

In an interview with a hospital nurse (name withheld) at King Edward VIII Hospital, there are still more than 200 vacancies for nurses at the hospital and very little possibility of these posts being filled. According to Andy Gray (Health Systems Trust), 40% (n = 103 908) of registered nurses were working in the public sector in 2004. This implies that 62345 (60%) work in the private sector or other.

6.2.1.3 Challenges facing public healthcare patients

Ten (n = 10) public sector patients at a provincial hospital along the North Coast, KwaZulu-Natal were interviewed during the course of the study. Excerpts relating to the current concerns among the public patients interviewed are as follows:

- I am a diabetic. I need medication to control my health. Most of the time the hospital is short of my medication. I am forced to buy medication from local pharmacies which are expensive.
- We have poor healthcare in state hospitals. Look what happened to the infant deaths at Ghandi Hospital. It is frightening. But as usual, nothing will be done.
- I am here with my sick child who is dying of Aids. The doctors cannot keep him at the hospital because there are no beds. They can do nothing to help me.
- I have arthritis (bone inflammation). I am only given two weeks supply of medication at a time because I'm told the medication is so expensive. My next appointment at the hospital is next month. I do not know what to do.
- Waiting for treatment and medication at this hospital is long and tiring. I get to the hospital at 4 o' clock in the morning. I usually see the doctor at 10 o'clock and I collect my medication in the afternoon. I am lucky to leave every month before 2 o' clock.
- Treatment in all state hospitals is bad. Nurses and doctors treat us as if we are numbers – go here go there. We are given no respect because we are poor.
- The hospital is always short of my medication. I have to come on another day to collect the medication not given to me. On my grant money, I am finding it very hard.
- I stay 100 km from the hospital. We have no clinics in our area. Our government is not helping us. People in my area are dying of Aids and they cannot come here for medication because it is too far.
- I am 75 years old. I wait in the queue for sometimes 8 hours for my monthly treatment. The doctors should help us first.

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- My friends are dying of Aids. The government is not giving the Aids medication to get better. Because they cannot work, their children are hungry and they get sick often.

6.2.1.4 Challenges facing private healthcare patients

Ten private healthcare patients (n = 10) from a retail pharmacy in Ballito, KwaZulu-Natal were interviewed during the course of the study. 60% (n = 10) of the patients were on medical aid whilst 40% (n = 10) were private funders. Those with medical aid paid an average of R4 000 per month as a medical aid contribution. Excerpts from the private patient interviews are as follows:

- We are not paying as little for medication as promised by the government. Pharmaceutical companies are prohibited from giving any discounts even for bulk purchases. My pharmacist bought in bulk and I used to get the benefit of economies of scale from him. I now pay more.
- I am a cancer patient. I pay roughly R2 000 per month on my medication. My pharmacist no longer stocks my medication as his operational costs for my medication exceeds the R29.00 he is receiving on it. I do not blame him. I'm now forced to go to Durban to purchase my medication – more expenses for me.
- All I know is that I pay levies and levies when I go to collect my chronic medication. The Minister of Health is to take full responsibility of this health crisis. With most pharmacies closing, does she suggest we go to pharmacies at state hospitals? That is ridiculous. These pharmacies are already overcrowded, under-stocked and understaffed. Additional pressure of new patients, who would normally get their medication from the private sector, would only bring further chaos.
- The spiralling cost of medical aid has forced me to limit my health coverage. I pay for my day to day medication. I have a hospital plan only. I pay R1 000 per month for my wife and I. We still have to pay a portion of the hospital expenses as well. We are pensioners. We are struggling.

- I am a pensioner. I am fortunate to have medical aid. The administration fee of R18.00 per item is ridiculous. I take 5 chronic medications – R90.00. My medical aid does not pay the administration fee that is being charged, leaving me to foot the bill. I am left with nothing at the end of the month. I pity the poor pharmacists though, it is not their fault.
- Previously, my doctor offered a consult and medication at an affordable price. With doctors no longer allowed to dispense, our government is hurting us. I now pay for the doctors consult as well as the visit to the pharmacy.
- Medical aid coverage for my wife, two children and I is R4 000 per month. My take home pay is R5 000. In addition, I have to pay administration fees to pharmacies. Something has to be done.
- I am a pensioner and I have high blood pressure. My pharmacist used to check my pressure for free. Since these new regulations, my pharmacist charges for this service as well as for medication deliveries. This was convenient for me as I do not have transport.
- My medical aid scheme works on formulary based medication (generics). I pay R2 000 a month as my contribution. I still cannot get certain medication on my medical aid. My funds are normally exhausted by July every year. I wonder sometimes whether I should cancel my medical aid and keep my contribution in a savings scheme.
- I am definitely affected by this new law. My medication costs R600.00 cash a month. It's no use telling me to go to a provincial hospital, because of my back problems. You sit for hours and then they haven't got the medication. I used to get 30% discount for cash. I no longer get it. Now 30% of R600.00 is R180.00, it is a lot of money. The laws are not helping us cash customers.

