UNIVERSITY OF KWAZULU-NATAL

EVALUATING PUBLIC SECTOR SERVICE DELIVERY AT KWAZULU-NATAL PROVINCIAL HOSPITALS: A CASE STUDY OF THE DURBAN METROPOLITAN AND ILEMBE REGION

By

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SUPERVISOR'S PERMISSION TO SUBMIT FOR EXAMINATION

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As the candidate's supervisor, I agree to the submission of this dissertation for examination.

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DECLARATION

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LIST OF ACRONYMS

ANC – African National Congress

BPPs – Batho Pele Principles

DoH – Department of Health

DPSA – Department of Public Service and Administration

HR – Human Resources

HRDS – Human Resources Development Strategy

HRM – Human Resources Management

ICT – Information and Communication Technology

IDP – Integrated Development Plan

KZN – KwaZulu-Natal

MPCCs – Multi-purpose community centres

NGO – Non-governmental Organization

NHS – National Health Scheme

NPM – New Public Management

PCC – Patient-centred Care

PSC – Public Service Commission

RDP – Reconstruction and Development Programme

SA – South Africa

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ABSTRACT

The Constitution of the Republic of South Africa,1996 (Act 108 of 1996) and the Patients' Rights Charter (Patients' Rights Charter: Online) guarantee all citizens the right to basic health care services (South Africa, 1996: chapter 3). Furthermore, the White Paper on the Transformation of the Public Service (South Africa, 1997) states that the delivery of healthcare should be guided by the principles contained in the framework of *Batho Pele*, a Sotho term meaning "People First".

Hospitals play an important role in delivering healthcare. However, strong allegations have been made about the inability of various provincial hospitals to provide health care in line with the Constitution and the Patients' Rights Charter.

Customer satisfactionis a vital measure of performance for firms, industries and national economies (Anderson *et al*., 1994).The growing health care literature suggests that patient satisfaction should motivate strategic decisions in the healthcare sector (Andaleeb, 2001). Research has indicated that the services provided by a company or institution can be measured by determining the inconsistency between what the customer wants (expectations) and how the customer experiences the service (perceptions).

Little research has been conducted to date in KwaZulu-Natal provincial hospitals to evaluate the progress made in improving service delivery of healthcare; the healthcare system and the administration thereof, which is a major cause of poor service delivery in the provincial hospitals.

This research study aims to contribute towards the identification of health care requirements by articulating the expectations of patients. Following a literature review which provided insight into the conceptual and contextual framework of public administration and the role of knowledge management in enhancing public sector service delivery, empirical data were gathered by means of questionnaires administered to patients, nurses and doctors at three hospitals in iLembe region and eThekwini Metropolitan Municipality in KwaZulu-Natal – Addington, King Edward VIII and Stanger Hospitals – that serve urban, rural and semirural communities.

The study's findings revealed that there is indeed, reason for concern with regard to the identified service delivery goals and with regard to improving the health care system in

general. The findings show that there is a weak, non-significant, negative linear relationship between the services offered at the three provincial hospitals compared with the expectations of patients who were admitted to these hospitals during the time the research was conducted. There is a need for further research regarding the interface between public sector provincial hospital services and service delivery, and the quality of services offered by hospitals in order to comply with *Batho Pele* Principles.

It is anticipated that the study's recommendations will assist hospitals in the eThekwini Metro and iLembe region in dealing with the challenges they face with regard to hospital service delivery and the monitoring and evaluating of *Batho Pele* Principles in the quest for a more efficient and effective delivery mandate.

CHAPTER ONE

1.1 INTRODUCTION

The Constitution of the Republic of South Africa,1996 (Act 108 of 1996) guarantees all citizens the right to basic health care services (South Africa, 1996: chapter 3). In pursuance of these rights, the Patients' Rights Charter states that "everyone has the right of access to health care services that include (amongst other things), receiving appropriate emergency care at any healthcare facility that is open regardless of one's ability to pay" (Patients' Rights Charter: Online).

Recent media reports (cf. Taiz, 1998, Online: Thom, 2001, Online: South African Health Review 1999, Online: Smith, 1999, Online; Blumenfeld, Online: Cape Argus, 2010 Online) reflect that the injunctions of this Charter fall short of being realized and that South African health care is itself in dire need of urgent healing. Strong allegations have been made about the inability of various provincial hospitals to provide health care in line with the Constitution and the Patients' Rights Charter. In addition to alleged poor delivery of health care services, or perhaps the cause thereof, Taiz (1998: Online; cf. Smith: Online) cites a performance audit by the Office of the Auditor-General that revealed poor administration, theft, and misspending in academic hospitals in KwaZulu-Natal (KZN) and Gauteng.

Kersbergen (1996:169) states that the healthcare system of the 21st century is shifting as a result of healthcare reforms focusing on cost, quality and access. As quality healthcare services become government policy, the healthcare industry is expected to provide high quality healthcare in an economically challenging environment. According to James (2005:2), the emphasis on the delivery of quality healthcare services and the stability thereof has become an attribute of healthcare policies worldwide. In South Africa, a developing country with a population of approximately 49 million people served by a healthcare system undergoing many changes, Killian (1995:419-420) notes that capital and resource challenges hinder such efforts.

The White Paper on the Transformation of the Public Service (South Africa, 1997) states that the delivery of healthcare should be guided by the principles contained in the framework of *Batho Pele*, a Sotho term meaning 'People First'.

Three principle values capture *Batho Pele*: belonging, caring and service. This implies that the healthcare service must be transformed to become representative, coherent, transparent, efficient, effective, accountable and responsive to the need of patients/clients as the consumers of healthcare. Healthcare institutions are called upon to deliver people-centred and people-driven services that are characterized by equity, quality, timeousness and a strong code of ethics (South Africa, 1997).

According to Lazarus & Butler (2001:22) and Williams (1998:264), healthcare consumers are demonstrating an increased awareness of their rights and are demanding increased accessibility to healthcare facilities around the country. Moreover, patients have become increasingly conscious of health issues as a result of education; this has led to the need to revisit quality issues in healthcare service delivery (Muller, 1996:68-98). In this vein, James (2005:3) writes that the "healthcare industry is shifting from competition based on price to competition based on quality and performance". According to Bell, Krivich& Boyd (1997:22) the traditionally accepted perception is that the value of the service rendered represents the cost and quality, which is escalating, and also includes a third aspect, client satisfaction.

Hiodenhovi, Nojanen and Laippala (2002:59) observe that a client's satisfaction with a service or product is the main aim of product design. This is based on the notion that consumer satisfaction has an effect on business success. As a result, the perceptions of the consumers of healthcare are as important as the quality of the product and service produced and this is an important value in quality circles (James, 2005:3). Hiidenhovi*et al*. (2002:59-60) note that increased concentration on healthcare stimulated the examination of hospital processes from a quality perspective, with the aim of achieving improved productivity and cost-effectiveness.

Researchers such as Carey (2000:43) state that "outpatient departments can be seen as an industrial plant where technological know-how is transferred to patients through service delivery; service-delivery could therefore be seen as a cornerstone of the healthcare system's business". Therefore outpatients as consumers of healthcare can draw conclusions about the quality of service delivery on the basis of their experience of such services.

According to Hiidenhovi, *et al*. (2002:60), quality service delivery is a multiphase interactive action, which coincides with the attributes of quality and hence meets the needs of both consumers and healthcare practitioners in a way that adds valuable meaning to the healthcare experiences of outpatients. This study examines whether or not this was the case in provincial hospitals in KZN.

According to Anderson and Fornell (1994) hospitals should deliver a good quality, 'zero defect' service to their customers. Severaldiverse service measures and indicators exist for measuring the quality of health care, one of the most important of which is patient (customer) satisfaction. Customer satisfactionis a vital measure of performance for firms, industries and national economies (Anderson *et al*., 1994). Fulfilling the needs of patients can save hospitals money by reducing the amount of time spent on resolving patients' complaints (Press, Ganey and Malone, 1991*)*. Health care quality can be improved by establishing patient preferences and customizing care to meet their needs (Macario, Weinger, Carney & Kim, 1999).

The patient's right to be heard should be given a greater role in the design of the health caredelivery processes. The growing health care literature suggests that patient satisfaction should motivate strategic decisions in the healthcare sector (Andaleeb, 2001). Research has indicated that the services provided by a company or institution can be measured by determining the inconsistency between what the customer wants (expectations) and how the customer experiences the service (perceptions).

Customer expectations are formed by word-ofmouth communication, personal needs, past experience and what and how the staff communicates with the customer (Zeithaml, Parasuraman and Berry, 1990). In recent years, South Africa has witnessed a number of service delivery protest actions. In line with the key priorities in service delivery, the South African government issued the White Paper on Transforming Public Service Delivery(WPTPSD) in 1997. This was in line with *Batho Pele*, which sets out 11 guiding principles for public sector institutions in their efforts to deliver services efficiently and effectively. In terms of healthcare services, this will be achieved by, among other things, promoting an improvement in medical facilities, cost containment and the endorsement of domestic medical technology.

According to Bovens, Hart and Peters (2001), South African health care institutions and government are in a symbiotic relationship in terms of health care costs and the institutional framework consisting of professional medical associations, medical aid schemes, hospitals

and clinics as well as public sector service delivery in government hospitals (Antonsen and Greve, 1999 and Bovens *et al*., 2001).

1.2 NEED FOR THE STUDY

Health care in South Africa suffers from a lack of effective and efficient service delivery, and hence from a lack of credibility. The current picture painted by the media is certainly a far cry from the ideals set out in the Reconstruction and Development Programme (RDP, sec.2.12), the South African Constitution, 1996 and the Patients' Rights Charter. While it seems evident that the National Health System (NHS) in South Africa suffers from a lack financial resources (Thom: Online, Smith: Online), the RDP (sec. 2.12.5.8, 2.12.5.9) indicates that the health system cannot be successful if it excludes community participation.

Ngwenya and Friedman (1995: Online) emphasize the need for public participation in the NHS. They suggest that disadvantaged communities (the focus of the RDP) are "very eager to become actively involved in their own health care", and they lament the dearth of institutionalized enabling mechanisms.

In contrast, Verba, Nie& Kim (1978) observe that participation is a function of socio-economic status (SES, i.e., the higher one's economic status, the higher the likelihood of participation in order to influence issues that might affect one); they, too, call for increased public participation in the development of the National Health Service, (NHS), and for patients' real, rather than imagined, needs to be investigated, discovered, and taken into account (Patients' Rights Charter, sec 2). The current study aims to promote the identification of these needs.

In view of the above, this research study aims to provide information on, and an understanding of the expectations and perceptions of patients as clients of the NHS. Such an understanding would hopefully feed into healthcare policy-making, adding a dimension lacking in the *South African Demographic andHealth Survey* conducted in 1998, which focused on a quantitative statistical understanding of South African health demographics rather than on an understanding of the expectations and perceptions of a citizenry that is all but resigned to health care as it currently exists in South African provincial hospitals. The importance of gauging such expectations and perceived performance cannot be underestimated. In an interview with Thom (Online: 2001), Dr L. Rispel, former Chief of Operations in the Gauteng Hospital Services stated that "patients' satisfaction and patients'

perceptions tie in with how people felt they are being treated when they go to a healthcare facility, and with the 'hotel facilities' – how clean the place is, whether there is clean linen and whether people wear name tags". Norton, Curtiss & Hart (2001:18, 19) note that "on-target consumer research can uncover any number of ideas. The best research method allows patients to tell stories. It is also important to include observation of patient behaviours and to create exercises that help them to express their hopes."Hence research that seeks to understand the expectations and perceptions of patients with regard to health care can, if taken cognizance of, assist in the improvement of such care.

The Hospital Revitalization Programme embarked upon by the KZN and Gauteng Departments of Health comprises a multi-pronged strategy, which includes the improvement of service quality seen both from the objective clinical perspective and from the service users' subjective experience (Department of Health, 2001:38, 41).Understanding patients' expectations and experiences of the performance of health care service providers could assist government to become relevantly responsive, which, in turn could improve service delivery and provide a viable alternative for those who reluctantly turn to private hospitals which they cannot always afford.

Furthermore, taking heed of patients' perceptions may allow government, more specifically provincial health care services, to corner or create a niche market in healthcare (Norton, *et al*., 2001:17-20; Benko 2001: 28-32), becoming the first choice service provider. Mitchell (1998), for example, found that satisfied clients are more likely to accept and continue to support health care services, and that patient satisfaction is important in the public sector because it can influence compliance.

While the stated goals are laudable, it is also important, from a systems perspective, to consider some of the main environmental challenges to improved national health care encounters in the South Africa context. This will be dealt with in more detail in the next and following chapters. Clapper and de Jager (2004) observe that the South African government's need to urgently address the state of national health care places great pressure on its limited resource base, particularly against the background of its extensive portfolio of transformation priorities. Persistent allegations have been made about the incompetence of various provinces to provide health care in line with South African Constitution and the Patients' Rights Charter. Although the concept of human rights is fairly new in South Africa, healthcare

services must be in line with human rights and they must be provided in a dignified manner in keeping with *Batho Pele*Principles (BPPs).

Research conducted in specific public hospitals has unearthed practices which run contrary to the BPPs. These ranged from not having beds to admit patients from the casualty department, to a lack of supplies, patients complaining about nurses being disrespectful to them and a shortage of doctors and nurses. It is evident from daily television news reports and newspapers as well as informal conversations that the public is dissatisfied with service delivery in many public hospitals.

There is considerable literature on South African public service sector delivery. This literature focuses on municipalities, public hospitals and public schools. Insufficient research has been conducted in KZN with regards to the role of government in-service delivery and more specifically to public hospitals at provincial level. It is common knowledge that service delivery at the provincial hospitals is not up to standard. This study examines the demand for effective services and provides recommendations for the adoption of new processes. Service delivery within provincial hospitals has huge potential for development.

In the current information age and knowledge economy, it is becoming increasingly necessary for organizations to prioritize service delivery in order to gain a competitive advantage and to function efficiently. While the notion of competitive advantage is not necessarily relevant to the public sector, it has significant implications in provincial hospitals. One of these is that organizations should be strategically aligned with their clients in order to provide better services (Fowler &Pryke, 2003:254). This is especially important for public sector hospitals which are largely responsible for public health care; this study will identify reasons for lack of efficacy in KZN hospitals.

The implementation of the *Batho Pele* policy has been successful to a differentextent in the various provinces, and following a decade of implementation,it was observed that “although systems and structures have been mainlytransformed in the public service, not much has been done to actually change theorganisational culture and values so that they are consistent with ‘*Batho Pel*e’(Mokgoro, 2003:7).

The eThekwini metro is a good example of a government organization where the implementation of *Batho Pele* proved to be effective and efficient. In this municipality, management recognized that change begins within the organization,and could only be

achieved through acquiring the necessary skills and competencies, which also requires officials with a particular set of morals, values,attitudes and behaviours. These will need to be aligned to the goals and objectives of the municipality to fulfil the mandate of publicservice delivery.

The eThekwiniMunicipality's (2006:14-27) *Batho Pele* progress report indicates the success of *izimbizos* (community forums), customer satisfaction surveys, unannounced site visits and service excellence awards as well as the establishment ofmulti-purpose community centres (MPCCs) to improve access to multiple government services.

TheDepartment of Public Service and Administration (DPSA) commissioned a *Batho Pele* Policy Reviewin 2003. The report indicated that although systems and structures have been transformed in the public service, there is little improvement in terms of changes regarding theorganisational culture and values consistent with *Batho Pele* requirements. According to van der Waldt (2004: 83), *Batho Pele* was a very important step to improve public sector service delivery, and this is aligned with the concept of structured public service goals, which are client-centred in terms of norms, values, performance, culture and attitudes.

The democratic government in South Africa has adopted a new policy framework that promotes a better life for all through effective, efficient services. This debate is advanced in a paper published by the ruling African National Congress (ANC) in 2002. Titled, "Transforming the State and Governance", it states that:

> Batho Pele principlesof responsiveness, access, transparency and accountability require culturalchange that has to happen in order to claim the true transformation of the cultureof the public service. These principles apply within the public sector, as well as inits external operations with the people. After five years of implementation, thevagueness with which progress is being reported to the people in terms of this significant policy can be interpreted as failure to successfully implement andinclude it in the public sector workplace (Mokgoro, 2003: 8).

Little research has been conducted to date in KZN provincial hospitals to evaluate the progress made in improving the delivery of healthcare; the healthcare system and the administration thereof, which is a major cause of poor service delivery in the provincial hospitals.

1.3 KEY QUESTIONS

This research study aims to contribute towards the identification of health care requirements by articulating the expectations of patients. In pursuit of this, the following research questions are asked:

- Is the government doing enough to ensure that the standard of services rendered at provincial hospitals meet the *Batho Pele* principles?
- What are the challenges hindering service delivery in the public health care sector?
- Does the public health care sector use its monitoring and evaluation tools adequately to measure and improve the efficacy of services rendered?
- Does the provincial hospitals' service delivery meet the expectations of patients in their interaction with these provincial hospitals?
- What are patients' perceptions of the performance of the provincial hospitals in their efforts to provide healthcare services?

The answers to the key questions should provide an indication of the extent to which patients are satisfied with regards to specific service quality rendered by the provincial hospitals.

1.4 OBJECTIVES OF THE STUDY

- To evaluate the implementation of *Batho Pele* principles and service delivery plans in provincial hospitals as experienced by patients;
- To identify service delivery shortfalls as described by patients and members of the public in provincial hospitals; and
- To identify customer service experiences relating to etiquette, waiting time and the availability of required resources in public sector provincial hospitals.

1.5 RESEARCH METHODOLOGY AND DATA PRESENTATION

The research methodology chosen for a study needs to satisfy the requirements of being relevant, feasible, accurate, objective and ethical. Data were analysed and are presented in the form of tables and graphsin Chapter Five.

1.6 RESEARCH DESIGN AND METHODOLOGY

A quantitative descriptive approach was used to explore and document the evaluation of service delivery in public sector provincial hospitals by patients in selected wards in three public hospitals in KZN. The descriptive research design is appropriate for this study, as little research has been conducted on this phenomenon; description will allow for the identification of shortfalls in service delivery in the public sector hospitals (Burns & Grove, 2005:747).

1.6.1 POPULATION AND SAMPLING

Focus group interviews were conducted on different days in the three targeted hospitals. These interviews were held with patients, doctors and nurses. The accessible population comprised more than 70 patients, 10 doctors and 30 nurses in each hospital. With a sample of 77 patients from Addington Hospital and 74 from King Edward VIII Hospital in the eThekwini Metropolitan Municipality; and 71 from Stanger Hospital in the Ilembe region, the total number of respondents who were patients was 222. Doctors and nurses were chosen as a sample because all public servants are required to care for their customers in line with *Batho Pele* in order to achieve the government mandate of excellent service delivery; including them will enable an evaluation of whether or not these principles are being upheld.

The research sample was chosen by means of stratified random sampling. Non-probability sampling was used which means that not every element of the population has an opportunity to be included in the sample.

The 222 patients were selected from long-stay wards, namely the medical, surgical and orthopaedic wards in all three hospitals. It was assumed that patients who stay for at least three days would be able to share more information on the service received as opposed to patients who were admitted for a short-term stay. The inclusion criteria stated that patients should be adult male or female patients from the designated wards who are between 18 and 75 years old, fully mentally orientated, from all race groups, and skilled in reading and writing.

1.6.2 RESEARCH INSTRUMENTS

A structured interview schedule was developed, based on different policy documents (*Batho Pele*) and the literature review. The instrument included open and closed-ended questions and consisted of five sections, namely, the acuity level of the patient; demographic information; service expectations; the Patients'RightsCharter and perception-related questions.

1.6.3 PRIMARY DATA

- **Questionnaires**

Questionnaires were administered to 222 patients at three hospitals in iLembe region and eThekwini Metropolitan Municipality in KZN that serve urban, rural and semirural communities, to obtain the required responses regarding service delivery in the two regions.

These questionnaires were designed to provide information relevant to the aims and objectives of this investigation noted earlier.

The questionnaires were pre-tested with 10 respondents to determine whether or not the respondents understood the instructions and questions and to monitor the amount of time needed by the researcher and the research assistant to complete the interviews and to capture the answers on the schedule.

1.6.4 SECONDARY DATA

The following documents were examined:

- Department of Health hospitals' management reports;
- Journal articles;
- Conference papers;
- Policy documents; and
- Public service policy documents.

1.6.5 DATA COLLECTION

Data were collected in three wards in each hospital in consultation with the Unit Managers. Respondents who met the inclusion criteria were identified with the assistance of the Unit

Managers and those respondents were approached personally. Respondents who agreed to participate signed an informed consent form before the interview was conducted by the researcher and research assistant and the responses were recorded. The process was repeated until the total sample size of 222 was reached in the three hospitals.

The return rate for the 222 questionnaires was 95%. An attempt was made to select categories of patients randomly; a high degree of illiteracy among patients was expected to make such an effort difficult. Where patients were unable to complete the questionnaire, substitute respondents were identified and solicited in order to overcome the problem of no or inaccurate responses which might have raised questions of validity.

1.6.6 DATA ANALYSIS

The SPSS 16 package or the MS Excel programme was used to capture and analyse the data and findings, which are presented in tables and graphs in Chapter Five. Responses to the open-ended questions were grouped, analysed and described.

1.6.7 SURVEY TOOL

A five-point Likert scale was used to test the expectations of the patients and theperceived performance of the hospitals as indicated by a number of predetermined items that formed the questionnaires. This measurement scale consisted of the following items:

(1) Very high expectations/ Excellent performance

(2) High expectations/ Very Good performance

(3) Neutral

(4) Low expectations

(5) Very low expectations/ Poor performance.

The scale used designates that the mean (0) closer to (1) may be regarded as a more desirable situation, contrasting with a mean closer to five (5), which would indicate the least desirable situation. A rank method was also used to compare significant findings. The empirical approach followed in this study was based on a model designed by Kotler and Andreasen (1996).

1.7 RELIABILITY AND VALIDITY

According to Brink, Van der Walt and Van Rensburg (2006), validity refers to the ability of an instrument to measure exactly what it is supposed to measure and nothing else. Accessible language was used in the interview schedule to ensure that respondents understood the questions. Face validity refers to whether the instrument is measuring the content desired for the study or not (Burns & Grove, 2005:737). This will enhance the concepts relevant to service delivery in terms of the representativeness of the concepts in measuring the variable being measured (Brink *et al*., 2006:160; Polit& Beck, 2004:423). In this study content validity was achieved by all aspects relevant to public sector hospital service delivery in the questions. An analysis was carried out to test the validity and the reliability of the questionnaire. This yielded on an overall Conbach AlphaCoefficient of 0.0, indicating a high validity measurement in terms of the scale questions expectations and perceived performance, and hence it may be considered reliable.