The mission and vision of the Department of Health is achievable if the stakeholders take ownership of it. The Department needs to accept that their present situation is less than ideal and that they need to develop a strategic plan to achieve these objectives. Quality healthcare is within South Africa's grasp. Getting there is the challenge (Gray, 2005).

6.3 Unique resources and core competencies

South Africa's private healthcare sector has emerged as the 4th best in the world in terms of quality, cost, efficiency and access, according to a global survey commissioned by Discovery Health. The private sector also boasts a number of world firsts, which include the 1995 benchmark heart/lung transplant and bilateral sequential lung transplant in 2002 (Venter, 2005).

Despite pressing issues, the Department of Health tries to achieve equity and efficiency through its unified healthcare policies. Bearing in mind that the public sector is funded through general taxation and without large private sector support, more than 500 new clinics stand in areas where formally people used to walk several hours for treatment. The Department, together with national rail carrier, Transnet, also operates a healthcare train (the Phelophepa Train) that brings affordable healthcare to many rural communities (Bassett, 2003).

6.4 Analysis of the South African healthcare environment

Fleisher and Bensoussan (2003) clearly set out that the 'starting point of any analysis is some form of environmental analysis'. The remote environment comprises factors that originate beyond, and usually irrespective of the Department's operating situation and political, economic, social and technological factors. The following PEST analysis will present the Department of Health with opportunities, threats as well as constraints.

6.4.1 External environment

6.4.1.1 PEST analysis

- **Political**

Healthcare professionals have become subject to increasing government control over the past decade. The poor working conditions in the Department of Health and the recent private healthcare regulations have forced some health professionals to seek greener pastures abroad. The Department of Health has attempted to stem the haemorrhage of health professionals to places like the United Kingdom by attempting to turn off the tap at the point of exit. This approach has involved getting the health authorities in the United

Kingdom to agree not to recruit South African's. These approaches have generally been ineffective and are probably counter-productive. The need in Britain for health professionals being so great and the British pound being so strong in comparison to the South African Rand mean that these attempts to keep health professionals in South Africa are unlikely to meet with success. A more creative approach by the Department has been proposed whereby health professionals will be allowed sabbaticals where they will be allowed to travel overseas for work purposes and still retain their pension and staff benefits in South Africa. The Department of Health has shown signs of adopting a more positive approach to health professionals of late, however, there still remains that distrust between the two groups.

- **Economic**

The Department is responsible for 80% of the population and there is general concern that despite the funding available, and even with an increasing budget allocation, the Department will not be able to keep up with the rising cost of healthcare, especially on sophisticated treatment (Cawood, 2005).

An opportunity has been created as some medical aids are insisting on their members seeking treatment in government hospitals (Naidoo, SN. 2005). Over the past decade, the cost of medical cover has put ever-increasing pressure on the individuals' disposable income. Where members spent 2% of their pay on medical cover 10 years ago, they now spend a whopping 20%. With medical scheme increases of 9-18%, more haemorrhaging can be expected in the future forcing many private medical insurance patients to opt out (Pillay, 2005).

If these private patients could be adequately provided for in the public hospitals, it could be a useful means of supplementing both public hospital and staff income and well as reducing medical aid premiums. This process needs to be well managed. It is unlikely that busy hospital staff will be prepared to take on the extra load of medical aid patients unless they perceive a reward for their efforts.

- **Social**

HIV/AIDS is impacting on all aspects of healthcare around the world. The advent of this disease is both a challenge and an opportunity. It is a human tragedy of the first order that South Africa is obviously committed to fighting and the disease will consume resources and attract resources away from other avenues of healthcare, especially in the public healthcare sector. Studies estimate that 24.5% of the population is infected with the virus (Reddy, 2005). However, it may be an opportunity for the private healthcare sector to demonstrate their relevance to the Department of Health. A partnership can be established to resolve the healthcare problems by maximising the usage of all available healthcare providers and facilities (Cawood, 2005). Studies reveal that additional infrastructure factors that can have an impact on health differ from 3% in peri-urban to 43% in rural areas (Health Systems Trust, 2004). Fifty two percent of Australians with HIV/AIDS were receiving anti-retroviral treatment in 2002. The Department of Health and the private healthcare sector must position themselves to meet these similar obligations.

- **Technological/Innovative**

To avoid obsolescence and promote innovation, the Department of Health must be aware of global advances that might influence the healthcare industry. Creative adaptations to national health models in Australia and other countries can suggest new possibilities for improvements in South African healthcare.

The Australian health system is widely regarded by the World Health Organisation (WHO) as being world class, in terms of its effectiveness and efficiency. The system is a mixture of public and private sector health service providers and a range of funding and regulatory mechanisms. The aim of the Australian national health system is to give all Australians, regardless of their personal circumstances, access to affordable health care at an affordable cost or at no cost, while allowing choice individuals through substantial private sector involvement in delivery and financing (www.health.gov.au).