In order to determine whether or not significant differences existed between the experiences and expectations of patients in the three hospitals, an Analysis of Variance (ANOVA) was performed on the questions. This measures the expectations and perceived performance of the various service quality items measured and included in the questionnaire.

1.8LIMITATIONS OF STUDY

The respondents were selected from three hospital wards only in the Durban Metropolitan and iLembe districts of KZN. This study was limited to patients who had spent three or more days in these hospitals because it was felt that they could provide more insight into the service standards than patients on a shorter-term stay.

1.8.1 STRENGTHS TO OVERCOME LIMITATIONS

The study enabled the researcher to focus on service delivery within a specific demographic region. This methodology was cost-effective and productive because it enhanced monitoring and evaluation of the findings within a specified, accessible focus group.

1.9 DEFINITION OF TERMINOLOGIES

The following key definitions are provided below:

1.9.1 *BATHO PELE* (PRINCIPLES) BPP: refers to an official national document formulated to improve public service delivery in South Africa, including the health care service (South Africa, 1997:9).

1.9.2 CHARTER: implies an official document granting or defining rights (*Oxford English Dictionary*, 2004:479), and in this study it refers to the care which a patient can expect from health care workers according to the Patients' Rights Charter.

1.9.3 RESPONSIBILITY: is a term which means to act in return, to have an obligation, to account for something, being answerable to someone or something (Searle, 2004:174). Responsibility refers to the obligation of all categories of health care personnel in public hospitals, to respect the rights of patients and to deliver services in accordance with the BPPs and related policies.

1.9.4 RIGHTS: refer to that which is morally good or justified (*Oxford English Dictionary*, 2004:479). In the context of this study patients' rights refer to the care which a patient can expect from health care workers according to the Patients' Rights Charter and BPPs.

1.9.5 POLICY: is usually a written document to ensure standardization and to provide guidance (Bezuidenhout, 2008:42). In this study the term 'policy' refers to national and hospital policies that guide the actions of health care personnel in order to implement BPPs through efficient delivery of health care.

1.9.6 QUALITY: is described by Muller, Bezuidenhout and Jooste (2006:534) as the degree of excellence or the extent to which an organization meets clients' needs and exceeds their expectations. In the context of this study it refers to the health care rendered in a public hospital in line with official government and hospital policies.

1.9.7PUBLIC SERVICES AND SERVICE DELIVERY: Public service delivery is defined as services rendered by government to its citizens either directly or indirectlythrough the financing of private provision (Mathebula, 2010: 21).

1.9.8 IN-PATIENT: In order to understand the content of this research, an in-patient is defined as an officially registered patient admitted to a particular hospital.

1.9.9 OUTPATIENT: Is someone who attends the hospital to see the doctor and receive medication, but is not admitted.

1.9.10 QUALITY OF SERVICE DELIVERY: Hiidenhovi, Nojonen and Laippala (2002:60), define quality of service delivery as "to act or multiphase interactive action carried out by staff in one moment or situation, the dimensions of which are assurance of competence, active attentiveness, dissemination of information, polite manners by staff and flexible helpfulness, which add valuable meaning to outpatients health care experience".

1.10 OVERVIEW OF CHAPTERS

1.10.1 CHAPTER ONE - STUDY OVERVIEW

This chapter is divided into three parts:

- The field of study and the research approaches are outlined, including the research objectives, aims of the study, and an overview of the study.
- The theoretical structure of the study is outlined.
- Certain themes that are laid out in Chapter One recur throughout the study. In addition, this chapter presents the structure of the different chapters.

1.10.2 CHAPTER TWO (part 1) –THE PUBLIC SERVICE AND DELIVERY IN SOUTH AFRICA- AN OVERVIEW

This chapter examines the role of public service delivery in post-apartheid South Africa. It presents a situational analysis of the reform of the traditional bureaucracy and the Public Service Commission (PSC). It further examines the White Paper on transforming public service delivery through *Batho Pele* and assesses the progress made in implementing *Batho Pele* through the public services framework.

1.10.3 CHAPTER TWO (PART 2)

Major theoretical contributions to the discipline of public sector administration on service delivery are explored, as well as the role of knowledge management in enhancing service

delivery. This chapter locates knowledge management and civil servants as well as civil services. The importance of the service delivery agenda through customer-orientated service delivery, e-governance, cultural factors, literacy levels and South Africa and Kenya as knowledge societies is also briefly discussed.

1.10.4 CHAPTER THREE: SERVICE DELIVERY IN LOCAL GOVERNMENT

Chapter three examines the fundamental premeditated role of local government and national government, particularly in service delivery improvement strategies. It also explores the synthesis of service delivery in public provincial hospitals. The focus of this chapter is also on patient-centeredness for an improved health services strategy as well as the organization of work and outcomes in health care.

The chapter examines dialogue beyond citizens' involvement; it examines a number of issues such as the effect of patient-centred care on the quality of care and patient satisfaction and the role of employee turnover. As the focus of this research is service delivery this chapter also focuses on the problems experienced in provincial hospitals in South Africa in terms of both provincial hospital management and the total hospital services.

1.10.5 CHAPTER FOUR- NATIONAL HEALTH INSURANCE

This chapter examines the establishment of NHI, implementation costs and its potential to improve the healthcare system in South Africa. It further explores the treatment plan and redirecting resources and costs drivers in order to ensure successful NHI implementation. The focus is on the reform intentions of NHI and the population covered by NHI. The popular notion of re-engineering the primary health care system and district clinical specialists support teams is reviewed. School healthcare is also examined within municipal health care. This chapter also examines the human resources (HR) aspect of effective service delivery in South African public hospitals.

1.10.6 CHAPTER FIVE- RESEARCH METHODOLOGY

Chapter Five discusses the research design and methodology and presents the different types of statistical analyses arising from the empirical study. The researcher used nonparametric, or *distribution free* tests, so called because the assumptions underlying their use are "fewer and weaker than those associated with parametric tests" (Yu, 2002). To put it another way, nonparametric tests require few if any assumptions about the shapes of the underlying population distributions. For this reason, they are often used in place of parametric tests

if/when one feels that the assumptions of the parametric test have been too grossly violated (e.g., if the distributions are too severely skewed).

1.10.7 CHAPTER SEVEN - GENERAL CONCLUSIONS AND RECOMMENDATIONS

This chapter draws conclusions and recommendations from the findings of the empirical research. It is hoped that these recommendations will assist eThekwini Metro and iLembe region hospitals to deal with the challenges they face with regard to hospital service delivery and the monitoring and evaluating of BPPs in these provincial hospitals in the quest for more efficient and effective delivery.

1.11 SUMMARY

The White Paper on the Transformation of the South African Public Services was published in October 1997 (South Africa, 1997:9). This document is also known as *Batho Pele*, which, as earlier explained, is a Sesotho expression meaning 'people first'. The White Paper sets out eight principles against which a transformed South African public service will be judged, for its effectiveness in the delivery of services which meet the basic needs of all South African citizens. These principles are consultation; service delivery; access; information; openness and transparency; redress and value for money (South Africa, 1997:9).

The Constitution of the Republic of South Africa introduced a Bill of Rights, which forms the cornerstone of democracy in South Africa. It enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom. Because all national departments have to adhere to the principles and rights contained in the Constitution, the Department of Health (DoH) is committed to upholding, promoting and protecting the rights of patients. This commitment is guided by the BPPs and several legislative and policy documents.

This research study's aims and objectives, as well as the key questions which form part of the research, have been articulated. Chapter one has outlined the research methodology, including interviewing doctors and nurses and the distribution of questionnaires to patients in hospital wards. This chapter has also highlighted the manner in which statistics were obtained

and analysed. Numbers of important terminologies have been defined and the limitations of the study were described.

CHAPTER TWO

PART 1: LITERATURE REVIEW

2.1 THE PUBLIC SERVICE AND DELIVERY IN SOUTH AFRICA- AN OVERVIEW

INTRODUCTION

The 'new' South Africa (SA) came into existence in 1994. The ANC-led government was faced with an immense mission of fiscal, political, social and economic transformation, in order to achieve an acceptable standard of living through effective public service delivery. Russell and Bvuma(2001) cite the following challenges facing the ANC-led government:

- Significant segregation from modern influences;
- The impact of excluding the majority of the population of the country from opportunities to exercise power and influence in the public service; and
- The failure to conquer certain rampant social and economic problems such as HIV/AIDS, unemployment, poverty and crime.

Russel and Bvuma (2001) observe that the SA public service offered an ambiguous face to the globe in 1994 with significant know-how in pockets but an overwhelming obligation to revolutionize the public service focus, culture and procedures. The public service needed to be transformed from a conventional, broad and expensive entity, into a more flexible and less bureaucratic organ of society. Institutional, cultural and policy changes were required, as well as major new directions in resource distribution as more programmes were added to meet the needs of disadvantaged communities not previously served.

The degree of transformation required was enormous, and included widespread reform of traditional public service structures, as well as a range of new approaches in different spheres of service delivery. Russell and Bvuma(2001) state, "the present focus on the development of alternative service delivery partly reflects arecognition that reforming the traditional bureaucracy, while necessary, will not of itself guarantee the service delivery needs".

2.1.1 Reform of the traditional bureaucracy

The public service is charged with achieving the aspirations of the new South Africa underlined by well-known clauses in the Constitution, which set out the ethics and morality to guide government in every sphere, and to provide the foundation for the construction and operations of the public service. Since 1994, a substantial number of changes have been implemented. In terms of the requirements of the South African Constitution (1996) the changes have included the following:

1) The validation and incorporation of national, provincial and 'homeland'systemsinto a single public service in order to unify the public sector, and the construction of a new public service whose standards and traditions support the new nation. In 1994, the old system was replaced with nine provinces and the former homelands were done away with.

2) There was a need to create new central personnel agencies to offerstrong leverage for change in the public sector. The new administration valued the centrality of the public service to achieve more than what was anticipated of it; early steps were taken to provide an institutional framework that would give the new administration a powerful tool to implement effective changes. After the new administration took office, a new Department of Public Service and Administration (DPSA) was established. The Public Service Laws Amendment Act 1997 assigned public service responsibilities to the Minister for Public Service and Administration, including creating and abolishing departments and agencies, employment, personnel practices, classification and pay, and transformation and reform (South African Constitution, 1996).

2.1.2 ***The Public Service Commission (PSC)'s role was defined by Section 196 of the 1996 Constitution as follows***:

- To encourage ethics and values (set out in the Constitution and section 195) right through the public service and administration;
- To examine, monitor and assess the administration and personnel practices of the public service; and
- To advise on measures of effective and efficient public service performance.

The PSC's role was to strengthen the review process and to stamp its authority on issues such as the promotion of equal employment opportunities, ethical behaviour and management approaches. Key departments were created to enforce and influence the evolution of the public service, such as the Department of Treasury to deal with the financial controls, and a Department of Cooperative Governance and Traditional Affairs, which plays an important role through its influence on provincial and local government, given that South Africa has a unitary foundation and hence both the national and provincial public service form part of a single public service some 980 000 strong. Transformation initiatives in South Africa's public service are normally directed at departments and provinces.

New public service legislation and policies were enacted**.**There were also central agency reforms, with legislation passed in 1996, and regulations adopted in 1999 providing for thedevolution of most personnel powers to the Minister.

At that time, English was adopted as the national language of administration. The long-established South African public service had used Afrikaans as the main language, which represented a difficulty for communities that spoke other languages. The capacity of the public service reforms was further extended by the broad adoption of English and the related need to convert all of the administrative documents into English and to createnewPublic Service Regulations in English.

These changes undertaken by the new dispensation were critically significant, basic and comprehensive; however, most importantly, the new administration had to deal with internal matters and problems in order to swiftly and efficiently effect changes to the public service structure, procedures and policies in order to serve previously disadvantaged communities, for example, rural people who lacked basic public services such as clean water, healthcare, housing or roads.

Some of the new departments proved capable of speeding up the direction and pace of their service delivery activities, while others experienced extreme strain. It became clear that service delivery needed to be a vital focal point of government. Later, better service delivery became the key goal, and service delivery outcomes became the yardstick by which the public service was judged, especially in a country where service delivery benefits had long been unfairly distributed.

The following service delivery enhancement initiatives were adopted:

- *Batho Pele*;
- Public/private partnerships; and
- Alternative service delivery.

2.1.3 The White Paper on Transforming Public Service Delivery- Batho Pele (1997)

The White Paper on Transforming Public Service delivery, the so-called '*Batho Pele'* White Paper', was published in 1997. It mandated departments to advance their service delivery in terms of eight service delivery standards:

1) *To consult with customers on a regular basis*. The general public should be consulted about the level and value of the public service they receive and wherever possible be given a choice about the kind of service they would like to be offered to them.

2) *To set service standards.* The public should be informed what level of quality of service rendered by the public service they will receive so that they are aware of what to expect.

3) *To boost access to service.* All citizens should have equal access to the services to which they are entitled.

4) *To ensure higher levels of courtesy.* Citizens should be treated with courtesy and consideration.

5) *To offer added and improved information about services.* Citizensshould be given full, correct information about the public service they receive.

6) *To increase honesty and transparency about services.* People must be informed how national and provincial departments are run, how much they cost and who is in charge.

7) *To remedy failure and inaccuracy*. If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy,

effective remedy; when complaints are made, citizens should receive a sympathetic, positive response.

8) *To give the best possible value for money.* Public services should be provided economically and efficiently in order to give citizens the best possible value for money. (The White Paper on Transforming Public Service Delivery - *Batho Pele*, 1997).

2.1.4 Assessing progress

The *Batho Pele* mission was a rational and well-marketed effort to encourage service quality consciousness across operating units. Seminars were held and posters were distributed, and a range of pioneering measures were implemented to broaden acceptance. For example, in KZN, the PriceWatershouseCoopers Premier's Good Governance Award was introduced (PriceWaterhouseCoopers, 2000). Contestants were required to self-assess the service delivery performance of their components against the eight *Batho Pele* principles. The award proved to be an effective tool, but also provided a picture of *Batho Pele* as an attractive framework that captured the imagination of many public servants.

In June 2000, an initial broad survey of the *Batho Pele* plan was undertaken for the PSC. The survey was only conducted in six national departments and five provincial departments. Although a range of functions was covered, the 11 departments surveyed form a small fraction of the total (130). The investigation method utilised a questionnaire, random visits to service points and two customer surveys. It revealed somewhat uneven compliance with BPPs, with greater compliance in the national departments than in the provincial department, where compliance was very limited. The conclusions of the survey were as follows (Public Service Commission, 2000):

- Little was being done to inform members of the public about their rights and to ascertain their needs. School governing bodies, particularly in the rural areas, and community policing forums are complex structures that were weak and in need of support.

- All departments should institute and use appropriate, prescribed consultative bodies;

- Service standards were often not appropriately displayed and users of services were not alerted to what service standards they should be demanding;
- Essential service standards should be displayed in all public areas of public service buildings;
- There is a broad range of local and regional variations in terms of quality and exposure.
- All departments ought to demonstrate a commitment to improving access to services, particularly those which are seen as human constitutional rights, complete with progress targets and resources where required.
- Consideration for consumers is a crucial and attainable principle, and is central to the public service. Departments should initiate customer fulfilment surveys as part of an integrated monitoring and evaluation strategy. Such surveys should place strong emphasis on courtesy.
- There should be a comprehensible connection between dialogue and information.
- While ways of ensuring that information was provided were improved, more needed to be done in order to move away from simply using contact lists.
- Annual Reports produced by departments should follow an approved system with a simple aim: to offer reliable, similar data. This system was approved by the PSC in its more recent report on Government Annual Reports.
- Inadequate efforts had been made to provide complaint management services.
- A small number of departments had embarked on an analysis of their performance.
- There is an obvious need to carry out an assessment of possible ways to enhance services in innovative ways (differentiated service delivery options).

The authors of the survey, while supporting of the intentions of *Batho Pele*, felt "that service delivery improvement activities were too often viewed as separate from the mainstream activities of departments, and that assistance should be provided to departments to enable better application of *Batho Pele*principles" (Public Service Commission, 2000:40).

PART 2

2.2 SERVICE DELIVERY IN THE PUBLIC SECTOR IN SOUTH AFRICA

2.2.1 Definition of Service Delivery

In defining service deliveryBerry, Forder, Sultan and Torres(2004) note that service delivery is conceptualized as the association linking strategy (policy) makers, service providers, and poor people. It encompasses services and their supporting systems that are normally regarded as a government duty (accountability). These include community (social) services (primary education and basic health services), infrastructure (water and sanitation, roads and bridges) and services that promote personal security (justice, police). Pro-poor service delivery refers to interventions that maximize the access and participation of the poor by strengthening the relationships between policy makers, providers and service users (Berry *etal.*, 2004).

The delivery of basic services is a central task of poverty reduction. Water, education, healthcare and personal security are among poor people's highest priorities and expanding inclusive service delivery is critical to achieving the Millennium Development Goals (Berry*et al.*, 2004). Strategies to improve service delivery typically emphasize the central role of the state in financing, providing and regulating services. The state bears the legal responsibility to ensure that the fundamental human rights to security, education and healthcare are realized. The state is also well placed to respond to the challenges of scale and market failure in ensuring access to services on the part of all groups. For these reasons, many development analysts have emphasized the central role that government plays in regulating, overseeing and monitoring the delivery of services (Narayan, Deepa, Chambers, Meera&Petersch, 2000).

2.2.2 THE ROLE OF KNOWLEDGE MANAGEMENT IN ENHANCING GOVERNMENT SERVICE DELIVERY

The World Bank (2001) avers that knowledge management has become a fundamental source of wealth creation, supplementing industrial capital and land. The World Bank sees knowledge management as representing a management modernization challenge for the public sector, which involves adapting classical management tools in a way that systematically promotes knowledge sharing. The sharing of knowledge in organizations or departments is one of the fundamental functions of any knowledge management programme.

It is the contention of the World Bank that countries are anxious to put knowledge management programmes in place in the public sector, but lack the knowledge or experience to do so.

Withers (2006), suggests, that the public service needs to pay serious attention to information management, also known as knowledge administration, as a critically efficient service tool. Withers (2006) explains that this could embrace efficient oversight of stock, use, creation and preservation of knowledge and information, with particular attention being given to the placement of this in executive decision-making and the incentive and reward structure of a department or agency.

South Africa and Kenya, like most countries in the sub-Saharan region and in contrast to many countries in the developed world, has not yet productively integrated knowledge management in its government departments (Ondari-Okemwa, 2006). This tardiness can be attributed to the fact that knowledge is not leveraged effectively and because other countries in the region lag behind developed countries insofar as the application of information and communication technology and the introduction of e-governance in concerned. The civil service is furthermore plagued by numerous impediments that inhibit the generation and sharing of knowledge, the most severe of which are its entrenched bureaucracy, lack of incentives, cultural barriers and technological inadequacies (Ondari-Okemwa, 2006). With reference to technological barriers, it is evident that the ICT infrastructure urgently needs upgrading to facilitate the introduction of e-governance, which in turn will enable the effective implementation of knowledge management programmes. Despite the impediments, it is our conviction that the delivery of basic government services can be improved if the civil service were to adopt knowledge management practice that is firmly integrated into service delivery procedures. Civic servants should be motivated actively to generate, manage and share knowledge and information.

2.2.3 Knowledge Management

Knowledge management has been defined in various ways. Sun (2004), for example, states that it is basically concerned with knowledge processing that is permeated by each of the following stages: Understanding and discovering knowledge; capturing and acquiring knowledge from a variety of sources; selecting, filtering and classifying existing knowledge; storing and saving knowledge; designing knowledge ontologies; adapting and/or creating new knowledge; measuring and evaluating knowledge; visualizing knowledge; distributing and or

transferring knowledge to others; sharing and applying knowledge; and retaining and maintaining knowledge as an asset.

Alevi and Leidner (1999), in turn, define knowledge management as a systematic and organizationally specific process for acquiring, organizing and communicating both tacit and explicit knowledge so that employees may utilize it to be more effective and productive in their work. Knowledge management seeks to promote re-use, sharing and re-purposing of an organization's tacit and explicit knowledge and shared awareness of the state of an organization's environment. The differentiation between tacit and explicit knowledge was first mooted by Nonaka and his associates (Nonaka, 1994;Nonaka and Konno, 1998;Nonaka and Tekeuchi, 1995). It is their view that explicit knowledge can be expressed in words or numbers; it can be shared in the form of data, scientific formulae, specifications, manuals etc., and can be readily transmitted between individuals, formally and systematically. Tacit knowledge, on the other hand, is highly personal and difficult to share with others.

2.2.5 Bureaucracy

Sinofsky (2005) defines bureaucracy as management or administration by a hierarchical authority among numerous offices and by fixed procedures. Bureaucracy is associated with the civil service and civil servants. Civil servants in all civil services are known to stick to procedures and rules, and cannot perform outside of their defined duties. Bureaucracy is not confined to national government only, as shown by Benner, Mergenthaler and Rotmann (2008). Benner *et al.*, 2008 contend that large international public organizations like the United Nations and its organs make mistakes and keep on repeating the same mistakes rather than learning from them. Sinofsky (2005) avers that "in the world of technology and the internet, the one who is out with no rules, no processes, and no hierarchy is the one who is going to win big, while all those sloths with their spreadsheets and dashboards are all bunched up trying to plan their way out of a paper bag."

Knowledge management has mainly been associated with profit-making corporations, which may be a major reason for the organizational culture that predominates in the public sector (Ondari-Okemwa and Smith, 2007). Logde and Kalitowski (2007), in their study on *Innovations in Government*, argue that:

- Civil services are bloated, rigid, hierarchical and over-centralized;

- Its monopoly status ensures that the public sector is unresponsive and inefficient;
- Government is driven by the interests of producers, and is not efficient;
- Government is driven by the interest of producers, not users;
- There is an absence of a performance culture; and
- Civil servants are unaccountable and over-privileged.

These are not very desirable characteristics for the civil service of any government. However, these characteristics are prevalent in nearly all civic services in sub-Saharan Africa, including South Africa. Many top civil servants in sub-Saharan Africa would argue that these characteristics were inherited from the European colonizers and have served post-colonial civil servants well. New Public Management (NPM) views the ideal government as being "flat, flexible, specialized and decentralized", according to Pollitt and Boukaert (2004). The NPM model of management advocates a number of reforms meant to remake the public sector in the image of the private sector. The NPM model has attempted to introduce a 'bottom-line' mentality for the civil service to operate like the private sector.

2.2.6The civil service in a changing world

It may not be very obvious to the top civil servants in Kenya and the rest of sub-Saharan Africa, but civil services everywhere now exist in a rapidly changing world. The demands placed on the civil service are dictated and determined by the wider environment. Civil services all over the world have to adapt to a number of long-term societal trends that are changing the ways in which government is run in the 21st century. Lodge and Kalitowski (2007) identity some of these trends as including:

- Globalization;
- Demographic change-especially an ageing and more diverse population;
- Global migration flows;
- The information technology revolution;

- Increased marketization and the blurring of boundaries between the public and private sectors;
- A less deferential and trusting attitude towards government;
- More intrusive mass media;
- An increase in so-called 'wicked problems' such as corruption, fraud and maladministration that require a united,, cross-boundary response; and
- Problems that can only be addressed through cooperation and behaviour change.

According to Pinchot and Pinchot (1993), institutions are changing as the relationship between employee and employer alters in deep and permanent ways in response to the need for all to contribute their intelligence, creativity, and responsibility to society. It is now expected that employees in both the public and private sectors should be innovative, care for customers, work in teams and collaborate with others as well as follow their own initiative rather than just follow orders. The situation in the public service is, however, complex and fraught with anomalies - while members of the public are, on the one hand, the public servants' customers, on the other, as tax payers, they are the employers of all public agencies.

In an address to the *African Management Development Institute Network Conference* in 2007, former Minister of Public Service and Administration, Geraldine Fraser-Moleketi underscored the importance of knowledge management in the African civil service of the 21st century:

> The 21st Century African public service has to be a learning organization, a learning organization in which people at all levels, individually and collectively, are continually increasing their capacity to produce the result they really care about, where the organization encourages new ways of thinking, where the collective vision of creating the best is liberated, and where everybody continuously learns how to work together. If the African civil service is to lead Africa to attain its commitments to the Millennium Development Goals, new ways of doing business and continuously solving problems is essential (Fraser-Moleketi, 2007).

2.2.7 Knowledge management and government service delivery

Through the public service, every government strives to deliver basic services to its citizens as effectively as possible. These services may relate to improving the economic infrastructure, improving efficiency and effectiveness, and establishing a business-friendly environment by reducing the cost of setting up and doing business. Government-owned corporations often serve as levers that open growth potential and create macro-economic stability. Riley (2003), however, contends that in recent years there has been much public cynicism towards politicians and public officials. According to Riley (2003), much of this cynicism is based, amongst other things, on a lack of knowledge and understanding of the inner workings of government, a lack of communication to keep people informed, and government's failure to engage ordinary citizens in public policy development. In Kenya and other countries in the sub-Saharan region, members of the public are rarely involved in or consulted on matters of public policy formulation or implementation. This is related to the culture of secrecy that is still prevalent in government services in many African countries. The key factor in the information/knowledge society is the generation and exploitation of knowledge; according to the World Bank (2007), today most technologically advanced economies are truly knowledge based. The European Commission's (2000) Joint Research Centre estimates that as much as 70 to 80% of economic growth can now be said to be due to new and better knowledge.

Wig (2002) is also of the opinion that knowledge management could make a significant contribution to rendering a country's public administration more effective in the following ways:

- By enhancing the administrative side of the government service;
- By aiding the citizens of the country to influence government operations and decision making;
- Through the construction of aggressive collective intellectual capabilities; and
- By enhancing the development of a strong, reliable and knowledgeable labour force.

He further argues that the knowledge management objectives for the public administration in a democracy may be expressed as the intent to provide:

- Effective public administration services and functions to implement the public agenda;
- A stable, just, orderly and secure society;
- Acceptable quality of life, particularly through building, maintaining, and leveraging commercial and public intellectual capital; and
- A prosperous society for developing its citizens to become competent knowledge workers and its institutions to be competitive.

Heck and Rogger (2004),in turn, suggest that knowledge management intervention in the public service could in the mid-and long-term achieve the following:

- Significant improvement of service delivery in terms of efficient, transparent and quality service as a result of the transparent and configurable flow of information and more equitable distribution of responsibilities;
- Creating a public administration that is based on well-organized and technically functional internal business processes, e.g the development of e-government projects; and
- Leveraging optimizing skills that are related to workflow in the various government departments.

Wexler (2001) specifically refers to the benefits of utilizing the visual technique of knowledge mapping to coordinate and steer through multifaceted webs of knowledge possessed by institutions. There is an emphasis on the role that *knowledge mapping* can play to render experts' knowledge unambiguous with the purpose of creating an understanding that could beshared. *Knowledge maps,* if created in the civil service, can offer an impression of knowledge that can be found in government departments and the identification of the people who possess such knowledge.

It is clear that there are numerous applications and benefits that can derive from implementing effective information management strategies in a government department. It is therefore not surprising that knowledge management is increasingly playing a more important role in this environment. The literature, however, suggests that while this might be true in more developed countries, it does not necessarily pertain to many countries in Africa. The

study conducted by Ondari-Okemva (2006) clearly indicates that Kenya and many countries in sub-Saharan Africa have not yet effectively integrated information management into their government departments/agencies and that, as a consequence, the delivery of basic government services is generally not at the required levels in terms of quality, efficiency and transparency.

2.3 KNOWLEDGE AND MANAGEMENT IN THE PUBLIC SECTOR

In order to achieve successful public sector service delivery, knowledge management processes must be utilized as a means of gaining a competitive edge (Fowler &Pryke, 2003). The manifestation of knowledge management within the public service sector, albeit not unheard of, is less prevalent (Fowler &Pryke 2003). However, as a government adopts policies that acknowledge the information age, there is a stronger inclination toward knowledge management within the government sphere (Fowler &Pryke, 2003). Knowledge management has a number of benefits for public sector organizations. Cong and Pandya (2003) have identified these benefits as follows:

- Knowledge management creates the opportunity for employees to develop their skills, performance and experience through group work and knowledge sharing;
- Knowledge management improves organizational performance by means of better quality, innovation, productivity and efficiency;
- Knowledge management facilitates better decision making, more collaboration, restructuring of organizational processes and a decline in the duplication of work, consequently cutting operational costs and improving service delivery;
- Knowledge management increases the financial worth of an organization;
- Knowledge sharing creates value in an organization and strategically enables a competitive edge.

The significance of knowledge management for the public sector is apparent; however, many public sector organizations have been disinclined to explore what it can offer (Edge, 2005).

2.4 FORCES OF CHANGE

Weber's bureaucratic model has been a guiding force in the development of government structures and research. Wilson and Malik (1995) and Hughes (2003) pointed out, that there has been considerable criticism of this design, which focuses on creating stable and specific goals characterized by a high degree of formal definitions and written rules. O'Neill (2000) argues that the improvement of education and health services and welfare reform does not rest with a single organization or structure, but successfully achieving the desired performance outcomes depends on complex, multi-disciplinary teams (process-based structures) and network-based structures. These relationships and partnerships in the public, private and non-profit sectors are becoming more and more blurred, thus raising questions about the role and responsibilities of each sector, especially in policy development and accountability (Tushman, 1997;O'Neill, 2000; Levy and Tapscott, 2001).

2.5 THE PRACTICAL EXECUTION OF ORGANIZING

Gibson, Ivencevich and Donnelly (1994) observe that structural changes within an organization affect all aspects of formal tasks and how authority is defined within an organization. The organizational structure thus creates the basis for relatively stable human and social relationships (Gibson, *et al.*, 1994). These relationships are underscored by the choices made between centralization and decentralization, and they determine how organizational structure and power over decision-making are applied within service delivery (Mintzburg, 1994; Gibson, *et al.*, 1994).

Decentralized governance is embodied in the 1996 South African Constitution (Sections 40 and 41(1)), which sets out the powers and functions of the three spheres of government (Department of Health, 2001; Kuye, Thornihill and Fourie, 2002). The health sector has adopted decentralization as a governance and management model. Decentralized management is very different from a rigid, bureaucratic hierarchy (Hughes, 2003). It has a greater client focus and allows choice and competition and the use of the market instrument. Assigning accountability for results to managers within a decentralized environment is considerably different from following instructions and rules set down within a hierarchical environment (Hughes, 2003). The World Bank views the decentralization of public health services as a precondition for improving efficiency and responsiveness in local health

conditions and demands (Department of Health, 2001). However, a decentralized health care system must be seen as a gradual process, not without its own unique problems. De-concentration and devolution are used to strengthen the public sector and the ability to generate a more coherent and useful public-private mix within the health system is necessary to achieve the desired objectives (Department of Health, 2001).

2.6 CUSTOMER ORIENTATED SERVICE DELIVERY

Customer oriented service delivery is the objective of various initiatives introduced by the South African government. One-stop shops, the e-Government project and a call centre are but some of such initiatives (Levin, 2004). The manner in which overall services are provided is influenced by the principles of *Batho Pele.* These principles ensure that service delivery is citizen-centred. The BPPs include:

- **Service standards**

Citizens should be informed about the service level and quality of services they will receive to create an awareness of what to expect, and consequently, to provide benchmarking and redress. Service standards should be specific and measurable standards for the quality of services and should be published at national, provincial and departmental levels. Standards and the performance of health care providers must be measured at least once a year. Users should be able to judge whether the promised services were received or not (South Africa, 1997:17-17). Service standards cannot be achieved without resources and infrastructure.

In a public hospital, service standards pertaining to the functioning of the ward should be displayed on the wall in the unit so that they are visible to patients and their families. This includes the nurses' shift rosters; the schedule for the serving of meals; schedules for nurses' tea and lunch breaks; and schedules for visiting times.

- **Access**

All citizens should have equal access to the services that they are entitled to. Increased access to service delivery includes access to health services on the part of patients who were previously disadvantaged as a result of the lack of infrastructure and barriers to access such as social, cultural, physical, communication and attitudinal factors (South

Africa, 1997:18). Access to health care is also addressed in the Patients' Rights Charter that requires the availability of adequate resources in order to deliver health care services.

- **Courtesy**

Citizens should be treated with courtesy and consideration. Patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy, politeness and understanding, as well as with consideration and respect. Discourtesy must not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioural norms to junior health care workers (South Africa, 1997:19). Courtesy is underwritten by the Bill of Rights and the Patients' Rights Charter.

- **Information**

Full, accurate information about the public service they are entitled to should be provided to citizens. There should be openness and transparency. Citizens should be informed about how national and provincial government operates; its functions and structures. Patients should be empowered to understand the health services they are entitled to receive, their illness, diagnosis and treatment. The National Department of Health White Paper states that healthcare providers should determine what patients need to know and then decide on the best way to provide this information in understandable language free from jargon (South Africa, 1997:19). Patients who are well informed are able to participate in the treatment decision and are more likely to comply with their treatment plans (NDOH, 2007:13).

- **Redress**

Citizens should be informed of the structures available to address the government in the event that they are unhappy with the manner in which services have been provided; citizens who have a complaint should be offered an apology and receive a sympathetic and positive response. The principle of redress requires an effective approach to handling complaints which should be viewed as opportunities to identify and address problems and improve service delivery. Complaints should be addressed without delay, must be investigated fully and impartially and must be treated confidentially to protect the complainants. The hospital must have a strategy for providing feedback about complaints that will serve as training opportunities for health care providers. All staff should be aware of the procedures for handling complaints (South Africa, 1997:21-22).

- **Value for money**

Public services should be provided in an economical and efficient manner so that citizens are given value for money (White Paper on Public Service Transformation, 1995). The White Paper states that services should be cost-effective and delivered within departmental resource allocations. Procedures should be simplified and waste and inefficiency eliminated (South Africa, 1997; 22). Unit managers are required to plan, organize and control all resources in such a way that cost-effective patient care can be rendered. Nursing units must control their resources in order to prevent unnecessary shortages, for example linen shortages. This principle is closely related to access to health care as discussed in the Patients' Rights Charter.

2.6.1 Citizens as effective policy partners

Ondari-Okemwa's (2006) study clearly indicates that the Kenyan, South African and the rest of the sub-Saharan region's civil service is not geared towards involving its citizens in policy development and in preparing them to become effective policy partners. Policies are formulated and implemented by government policy makers without any input from the citizenry; as a consequence ordinarily citizens are unaware of the effect that the policies that have been promulgated have on their lives. Some organizations in European countries have devised ways of involving citizens in formulating and implementing public policies which affect them. For example, in the run-up to the 2009 Euro-elections, the European Citizens' Consultations 2009 (ECC 2009) brought together randomly selected citizens from all 27 EU Member States to discuss key challenges facing the EU with one another and then with policy-makers. ECC 2009 focused on the challenges of greatest concern to EU citizens, seeking to answer the question "what can the EU do to shape our economy and social future in a globalized world?"

'Family and social welfare' were among the topics chosen by citizens for in-depth discussion at ECC 2009, and the latest Eurobarometer opinion poll shows that social and economic issues remain high on the public agenda. As the EU institutions begin work on a post-2010 successor to the Lisbon Agenda for economic growth and competitiveness, ECC 2009 has provided relevant input for decision-makers. The ECC (2009) had six objectives:

- Promoting interaction between citizens and policy-makers: Fostering debate between citizens and policy makers in the run-up to and after the European elections;
- Citizens as policy advisors: feeding citizens' opinions into the political debate at both European and national levels;
- Citizens participating as a policy instrument of the future: mainstreaming trend-setting and long-term oriented citizen consultations at the European level;
- Closing the gap between the EU and its citizens: bringing the EU closer to citizens and citizens closer to the EU;
- Increasing the general public's interest in the EU: generating substantial media coverage of the dialogue between the EU its citizens; and
- Partnerships in participation: deepening European co-operation within existing civil society networks and their respective partner networks, as well as providing e-participation.

This kind of citizen participation in making policies is lacking in Kenya and sub-Saharan Africa in general. In an opinion piece published in a local newspaper, Njonjo (2009) implored the government of Kenya to involve the Kenyan public in law-making. Members of the public in Kenya and in the larger sub-Saharan region are rarely involved in policy or law-making. It is clear that such a situation is untenable and it is suggested that by introducing effective knowledge management programmes, the Kenyan government could enable its citizenry to become effective policy partners.

2.6.2 E-government and a customer-centred public administration

According to Oakley (2003), e-government involves the use of information technology to raise the quality of the services government delivers to citizens and businesses. It is hoped that it will also reinforce the connection between public officials and communities, thereby leading to a stronger, more accountable and inclusive democracy. Customer-centred public administration emphasizes customer involvement and the quality of public service (Ra and Joo, 2005). 'Value for money' and /or 'putting the customer first' are some of the issues addressed by customer-centred public administration.

According to Skelcher (1992), ‘customer’ refers to the direct users of public services, the direct or indirect recipients of public organizations’ activities, those benefitting or not benefitting frompublic organizations’ activity or inactivity, and those who do not fall into any of the above groups but have an interest in public service. Skelcher further argues that adopting the customer as the focus for improvements in public service delivery requires organizations to adopt the customer’s needs approach, together with an increase in customer power.

Heck and Rogger (2004) suggest that the introduction of e-government enables public administration to move towards more customer-centred services as it brings with it a redistribution of tasks and hence of knowledge. It was observed that the Kenyan civil service is not particularly customer-centred and that service delivery is of uneven quality and availability. Citizens receive services as and when the civil servants have the time and ability to render them; service delivery is often delayed and is of poor quality. It is suggested that if the South African and Kenyan governments were to introduce e-governance, there would be an improved redistribution of tasks and knowledge and hence a move towards customer-centred services and enhanced service delivery. Knowledge management would be one of the pillars enhancing service delivery in the South African and Kenyan civil services.

2.6.3 Cultural factors

Culture can act as both an enabler and an impediment to the generation, distribution and sharing of knowledge and information. According to Barnard, Cloete and Patel (2003), in a developing context, cultural factors are particularly important for the successful deployment of most electronic services. They refer specifically to the tension that often exists between many traditional and modern, electronic environments. Kenya, South Africa and the rest of sub-Saharan Africa are developing nations and have not yet fully adapted to the electronic environment. Careful consideration should therefore be given to cultural factors when such technologies are deployed. A culture of sharing knowledge and information is still lacking in Kenya and the rest of sub-SaharanAfricaand traditional cultures in these countries discourage such sharing.

2.6.4 Literacy levels in Africa: Kenya

Although the World Bank (2007) has recorded an impressive adult literacy rate of 77.1% for persons aged 15 and above in Kenya, these figures merely represent functional literacy rates. In many of the region's countries, including South Africa, low literacy rates prevail, especially in the rural areas, and information literacy rates, even among civil servants, are low; this can hinder the distribution and sharing of knowledge and information.

TABLE 2.1: Variable indicating Kenya's Level of Preparedness for Knowledge Society (World Bank 2007).

Variable	Kenya (most recent) Group: All		Kenya (1995) Group:All	
	actual	Normalised	actual	Normalised
Annual GDP growth %	2.94	2.69	2.40	3.05
Human development index	0.491	1.23	0.523	2.00
Tariff & Nontariff Barrierse	4.00	1.71	4.00	4.03
Regulatory Quality	0.32	3.64	0.43	2.27
Research in R&D/Mil. People	n/a	n/a	n/a	n/a
Scientific & Technical Journal Areticle/ Mil.People	7.89	3.74	11.40	4.27
Patents Granted by USPTO/Mil People	0.25	4.62	0.04	3.94
Adult Literacy Rate (% age 15 and above)	73.60	2.42	77.10	3.23
Gross Secondary Enrolment	48.00	2.09	24.40	1.40
Gross Tertiary Enrolment	2.90	0.96	2.70	1.28
Total Telephone per 1,000 people	85.00	1.82	9.50	1.82
Computers per 1,000 People	13.20	1.90	0.70	0.73
Internet Users per 1,000 People	44.80	3.11	0.00	0.00
DP gro Growth and Patent Application Granted by the USPTO are the average for 2001-2005 (Most recen 2005(most recent) and 1993-1997(1995) most of the remaining recent data if for 2004-05				

2.6.5 South Africa and Kenya's level of preparedness to become knowledge societies

According to the World Bank (2007), for a country or a region to harness its human and social capital so that it can take its place among today's knowledge economies, requires less financial investment than policy reform. They therefore suggest that a country should embark on policy initiatives that would transform its education system to meet the demand of a global economy driven by advances in knowledge and technology; encourage private businesses to invest in research and development; and create business and research initiatives that foster innovation.

Research by the World Bank Institute (World Bank, 2007) has found that a policy framework that can promote knowledge economies rests on four *pillars*, all involving long-term commitment. The*firstpillar* relates to the provision of economic incentives and an

institutional environment that encourage entrepreneurship, the development of new activities and modernization. The*secondpillar* that a country needs to build is a skilled and flexible labour force. A country should provide quality education and life-long learning to its people, both male and female. The *thirdpillar* relates to building a knowledge society where dynamic information and telecommunications infrastructure provide efficient services and tools to all sectors of society. As a country sets out to restructure and develop its telecommunications infrastructure, it should ensure wider and less costly access to telephone lines and to the internet. The *fourthpillar* refers to the creation of a system of science and research centres, universities, and other organizations that can interact to promote innovation and create new products and services. Building such innovation systems would facilitate the pooling of resources for research projects, ensuring financing and/or commercialization of research, promoting excellence through professional associations of experts and peer-review mechanisms, and the creation of specialized research and development centres.

In its assessment of how Kenya fares with reference to these *pillars*, the World Bank (2007) scores Kenya below average on all four. Table 1 shows Kenya's scores in the World Bank's assessment of a country's readiness for a knowledge economy. The highest possible score is 10. Once again it can be seen that Kenya scores below average for all categories and that the country is particularly weak in the field of tertiary education. These factors indicate that Kenya has not yet become a knowledge society, and a considerable amount of work needs to be before it can become one.

Closely related to these factors is a country's level of readiness to introduce e-governance. It is generally accepted that information and communication technology (ICTs) are important enablers that ensure that knowledge management programmes run effectively. It is further clear that the utilization of ICTs or e-governance in the public sector has become a crucial factor in ensuring good service delivery. According to Coleman (2005), there has been a rapid growth of information and communication technologies which can transform the generation and delivery of public services, thereby reconfiguring relationships between government and citizens (G2C)), government and business (G2B) and within and between governments (G2G). Coleman further contends that e-governance has the potential to:

- Improve the performance of public institutions and make them more transparent and responsive;

- Facilitate strategic connections in government by creating joined-up administrations in which users can access information and services *via* portals or 'one-stop-shops'; and

- Empower civil society organizations and citizens by making knowledge and other resources more directly accessible.

The study conducted by Ondari-Okemwa (2006) as well as the assessment by the World Bank (2007) (as outlined above) clearly indicate that Kenya lacks an adequate ICT infrastructure to enable it to effectively implement e-governance and knowledge management programmes in the public sector. They therefore advocate that the ICT infrastructure needs to be significantly upgraded to ensure that it is at the appropriate level of sophistication to implement effective e-governance and knowledge management programmes. The researchers suggest that if this can be achieved the quality and promptness of service delivery in the public sector will improve significantly.

2.7 CONCLUSION

It is clear that knowledge management has the potential to improve service delivery in the civil service. It is, however, further evident that knowledge management has not yet been adequately integrated into the Kenyan and sub-Saharan African civil service. The Southern Africa and Kenyan civil services in particular, which are particularly embedded in bureaucracy, provides very few incentives to encourage civil servants to generate, distribute and share knowledge and information. Many employees in the Kenyan civil service are traditional career civil servants who cannot envisage and appreciate the potential of knowledge management and the benefits of knowledge leveraging.

Many of these civil servants are still wary of sharing knowledge or information as they perceive that by hoarding knowledge they enhance their own value and competitiveness. South Africa and other African states consequently have a long way to go before they can become knowledge societies where knowledge is freely generated and effectively used in the public sector. These factors are clearly indicated by the low scores the country achieves on the variables which determine a country's capacity to effect a knowledge economy.

The civil service is further plagued by numerous impediments that inhibit the generating and sharing of knowledge, the most severe of which are its entrenched bureaucracy, lack of incentives, culture barriers and technological inadequacies. With reference to technological barriers it is evident that the ICT infrastructure urgently needs upgrading to facilitate the introduction of e-governance, which in turn will enable the effective implementation of knowledge management programmes.

The researchers firmly believe that if the delivery of basic government services is to be improved; the civil service should be encouraged to adopt knowledge management practices that are firmly integrated into service delivery procedures. Civic servants should further be encouraged and motivated to actively generate, manage and share knowledge and information.

CHAPTER THREE

3.1 SERVICE DELIVERY IN LOCAL GOVERNMENT AND NATIONAL DEPARTMENTS

Internationally, governance has emerged as a focal point in the discipline and practice of public administration and its nature, extent and characteristics have changed the environment within which public administration functions. Public administration as an integrated paradigm has to achieve, maintain, enhance and sustain the collective promotion of the spiritual welfare of society (Nealer and Raga, 2007:171).