6.4.1.2 Opportunities and Threats

Opportunities

- The Department of Health and the private sector further entrenching their partnership to resolve the healthcare problems in the country by using the available healthcare facilities and providers.
- Adapting the Australian National Health System to local conditions.
- Sharpen the primary healthcare skills of medical practitioners in the private sector, encouraging them to work a sessional basis in the public sector, especially in rural areas.
- Improving skills development by allowing professionals to work abroad.
- Targeting the youth of South Africa that are not adhering to a healthy lifestyle.

Threats

- Unemployment in South Africa – patients neglect health for basic food necessities.
- Exponential growth of HIV/AIDS in the country.
- Emigration of healthcare workers – seeking greener pastures abroad – further limits the number of healthcare providers in South Africa.
- Future medical aid hikes is likely to force middle income earners to opt out of private medical cover.
- South Africa's targeting of the public healthcare sector must not be at the risk of alienating the government's feasible private healthcare sector.

6.4.2 Internal environment

The next step in the strategic assessment process is the analysis of the internal resources and capabilities of the Department of Health as well as the private healthcare sector.

6.4.2.1 Human resources

One of the greatest source of a unique distinctive capability in South African healthcare is its' human resource. The United States of America and Britain have a perennial human resource shortage and regularly recruits healthcare professionals from South Africa. Figures from 2001 show that as many as 25 000 South African healthcare professionals work abroad (Blaine, 2004). There is approximately 137 000 medical doctors, pharmacists and nurses (Private – 95 000, Public – 42 000) in the country at present.

The reasons for the shortage of healthcare professionals in the Department of Health are diverse but the poor working conditions and the absence of a comprehensive human resource plan have a part to play. According to the 2003/2004 South African Health Review, 31% of public health posts were vacant in the country. The recent private healthcare regulations promulgated by the Department of Health have influenced private healthcare professionals to seek greener pastures in the USA and Britain (Gray, 2005).

The Department of Health has to defuse some of these grievances to meet the healthcare challenges of the future. The human resource issue may well present the greatest challenge, given that a strong health system requires the continued presence of a skilled human resource base (Naidoo, S. 2005).

6.4.2.2 Healthcare facilities

South Africa's private sector has emerged as the fourth best in the world in terms of quality, cost, efficiency and access, according to a global survey (Venter, 2005). In the public sector, standards vary according to location. Large, urban hospitals offer good, if clogged-up service. Despite a massive building programme, many rural facilities are run-down, with broken equipment, two patients per bed, long waiting queues and a shortage of medication. Ambulances are worn out (Hernandez, 2005; Tselane, 2005).

In June 2004, the private healthcare sector had 3 988 retail pharmacies registered with the South African Pharmacy Council. As at February 2005, 124 retail outlets have closed as a result of the Department's dispensing regulations (Shevel, 2005a). Retail pharmacists argue that the dispensing fee will not cover their operational costs and many more pharmacies will close in the near future. 'Pharmacists simply need more feet into their pharmacies' (Cawood, 2005). Serving 38 million public patients places a huge burden on the Department's pharmaceutical services. Government needs to implement strategies that will make the private sector still lucrative despite the regulations, while embracing the Department's health policy of ensuring accessibility, high quality healthcare to all.

6.4.2.3 Team-Spirit

Team spirit is a soft resource but one that can be regarded as a non-reproducible capability. The ongoing source of tension between the Department of Health and the private healthcare sector tends to limit the degree of team work in the country. Collaboration and co-operation is almost non-existent. The recent court battle is the obvious source of discontent. Team spirit between is absent and mistrust between the two healthcare sectors dates back many years. This is reflected by the rather patchy attempts to introduce healthcare innovations in the country such as the private healthcare regulations.

6.4.2.4 Strengths and Weaknesses

Strengths

- Internationally recognised healthcare workers.
- Private healthcare sector rated 4th in the world.
- Automated distribution system (private healthcare).
- Strong commitment to Research and Development (HIV/AIDS).

Weaknesses

- Ongoing conflict between government and private healthcare sector – no compromise as yet.
- Government's inability to impact on the exponential growth of HIV/AIDS.
- Government's inability to fill vacant posts in the public sector.
- Poor healthcare infrastructures in rural areas.
- Run down public healthcare facilities.

From the SWOT analysis carried out, the Department of Health and the private healthcare sector will support strategies that are aggressive and have a turnaround orientation. The country presently has numerous environmental opportunities (public/private healthcare sectors working hand in hand) but has substantial critical internal weaknesses (administration, mismanagement of funds).