In South Africa (SA), addressing the need to bring about more effective and efficient public service delivery on the part of government and its executive public sector institutions, has come a long way since the time when there were more than 1100 racially segregated municipalities. Themore than 800 municipalities in 1996 were merged to form the current 283 municipalities which are now focused on expanding local economies and maintaining the provision of existing basic municipal services as well as extending them to areas under their jurisdiction that were previously neglected.

Since 2001, far-reaching changes have taken place in South Africa's municipalities. A firm legislative foundation has been established for improved public service delivery in the future. But this should not encourage complacency because many challenges remain and new issues continually present themselves (South African Cities Network, 2006:6-2).

To ensure that the effective and efficient delivery of public services, especially at the local government sphere is improved in SA, the government will have to take cognizance of the most urgent societal needs and challenges and prioritize and address them in a more coordinated, pro-active and macro goal-orientated manner. This will enable national government to among other pressing objectives, clean up the society and develop the country's infrastructure (Nealer and Raga, 2007:172).

3.2 SERVICE DELIVERY IMPROVEMENT STRATEGIES

Various key role players came to the fore in the government's quest to improve the standard of public service delivery in the country. For example, the Department of Water Affairs (DWA) is the custodian of SA's water and the lead national department in the water supply and sanitation sector (Water ServicesAct,Act 108 of 1997). The Department embarked on a restructuring process that would see public water service delivery at the municipal level strengthened by, for example, redeploying some of the Department's employees to municipalities, water utilities and other agencies (*Volksblad*, 2006/09/02: On-line).

The Department of Provincial and Local Government (DPLG) takes primary responsibility for promoting the Integrated Development Plans (IDPs) of municipalities, ensuring that provinces and municipalities have sufficient capacity and are provided with an equitable share of the municipal infrastructure grants, and effective monitoring. The Department of Health (DoH) co-ordinates all aspects of public health, and the National Department of Housing has established standards for public housing development and also co-ordinates the housing subsidy administered by the provincial housing departments. The Department of Public Works acts as the implementing agent on behalf of national and provincial government when schools and clinics are constructed. This Department furthermore has a responsibility to ensure that adequate water, electricity and sanitation facilities are installed in government and public buildings (including municipalities) (Fuggle and Rabie, 2005:77). There are also other role-players, such as the private sector, which can, for example, manufacture and install sanitation systems, partner with municipalities in service provision and provide finance. Non-governmental organizations (NGOs) can also assist with specific programmes (for example, the Mvula Trust focuses on the delivery of water services through community approaches) (Muller, 2002:On-line), facilitate community participation, develop community-based construction teams and implement and monitor projects (DWAF, 2002:On-line).

In order to facilitate and maintain improved public service delivery at the grassroots level in SA, more effective intra-, inter- as well as extra-governmental relations are essential. The abovementioned key role players must, therefore, strive to maintain positive and highly coordinated relationships among themselves, between themselves and other similar public sector institutions, and lastly, with institutions, enterprises and individuals outside their specific institutions (Nealer and Raga, 2007).

To assist with these crucial government relations, multi-purpose community centres(MPCCs) representing at least six government departments offering services to people in a specific municipal area, have been identified as the primary vehicle for the implementation of development, communication and information programmes, as they are able to serve as a base from which a wide range of public services and products can reach communities more effectively and efficiently (NISSC, 2001). They normally provide access to modern technology in the form of an ICT such as a Telecentre from which road shows, campaigns, exhibitions, community participation events, and specific public service take place; information products and services are sent out to all parts of the surrounding area of responsibility and where government departments from the national, provincial and local spheres offer information and services such as applications for identity documents, pensions, health information, unemployment offices, government information offices, passports, and training on the use of computers, the internet and other on-line services. Such services add value to those that are offered by the NGO and business sectors (Nealer and Rage, 2007).

Due to the limited nature and extent of public resources in SA, another useful vehicle to improve public service delivery, especially at the local government sphere, has been the creation of formal partnerships between two public sector institutions or between a public sector institution and a private enterprise or individual contract (Public-Private Partnerships (PPPs)) Such a partnership might involve a municipality taking on board a partner which can provide the capital, expertise and technology which a municipality does not possess or can attain. In terms of the Municipal Finance Management Act, 2003 (Act 56 of 2003), a municipality may only enter into a PPP agreement if the municipality can demonstrate that the agreement will provide value for money to the municipality, be affordable for the municipality, and transfer appropriate technical, operational and financial risk to the other (public or private) party (Craythorne, 2006:282). In order to improve the organizational structuring and planning of the South African government, the provincial sphere of government should be merged into the national and local sphere and the functions and legislative authorities of municipalities increased to bring about more effective and efficient greater city government (Craythorne 2006:42). This will require a new regional perspective as well as institutional organizations that can foster productive cooperation on matters of mutual concern and which can implement effective local governance in a framework of interconnected space characterized by dynamic flows of people, goods and movement.

To improve communication and coordination among key role-players, political office bearers, municipal officials, community organizations and residents should liaise more freely with one another in order to learn moreand to strengthen their coordinated attempts to bring about more effective, efficient and economical local public service delivery. This can only be realized through more effective communication by means of newsletters, brochures, open days/launches and effective assistance from the media in focusing on important issues identified by citizens and promoting grassroots democracy and popular participation in development (*City Press*, 2005/11/27:On-line).

Improved access to service delivery buildings and services as well as a holistic approach to more effective and user-friendly customer care should be arranged (e.g., chairs for senior citizens and adequate toilet facilities) to minimize queuing. Electronic technology such as automatic teller machines should be investigated and implemented to enable users to, for example, check their rent statements, buy electricity and make payments using their bank cards instead of cash (*Daily Sun*, 2005/05/12: On-line).

3.3 SERVICE DELIVERY IN PUBLIC AND PROVINCIAL HOSPITALS

Health care organizations and hospitals have an important role to play in this growing service industry. They are the only organizations that directly provide human health care. Because of their importance, hospitals should deliver a good quality, 'zero defect' service to their customers. Numerous and varied service measures and indicators exist for measuring the quality of health care, of which one of the most important indicators is patient (customer) satisfaction. Customer satisfaction drives future profitability and is a vital measure of performance for firms, industries and national economies (Anderson &Fornell, 1994). Satisfying patients can save hospitals money by reducing the amount of time spent on resolving patients' complaints (Press *et al.,* 1991*).*The quality of health care can be improved by eliciting patient preferences and customizing care, to meet the needs of the patient (Macario*et al.,* 1999). The patient's voice must begin to play a greater role in the design of health care service delivery processes. In addition, the emerging health care literature suggests that patient satisfaction is a dominant concern that is intertwined with strategic decisions in the health service (Andaleeb, 2001). Research has shown that the services provided by a company or institution can be measured by determining the discrepancy between what the customer wants (customer expectations) and how the customer experiences

the service (customer perceptions). Customer expectations are formed by word-of-mouth communication, personal needs, past experience and what and how the staff communicates to the customer (Zeithaml*et al*., 1990).

The citizens of SA deserves efficient and effective delivery of services and this demand has increased in recent years as the country has witnessed service delivery protests. In line with the government's key priorities in achieving service delivery, the government published the White Paper on Transforming Public Service Delivery (WPTPSD) in 1997. This formed part of the policy document, commonly termed 'Batho Pele' ("People First" in Sotho), that reflects the customer-centric nature of SA's service delivery reforms and contained eight guiding principles for public sector institutions in their efforts to deliver services efficiently and effectively.

Public health care provision must promote innovation in medical facilities, cost containment and the promotion of domestic medical technology. According to Bovens, Hart and Peters, (2001), South African health care institutions and government are bound together in a symbiotic relationship within the health sector that includes health care costs, institutional arrangements consisting of professional medical associations, medical aid schemes, hospital and clinics and improvements in public sector service delivery in government hospitals (Antonsen and Greve, 1999; Bovens, Hart *et al*., 2001).

3.3.1 Organization of Work and Outcomes in Healthcare

The study of the effect of patient-centred care on patients and employees draws on a growing body of literature on the organization of work in healthcare. Although the direct assessment of work practices and performance in healthcare follows similar inquiries in other industries, researchers have examined the relationship between a variety of work arrangements and patient care indicators. For example, researchers have studied the relationship between human resources management (HRM) practices, teamwork and relational coordination, and the quality of patient care (e.g., see Gittell*et al*., 2010; Gittel*et al*., 2008; West *et al*., 2006; Preuss, 2003; West *et al*., 2002; Borrill*et al*., 2000; Aiken *et al*., 1994). West *et al*. (2002:1305) provided one of the first comprehensive analyses of the link between work practice and healthcare-related performance outcomes.

3.3.2 The Effects of Patient-Centred Care on Quality of Care and Patient Satisfaction

The overarching goal of the patient-centred care model is to provide care that is the most conducive to patients' preferences, needs, and desires (Robinson *et al*., 2008; Wolf *et al*., 2008; Davis *et al*., 2005). This approach departs from the physician- or institution-centred model, which places almost all the power and authority regarding patient care in the hands of the treating professionals, primarily the physicians, and the organizations in which treatment is provided (e.g., see Robinson *et al*., 2008; Wolf *et al*., 2008; Bergeson and Dean 2006; Epstein *et al*., 2005; Flach*et al*., 2004).

Patient-centred care is founded on the nation that information should be shared between physicians and patients and, more importantly, that decision-making is based on patient involvement so that viable treatment or medication options take into account patient preferences and perspectives (Davis *et al*., 2005; Corrigan *et al*., 2001). The model also entails a restructuring of work-place practices in order to facilitate greater levels of interaction between frontline staff- primarily nurses and nurse aides- and clinicians. The primary mechanism used to deliver patient-centred care is the organization of work around interdisciplinary teams (Wolf *et al*., 2008; Lemieux-Charles and McGuire, 2006).

The literature has identified five dimensions of the patient-centred delivery care model: 1). Access to care; 2). Patient engagement in care or patient preferences; 3). Patient education through information systems; 4). Coordination of care across hospital staff; and 5). Emotional support for patients (Audet*et al*., 2006; Bergeson and Dean 2006; Davis *et al*.,2004; Fiach*et al*., 2004; for similar dimensions, see Corrigan *et al*., 2001:49).

Despite the increased use of patient-centred care methods, empirical research has not kept pace with them, and the evidence regarding their effectiveness is limited (Charmel and Frampton 2008; Wolf *et al*., 2008). What evidence there is supports a positive relationship between the adoption of the model and improved care outcomes (Stewart *et al*., 2000; Rathert and May 2007; see Wolf *et al*., 2008).

3.3.3 The Role of Employee Turnover

One of the ways in which patient-centred care can have an indirect effect on quality of care is through its emphasis on employees' working conditions (Rathert and May 2007;

Rather*etal*.,2009). Patient-centred care places the patient at the centre of process. Huselid (1995) provided strong empirical support of the mediating role of turnover in the relationship between high performance work systems and financial performance. This evidence suggests that the effects of dramatic workplace innovation were delivered, in part, through decreasing employee turnover. In a study of work practice in the telecommunications industry, Batt (2002) also found support for the argument that lower turnover rates arise from the effects of work restructuring on organizational outcomes.

Although researchers believe that turnover plays a similar role in the indirect relationship between patient-centred care and medical errors and patient satisfaction, the theoretical foundation for this relationship cannot rest on the simple cost of turnover argument, since the reduction of medical errors and the increase in patient satisfaction are not as responsive to turnover cost reduction as sales and financial performance might be.

3.4 PROBLEMS EXPERIENCED BY PROVINCIAL HOSPITALS IN SOUTH AFRICA

The need for the South African government urgently to address the state of national healthcare places great pressure on its resource base, particularly against the background of its extensive portfolio of transformation priorities (cf. South Africa, 1995:5.1). Tepperman (2002:131) rightly asserts that "(T)ransitional governments come into office with many priorities and obligations yet few resources. This fact all but ensures that any approach they take to the past will be problematic and incomplete." In considering the limited resources available for national health care, Dr Rispell, for example, laments "… how do you actually build capacity and ensure there is an enabling environment to take forward some of the policies, because I think *our policies are good"* (Thom, 2001: Online, emphasis supplied). In addition to resource constraints, inefficient administration, theft, misspending and weak accountability measures evidently plague the hospitals in most provinces. All these factors, and more, lead to budget cuts (Smith, 1999: Online); even while the goal of an improved health service remains real and increasingly urgent.

Despite the above South African realities, Mitchell (1998:2) cautions that managed care organizations have the obligation to prove to their clients that cost containment, even if necessary due to limited resources, does not necessarily imply that the quality of the service

rendered is being compromised. The difficulty of attaining this stated obligation is undoubtedly increased in an environment such as the one the National Health Service (NHS) finds itself in; one that is haunted by a history of inefficient and discriminatory service delivery. For example, in 1993 the RDP, addressing, among other things, the state of South Africa health services, maintained that the mental, physical and social health of South Africans has been severely damaged by apartheid policies and their consequences. "The health care and social services that were developed are grossly ineffective and inadequate. Health services are fragmented, inefficient and ineffective, and resources are grossly mismanaged and poorly distributed. The situation in rural areas is particularly bad" (RDP, sec 2.12.1).

Due to their levels of indigence, the majority of the patients that make use of provincial hospitals have no option but to do so despite the allegations of inefficient service delivery, hospitals being "on the brink of collapse" (Gauteng Provincial Government, 2001: Online); assaults by nurses on patients (Gauteng Provincial Government, Nov. 2001 Online), theft (Taitz, 1998: Online), inaccessibility (Van Niekerk, Fourie& Pretorius 1992: 61-64), and patients being turned away (Blumenfeld, 2002: Online, *Cape Argus*, 16/9/2002: Online), among other threats that may militate against the voluntary use of such facilities, if and where they exist.

Given the above, it is crucial that attention be paid to ways to increase the quality of services provided by the health care sector in South Africa. Given the stated evidence of weak, inefficient and ineffective delivery, and in the light of the White Paper on Transforming Public Service Delivery(South Africa 1997) that has as its primary goal a transformed and improved service delivery, it is clear that a veritable sea-change is needed in South African nationalhealth care.

Acknowledging the calamitous nature of the NHS environment, this research study aims to contribute to the alleviation of the health care dilemma by articulating the expectations of patients who are in need of improved health care services and by gauging the perceived performance of the hospitals from the point of view of the patients. In pursuit of these goals the following aspects were investigated:

- The expectations of patients in their interactions with provincial hospitals; and

- The patients' perceptions of the performance of the hospital in their efforts to provide the services that determine their reason for existence.

Taken together the above measures provide an indication of the extent to which patients are satisfied with regard to specific service quality attributes.

Woolard (2002: 2) argues that while poverty is not confined to any one racial group in SA it is concentrated among Black people, particularly Africans.

3.5 SERVICE QUALITY AND HEALTH CARE IN PROVINCIAL HOSPITALS

Quality is described by Muller *et al*.(2006:534) as the degree of excellence or the extent to which an organization meets clients' needs and exceeds their expectations. In the context of this study, it refers to the healthcare rendered in the public sector provincial hospitals in line with official government and hospital policies.

The quality of service rendered is an important ingredient in the success of all businesses and organizations in order to be profitable in the long run. Devlin and Dong's (1994:562) research shows that the provision of a high quality service is directly related to increased profits, market share and cost savings. According to Friedenburg (1997:31) the latest revolution in medical care is supposedly the era of quality control, quality of service and effectiveness of medical treatment. These emphases are in line with the aims of the White Paper on Transforming Public Service Delivery (1997) which emphasizes improved public service delivery goals founded squarely on the RDP and the South African Constitution (1996 aspects pointed out earlier).

Dyck (1996:541-549) asserts that understanding customers' expectations is the most important requirement in order to formulate a strategy to render good care. She further indicates that the level of customer care is normally measured by the extent of the differentiation between customer desires and their awareness of the services they receive; premises on which the current research project is founded. Zeithaml and Bitner (1996) and Devlin and Dong (1994) are in agreement that organizations have to give attention to the expectations of clients as well as the perceptions that they hold of both the organization and its employees' (i.e., service providers') character traits such as reliability, willingness to help, product knowledge, courtesy, client-centred focus, communication and the accessibility of

the service. Band (1991) and Donabedian (1988) consider the above elements representative of a clear definition of service quality. They are in keeping with the *Batho Pele* White Paperand the goals of the Patients' Rights Charter; hence they also inform the premises of the current study.

3.6 EXPECTATION MANAGEMENT AND RATING IN PROVINCIAL HOSPITALS

Consumers' experience of service quality may be assessed by comparing what they want, need or expert from a service provider with their perception of what they receive from that service provider(Berry &Parasuraman, 19991:57; Dyck 1996: 541-549). It follows, therefore, that it is important for service providers to deliver appropriately on the expected service quality within the confines of its resources. A primary assumption of this research study is that, since hospital patients are consumers of services, and since hospitals are service providers, it is important for hospitals to be acutely aware of the needs and expectations of current and prospective patients, individually and on aggregate, in order to respond appropriately to these needs.

According to Berry and Parasuraman (1991:63) an institution may manage the expectations of consumers of their products and/or service by ensuring that advertised promises reflect their ability and capacities, that they emphasize reliability, and that they communicate the need for consultation, higher service standards, courtesy towards customers, accessibility, service information, openness and transparency about service provider activities, the right to complainand redress, and the right to excellent service provision (South Africa 1997: sec 4). This requires that all national and provincial departments make continuous and sustained improvements in service delivery a top priority (sec 1.2.3).

The measurement of what patients expect from health service providers, as opposed to the actual health care service delivered is complex. It may be assumed, however, that all patients have a particular level of expectation of health care, and hence of health care providers, before approaching them. If these expectations are not met, dissatisfaction ensues. Expectations derive to some extent from peoples' past experiences with the same or similar situations, and from the statements of others based on their experience with the same or similar situation (Kotler and Andreasen 1996:605).

The outcome of the process, *viz*., consumer satisfaction or consumer dissatisfaction, will differ from person to person, making measurement of the phenomena an increasingly complex matter. In this regard Friedenberg (1997:31a) and Carr-Hill (1992:242) state that the complexities involved in measuring patient satisfaction may render the quest futile. Oswald and Turner (1998:18) concur and assert that it is extremely difficult for consumers to evaluate the quality of health care since they lack the expertise to gauge the clinical aspects thereof.

Hill and McCrory (1997:231) suggest that "if a consumer believes any service attribute to be important he/she would expect the quality of that attribute to be high, and hence will rate that attribute highly". The expectations that such a consumer may hold about that particular attribute may be inferred from the resultant rating.Kotler and Andreasen (1996:608-609) confirm that any attempt to measure satisfaction should assume that both importance and expectations are valid and hence should be measured to compare the variables of the service provided.

3.7 SATISFACTION WITH PROVINCIAL HOSPITALS' HEALTH SERVICES

Fulfilmentimplies that an individual's experience of a performance or product has fulfilled the consumer's expectations (Kotler&Andreason, 1996:604). Satisfaction is thus a function of the relative levels of expectations and the perceived performance. Indications of fulfilment include:

- A situation where the results exceed expectations; this leads to high levels of satisfaction;
- If the results of an experience match expectations, a high measure of satisfaction is induced;
- If a positive outcome is not forthcoming, this leads to dissatisfaction.

ZeithamlandBitner (1996:124) point out that satisfaction is an internal and personal matter, and is influenced by perceptions of service quality, product quality, price, situational, and other personal factors. Friendberg (1997:31) and Carr-Hill's (1992:242) cautionary observation that one of the limitations of satisfaction surveys is that patients have no yardstick to measure quality by, with the result that their perception of quality may relate more to convenience and cost factors, is also important to keep in mind.

In relation to the service encounter, Band's research shows that consumers are more tolerant with regards to problems regarding service delivery if they are treated with respect (Bands 1991;25). The Patients' Rights Charter acknowledges the importance of respecting patients, stating that everyone has the right to access to a health care service that ensures courtesy and the human dignity of patients, and empathy and tolerance on the part of health care workers. It adds that where such respect is subverted by bad service and dehumanizing treatment, a person can, and should, exercise the right to complain (sec 12; cf. South Africa 1997: sec 1.2.2,4.7). Bearden *et al*. (1995:123) note that, while most dissatisfied consumers do not lodge their complaints directly with the institution rendering the service, those who do complain should not be ignored, since they talk to, and influence other prospective consumers.

Carr-Hill's (1992;242) investigation concludes that patient satisfaction is considerably higher if the physician is friendly and the patient's expectations are met. Friedman (1997:31a) concurs with these findings, and argues that patients need to identify with their physician, since the healing process is facilitated when patients trust and have faith in their physician. It is against the above background that the aims and principle of the *BathoPele* White Paper are relevant to the improvement of the NHS in SA.

TABLE 3.1: Outpatients' Experience of Quality Service (*Health SA Gesondheid* Vol. 13. 1- 2008)

MAIN CATEGORY	SUB-CATEGORY	THEMES
Positive experience	Satisfaction with medical management	Helpful doctors
Negative experience	Lack of service commitment and service orientation	Unresponsive and disorganized, untidy environment
	Experience of a culture of non-caring and lack of hospitality	Impatient and distrustful nurses
	Powerlessness	Lack of information or choice
	Violence	Anger, aggression and frustration
	Non-enabling environment	Unfriendliness, lack of coordination, lack of safety
	Dehumanization	Lack of consideration, respect for the person and professionalism

3.8 OUTPATIENTS' ANGER, AGGRESSION AND FRUSTRATION RELATED TO POOR SERVICES IN PROVINCIAL HOSPITALS

Anger is an emotional defence to protect an individual's integrity against a perceived threat and agent of harm (Roberts, 1986). The feelings of anger experienced by outpatients are derived from frustration and powerlessness. One patient described this as follows: *"I come here quite early this morning hoping to be helped soon as I also know that it can become quite busy in this place… [but], then I had to wait here for hours without being helped… most of the times I left the hospital being angry…"* Frustration frequently produces anger when one is blocked from achieving a goal. Powerlessness, coupled with feelings of frustration, often makes the individual respond with anger. Anger internalized by the outpatient often results in hostile behaviour that leads to violence. One participant described his experience of aggression and violence on the part of the nursing staff as follows: *"I remember one time when the nurse gets the porter to slap a patient who was confused… and then they laughed afterwards…"*

The *Oxford Dictionary* (1994) defines violence as "an unlawful use of force… involving great physical force which is due to the intense experiences of vehemence in a particular situation"

(Ferns, 2006: 42). However, violence is a subjective phenomenon and therefore people interpret it in different ways. The participants in a focus group discussion cited numerous examples of violence they endured as outpatients. One patient said that,*"... people [patients and nurses] are fighting down there [outpatient department]".* Another participant alluded to anger against the nurse by a patient,*"Shame, I feel sorry for her... the patient called the nurse a bitch when she ask him to wait while she was attending to another patient... and then he slap the nurse...".*

Kaplan and Sadock (1998:159) explain this phenomenon as follows: "Anger is the fight and flight response to anxiety. Anxiety occurs from the frustration of unmet expectations or loss of self-respect. The anxiety is transformed into feelings or actions and relief is felt. Angry, hostile and destructive behaviour, thus being acts of aggression or violence is a primary response to frustration, and when the balance between impulse and internal control collapses, violence breaks out".