SOUTH AFRICA

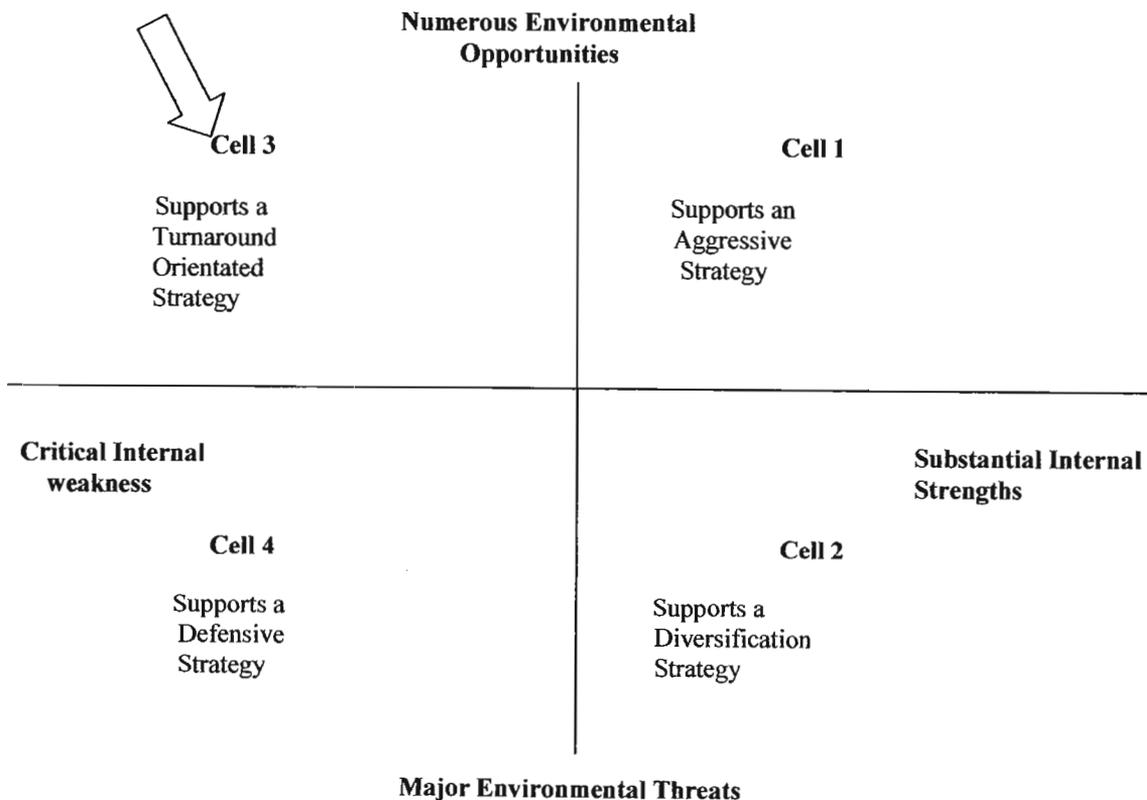


Figure 6.1 : SWOT Analysis – South Africa (Source: Bensoussan, 2003)

6.5 Applying the strategic models

At this point, the strategic models can now be applied to ascertain just how well the Department of Health and the private healthcare sector is faring. These models must be seen as the drivers of strategy.

6.5.1 The Department of Health and its brand

The Department has tended to neglect the issue of branding. South Africa has an excellent record when it comes to human resource. First world countries regularly recruit healthcare professions from the country. The country boasts researchers, especially in the field of HIV/AIDS, who are invited abroad as guest speakers and who contribute to global healthcare. From this aspect the brand is in reasonable shape. However, the pressing issues of working conditions in the Department of Health and the private healthcare regulations promulgated by the Department seems to be discouraging new recruits. If the Department of Health cannot present itself as a professional organisation that is structured, transparent and has formal planning processes, then potential healthcare students may begin to choose other vocations. There has been little formal effort by the Department to market itself to prospective healthcare students. The Department's website offers very little prospectus and is not regularly updated.

The South African public that can afford medical aid, are generally dissatisfied with the service provided by government. As far as indigent patients are concerned, the Department of Health's brand is in a poor state. There is a high level of complaints and negative publicity in the media. The health authorities have attempted to improve this image, however progress seems to be slow. The Department of Health owe it to patients to try and improve the brand by becoming more patient focused. Good concepts such as Batho Pele and Patient Rights Charter need to be implemented in practice rather than being restricted to fine sentiments on posters decorating offices.

6.5.2 South African healthcare culture

In light of the history of apartheid, it is not surprising that culture remains such a divisive problem between the Department of Health and the private healthcare sector. There is no commonality of purpose and there is a general suspicion of mistrust between the two healthcare sectors. There can be little doubt that South Africa's current healthcare paradigm does not match up to the reality.

The paradigm (what we believe)

- The Department of Health has evolved from a history of discrimination. Despite the difficulties, the Department is a modern healthcare provider.
- The Department has regulated private healthcare as part of an equity reform – to make medication and treatment affordable and accessible to all South Africans.
- The Department of Health is a transparent organisation and works in partnership with its stakeholders.

The reality

- The Department of Health is locked in an outdated approach to healthcare. Strategic planning must be the way forward if the country is to meet the healthcare challenges it faces especially in light of the HIV/AIDS pandemic.
- The private healthcare sector, which forms the basis of the South African economy, is in ruins. The closure of private practices has led to unemployment. Getting re-employed is slim. Patients are spending more disposable income to healthcare – administration fees, levies on medication. The regulations are hurting the very same people the Department is trying to help – the poor.
- The two sectors are enmeshed in conflict with the recent regulations. The recent court battles demonstrate just how much distrust there is between the two groups.

6.5.3 Gap Analysis

The gap analysis can now be applied at the conclusion of the analytic component of the process, as currently, there is no formal strategic plan for the Department of Health and the private healthcare sector. There appears to be a large gap between South Africa's current reality and the country's potential as a healthcare provider. Currently there is a shortage of facilities and healthcare professionals in the public sector, private healthcare is becoming increasingly unaffordable and the culture between the Department of Health and the private healthcare sector is divisive and lacks trust. In light of this, South African healthcare is experiencing great difficulties in moving forward.

Public healthcare interventions (especially HIV/AIDS), the rationale use of medication, increasing staff personnel and facilities were the responses amongst the public healthcare interviewees to improve healthcare.

In response to the way forward, private healthcare interviewees stressed the need for a national health system similar to that of Australia and England or revert back to the country's previous health laws. The general consensus was that new, clear and reasonable regulations were needed. Although pharmacies are closing down, 60% (n = 6) felt that it was not too late for the Minister of Health to reverse her inflexible position and engage in negotiations with the private healthcare sector. This would be in the best interests of all concerned, particularly the patients.

6.6 The Issues

The final part in the analysis of the composite model is the issues. Findings from the study reveal that the challenges faced by the Department in providing effective treatment and care for South African's include:

- The continuing lack of human resources such as doctors, pharmacists and nurses in the public sector. The scarcity of human resource could possibly be exacerbated by the high prevalence of HIV among health workers estimated to be around 16% (Health Systems Trust, 2004). The human resource issue may well present the

greatest challenge, given that a strong health system requires the continued presence of a skilled human resource base.

- The lack of adequate infrastructure, including water, sanitation, electricity, communication and consultation rooms and weak support systems such as laboratory services, transport and medical supplies.
- The current situation of fragmented patient information systems. The ability to track and treat patients regardless of where they present is key to ensuring suitable levels of adherence and monitoring of treatment outcomes.
- The rising incidence of HIV/AIDS is and will continue to place considerable strain on the healthcare system.
- There has been a very important focus on increased delivery of care to increased number of people. The challenge now is to ensure that the care delivered is of a good quality. An attitude of care, concern and courtesy towards patients is sorely lacking. The delivery of standardised, high quality and patient-centred healthcare is desperately needed.
- Finally, the private sector has expanded rapidly but with rapid cost escalation. This is making medical scheme coverage increasingly unaffordable to lower income earners and social health insurance more difficult to achieve. This suggests that strategic measures must be included to make medical scheme coverage more affordable and sustainable.

The Department of Health and key health stakeholders need to kick start strategic planning as a matter of urgency and change is essential. There is no doubt that healthcare will continue to muddle through if the country continues as is, however, a better future is possible and is within the country's grasp. A vision of what could be, needs to be formalised and all the healthcare stakeholders need to commit themselves to striving for it. The following issues need to be addressed: process redesign, human resource, healthcare interventions, marketing the Department of Health and changing the culture and structure of the two healthcare sectors.

Chapter Seven

Recommendations and Conclusion

7.1 Introduction

A strategic plan will need to be developed to preserve the Department of Health's healthcare mission. The environmental and organisational review has identified several challenges as well as several problem areas within the Department of Health as well as the private healthcare sector. These issues will need to be addressed if South Africa hopes to develop into a modern internationally competitive and respected healthcare provider. In light of this analysis, a structured response to these challenges is required with concrete recommendations that are practical and achievable for the well-being of the nation.

7.2 Recommendations

7.2.1 Process redesign strategies

The time has come for the Department of Health and the private healthcare sector to further entrench their partnership agreements, to resolve these healthcare challenges by using the already limited number of healthcare providers. The private sector can have an important role to play in the distribution of medicine and the monitoring of diseases like tuberculosis and HIV/AIDS. (Cawood, 2005; Pillay, 2005).

The proposed partnership health model similar to that of Australian national health model will guarantee universal access to primary healthcare for all South Africans. The model will use the existing public health sector bolstered by facilities in the private healthcare sector.

7.2.1.1 Suitability of the identified strategy

7.2.1.1.1 Feasibility of the strategy

- **Human resources**

Without stronger human resources, the dream of equitable access to high quality care will not be realised. A national health system will bring about 137 000 medical doctors,

pharmacists and nurses, joining forces, to serve the entire 43 million citizens – a 200% (42 000 – public, 95 000 – private) increase in the number of healthcare workers to serve the public sector patients.