The occurrence of violence experienced by outpatients can be described as the language in which deep-rooted intra-personal and interpersonal conflicts express themselves (Krug, Mercy, Dehlberg and Zwi, 2002: 1085). Outpatients cited frustration that builds up into aggression as the underlying dynamic for this violence. Violence is a message that something is out of balance between the internal and external environments of the individual. As the language of aggression, frustration and feelings of powerlessness, violence is laden with meaning. Violence as a symptom points to something deeper, and if one simply eliminates the symptom, one does not solve the underlying problem (Gilmore, 2006:254; Krug *et al.*, 2002: 1085; Smith, Pittman &McKoy, 1999:5-6).

Violence experienced by patients or staff in the outpatient department violates two fundamental principles in ethical thought, Beneficence and Nonmaleficience, which imply the concept of doing good and preventing harm (Pera& Van Tonder, 2005:32). As such, violence in the workplace, irrespective of its form, ought not to be tolerated and measures should be instituted to safeguard people, including patients, against occurrences of violence (Ferns, 2006:44). In this regard Smith-Pittman and McKoy (1999:12) state that "… unless interventions are developed and appropriately applied, violence at work will increase in frequency and intensity". Thus, the responsibility for a safe and healthy work environment rests on all stakeholders' shoulders and ought to be a shared responsibility. Strategies to counteract violence should take cognizance of the environment in which violence occurs.

3.9 CONCLUSION

In conclusion it can be stated that the place and role of the local government sphere in SA is now clear, and that the necessary legislation and executive structures are in place. It is now up to the service providers to implement government policies to ensure the effective and efficient rendering of public services to citizens. By taking this process step by step and tackling every unsatisfactory service delivery challenge individually, a positive difference can be facilitated to ensure that all citizens lead a better life.

CHAPTER FOUR

4.1 NATIONAL HEALTH INSURANCE

Does South Africa have sufficient human and financial capital, let alone the management capacity, to give birth to and nurture to full maturity the anxiously awaited National Health Insurance (NHI)? Debate during the South African Medical Association (SAMA) NHI conference in Gauteng in October 2010 was fierce, but all 360 delegates agreed: Without urgent reform of the public health care system, any NHI will at best splutter along, ailing and unable to achieve its vital and noble goals. The private sector and SAMA are keen to help, but want more details (Bateman, 2010:100:791-793).

4.2 NHI CONSENSUS: FIX THE EXISTING SYSTEM OR RISK FAILURE

"Does 'ManaMzantsi have the human and financial capital, let alone the management capacity, to carry, give birth to and the nurture this NHI child to maturity?" (Bateman,2010)

Bateman (2010) notes that the core debate during the two-day conference concerned the essential ingredients for tailoring an appropriate and effective NHI. Minister of Health, Dr Aaron Motsoaledifound no dissenters when he diagnosed the cause of the malaise as a destructive, unsustainable, expensive curative health system, where, he quipped, each of the 50 million South Africans seems entitled to one major disease per year. His10-point treatment plan highlighted what is wrong, pointing to a historical lack of leadership or social compact with all role players (now being addressed, *inter alia,* through ambitious public/private counselling and testing campaigns aimed at reaching 15 million people by June 2011). Motsoaledi (2010) admitted that hospital hygiene and infection control are "dismal", that there is a dire lack of minimum standards, and openly complained that the planning and development of human resources had "gone completely haywire".

4.3 TREATMENT PLAN

According to Motsoaledi (2010) poor infrastructure was being addressed *via* the renovation of five major hospitals, the cost of which would exceed the construction price of all Soccer

World Cup stadia. There was finally a realistic and comprehensive plan to tackle the HIV/AIDS pandemic, with targets, best treatment protocols, major financing and drug supply cost containment and improved drug supply chain management tools. There would also be a "pragmatic rationalization" of some 60000 community development workers while the overall drug policy, acquisition, supply chain and expiry/wastage were being probed and overhauled.

Expanding on several points, Motsoaledi said the nursing curriculum was completely "messed up" when colleges were closed down and the decision taken in 1986 to only train *via* universities, resulted in "army commanders and no riflemen" (one estimate is 98000 professional nurses to 35000 enrolled nurses). Eight medical schools had produced only 1 200 doctors for the past eight years, illustrating the dire need for a ninth such school. Keen to illustrate just how far his government had moved from the denialism and obfuscation of the Mbeki/Tshabalala-Msimang era, Motsoaledi said the overall plan was aimed at countering a forbidding fourfold epidemic of HIV/TB, maternal, new-born and child mortality and morbidity, non-communicable diseases, and injury and violence. "Most other countries are spending less for far better health outcomes. Our spending has not kept pace with the disease burden. Is this money or mismanagement? Mismanagement is clear, but spending also declined at a time when our burden of disease was increasing."

Motsoaledi said 'Bantu education' had left the country "with a monster in our midst", where most locals compared poorly with residents of other Southern African Development Community (SADC) countries. Worse still, South Africa bears 17% of the world's HIV pandemic (with just 0.7% of the global population)- 23 time the global average. TB prevalence was the world's worst at seven times the global average, while HIV/TB co-infection stood at 73%. Motsoaledi describe the maternal new-born and child mortality and morbidity figures as "embarrassing", having "soared way above the Millennium Development Goals bar when other countries are showing improvements".

4.4 REDIRECTING RESOURCES AND IDENTIFICATION OF COST DRIVERS

The chairperson of the 23-person NHI Ministerial Advisory Task Team, Dr Olive Shisana (2010) said the project's success and incremental roll-out from 2012, when it would cost R128 billion (nearly tripling to R375.5 billion by 2025), would be built on the 'redirection' of

resources *via* stringent budget measures and the identification of cost drivers. The biggest systemic cost drivers at present were ARVs (where much greater purchasing efficiencies could be achieved), the National Health Laboratory Service (NHLS) and equipment. Shisana (2010) said probes into the health care staffing crisis showed a disproportionate increase in management and administrative structures at national and provincial level. Nursing colleges will be opened shortly, and the emphasis will be on a better balance between academic and bedside training.

There is a need for supportive legislation and minimum standards for compliance. NHI hospital accreditation was gradually being completed while management standards were being drastically improved through a hospital-by-hospital audit of managers and CEOs. Shisana (2010) added, "We must make sure we have sufficient health professionals capable of doing the work they are supposed to and ensure a change of attitude and clinical standards across the board in management. We'd like to see public hospital facilities become just as good as private."

Economist and *ad hoc* government advisor, Alex van der Heever, parodied the NHS committee's commitment in 1995 to the rapid establishment of a district health system which it claimed was of the highest priority and at the core of the entire health strategy.The 1997 white paper outlined a primary health care package that put communities at the centre of delivery, electing people to advocate for them on health matters. Instead, what the country got (six years later in the National Health Act) were six people (one representing the provincial health minister and five nominees from relevant municipal councils) and three to five people drawn from metropolitan, district and local municipality councils.

4.5 REFORM TRACK RECORD BODES ILL

Van der Heever (2010) observed that reform promises do not mean a lot if one has seen them all before. The district health system is at the core of effective health delivery. None of what was proposed at that level has happened. While it is very easy to promise grand things, the reality will probably be very different. According to Van der Heever (2010) South Africa had a major "performance problem" in the delivery of public services in general with education matching health, "which strongly points to a generalized problem with governance and accountability". This "inconvenient evidence" was being largely ignored in current

debates. When it comes to financing of the health sector, no peer developing country spent 8% of its Gross Domestic Product (GDP) (envisaged for South Africa, up from the current 3.4%) through the public sector. Tony Twine, top economist with Econometrix (a highly regarded private analysis and planning consultancy), questioned the NHI budgeting assumption that South Africa would achieve an economic growth rate of more than 7% per year for 13 consecutive years. Growth of between 3.5% and 4.5% was far more realistic, meaning that health care expenditure would consume between 22.8% and 28.2% of all government spending and up to 8.5% of GDP by 2025. "If GDP growth remains as low as 2% per year, as it did for 20 years between 1975 and 1995, the NHI would simply be unaffordable," Twine warned, adding that his realistic prediction of 3.5% - 4.5% might be affordable but would create deep friction with other high-priority government targets (education, housing and productive infrastructure). Twine said increasing the general tax load (as proposed) "too much" would simply weigh down the economy, limiting growth and job creation. In a seeming riposte to Van den Heever's criticisms of the district health system, Shisana said her team had based their proposals on a systematic review of 85 studies of primary care models globally.

4.6 CONCLUSION

The NHI initiative is a clear indication that the South Africa government is heeding the aim of the Millennium Development Goals to improve the lives of its citizens. The NHI is the first of its kind in Africa and demonstrates government's commitment to fight poor service delivery and meet the needs of SA citizens who cannot afford private medical assistance.

4.7 LINKING HUMAN RESOURCES DEVELOPMENT TO EFFECTIVE SERVICE DELIVERY IN SOUTH AFRICAN PUBLIC SECTOR HOSPITALS

4.7.1 INTRODUCTION

The public sector is the largest employer in South Africa, with more than a million employees. The government has to carry out its roles and responsibilities in the most efficient and effective manner possible. This requires investment in the skills and capabilities of public servants and the smooth and effective running of the public sector. This is a priority for the government, not only to ensure its own success but also to ensure that the general wellbeing of communities is promoted. The government has thus introduced policies to ensure that its employees are developed, for example, the White Paper on Human Resources Management in the Public Service *(*DPSA, 1997), the Human Resources Development Strategy(DPSA, 2002), and theSkills Development Act, 97 of 1998, to name but a few.

4.7.2 DEVELOPING HUMAN RESOURCES IN THE PUBLIC SECTOR

Public sector employees are part of an ever-changing environment. The environment in which they function has become increasingly complex, making the execution of their functions and the rendering of services to the public complicated and challenging. It is thus crucial that there is a motivated, loyal, committed, dedicated, knowledgeable, skilled and trained workforce that will be able to adapt positively to the ever-changing environment. The United Nations Committee of Experts on Public Administration (2002:3) stated that building public sector human capacity in terms of knowledge, skills, motivation and commitment, networks and mastery of information technology is fundamental and crucial to the effective and efficient translation of the values, objectives and goals of government. The SA government has reaffirmed its commitment to help its employees develop effectively, adapt to the ever-changing environment and execute their functions efficiently. The four principles on which these efforts rest are commitment, planning, action and evaluation.

According to Rapea (2002), commitment is about the government's resolve to develop its people and practical evidence that this is actually taking place in a planned and systematic manner. It is also about people being encouraged to improve their own and others' performance. Within departments, day-to-day responsibility for developing and managing human resources has primarily become the responsibility of individual line managers. They now have the freedom,

within the limits of their budget, to determine the necessary number of officials and levels of skills needed to deliver the required results. They also have greater responsibility for performance management, as well as the conduct and career development of their staff (DPSA, 1997:24). Du Preez (2002) indicates that roles and responsibilities are integral in achieving optimum service delivery. Line managers, for example, should see to it that all relevant activities are well managed within reasonable time periods. In order to do this, a clear demarcation of tasks and responsibilities is necessary so that line managers remain in control and can ensure that objectives are achieved.

4.7.3 HUMAN RESOURCES DEVELOPMENT STRATEGY

The Human Resources Development Strategy (HRDS)was adopted to support an holistic approach to training and development in the public sector. To enable it to actualize its constitutional mandate of creating a better life for all, the government envisages a public sector that is guided by the ethos of service and committed to the provision of high quality services (DPSA, 2002:5). The HRDS ensures that the different components of the state work together to deliver opportunities for human development. Its key mission is "to maximize the potential of the people of South Africa through the acquisition of knowledge and skills to work productively and competitively in order to achieve a rising qualityof life for all and to set in place an operational plan together with the necessary institutional arrangements to achieve this" (HRDS, 2002:9).

The Strategy briefly deals with the development of human resources, the implementation framework for the strategy, finance and budgeting, as well as monitoring, reporting and evaluation. It sets out:

- The strategies put in place to deal with the development of human resources and their results;
- The challenges facing human resource development and the problems to be addressed;
- The supporting interventions with specific reference to the role of the South African Management Development Institute; and
- The integrated Human Resources Management System.

4.7.4 THE GOVERNMENT AS A VEHICLE FOR REFORM AND ENHANCING HUMAN RESOURCES

Contributing to the popular perception that governments are less effective than they have been in the past, the challenges governments face today are greater than those confronting them in past centuries. Today's governments are faced with recession, wars, terrorism, global poverty and climate change (Binza and Seemela, 2010). Peter and Savoie write that

government must now attempt to manage economic development guided by the theory of Non-Performing Assets, which is based on the conventional public administration nexus rather than NPM, which is founded onbusiness propositions. Economic and governance planning requires government to use experts with skills and expertise to reform organizations to become effective and efficient(Sweezy, 1993).

According to the World Bank, public sector institutional reform and enhancing human resources in times of economic downturn are necessary steps in organizational re-engineering of "dysfunctional public institutions that would not be effective in shaping the way public functions are supposed to be carried out". The new organizational structure and culture must assure people that government achieves the highest attainable quality of planning and recovery results. Government must be cautious of misguided resource allocation, excessive government intervention in development even beyond recession, and corruption among the personnel entrusted with managing public resources (Binza and Seemela, 2010).

According to Berman (2010), changes have also occurred in the way government does business and the way the publicsector institutions are managed in order to respond to citizens' needs and to global challenges. Reforms at all levels of government must be implemented at a faster pace, and goals or policy development targets that are set should be achieved timeously. The HRDS (DPSA, 2002) indicates growing impatience among the general public with poor service delivery. In most rural and township areas services are not accessible, there is a lack of information on government services and employees in government institutions are unfriendly. Furthermore, it has been identified that there is a lack of transparency and accountability and that quality services are not being delivered. Constantino-David (2004:10) notes that certain factors hamper effective service delivery, including the fact that human resources tend to be the largest cost factor within government; public employees are

sometimes not viewed as assets in the public sector, which leads to demoralization, ineffectiveness, lack of commitment and apathy; the public themselves view government as incompetent and highly corrupt.

A study conducted by Gaffoor and Cloete (2010) titled: *Knowledge Management in Local Government: a Case of Stellenbosch Municipality*, revealed that public sector service delivery needs a serious shake up in order to achieve what voters were promised,i.e faster and more efficient service delivery from the government through its public sector organizations. According to the HRDS study conducted in 2002 (DPSA, 2002: 15), the public sector is facing the following challenges:

- Ensuring effective service delivery;
- Shortage of skilled labour and limited resources;
- Complex organizational structures;
- Lack of information systems;
- Poor performance in the public service;
- Poor financial practices;
- Confronting the poor interface between systems; and
- Impact of HIV/AIDS.

4.7.5 EFFECTIVENESS OF THE HUMAN RESOURCES TRAINING PROGRAMME IN PUBLIC HOSPITALS

Peter Senge is considered one of the first researchers to study learning organizations, and is thus referred to as 'Mr Learning Organization' (Marquardt, 1999:79). Senge in Boyette and Boyette (1998:82) writes that "as the world becomes more interconnected and business becomes more complex and dynamic, work must become more learningful (sic.)". Developing a learning organization implies switching from traditional training to organizational learning. It is important to start with a definition of learning. Learning means acquiring knowledge and skills (*Oxford Advanced Learner's Dictionary* 1995:671). Knowledge means to knowwhy something happens or works. Skill is the application of

knowledge i.e., the know-how part of learning or the ability to use the knowwhy to make something happen (Boyett and Boyett, 1998; 85). To provide services to all people successfully, organizations must enable their human resources to learn so as to acquire knowledge and skills. Performance and productivity can be improved when organizations become learning organizations.Boonstra (2004:104) outlines the characteristics of a learning and training organization in the form of *Ten Commandments*, and emphasizes that managers and leaders should consider these commandments prerequisites for developing effective learning organizations. The commandments are:

- Welcome new ideas-especially from below.
- Insist that people need approval from only one level.
- Praise when praise is due and only criticize constructively.
- Encourage open debate, ending in consensus on suggestions.
- Treat problems as opportunities.
- Use trust, not supervision as the main form of control.
- Operate a freedom of information policy.
- Institute change after consultation with those affected.
- Take, announce and implement unpleasant decisions in person.
- Share knowledge with others and share theirs.

The Ten Commandments show that brainpower has taken over from fixed assets and mobile muscle as the prime means of production. Meyer (1999:91) notes the importance of examining the concept of a learning organization at top management level and recommends that managers undergo training to understand the concept, its impact and how to make the environment friendly for on-going learning. West (1994:15) writes that members of an organization must be equipped with skills and expertise to create and sustain organizational values and implement policies, programmes and projects effectively and efficiently. Skills development is considered the key factor in meeting an employer's strategic, business and operational goals, as both public and private organizations operate in a global competitive environment.

4.8 DEVELOPING HUMAN RESOURCES TRAINING NEEDS

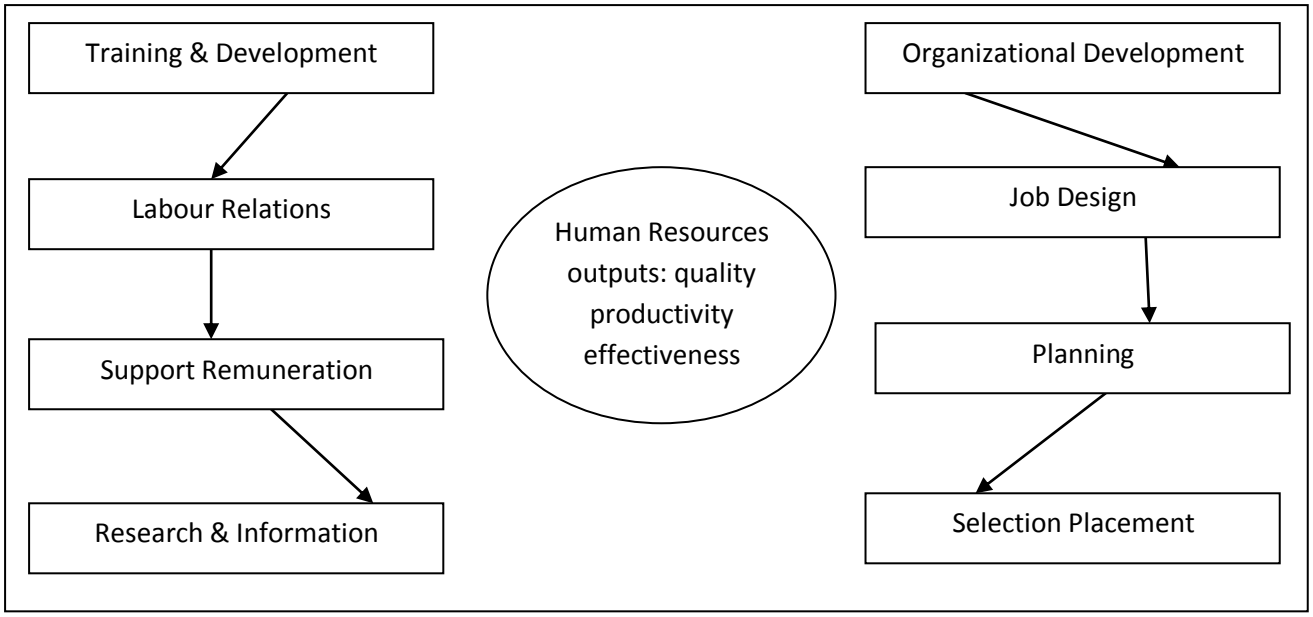
4.8.1 Organizational Development

Harri-Augstein*et al*., (1995:2) define organizational development as a "... complex educational strategy intended to change the beliefs, attributes, values, and structure of organizations so that they can better adapt to new technologies, markets and challenges in changing environments". Organizational development is a planned and calculated attempt to move the organization as a unit to behavioural, open and organic model. To develop a learning organization, human resources managers and leaders need to make decisions on the basis of competence rather than authority. In addition, they must develop a communication system that facilitates mutual openness and candour in facing organizational challenges.

4.8.2 Training and Development

In the bid to develop a learning organization, human resources must be provided with knowledge and skills. Innovative interventions are required to ensure that the training is relevant to the job, and that through training, the performance and productivity of staff are improved (Craig, 1987:317). Field and Ford (1995:84) note the importance of conducting a needs assessment prior to training and development in order to determine the gap between "... what employees must do and what they actually can do". The Public Service Staff Code, Section 3.1 (g) defines learning as "... all those planned and purposeful activities which improve the knowledge, skills, insight, attitude, behaviour, values, working and thinking habits of the public servants or prospective public servants in such a way that they are able to perform designated or intended tasks more efficiently..." and are productive. Development is defined by Cheminais, *et al*. (1998: 189) as the planned process of ensuring the continuous acquisition of experiences, skills and the right attitude that impact on management effectiveness. It is clear that development enables people to perform their functions better.

Figure 4.1ThePlace of Training and Development in Human Resources Management



(Brinkerhoff in Cheminals, et al. 1998:193)

Training materials must be tailored in such a way that the identified gap is bridged. Grobler***et al***. (2002: 317) suggest three levels at which assessment can be conducted, i.e. organizational analysis, operational analysis and personal analysis.

4.8.3 Organizational Analysis

Organizational analysis includes the examination of organizational goals, resources, the training climate and the scanning of both the internal and external environment to combat threats and weaknesses. The purpose of organizational analysis is to unearth problem areas that may be a factor in staff development and retention.

4.8.4 Operational Analysis

Operational analysis is conducted to determine how a job should be performed. It is imperative for learning organizations to conduct research on a regular basis and to source the data necessary to encourage staff innovation and, thus, to improve organizational efficiency and effectiveness in meeting customers' needs. It is through research that organizations replace old technologies with new ones to improve the velocity of production. It is important that staff at operational level "... understand the complexities of global market change without becoming enmeshed in technical minutia" (Wade, 1995:22). Research enables the training material to be updated and the development of new work methods that have an impact on the

sustainability of service delivery. The emphasis is not only on the training programme and material, but also on the modes of delivery and the content of the training (Grobler, *et al*.,2002:318).

4.8.5 Personal Analysis

According to Wade (1995:22) personal analysis focuses on the application of the skills and knowledge acquired by the trainee during the training. Employee assessment, Wade (1995:23) argues, would determine whether the training is of good quality or not. In addition, personal analysis must determine whether or not the problem is with the trainer or the trainee. If the problem lies with the employee, efforts are made to assist him or her to perform effectively. Performance improvement programmes must be introduced for employees who do not perform as expected after training.