- **Pharmaceutical facilities**

The public healthcare sector has 339 hospital and 131 clinic pharmacies (South African Pharmacy Council) to serve almost 35 million people. It is here where the 3800 private community pharmacies can play an important role in the distribution of medication and the monitoring of diseases like tuberculosis, thereby alleviating the huge burden placed on the Department of Health in the delivery of pharmaceutical services in rural areas.

7.2.1.1.2 Acceptability of the strategy

In deciding whether the country's proposed healthcare strategy is acceptable, it is necessary to consider risk and return of the investment.

From a risk perspective, this relates to how risky the strategies are and what the chances of failure are. The proposed healthcare strategy is indeed risky. The health plan is an opportunity for both the Department of Health and the private sector to reconcile their differences and work more closely together. The potential is huge, for all stakeholders concerned – get it right and South Africa becomes a better place, get it wrong and the parties concerned will find themselves deeper enmeshed in conflict. However, when one considers healthcare as a basic right and not a service, the strategy becomes less risky.

From a return prospective, the proposed national health system can generate good returns.

- **Public sector** – a healthy nation will be a productive nation resulting in improvements to the economy.
- **Private sector** – the private sector will accommodate a further 80% of the population, making the sector still lucrative despite the Department's recent healthcare regulations.

7.2.1.2 Strategy implementation

The South African government has the following supporting institutional structures and resources to implement the strategy.

- The South African Department of Health
- Private consortia ~ Pharmascript Holdings
- Cost effective Pharmaceutical Companies
- 150 000 medical practitioners, pharmacists and nurses
- 3 864 private retail pharmacies and 470 public dispensaries

Scriptpharm Holdings, a private healthcare consortia and the Department of Health are recommended to administer the proposed national health scheme.