After the above three phases have been completed, training and development can take place. Carrel *et al*.(1999:354) note two types of training, namely: on-the-job training and off-the-job training. The former includes training techniques such as job instructions given by an employee's supervisor or an experienced co-worker in the form of job orientation, enlarged and enriched job responsibilities and mentorship. The latter refers to the training performed away from the employee's immediate work areas. Examples of off-the-job training methods include video tapes, lectures, conferences or discussions and simulation or vestibule training. These methods allow participants to share experiences; resources which can be useful in their individual organizations (Carrell*et al*., 1999:318).

Carrell*et al*. (1999:318) are of the view that training and development can place the novices in an organization at a competitive advantage. During orientation, new employees are trainedto use work procedures effectively in line with their job description, and to observe the organizational rules and other work-related expectations. Chawla and Renesch (1995:145) see orientation as the "...socialization of new employees which must occur on the job concurrently with job skills training under the guardianship of the line supervisor and clearly identified aims of colleagues".

The essential feature of any HRD and training programme is that trainees are provided with the right sequence of experience and are assisted to understand and learn from that experience (Armstrong, 1991:415). Such a planned experience must be preceded by the organization clearly identifying the aims of its training and development programme. According to Gerber,

Nel and Van Dyk (1995:462) the purposes of training and development include the following:

- To equip the workforce, including disabled persons, with the skills, values and attitudes required to support the development of the economy in the formal and informal sector.
- To optimize the training capacity of employees by means of bridging training, the teaching of reading, writing, numeracy, and job and learning skills as well as further training.

Heneman, Schab, Fossun and Dyer (1983:348) regard the following as some of the more immediate goals of particular training programmes:

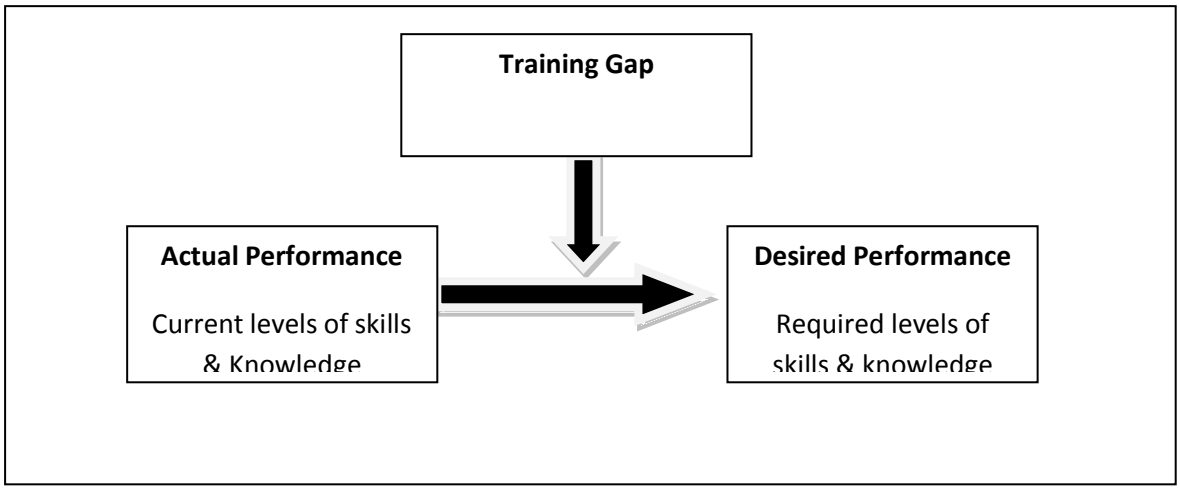
- To orientate new employees to the organization and their jobs;
- To improve employee performance levels in their present jobs;
- To enable employees to maintain their performance levels as their present jobs change; and
- To prepare employees for new jobs.

According to Ghosh and Kumar (1991:151) one of the reasons for undertaking training and development is for the organization to ensure that it achieves the best possible returns from its employees. To this effect, the main objective of any training and development will be to achieve some kind of change in knowledge, skills, experience, behaviour or attitudes, which enhances the effectiveness of the employee (McCracken & Wallace, 2000:286; Torrington, Hall & Taylor, 2002: 401). Specifically, HRD and training will be used to:

- Develop individual skills and abilities to improve job performance;
- Familiarize employees with new systems, procedure and methods of working; and
- Help employees to become familiar with the requirements of their particular job and those of the organization.

It is essential that any HRD and training that are provided are based on a systematic analysis of their contribution to the effectiveness of the organization (Mayo, 2000:7). The following model aims to ensure that this is the case:

Figure 4.2 A Model for HRD and Training (Ndevu, A.Lle and I.U Lle, Vol 42 no 5. 2007)



4.9 LEARNING APPROACHES (Creating a learning environment)

4.9.1 Strategic Learning

Strategic learning is defined as an "...open process of exploring complex and ambiguous issues affecting organizations, teams and individuals. It involves reflecting on and debating the linkages, tensions and conflicts between issues and seeing these in the wider context" (Stacey, 1993:90). Skills acquired from strategic learning are those that managers would apply or use in directing an organization; managing resources and resolving industrial conflict; team building; strategic partnerships; forging networks that are beneficial to the organization; and in defining the roles of individual employees at all levels (Stacey, 1993:90). Strategic learning is implemented according to six phases, namely:

- Surfacing– to identify hard and soft issues to determine challenges and opportunities for learning and organizational growth and sustainability.
- Analysing– managers must know and differentiate between main and sub-problems and evaluate which problems required urgent attention. Resources must be available and prioritized in terms of importance, urgency and degree of difficulty. In the present South African environment more financial resources and opportunities are created for people to acquire knowledge, skills and expertise in professions identified as scarce (science, engineering and technology).

- Reshaping – searching for and developing advanced techniques to deal with sophisticated problems. This involves reshaping the organizational structure and systems to respond effectively to postmodern realities with regard to service delivery and other challenges stemming from globalization.
- Targeting– leaders and managers must be able to provide possible expected outcomes. Expectations must be set and reinforced by means of rules and regulations. Russ-Eft (1997:137) argues that targeting opens other avenues for companies and other learning organizations to take advantage of strategic learning by adopting a Japanese method of strategic learning, horizontal promotion, where employees have the opportunity to test and improve their skills in a wide variety of roles.
- Resolving– employees should be equipped with the programming and problem-solving skills necessary to achieve policy objectives and organizational goals within a given time frame and resource constraints. The process of learning needs to be facilitated and monitored for transparency and accountability purposes.
- Experimenting– the beneficiaries of strategic learning are able to take proactive steps towards minimizing threats to the organization and in designing a workable path towards improving quality of service (Stacey, 1993:9).

It is important to note the argument by Boonstra(2004:100) that strategic learning is not a politics or power-free process as the doing part takes place within the political milieu and is about active analysis of power structures and influence. In most cases, it is applied through strategic thinking to draw the attention of employees at operational levels and managers at the strategic level.

TABLE 4.1: Operational Thinking and Learning from Strategic Learning

Strategic learning and thinking	Operational learning and thinking
Open, creative and intuitive	Programmed and deductive
Ambiguous and ill-structured	Clear boundaries and structure
Surfacing and questioning of assumptions	Assumptions are given
Fluid and interactive process	Linear and predictable process
Hard and soft output patterns and hard insights	Hard outputs-detailed but determinant
High uncertainty, fear and defensiveness	Low uncertainty and fear

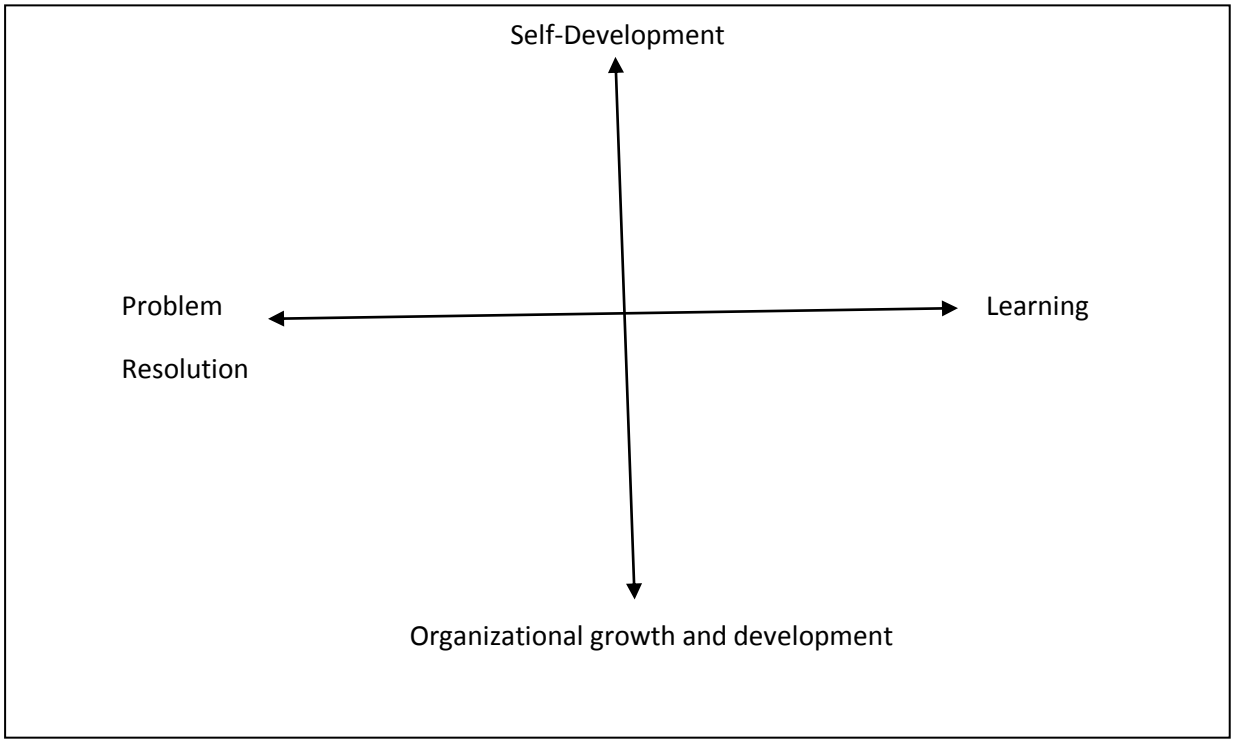
(Boonstra 2004:101-103)

4.9.2 Action learning

The essence of action learning is that learning and action are concurrent (Marquardt, 1999:3). Organizations are faced with too many demands and have too little time and finite resources to respond efficiently; hence learning and action are considered the two sides of the same coin. They can neither be excluded from each other nor does action happen in isolation from learning and *vice versa*. Action learning is defined as a process and programme that involves a small group of people (three to five) effectively and efficiently learning simultaneously solving organizational problems. Learning and actions benefit both the individual and the organization. This means that action learning has an impact on self-development and organizational growth and development (see figure 4). Revans (1982:750) concurs with the above view, writing that "... action learning creates a culture, morale for learning and constant learning opportunities for people".

Writers like Dilworth (1995:45) view action learning as the DNA of a learning organization, because it directs the learning function and allows the organization to adapt better to the continuously changing environment in order to meet people's needs.

Figure 4.3 Seesaw of Action Learning source: Marquardt (1999:7)



Problem: Action learning is built around a problem, the resolution of which is of high importance to an individual, team and organization. The organization must mobilize resources to enable people to engineer solutions to the problem.

Group: The group is a core entity of action learning to effectively examine organizational problems and recommend solutions that are acceptable and implementable. Action learning enables people to establish the nature and cause of the problem and then reflect and identify possible solutions.

Leadership development: (Junior) managers are developed and mentored to take on future challenging assignments and positions. People become empowered and capacitated to act effectively in implementing organizational policies and programmes. In action learning, leaders are considered to play critical roles in order to take the organization to an advanced stage of development and transformation. Marquardt (1999:111) comments on the roles of leadership and shares the significance of leadership development in the learning organization. The leader must be a systems thinker who has the ability to see connections between issues, events, and data points; change agent-leaders must have a high degree of competence in creating and managing change for the survival of the organization.

4.9.3 Monitoring and Evaluation of Training

Hendricks (2005:21) states that training managers, practitioners and institutional bodies charged with capacity building initiatives should constantly monitor and evaluate the impact of training in an attempt to align organizational and performance objectives. The value of training should be quantified. This process will support and increase the credibility of the training function. Kirkpatrick (1994:37), an American training specialist defines training and development evaluation as "the determination of the effectiveness of training" He designed an evaluation system that addresses evaluation at four levels, namely (Coetzee, Botha, Kiley and Truman, 2007: 269):

Level 1: Reaction

This level measures the extent to which participants liked the training course.

Level 2: Learning

The learning level evaluates whether there has been any significant change in the level of knowledge, skills, attitude and behaviour or not. According to Aliger, Tannenbaum, Bennet, Traver and Shortland (cited in Coetzee *et al*., 2007:270) learning results in immediate knowledge and retention and demonstration of behaviours or skills.

Level 3: Behaviour

This level determines whether the learners can practically translate the knowledge and skills acquired to their working environment or not. Kirkpatrick (1994:39) contends that certain requirements need to be met before changes in behaviour can occur. These are as follows:

- Desire to change;
- Know-how of what to do and how to do it;
- The right climate in the work place;
- Support in applying the learning in the workplace; and
- Reward for applying learning.

Level 4: Result

This involves measuring the impact of the training intervention on the organization. The development, implementation, monitoring and evaluation of all training capacity initiatives and the extent to which the strategic goals and objectives of the organization are achieved need to be critically evaluated. This impact assessment should take cognizance of changes in individual competence, on the job performance, organizational improvements, and the level of quality of the services delivered to customers.

4.10 CONCLUSION

This part of literature review focused on the development of human resources and training in the South African public sector. In doing so the emphasis was placed on the Human Resources Development Strategy and how it currently impacts public employees. More specifically, the challenges of ensuring effective service delivery were addressed and the link between human resources development and effective service delivery was examined. Government must play a pertinent and vital role in the development of human resources. This will enable public sector employees to achieve success and satisfaction.

There is a strong need for the government and public sector employees to interact in a positive and cooperative manner. Roles and responsibilities must be clearly defined and communicated to avoid conflict or ineffectiveness. The main aim of developing public sector employees is to ensure that they acquire the skills, knowledge and expertise to execute their functions in the best way possible. Training and development policies need to be implemented effectively and resources should be made available to support these policies.

CHAPTER FIVE

RESEARCH METHODOLOGY

5. 1 INTRODUTION

Authors such as Fox and Bayat (2007: 5) describe research as an examination which intends to determine evidence or get information. Research is a worldwide activity, which involves, for the most part, a detailed or explicit actual experience which is independently investigated to produce a theoretical understanding of observable facts. The development of a research study basically begins with the formulation of a dilemma, followed by questions to unpack the dilemma; therefore the methods used to obtain information are essential in order to answer the questions.

This chapter describes the methodology adopted in this study of public sector service delivery in provincial hospitals in the eThekwini Metropolitanand iLembe regions. The research objectives, research questions, study design, studylocation, study population, sampling strategy and size, data collection, datamanagement, data analysis, mechanisms to assure the quality of the study, ethical considerations and limitations of the study are described.

The empirical investigation focuses on an evaluation of public sector hospital service delivery in provincial hospitals in the eThekwini Metropolitan and iLembe regions. This research is necessary to highlight the significance of service delivery at provincial hospitals and to examine the extent of the implementation of *Batho Pele* in these provincial hospitals. The results of this survey serve as a useful 'barometer' to ascertain the stumbling blocks in provincial hospital service delivery and to ensure that the BBPs serve the interests of patients. The research also served to create an integrative approach to invoke enhanced public participation and to re-orientate the strategic intent of the public hospitals regarding patient satisfaction and efficient service delivery.

The research problems in this study arose not only from personal observations and experiences of working with the communities represented in the study, but from the identification of the problem of poor service delivery in provincial hospitals in previously published historical, theoretical and empirical work in the field.

5.2 OBJECTIVES OF THE STUDY

This study had the following key objectives:

- To evaluate the implementation of *Batho Pele* Principles (BPPs) and service delivery plans in provincial hospitals as experienced by patients;
- To identify service delivery shortfalls as described by patients and members of the public in provincial hospitals; and
- To record customer service experiences relating to etiquette, waiting time and the availability of required resources in public sector provincial hospitals.

Within a field of systematic study, the above objectives are examined *via* the context of the evaluation of service *vis-à-vis* the implementation of BPPs, using a case study approach involving the eThekwini Metropolitan and iLembe regions.

5.3 KEY QUESTIONS

- Is the government doing enough to ensure that the standard of services rendered at provincial hospitals meets the BPPs?
- What challenges are hindering service delivery in the public health care sector?
- Does the public health care sector use its monitoring and evaluation tools adequately to measure and improve the efficacy of services rendered?
- Does the provincial hospitals' service delivery meet the expectation of patients in their interaction with these hospitals?
- What are the patients' perceptions of the performance of the provincial hospitals in their efforts to provide the services that determine their reasons for existence?

Taken together the above measures provide an indication of: the extent to which patients are satisfied with regards to specific service quality attributes rendered by the provincial hospitals.

5.4 LITERATURE REVIEW

The literature review is a significant evaluation of past and current literature in a specific area of information and knowledge (Fox and Bayat, 2007:35). The researcher conducted a comprehensive review of contemporary literature which will contribute to the area of learning, and which provided a purposeful evaluation and interpretation of an appropriate approach to the study. The researcher then proceeded to investigate detailed developments unfolding in public sector service delivery, in particular the significance of the BPPs, the NHI, knowledge management, HR and hospital services while viewing the entire public sector as a vehicle to improve the quality of life in SA, particularly improvement of the country's health system.

The literature review provided different viewpoints on the subject matter of this research. The review was based on the following kinds of sources, which are considered to be relevant (Blanche, Durrheim and Painter, 2006:21):

- Chronological reviews, which carefully consider the sequential expansion of the literature, and a positive examination of community (public) involvement in public sector service delivery.

- Thematic reviews, which are planned around the diverse themes in the study, as well as debates. This assisted the researcher to look deeply into nature of this study i.e. public administration, and provincial hospitals improvement (the NewPublic Management approach), as clearly defined and analysed in Chapter Two.

- Academic review, which draws on hypothetical developments in a particular area, often showing how each theory is supported by empirical evidence. This is reflected in Chapter Six, in which the results are presented, analysed and discussed.

- Experimental review, which summarizes the observed findings, usually focuses ondiverse methodologies. The researcher used a variety of relevant methods and investigative tools with the aim of achieving reliability and validity.

5.5 RESEARCH DESIGN

The researcher set out to explore service delivery at provincial hospitals in the eThekwini Metropolitan and iLembe regions. The study focused on three hospitals, namely, King Edward VIII and AddingtonHospitals in Durban and Stanger Hospital in iLembe region. The researcher interviewed keysstakeholders in these hospitals, including nursing managers, medical managers and matrons to assist in the construction of relevant questions that would form a questionnaire.

It is clear that while some public sector healthcare employees understand the BPPs and patients' rights, others are not as knowledgeable. This information was critical to determine the design of the study survey (research questionnaire) and to administer the survey.

The questionnaire serves as an empirical structure and strategy to assist and direct the study activities and ensure that sound conclusions can be reached. The aim of the research design is to structure a research plan in such a way that the eventual validity of the research findings is maximized (Blanche *et al*., 2006: 37).

An empirical study was conducted with the help of trained fieldworkers. The questionnaires were administered over a period of a month. A total of 222 questionnaires were administered in the three hospitals, with at least 70 respondents per hospital in eThekwini Metropolitan and iLembe regions. At least thirty (30) doctors and nurses were interviewed at each of the three hospitals. A further forty (40) patients who were at the hospital for more than three days were also interviewed at all three hospitals. A stratified random probability sample was taken from each group of respondents to ensure representation of respondents from the different areas.

5.6 ANALYSIS OF RESEARCH

The empirical data were analysed using the Statistical Package for the Social Sciences (SPSS). A brief background on the use of this software is provided before presenting the statistical analysis. The letters 'SPSS' mean something different today from what they meant when the product was conceived. Chairman of the SPSS Board Norman H. Nie collaborated with C. Hadlai (Tex) Hull and Dale Bent, two fellow Stanford University graduate students to develop the first SPSS programme in 1968. As the 'package' has grown into a multinational product serving a wider variety of users, and as the business evolved from its academic roots to become a leading enterprise analytical solutions provider, one simply refers to SPSS Inc. for the company and

SPSS for the original product, SPSS for Windows, Release 16.0.http://www.spss.com/corpinfo/fags.htm.

SPSS is a computer application that provides statistical analysis of data. It allows for in-depth data access and preparation, analytical reporting, graphics and modelling. In analysing data, one of the most important aspects is to test for statistical correctness of models. The important question to answer here is: are statistical assumptions of models correct? To establish the answer to this enquiry, hypothesis testing was used to look for significance in relationships. This attempt resonates with the hypothesis presented in Chapter One of the research study.

5.7 RESEARCH METHODOLOGY

An exploratory research design was used to answer the research questions. According to Dillon *et al*. (1994:40-41), such a design provides ideas and insights into a broad or relatively vague problem. It also allows for a more precise statement of the problem, which in turn will allow casual or descriptive research designs to be used. Descriptive research is often employed when a researcher knows something about the problem being addressed. The broad methodology adopted to solve the main and sub-problems in this study is outlinedbelow. The literature survey focused on the public service, service delivery and *BathoPele* process through studies contained in books and journals.

5.8 SAMPLING PROCEDURE

Sampling techniques are the method used to choose a group from a wider population, as it is not possible to include the whole populationwhen conducting a survey. According to Bryman and Cramer (2001: 96), sampling is one of the most reliable methods of collecting statistics, particularly when the population is vague or exceptionally large.

Denscombe (2007:130) notes that even though data is collected in the form of a segment, what is found in that segment will be relevant to the rest of the population, although it would not be advisable to conclude that the result from the sample will simulate the entire sample population.The sample must be carefully considered; this will allow some level of confidence in its reliability and validity. Bless and Higson-Smith (2000: 85) identified the following attributes of effective samples:

- A distinct targeted population;

- A sufficiently well selected data sample; and
- A sample is an approximated representation of the entire population.

Jupp (2007: 312) observes that the sample, "must [be] a reflection of population strength (validity) which is the degree to which sample distributions reflect individuals of the population which the sample was collected from". The sample for this study will represent the patient population as the study targets people admitted to KZN provincial hospitals.