7.2.1.3 How the proposed national health model will work:

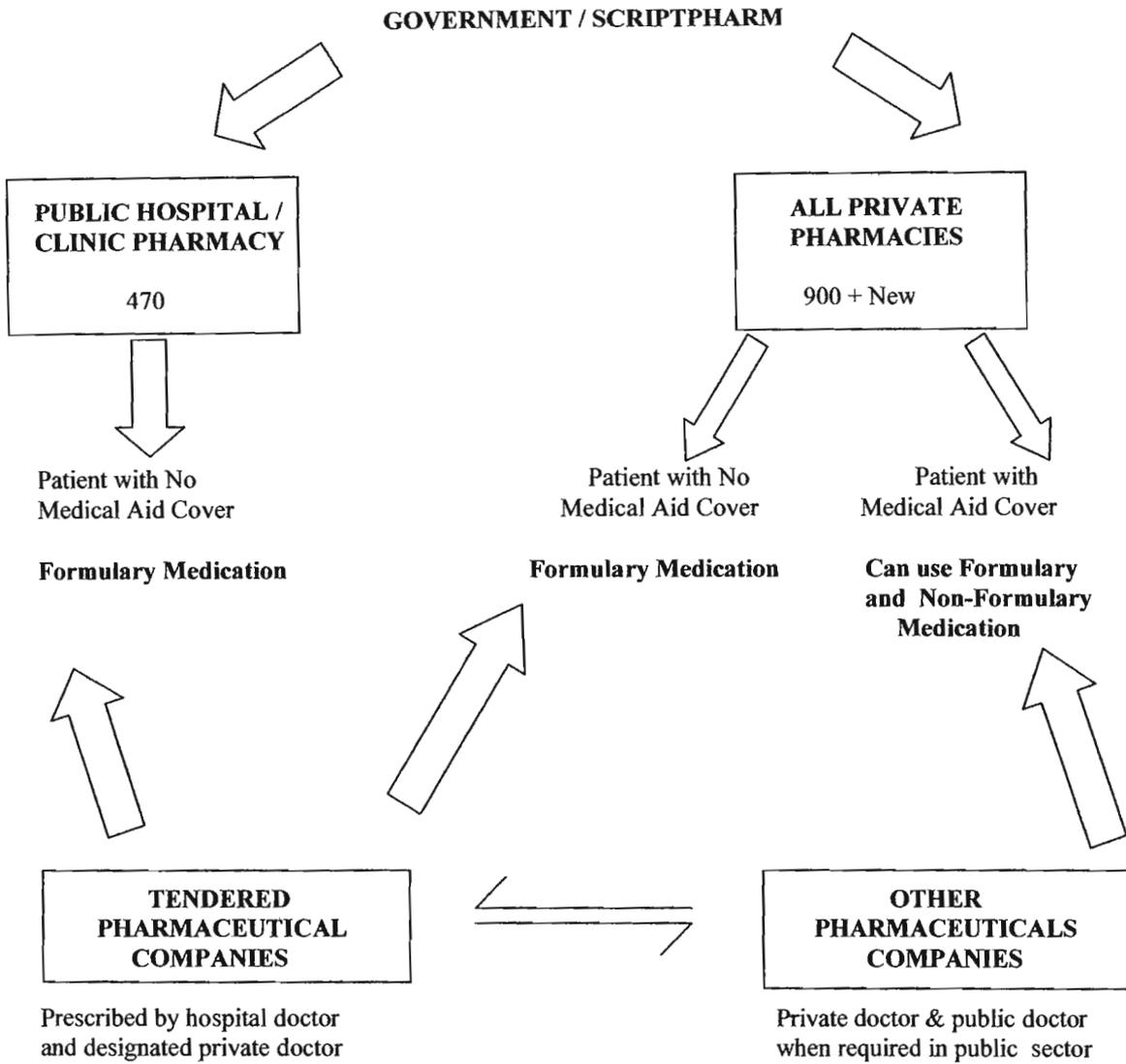


Figure 7.1 – South Africa’s proposed national health model (Source: Adapted – www.scriptpharm.co.za, www.doh.gov.za)

- Very similar to the Australian HIC, Scriptpharm and the Department of Health will collectively be responsible for the reliable, secure and innovative delivery of health claims, payments and information management.
- Patients will initially be seen at a healthcare facility, which could be a small clinic, an accredited private medical practitioner or a hospital.
- The public sector patient will be able to collect their medication at any health facility in the country. Medication prescribed and dispensed will be formulary based from the governments tendered pharmaceutical companies.
- Private retail pharmacists will be paid a dispensing fee for the supply of medication to the public sector patient. The same principle will apply for a private medical practitioner who wishes to examine a public healthcare patient.
- There are several options for funding the costs of the proposed national health system over and above the normal budget allocations for healthcare. These include general tax revenue, dedicated funding from tobacco and alcohol, dedicated payroll taxes, levies on medical schemes and the removal of tax subsidies on these medical schemes.

7.2.1.4 Benefits of the proposed national health model

7.2.1.4.1 Public patient

- The public patient's waiting period for the collection of medication will be progressively reduced.
- There will be an increase in the patients disposable income – patient will not have to travel considerable distances (taxi fare) for medication and treatment if a retail pharmacy or private medical practitioner is nearby
- The patients quality of life is vastly improved

7.2.1.4.2 Private patient

- By assisting the public healthcare sector patients – the overall health expenditure will decrease in South Africa – hence, medical cover will not increase substantially as it did in the past.
- Using formulary medication will extend patients medical aid benefits for a longer period – patient will have more disposable income to spend

7.2.1.4.3 Private sector workforce

- The private sector health personnel will be able to accommodate a further 80% of the South African population – more revenue (dispensing and prescribing fee)

7.2.1.4.4 The South African government

- A healthy nation will be a working nation. The economy of the country will improve.
- Revenue generated due to the National Health System can be used to upgrade public clinics and hospitals or build facilities in areas of need.
- The public healthcare workforce is no longer overworked. Health personnel will be seeing those patients who have no access to private facilities and those referred to by the private sector medical practitioners. Hence, government will be appropriately utilising healthcare workers and their knowledge.
- The proposed health model will create employment opportunities in the pharmaceutical industry. This will reduce the country's unemployment rate

7.2.1.4.5 Scriptpharm

- There will be a high return on investment for all shareholders considering the magnitude of this venture.

7.2.2 Human resource strategies

- An introduction of rural and scarce skills allowances to all health workers will hopefully be a significant move in supporting the retention of doctors, pharmacists and nurses in the public sector. However, increasing salaries alone will not necessarily restore the sense of purpose that is required to make public services function. Other sources of motivation including developing professional satisfaction, self-realisation, social respect and prestige in the healthcare profession must be taken.
- An increase in the intake of enrolled nursing students must be viewed as a priority. The recognition of prior learning of enrolled nursing assistants must also be considered and the South African government needs to review the remuneration of nurses, bringing it up to a reasonable competitive level (Tselane, 2005).
- The country needs to strengthen the training and support for the lower level workers in the public healthcare sector. This will relieve the pressure on professional staff.
- Medical institutions need to revise the admission criteria of students who wish to pursue careers in the medical and pharmaceutical fields, in particular the high premium placed on mathematics and science scores as the crucial criteria for admission (Sherwood, 2005).

7.2.3 Marketing strategies

- Key health gatekeepers must be more active in terms of marketing the Department of Health and the private healthcare sector. A more current and interactive website may attract more healthcare professionals from abroad. A high quality printed prospectus should be available for potential students and recruits.
- The Department should enter into arrangements with countries like the United Kingdom to have a structured migration system. Health workers from both sides can work in the other country for a specified period and return to their respective country to reinvest those skills.

7.2.4 Public health interventions strategies

Public (or population) health interventions are formally activities defined widely as representing the organised response by society to protect and promote health and to prevent illness, injury and disability. Less formally, they are visible as health awareness and promote campaigns and disease prevention services. The Department of Health and the private healthcare sector should focus more public health activities at people who are not ill, but have the potential to become ill due to their biological characteristics (such as age, in relation to falls) or their behaviours (such as promiscuity, in relation to HIV/AIDS and smoking, in relation to cancer) (Hernandez, 2005).