The sampling hypothesis is based on the theory that inferences can be drawn from the targeted population from which the data is collected (Descombe, 2007: 271). Bless and Higson-Smith (2000: 84) concur with this statement and state that the sampling hypothesis can be also used as a combination of a population and samples drawn from it. The intention of this study is to establish various kinds of a certain population; one of the objectives of sampling is to draw inferences about the unidentified population parameters from known sample statistics.The population, as defined by Bless and Higson-Smith (2000: 85) is the "set of basic fundamentals that the research focuses upon and to which the results obtained by testing the sample should be generalized". Other authors such as Bryman and Cramer (2001: 96) define a population as a separate cluster or unit which is used to study the data and not just populations in the predictable sense of the word.

Descombe (2007: 17) writes that prejudice is normally regarded as a non-constructive characteristic of study; the onus is on the researcher to try and avoid it. Prejudice can cause misrepresentation of the data or departure from the facts or even serious deviations from accepted research procedures. While research will always be affected by the researcher's own social position and ideology; in some sense, this may be conceived of an as organized fault; however researchers should strive to remain impartial and should always commit themselves to ethical practice and avoid prejudice or bias in every possible way.

Bless andHigson-Smith (2000:140) harbour the view that during the research process, the values of the researchers, their religion and cultural attitudes and convictions may play an important role and could direct the researcher to choose a particular population, adopt a certain sample, ask or abstain from asking specific questions, and intentionally fail to take into account theories that disagree with their approach due to prejudice.Therefore, the researcher must make sure that bias is narrowed down to the smallest possible degree and that

inconsistencies in research results can be explained after taking the shortcomings and limitations of the research into account.

5.8.1 Non-probability sampling

According to Bless andHigson-Smith (2000: 155) non-probability sampling is a sampling method where the prospect of each component of the population being included in a sample is unknown. According to Jupp (2006: 196), a number of techniques are associated with this approach, such as snowball, quota and convenience sampling.Denscombe (2007: 17) argues that when one uses non-probability sampling, the theory which underlies or simplifies probability sampling disappears; therefore each component of the study population stands an equivalent probability of being incorporated or included in the sample.

Denscombe(2007: 16) notes the following reasons for using non-probability sampling:

- It is not realistic to include a large number of examplesin the study;
- The researcher may not have adequate information about the population; or
- It may prove extremely complicated to contact a sample chosen through conventional, probability sampling techniques.

5.8.2 Probability sampling

This method ensures that the likelihood of each component of the population being included in the sample can be determined. Probability sampling is defined by Jupp (2006:238) as anytechnique of sampling that uses random collection to ensure that all units in the population have an equivalent chance of being selected. The hypothesis is that, provided adequately large numbers of examples are selected, and the range has been authentically ‘at random’, the results will be representative of the sample cross-section.

5.8.3 Stratified random sampling

This system of sampling is intended to ensure that the sample has definite descriptions, which are frequently representative of the population on key variables. Put another way, this means that the sampling is split into different populations and different groups, called strata so that each constituent of the population belongs to one stratum only. For example, the population

may be stratified according to the criterion of gender, in which case two strata - of males and females - will be generated (Bryman& Cramer 2001: 98).

Denscombe (2007: 15) writes that an important benefit of stratified sampling over pure random sampling is that the researcher can exercise some degree of management of the choices of the test or sample for assurance purposes, and that crucial factors are covered in proportion to the way they exist in the wider population. This is supported by Bryman and Cramer (2001: 99), who agree that the advantage of stratified sampling is that it offers the possibility of better accuracy by ensuring that the groups which are created by a stratifying criterion are represented in the same proportions as in the population.

5.8.4 Sample size for correlation with acceptable absolute precision

Researchers normally work with a 95% level of confidence, meaning that if the sample was chosen 100 times, at least 95 of the subjects would be certain to represent the characteristics of the population (Saunders, Lewis &Thornhill, 2000: 155).The margin of inaccuracy describes the accuracy of the estimates of the population. Nichols (1991: 52) states that, in practical terms, cost is frequently the major issue influencing the sample size. Furthermore, when choosing a sample size, it is wise for a researcher to estimate assurance or confidence intervals in some of the most important variables he/she is studying.According to Gustavsson (2007: 28) the volume of the sample affects the possibility of making the correct inferences; however, the technique used to select the sample is equally important.

5.9 DESCRIPTION OF TARGET POPULATION

Saunders *et al*.(2000: 150) describe a “population as the full set of cases from which a sample is taken”. Bless andHigson-Smith (2000: 84), state that the complete set of substance (people) is the main focal point of an investigation or study. Nichols (1991: 50) notes in the early stages of study design, the researcher needs to identify accurately which cluster or group of people or units he/she is interested in, and that particular group of interest is the targeted population. The targeted population for this study was patients and hospital staff doctors and nurses in three provincial hospitals in KZN.

5.10 DATA COLLECTION TECHNIQUES

Data collection refers to collecting data from a target group of a population or respondents by means of personal interviews, self-administered questionnaires or through direct contact (Pillay, 2007: 197). According to Bless andHigson-Smith (2000:97) data consist of measurements collected as a result of scientific interpretation or observations and can be classified according to the way in which it is collected or in terms of its intrinsic properties. Primary data is collected when researchers collect their own data for the purpose of a particular study. However, researchers often use data collected by other investigators relating to similar issues or use social data as in the case of a population survey. Such data constitute secondary data. The data collection techniques used in this study werepersonal interviews and the personal administering of questionnaires.

5.10.1 Data collection using personal interviews

A personal interview involvesface to face with a person you are asking questions too. Several studies point out that direct personal contact has the advantage of including non-verbal responses. Shadow movement and facial expression can convey a great dealwith the participant who is asked to answer questions relating to the research problem. Kahn and Cannell(cited inSaunders *et al*.,2000: 242) state that a personal interview is a purposeful discussionbetween two or more people.

Some of the distinct advantages of personal interviews are:

- They help the researcher gather the most valid and reliable data that are relevant to the research question;
- They are accurate and obtain high response rates;
- Interviewers can ensure that all items on the questionnaire havebeen considered and that respondents do not omit difficultquestions;
- They can be administered to respondents who cannot read or write;and
- They help overcome misunderstandings and misinterpretations ofwords or questions (Bless &Higson-Smith 2000: 108).

The researcher had an opportunity to interview and interact with the KZN MEC for Heath, Dr SibongiseniDhlomoin October 2011 regarding the challenges that are facing provincial hospitals in terms of service delivery and the effective implementation of the BPPs. This was also an opportunity to communicate to the MEC that this research study seeks to contribute to

an improvement in health care service delivery. This meeting also assisted the researcher to formulate a questionnaire focusing on the critical issues surrounding health care delivery.

5.10.2 DESIGN OF THE QUESTIONNAIRE

The empirical study consisted of data collection *via* a questionnaire survey. Questionnaires were administered over a period of a month by three fieldworkers, as outlined previously. The questionnaire was used to determine the level of service perceived to be rendered to patients (see Appendix 1).The questionnaire consisted of 14 sections:

Sectionone was the biographical section which sought information about the respondents. The questions related to the respondents' gender, race group age, occupation, associations, qualifications and ethnicity. The questions in the initial parts of the survey were based on *independent variables*.

The subsequent sections of the survey focused on *dependent variables* where respondents provided responses on the service received by patients at the hospitals and presented their views on the efficacy of the current service policies, hospital facilities, treatment from doctors and nurses and involvement in services and healthcare facilities.

TABLE 5.1 Questionnaire Layout

SECTION ONE	
Demographics	➢ Age ➢ Gender ➢ Status ➢ Occupation ➢ Education ➢ Language
SECTION TWO	
Household demographic information	➢ Geographical residential area (region) ➢ Kilometres travelled from home to hospital ➢ Hospital visiting/ admitted to
SECTION THREE	
Patients' opinion	On hospital access
SECTION FOUR	
Level of communication between	➢ Patients ➢ Nurses ➢ Doctors ➢ Other hospital officials (clerks)
SECTION FIVE	
Level of courtesy	Patients
SECTION SIX & SEVEN	
Level of cleanliness	➢ In the hospital wards (patients) ➢ Areas clean inside the hospitals
SECTION EIGHT	
Patients' opinion on	Security and safety in the hospital
SECTION NINE	
Awareness of patients on	Patients' rights
SECTION TEN	
Communication between patients & doctors	Medication given to patients
SECTION ELEVEN	
Level of satisfaction on	Inpatient items
SECTION TWELVE	
Patient satisfaction with food provided at the hospital	➢ Food ➢ Utensils ➢ Other services
SECTION THIRTEEN	
Patient satisfaction in terms of waiting time	Waiting time during the patients' stay
SECTION FOURTEEN	
Patient's expectations of	➢ Overall services at the hospital ➢ Perceptions of service rendered
Communication between hospital management	Doctors and nurses

The pre-coded questionnaire was carefully constructed to elicit comprehensive responses on the research topics. The questionnaires were administered to patients and hospital staff (doctors and nurses) in three hospitals in the eThekwini metropolitan and iLembe regions.

According to Willemse (1990: 9), the following requirements should be complied with in compiling a questionnaire:

- Confidentiality should be assured;
- Wherever possible, a choice of answers should be given to respondents;
- The questionnaire should be well laid out, with adequate space for responses;
- Questions should not be offensive or intrusive;
- Questions should not give cause for emotive language or require any calculations, and
- Questions should be short and simple.

The researcher took cognizance of the above factors when designing the questionnaire. As indicated earlier, the study questions are made up of variables that are dependent and independent. Bless and Higson-Smith (1995: 31) state that "an independent variable is that factor that is measured, manipulated or selected by the researcher to determine its relationship to an observed phenomenon, which constitutes the dependent variable". The dependent variable can also be described as the factors that are used to observe and measure the determined effect of the independent variable.

In this study, independent variables included ***(age group, gender, qualifications and occupation***). The dependent variables included current trends in ***(Batho Pele principles, service delivery, service standards, acuity levels, ensuring courtesy, providing better information to patients by the hospital officials, treatment received, hospital facilitiesand access to hospitals facilities).***

The questionnaire aimed to examine the level of service offered by these hospitals and the long-term strategy to achieve effective service delivery and satisfaction in order to comply with the BPPs and ensure an effective healthcare system. The intention is to evaluate service delivery at provincial hospitals in KZN with a view to improving this important service.
Given the focus of this study, the researcher examined the interdependencies of the key service delivery factors in the public sector through the eyes of patients and public sector employees.

5.11 CRITERIA FOR SELECTION OF RESEARCH ASSISTANTS

In order to ensure that the study was well conducted the researcher appointed assistants who understood both areas (greater KwaDukuza and Durban) very well and who were fluent in isiZulu and English. The questionnaires were constructed in English but were easily translated into

isiZulu for those who could perhaps not understand(read) English. The researcher and his three assistants were working together throughout the survey.

5.12 RESPONSE RATE

Approximately 95% of the questionnaires were returned. Some senior officials from the three hospitals, including doctors and nurses, were not available due to being absent or busy (emergencies); however this did not have a seriously negative impact on the survey.

5.13 NONPARAMETIC, PARAMETIC TESTS AND PEARSON'S CORRELATION

Nonparametric or *distribution free* tests are so-called because the assumptions underlying their use are "fewer and weaker than those associated with parametric tests" (Siegel & Castellan, 1988, p. 34). To put it another way, nonparametric tests require few if any assumptions about the shapes of the underlying population distributions. For this reason, they are often used in place of parametric tests if/when one feels that the assumptions of the parametric test have been too grossly violated (e.g., if the distributions are too severely skewed).

5.13.1 Parametric tests

In a parametric test a sample statistic is obtained to estimate the population parameter. Because this estimation process involves a sample, a sampling distribution, and a population, certain parametric assumptions are required to ensure that all the components are compatible with each other. Bivariate Correlation tests whether or not the relationship between two variables is linear (as one variable increases, the other also increases or as one variable increases, the other variable decreases). This type of bivariate correlation test requires that the variables both have a scale level of measurement (there is a rank order for the values and the distance in between the values can be determined).

5.14SAMPLE

The population size for the three sectors of respondents varied. A representative sample of 70 was chosen from three wards in each of the three hospitals in the two regions. Thirty hospital staff (doctors and nurses) also participated.

5.15 RELIABILITY AND VALIDITY

According to Brink *et al*. (2006) validity refers to the ability of the instrument to measure exactly what it is supposed to measure and nothing else. Accessible language was used in the interview schedules to ensure that the respondents understood the questions. Face validity refers to whether or not the instrument is measuring the content desired for the study (Burns & Grove, 2005:737). This was enhanced by including the concepts relevant to the BPPs, public service delivery, HR, training and NIH identified in the reviewed literature. Content validity concerns the representativeness of the concept in the measuring instrument of the variable being measured (Brink *et al*., 2006:160; Polit& Beck, 2004:423). In this study content validity was achieved by including all aspects relevant to hospital service delivery and the BPPs in the questions.

5.16 TECHNIQUES USED

According to Saunders *et al*., (2007) the correlation coefficient (r) helps to quantify the strength of the linear relationship between two ranked or quantifiable variables. This coefficient can take on any value between -1 and +1. A value of +1 represents a perfect positive correlation and this means that the two variables are precisely related and that as the values of one variable increase, the values of the other variable will increase. A value of -1 represents a perfect negative correlation and this also means that the two variables are precisely related. However, as the values of one variable increase those of the other decrease.

Graziano and Raulin (2004) state that the first step in interpreting the correlation is to note its direction and the size i.e., if there is a positive relationship between the variables or a negative relationship and also if the relationship is small (close to 0.00) or relatively large (close to +1.00 or -1.00). The values between 0 and 1 are interpreted as follows:

r=0.1 to 0.29 or r=-0.1 to -0.29	small correlation
r=0.30 to 0.49 or r=-0.30 to -0.49	medium correlation
r=0.50 to 1.0 or r=-0.50 to -1.0	large correlation

The statistical significance of the correlation needs to be tested to measure if the observed correlation is large enough to believe that there is a non-zero correlation between the two variables in the population from which the current sample was drawn. The statistical

significance tests the null hypothesis that there is a zero correlation between the variables in the population. The (*p*) value is the probability of achieving a correlation large or larger if the correlation in the population were actually zero.

If the probability is low, it means that there is little chance that the population correlation is zero and it can be concluded that there is a relationship between these variables in the population from which the sample was drawn. It is then said that the correlation is significant or that there is a statistically significant correlation to describe the situation. The probability should be quite low, either less than 0.05 or 0.01 (Graziano and Raulin, 2004).

5.16.1 Pearson's Product Method

Bryman and Bell (2007) explain that bivariate analysis is concerned with the analysis of two variables at a time in order to uncover whether or not the two variables are related. Pearson's product method is one of the methods used to examine relationships between intervals or ratio variables. The chief features of this method are as follows:

- The coefficient will almost certainly lie between 0 and 1; this indicates the strength of a relationship.
- The closer the coefficient is to 1, the stronger the relationship. The closer it is to 0, the weaker the relationship.
- The coefficient will be either positive or negative; this indicates the direction of a relationship.

This study has used Pearson's product method to study the relationship between patients' satisfaction and service received/delivered at the KZN provincial hospitals. There was no statistically significant relationship shown by these variables.

5.17 FREQUENCY

The simplest way of summarizing data for individual variables so that specificvalues can be read is to use a table (frequency distribution). For descriptive data, the table summarizes the number of cases, which is the frequency (Saunders *et al*., 2000: 338). In SPSS, the statistical programme employed for this study, afrequency distribution is 'obtained by selecting and analyzing (sic.) descriptivefrequencies which usually includes a per centage for each value" (Fielding &Gilbert in Pillay, 2007: 214).

5.18 GRAPHS AND BAR CHARTS

According to Pallant (2005) bar graphs can be simple or very complex, depending on how many variables one wishes to include. The bar graph can show the number of cases in particular categories or it can show the score on some continuous variable for different categories. Graphs and charts help to communicate information visually, simply and at a glance. A bar chart is used to compare two or more values. It is a way of summarizing a set ofcategorical data and illustrates the major features of the distribution of the data in a convenientform. It displays the data using a number of rectangles of the same width, each representing a particular category. Bar charts were used in the present study, to allow for ease of comparison between groups. These are a very common type of graph best suited for a qualitative independent variable. Since there is no uniform distance between levels of a qualitative variable, the discrete nature of the individual bars are well suited for this type of independent variable. Bar graphs allow for trends to be extracted between bars (e.g., showing that they are gradually getting longer or shorter).

5.19 PIE CHARTS

A pie chart is made up of different segments or slices in a circle. Each slice represents the number or per centage of cases in that category, and jointly the segments make up a complete pie. (On line) (http://www.en.wikipedia.org/wiki/piechart).

5.20 STATISTICAL SOFTWARE

To perform the analysis the researcher used SPSS (version 20). This is a set of complete programmes intended for social scientists. Even though it provides a broad series of statistical choices for design, investigation and presentations, it also allows the researcher to analyse with the aid of Stat graphics Centurion.

5.21 PREPARATION, CODING, ENTERING AND CLEANING DATA

The raw material produced from a survey is called data. The data are formed through lists of statistics (numbers) that are a representation of different scores on variables obtained from the patients and doctors from the three hospitals. Primarily this study used quantitative statistics which were collected during the survey. The unprocessed statistics obtained from the questionnaires were converted and transferred into an excel spreadsheet. Two hundred and twenty two (222) questionnaires were distributed and each question was numbered with a theme ranging from 1 to 14 (as indicated earlier).

This data is raw and has no order; therefore it contains many errors and misplaced and missing numbers or values. This information has to be converted into a well-organized error-free data set before it can analyse. After this process the next step would be for the statistician to arrange the data for coding, entering and cleaning. The statistician prepares the data for coding using systematic rules to convert the data from different sources. The data were subsequently entered through numerical codes; each chain of statistics represented aunique case and each column represented a unique variable. Finally, the statistician entered all the information twice and then compared the two spreadsheets to get rid of coding errors before using them for statistical analysis.

5.22 LIMITATIONS OF THE EMPIRICAL SURVEY

They were some limitations in the empirical study. Some respondents were unable to respond because of work pressure, inability to respond to certain questionsand lack of knowledge of the specifics of service delivery and the BPPs.

There were a few instances where respondents did not complete a question either as a result of being unsure or unfamiliar with the specificities surrounding service delivery.There are substantial differences between cultural backgrounds and language spoken and this created a difficulty while conducting the field survey. In order to overcome this constraint, the researcher employed the services of people who are familiar with both the culture and background in the region where the study was conducted and fluent in the language spoken in the field.

5.23 ETHICAL CONSIDERATIONS

The University of KwaZulu-Natal (UKZN) has an approved set of rules in the form of a procedure that each student must follow to meet ethical clearance requirements and to receive prior approval through an ethical clearance committee and the Research Division of the University before initial work on the management and administration of the questionnaires could begin. The ethical considerations were met by the researcher:

a) Informed consent

This form was obtained from the university and enabled the researcher to get the necessary permission from study participantsafter they were informed about the aims and objectives of the research.

b) Right to privacy

All the patients who participated in the survey were assured that their privacy would be protected and that their identity would always remain anonymous.

c) Protection from harm

The participants were given an absolute guarantee that they would incur no physical or emotional harm during the interview processes.

d) Involvement of the researcher

The administration and monitoring of the questionnaire was done by the researcher personally, assisted by the field workers who volunteered to participate in this study. The involvement of both the researcher and the volunteers eliminated any form of manipulation of responses.

5.24CONCLUSION

The discussion in this chapter centred on the objectives, key questions and research design of this study. The chapter also highlighted the sampling procedures used in the survey and the techniques and methods used to collected the data. Another focus of this chapter was to unpack the statistical techniques used for the analysis of the questionnaires. The research design and methodology used in the study, the objectives of the study, the intended population and the method used to draw the sample, were outlined.

Subsequent chapters will present a detailed examination of the questionnaires. As indicated, the statistics were analysed using SPSS version 20 series. This was an appropriate application for the statistical tests used in this study. The analysis of the questionnaires was done by the researcher and a professional statistician under the watchful eye of the researcher's supervisor appointed by the University.

CHAPTER SIX

PRESENTATION OF RESULTS

6.1 INTRODUCTION

In this chapter the results are analysed and presented in the form of tables, figures and statistical analysis.

6.2 METHODOLOGY ADOPTED

The data from completed survey questionnaires were coded and captured in SPSS (Statistical Package for Social Science) version 20, for Windows and used for descriptive and inferential analysis. The results from the data analysis are also presented in this section. The findings of the research are discussed against the background of the literature review. By interpreting the statistical analysis of the data collected, the extent to which the research objectives are met and the research questions are answered is demonstrated.

A total of 239 questionnaires were received out of 300 questionnaires distributed. Of the 61 that were not included in the research, 42 were received back well after the statistical analysis had been completed. The questionnaires received were sufficiently completed for statistical analysis. This represents a 100% usability rate. The return rate of usable responses was 80 percent.

6.3 STATISTICS – AN OVERVIEW

Having consulted a statistician it was decided to conduct Pearson's correlations.

Non-parametric tests or *distribution free* tests are so-called because the assumptions underlying their use are "fewer and weaker than those associated with parametric tests" (Siegel & Castellan, 1988, p. 34). To put it another way, nonparametric tests require few if any assumptions about the shapes of the underlying population distributions. For this reason, they are often used in place of parametric tests if/when one feels that the assumptions of the

parametric test have been too grossly violated (e.g., if the distributions are too severely skewed).

Parametric tests

In a parametric test a sample statistic is obtained to estimate the population parameter. Because this estimation process involves a sample, a sampling distribution, and a population, certain parametric assumptions are required to ensure that all the components are compatible with each other (Yu, 2002).

Pearson's Correlation

Bivariate correlation tests whether the relationship between two variables is linear or not (as one variable increases, the other also increases, or as one variable increases, the other variable decreases). This type of correlation test requires that the variables both have a scale level of measurement (there is a rank order for the values and the distance in between the values can be determined)**.**

Table 6.1 Age - Dispersion of Respondents

Age in years

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	18-30	85	35.6	38.3	38.3
	31-40	69	28.9	31.1	69.4
	41-55	45	18.8	20.3	89.6
	56-65+	23	9.6	10.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.1revealsthat 35.5% of the respondents fell into the 18-30 year group, followed by 31-40 years (28.9%), 41-55 years (18.8%) and 56-65 years (9.6%).

Table 6.2Gender - Dispersion of Respondents

Gender

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	female	154	64.4	69.4	69.4
	male	68	28.5	30.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.2 illustrates the gender dispersion of the respondents. Female respondents made up 64.4% of the sample and males 28.5%. Given that South Africa is a male dominated society, this result was not expected. The other 7.1% did not specify their gender on the questionnaire.

Table 6.3Marital Status - Dispersion of Respondents

Marital status

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Single [Never married]	141	59.0	63.5	63.5
	Married	67	28.0	30.2	93.7
	Widowed	8	3.3	3.6	97.3
	Divorced/ separated	6	2.5	2.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.3shows that59% of the study respondents are single, 28 % are married, 3.3% are widowed and 2.5% of the respondents are currently divorced.