7.2.5 Organisational strategies

The Department of Health and the private healthcare sector needs to change aspects about their organisational structure if they are going to be able to meet the challenges facing South African healthcare. Structural change falls under the ambit of process design. However this will be unsuccessful if the issue of culture is not addressed.

7.2.5.1 Changing the culture

Changing organisational culture is difficult and complex. The culture in both sectors is one of individualism. There is a lack of trust between the Department of Health and the private healthcare sector, with no shared vision and no concept of a strategic approach. There appears to be little drive to develop common interests. Each sector deals with whatever problem comes its way. For this attitude to change, there needs to be meaningful leadership from both sectors. The study has identified the paradigm that needs to be shifted in the healthcare cultural map and this can probably best be achieved by an incremental or covert approach. The key health gatekeepers need to be educated around the importance of culture, and this can probably best be done by using techniques such as strategic planning retreats or workshops as well as team building exercises. Neutral outside consultants may be useful as they would bring a fresh unbiased view to the South African healthcare situation. Once involved in the process, skilful guiding may allow an indigenous strategic mindset to evolve.

7.3 Limitations of the study

The sample size of 33 was apt for the study, given the work and timeframe limitations. The sample size is taken up in section 7.4. The study is limited by the fact that the choices and opinions expressed and conclusions drawn in this study remain personal. As a private retail pharmacist, the author of this thesis brings numerous bias to the work and these will influence the final product even if stringent measures to reduce the effect of bias are taken. A major limitation is the issue of implementation. Without implementation, this study will remain a theoretical paper exercise. For government to adopt the proposal, a change in leadership and culture is required from all healthcare stakeholders. Hope remains, that this study will be the stepping stone that will stimulate debate as a prelude to action.

7.4 Further research

The study offered five recommendations. The value of these recommendations needs to be further researched through a quantitative survey, with a population of several hundred. This is the further research planning from this work.

7.5 Conclusion

In preparation for the time when democracy would come to South Africa, the African National Congress (ANC) had developed a national health plan. The central vision of this plan was that every person had the right to achieve optimal health (Gray, 2005).

The research undertaken explored South Africa's health system after 11 years of democracy and how far the Department of Health has succeeded in attaining quality and equitable health as expressed in the Department's vision and mission statements. Although South Africa has the potential to be one of the leading healthcare providers in the world, the country seems to be in a perpetual state of health crisis. The study conducted has shown that the Department's healthcare brand is in a poor state:

- The ongoing source of tension between the Department and stakeholders (private sector) tends to limit the degree of team work in the country. Collaboration and co-operation is almost existent. The recent court battle is the obvious source of discontent.
- Private sector patient interviews suggest that the Department's controversial private healthcare regulations are hurting the very same people they are trying to protect – the poor. Patients are not paying as little for healthcare as promised by government.
- Interviewed public sector patients voiced their concerns over the poor quality healthcare provided by the Department, run down facilities, long waiting queues and a shortage of medication. There is also a dire need of health professionals.
- Health personnel cite low levels of job satisfaction, poor working conditions, despondency in the face of the HIV/AIDS epidemic and unsatisfactory management, as well as inadequate salaries, as underlying their dissatisfaction with working in the Department.

Questions can be asked as to whether the present direction offered by the Department can achieve a better future. Without stronger human resource, marketing, cultural changes and the redesign of processes, the dream of equitable access to high quality care (that is similar to the Australian national health system) will not be realised by the Department. Aligned with this, the necessity of strengthening the health system as a whole is brought sharply into focus by the demands placed on it in responding to HIV/AIDS. The yawning divide between private and public sectors represents the greatest inequity in the country's healthcare system, highlighting the necessity for strengthening cross-subsidisation between the sectors. In this regard, taking the stalled process of implementing a unified South African national health system must be viewed as priority.

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4. The South African Department of Health. Available online: www.doh.gov.za

Appendix One
List of Respondents

The following 33 respondents were interviewed (February – August 2005) for the Study:

- Cawood, M. Director – Scriptpharm Holdings
- Gray, A. Health Systems Trust
- Hernandez, E. Cuban Medical Practitioner – Greys Hospital
- King Edward Hospital Nursing Sister (name withheld)
- Mudaly, I. Private Medical Practitioner – rural Inanda
- Naidoo, R. Retail Pharmacist and Main Board Director – Scriptpharm Holdings
- Naidoo, S. Medical Practitioner – Community Service – rural Osindizweni Hospital
- Naidoo, SN. Consumer Council of South Africa
- Pillay, A. Medical Aid Administrator – Old Mutual
- Reddy, V. Medical Practitioner – Medicines Control Council
- Tselane, S. Hospital Manager – rural Umpumulo Hospital
- Sheridan, G. Australian citizen, Ilembe District – healthcare
- Visick, L. Australian citizen, Ilembe District - healthcare
- 10 Public Healthcare Patients
- 10 Private Healthcare Patients