Table 6.4Occupation - Dispersion of Respondents

Occupation

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Unemployed	134	56.1	60.4	60.4
	Student	20	8.4	9.0	69.4
	Administrative	5	2.1	2.3	71.6
	Domestic worker	9	3.8	4.1	75.7
	Professional	9	3.8	4.1	79.7
	Technical & other	9	3.8	4.1	83.8
	Home executive/Retired	10	4.2	4.5	88.3
	Managerial	4	1.7	1.8	90.1
	Self employed at home	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.4reveals that the majority of the respondents are unemployed (56.1%), followed by self-employed (9.2%), students (8.4%), home executives/retired (4.2%), and domestic worker; professional; technical and other (all 3.8%). Respondents involved in administration totalled 2.1% and in managerial positions 1.7%, with 7.1% of the respondents not answering this question.

Table 6.5Highest Education Level - Dispersion of Respondents

Highest educational qualification

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Between Grade 1-7	30	12.6	13.5	13.5
	Between Grade 8-12	94	39.3	42.3	55.9
	Passed Matric	58	24.3	26.1	82.0
	Certificate	13	5.4	5.9	87.8
	Diploma	16	6.7	7.2	95.0
	Degree	2	.8	.9	95.9
	Post-graduate	2	.8	.9	96.8
	Uneducated	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.5illustrates that 24.3% of the respondents have matric, 39.3% completed school between grades 8 and 12, 6.7% have a diploma, .8% have an undergraduate degree and .8% have a post-graduate degree. 2.8% of the respondents had no schooling at all.

Table 6.6 Principle Language Spoken at Home – Dispersion of Respondents

Principal language spoken at home

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Zulu	148	61.9	66.7	66.7
	Xhosa	18	7.5	8.1	74.8
	English	54	22.6	24.3	99.1
	Afrikaans	2	.8	.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.6 shows that the majority of the respondents speak isiZulu at home (61.9%), followed by English (22.8%), Xhosa (7.5%), and Afrikaans (.8%), with 7.1% of the respondents not answering this question.

Table 6.7 Geographical Residential Region - Dispersion of Respondents

Geographical residential region

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Durban North	43	18.0	19.4	19.4
	Durban East	27	11.3	12.2	31.5
	Durban South	50	20.9	22.5	54.1
	Durban West	20	8.4	9.0	63.1
	Stanger	46	19.2	20.7	83.8
	Ndwedwe	10	4.2	4.5	88.3
	Mandini	21	8.8	9.5	97.7
	Maphumulo	5	2.1	2.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.7reveals that the20.9% of the respondents are from the Durban South region, followed by Durban North at 18%, Stanger at 19.2%, Durban East at 11.3%, Mandini at 8.8%, Durban West at 8.4%, Ndwede at 4.2% and finally, Maphumulo at 2.1%.

Table 6.8Number of Kilometres Travelled to Reach the Hospital

How many kilometres do you travel to reach this hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0-10km	61	25.5	27.5	27.5
	11-50km	104	43.5	46.8	74.3
	51-70km	23	9.6	10.4	84.7
	71-90km	6	2.5	2.7	87.4
	91-99km	28	11.7	12.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.8shows that the majority of the respondents had to travel between 11 and 50km (43.5%), followed by 0 to 10km at 25.5%, 91 to 99km at 11.7%, 51 to 70km at 9.6% and 71 to 90km at 2.5%.

Table 6.9Hospital visited today - Dispersion of Respondents

Which Hospital are you visiting today?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Stanger	71	29.7	32.0	32.0
	King Edward	74	31.0	33.3	65.3
	Addington	77	32.2	34.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.9reveals that 32.2% of the respondents were visiting Addington Hospital, followed by King Edward VIII (31.0%) and Stanger (29.7%).

Table 6.10Time of arrival at the hospital

Time of your of arrival at this hospital

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Between 06h00 and 07h00	197	82.4	88.7	88.7
	Between 07h00 and 08h00	25	10.5	11.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.10shows that the majority of the respondents arrived between 06h00 and 07h00 (82.4%), with 10.5% arriving between 07h00 and 08h00 and 7.1% of the respondents did not answer this question.

Table 6.11Visible security at the hospital gates and inside the hospital - Dispersion of Respondents

Ware there visible security personnel at the hospital gates and inside the hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	176	73.6	79.3	79.3
	No	46	19.2	20.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The above table 6.11 reveals the visibility of security personnel at the hospital gates and inside the hospital. The majority of the respondents (73.6%) answered “yes” to this question, followed by “no” at 19.2%; 7.1% of the respondents did not answer this question.

Table 6.12Were signs to the OPD clear? - Dispersion of Respondents

Were signs to the OPD clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	181	75.7	81.5	81.5
	No	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.12 illustrates that the majority of the respondents (75.7%) answered "yes" to this question, followed by "no" at 17.2%; 7.1% of the respondents did not answer this question.

Table 6.13Were signs to the wards clear? - Dispersion of Respondents

Were signs to the wards clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
	Yes	157	65.7	70.7	70.7
Valid	No	65	27.2	29.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.13 above illustrates that the majority of the respondents (65.7%) answered "yes" to this question, followed by 27.2% who answered "no"; 7.1% of the respondents did not answer this question.

Table 6.14 Was it easy to find the disabled parking bay / wheel chair ramp? - Dispersion of Respondents

Was it easy to find the disabled parking bay/wheel chair ramp?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	39	16.3	17.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.14shows that76.6% of the respondents answered “yes” to this question, while 16.3% answered “no” and 7.1% of the respondents did not answer this question.

Table 6.15Signage to indicate where the toilets are is clear - Dispersion of Respondents

Signage to indicate where the toilets are clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	171	71.5	77.0	77.0
	No	51	21.3	23.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.15 reveals that 71.5% of the respondents concurred that there is clear signage to indicate where the toilets are, while 21.3% disagreed and 7.1% did not answer this question.

Table 6.16Signage to different areas of the hospital is clear - Dispersion of Respondents

Signage to different areas of the hospital is clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.1	81.1
	No	42	17.6	18.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.16shows that 75.3% of the respondents said that the signage pointing to different areas of the hospital is clear, with 17.6% disagreeing and 7.1% not answering this question.

Table 6.17Did the following staff who attended to you weara badge: Security Personnel? - Dispersion of Respondents

Did the staff who attended to you wear a badge: Security personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	36	15.1	16.2	87.8
	Unsure	27	11.3	12.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.17illustrates that 66.5% of the respondents answered “yes” to this question, while 15.1% answered “no”, 11.3% were unsure, and 7.1% did not answer this question.

Table 6.18Did the following staff who attended to you wear a badge: Clerk? - Dispersion of Respondents

Did the following staff who attended to you wear a badge: Clerk?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	193	80.8	86.9	86.9
	No	22	9.2	9.9	96.8
	Unsure	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.18 shows that80.8% of the respondents said that the clerks wore badges, while 9.2% said that they did not, 2.9% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.19Did the following staff who attended to you wear a badge: Nurse? - Dispersion of Respondents

Did the following staff who attended to you wear a badge: Nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	164	68.6	73.9	73.9
	No	41	17.2	18.5	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.19reveals that 68.8% of the respondents said that the nurses wore a badge, followed by 17.2% who said that they did not, 7.1% who were unsure, and 7.1% who did not answer this question.

Table 6.20Did the following staff who attended to you wear a badge: Doctor? - Dispersion of Respondents

Did the following staff who attended to you wear a badge: Doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	121	50.6	54.5	54.5
	No	59	24.7	26.6	81.1
	Unsure	42	17.6	18.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.20 shows that50.6% of the respondents answered “yes” to this question, followed by 24.7% who answered “no” 17.6% who were unsure, and 7.1% who did not answer this question.

Table 6.21Did the following staff who attended to you wear a badge: Pharmacy Personnel? - Dispersion of Respondents

Did the following staff who attended to you wear a badge: Pharmacy personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	102	42.7	50.5	50.5
	No	45	18.8	22.3	72.8
	Unsure	55	23.0	27.2	100.0
	Total	202	84.5	100.0	
Missing	System	37	15.5		
Total		239	100.0		

Table 6.21illustrates that42.7% of the respondents said that the pharmacy personnel wore a badge, follows by 23.0% who were unsure, 18.8% who said they did not wear a badge, and 15.5% who did not answer this question.

Table 6.22Did the following staff who attended to you wear a badge: Other? - Dispersion of Respondents

Did the following staff who attended to you wear a badge: Other?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	188	78.7	85.5	85.5
	No	16	6.7	7.3	92.7
	Unsure	16	6.7	7.3	100.0
	Total	220	92.1	100.0	
Missing	System	19	7.9		
Total		239	100.0		

Table 6.22shows that 78.7% of the respondents answered “yes” to this question, followed by 6.7% who answered “no” 6.7% who were unsure, and 7.9% who did not answer this question.

Table 6.23Were you able to communicate with staff in your own language? - Dispersion of Respondents

Were you able to communicate with staff in your own language?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	142	59.4	64.0	64.0
	No	40	16.7	18.0	82.0
	Unsure	40	16.7	18.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.23 shows that 59.4% of the respondents said that they were able to communicate with staff in their own language, followed by 16.7% who said that they were not, 16.7% who were unsure, and 7.1% who did not answer this question.

Table 6.24Where necessary, were the services of an interpreter arranged? - Dispersion of Respondents

Where necessary, were the services of an interpreter arranged?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	184	77.0	82.9	82.9
	No	27	11.3	12.2	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.24reveals that 77.0% of the respondents answered “yes” to this question, with 11.3% answering “no”, 4.6% who were unsure, and 7.1% who did not answer this question.

Table 6.25During your treatment were the procedures explained to you? - Dispersion of Respondents

During your treatment were the procedures explained to you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	167	69.9	75.2	75.2
	No	34	14.2	15.3	90.5
	Unsure	21	8.8	9.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.25 illustrates that 69.9% of the respondents said that the procedures were explained to them during their treatment, while 14.2% said that they were not, 8.8% were unsure, and 7.1% did not answer this question.

Table 6.26 Were your questions and queries dealt with satisfactorily? - Dispersion of Respondents

Were your questions and queries dealt with satisfactorily?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.1	81.1
	No	25	10.5	11.3	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.26shows that 75.3% answered “yes” to this question, followed by 10.5% who answered “no”, 7.1% who were unsure, and 7.1% who did not answer this question.

Table 6.27 Were you treated politely by the following staff members: Security personnel?

Were you treated politely by the following staff members: Security personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	158	66.1	71.2	71.2
	No	37	15.5	16.7	87.8
	Unsure	27	11.3	12.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.27 illustrates that the majority of the respondents (66.1%) agreed that they were treated politely by security personnel, while 15.5% said that they were not, 11.3% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.28Were you treated politely by the following staff members: Clerk? - Dispersion of Respondents

Were you treated politely by the following staff members: Clerk?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	189	79.1	85.1	85.1
	No	25	10.5	11.3	96.4
	Unsure	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.28 reveals that 79.1% of the respondents answered “yes” to this question, 10.5% answered “no”, 3.3% were unsure, and 7.1% did not answer this question.

Table 6.29Were you treated politely by the following staff members: Nurse? - Dispersion of Respondents

Were you treated politely by the following staff members: Nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.4	81.4
	No	29	12.1	13.1	94.6
	Unsure	12	5.0	5.4	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

Table 6.29 shows that 75.3% of the respondents said that they were treated politely by nurses, while 12.1% said that they were not, 5.0% were unsure, and 7.5% of the respondents did not answer this question.

Table 6.30 Were you treated politely by the following staff members: Doctor? - Dispersion of Respondents

Were you treated politely by the following staff members: Doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	141	59.0	63.5	63.5
	No	36	15.1	16.2	79.7
	Unsure	45	18.8	20.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.30 shows that 59.0% of the respondents answered “yes” to this question, 18.8% were unsure, 15.1% answered “no”, and 7.1% did not answer this question.

Table 6.31Were you treated politely by the following staff members: Pharmacy personnel? - Dispersion of Respondents

Were you treated politely by the following staff members: Pharmacy personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	109	45.6	53.2	53.2
	No	48	20.1	23.4	76.6
	Unsure	48	20.1	23.4	100.0
	Total	205	85.8	100.0	
Missing	System	34	14.2		
Total		239	100.0		

Table 6.31 illustrates that only 45.6% of the respondents felt that they were treated politely by pharmacy personnel, while 20.1% felt that they were not, 20.1% were unsure, and 14.2% of the respondents did not answer this question.

Table 6.32The nurse explained the findings before I saw the doctor

The nurse explained the findings before I saw the doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	177	74.1	79.7	79.7
	No	28	11.7	12.6	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.32 shows that 74.1% of the respondents said that the nurse explained the findings before they saw the doctor, 11.7% answered “no”, 7.1% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.33The doctor asked for permission before the examination - Dispersion of Respondents

The doctor asked for permission before the examination

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	188	78.7	84.7	84.7
	No	25	10.5	11.3	95.9
	Unsure	9	3.8	4.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.33reveals that 78.7% of the respondents said that the doctor asked for permission before conducting the examination, followed by 10.5% who said the doctor did not ask for permission, 3.8% who were unsure, and 7.1% of respondents who did not answer the question.

Table 6.34Doctor explained my condition to me - Dispersion of Respondents

Doctor explained my condition to me

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	28	11.7	12.6	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.34illustrates that the majority of the respondents (76.6%) said that the doctor explained their condition to them; 11.7% said that the doctor did not do so, 4.6% were unsure, and 7.1% did not answer this question.

Table 6.35 Were you treated in a respectful manner? – Dispersion of Respondents

Were you treated in a respectful manner?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	169	70.7	76.1	76.1
	No	36	15.1	16.2	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.35 shows that the majority of the respondents (70.7%) said that they were treated in a respectful manner; 15.1% said that they were not; 7.1% were unsure, and 7.1% of the respondents did not answer the question.

Table 6.36Advice was given on how to improve my health status - Dispersion of Respondents

Advice was given on how to improve my health status

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	20	8.4	9.0	91.0
	Unsure	20	8.4	9.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.36reveals that 76.2% of the respondents answered “yes” to this question, with 8.4% answering “no”; 8.4% unsure, and 7.1% who did not answer this question.

Table 6.37Was the outpatients' department clean? – Dispersion of Respondents

Was the outpatients' department clean?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	168	70.3	75.7	75.7
	No	25	10.5	11.3	86.9
	Unsure	29	12.1	13.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.37illustrates that 70.3% of the respondents said that theoutpatients' department was clean, 12.1% were unsure, 10.5% said it was not clean, and 7.1% of the respondents did not answer this question.

Table 6.38 Was the Pharmacy department clean? – Dispersion of Respondents

Was the Pharmacy department clean?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	172	72.0	77.5	77.5
	No	38	15.9	17.1	94.6
	Unsure	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.38reveals that the majority of the respondents (72.0%) answered ‘yes” to this question, with 15.9% answering “no”, 5.0% unsure, and 7.1% who did not answer this question.

Table 6.39 Were the toilets clean? – Dispersion of Respondents

Were the toilets clean?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	170	71.1	76.6	76.6
	No	44	18.4	19.8	96.4
	Unsure	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.39shows that the majority of the respondents (71.1%) reported that the toilets were clean; 18.4% said that they were not clean; 3.3% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.40There was toilet paper in the toilet - Dispersion of Respondents

Was there toilet paper in the toilet?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	151	63.2	68.0	68.0
	No	49	20.5	22.1	90.1
	Unsure	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.40illustrates that63.2% of the respondents said that there was toilet paper in the toilet, with 20.5% reported that there was none, 9.2% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.41 There was soap to wash hands in the toilet - Dispersion of Respondents

Was there soap to wash hands in the toilet?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	137	57.3	61.7	61.7
	No	68	28.5	30.6	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.41reveals that just over half (57.3%) of the respondents said that there was soap in the toilets to wash their hands, followed by 28.5% who said that there was no soap, 7.1% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.42There were paper towels/air dryer to dry hands in the toilet - Dispersion ofRespondents

Were there paper towels/air dryer to dry hands in the toilet?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	23	9.6	10.4	92.8
	Unsure	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.42 illustrates the majority (76.6%) of the respondents answered “yes” to this question, with 9.6% answering “no”, 6.7% unsure, and 7.1% of the respondents who did not answer this question.

Table 6.43Did the staff wash/spray their hands before and after examining you? - Dispersion of Respondents

Did the staff wash/spray their hands before and after examining you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	161	67.4	72.5	72.5
	No	33	13.8	14.9	87.4
	Unsure	28	11.7	12.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.43 shows that 67.4% of the respondents reported that staff did wash/spray their hands before examining them, while 13.8% said that they did not, 11.7% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.44Were you happy with overall cleanliness of the hospital? - Dispersion ofRespondents

Were you happy with overall cleanliness of the hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	172	72.0	77.5	77.5
	No	24	10.0	10.8	88.3
	Unsure	26	10.9	11.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.44reveals that the majority of the respondents (72.0%) were happy with the overall cleanliness of the hospital, while 10.9% were unsure, 10.0% of the respondents were not happy with the levels of cleanliness, and 7.1% did not answer this question.

Table 6.45Were the following areas in hospital clean: Grounds? - Dispersion of Respondents

Were the following areas in hospital clean: Grounds?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	170	71.1	76.6	76.6
	No	31	13.0	14.0	90.5
	Unsure	21	8.8	9.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.45 illustrates that 71.7% of the respondents answered “yes” to this question, 13.0% answered “no”, 8.8% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.46 Were the following areas in hospital clean: Corridors? - Dispersion of Respondents

Were the following areas in hospital clean: Corridors?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	160	66.9	72.1	72.1
	No	38	15.9	17.1	89.2
	Unsure	24	10.0	10.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.46 shows that 66.9% of the respondents reported that the hospital corridors were clean, 15.9% said that there were not, 10.0% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.47 Were the following areas in hospital clean: Buildings? - Dispersion of Respondents

Were the following areas in hospital clean: Buildings?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	149	62.3	67.1	67.1
	No	41	17.2	18.5	85.6
	Unsure	32	13.4	14.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.47reveals that the majority of the respondents (62.3%) agreed that there buildings were clean, 17.2% said that they were not clean, 13.4% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.48 Were the following areas in hospital clean: Ablution facilities? - Dispersion of Respondents

Were the following areas in hospital clean: Ablution facilities?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	41	17.2	18.5	90.1
	Unsure	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.48 illustrates that 66.5% of the respondents answered “yes’ to this question, 17.2% answered “no”, and 9.2% were unsure, while 7.1% of the respondents did not answer this question.

Table 6.49Were the following areas in hospital clean: Bed linen? - Dispersion of Respondents

Were the following areas in hospital clean: Bed linen?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	38	15.9	17.1	88.7
	Unsure	25	10.5	11.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.49 shows that the majority of the respondents (66.5%) felt that the bed linen was clean, while 15.9%, felt that it was not, 10.5% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.50Were the following areas in hospital clean: Was the ward free of pests?

Were the following areas in hospital clean: Was the ward free of pests?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	164	68.6	73.9	73.9
	No	42	17.6	18.9	92.8
	Unsure	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.50 illustrates that 68.6% agreed that the ward was free of pests, 17.6% said that it was not, 6.7% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.51Did the hospital staff draw your attention to patients' rights and responsibilities? - Dispersion of Respondents

Did the hospital staff draw your attention to patients' rights and responsibilities?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	169	70.7	76.1	76.1
	No	36	15.1	16.2	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.51 reveals that 70.7% of the respondents answered “yes” to this question, 15.1% answered “no”, 7.1% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.52Did your consultation with the nurse or doctor take place in a private manner? - Dispersion of Respondents

Did your consultation with the nurse or doctor take place in a private manner?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	181	75.7	81.5	81.5
	No	30	12.6	13.5	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.52 shows that the majority of the respondents (75.5%) agreed that the consultation took place in private manner, with 12.6% reporting that it did not, 4.6% who were unsure, and 7.1% of the respondents who did not answer this question.

Table 6.53Was a bench/chair provided for you to sit on while you waited? - Dispersion ofRespondents

Was a bench/chair provided for you to sit on while you waited?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	92	38.5	41.4	41.4
	No	116	48.5	52.3	93.7
	Unsure	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.53 illustrates that 48.5% of the respondents said that they were not provided with a bench/chair to sit on while they waited, while 38.5% reported that they were, 5.9% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.54Did you have a complaint? - Dispersion of Respondents

Did you have a complaint?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	119	49.8	53.6	53.6
	No	85	35.6	38.3	91.9
	Unsure	18	7.5	8.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.54 reveals that 49.8% of the respondents had a complaint, 35.6% did not, 7.5% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.55If you had a complaint, did you report it? - Dispersion of Respondents

If you had a complaint, did you report it?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	141	59.0	63.8	63.8
	No	55	23.0	24.9	88.7
	Unsure	25	10.5	11.3	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

Table 6.55 illustrates that the majority of the respondents (59.0%) reported their complaint, 23.0% did not, 10.5% were unsure, and 7.5% of the respondents did not answer this question.

Table 6.56If you had a complaint, were you satisfied with the way it was handled? - Dispersion of Respondents

If you had a complaint, were you satisfied with the way it was handled?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	168	70.3	75.7	75.7
	No	43	18.0	19.4	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.56 shows that the majority of the respondents (70.3%) were satisfied with the way their complaints were handled, followed by 18.0% who were not satisfied, 4.6% who were unsure, and 7.1% of the respondents who did not answer this question.

Table 6.57At night, was the nurse available when you called? – Dispersion of Respondents

At night, was the nurse available when you called?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	184	77.0	82.9	82.9
	No	25	10.5	11.3	94.1
	Unsure	13	5.4	5.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.57reveals that 77.0% of the respondents answered "yes" to this question, 10.5% answered "no", 5.4% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.58Did you feel safe in the hospital? – Dispersion of Respondents

Did you feel safe in the hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	26	10.9	11.7	93.7
	Unsure	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.58 illustrates that 76.2% of the respondents felt safe in the hospital, 10.9% did not, 5.9% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.59 Were you issued with the medication the doctor prescribed for you? – Dispersion of Respondents

Were you issued with the medication that the doctor prescribed for you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	23	9.6	10.4	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.59 shows that 76.2% of the respondents said that they were issued with the medication the doctor prescribed for them, 9.6% reported that they were not, 7.1% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.60Instructions regarding medication /follow up were provided - Dispersion of Respondents

Were instructions provided regarding medication /follow up?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	185	77.4	83.3	83.3
	No	22	9.2	9.9	93.2
	Unsure	15	6.3	6.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.60 reveals that the majority of the respondents (77.4%) answered “yes” to this question, 9.2% answered “no”, 6.3% were unsure, and 7.1% of the respondents did not answer this question.

Table 6.61Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so? - Dispersion of Respondents

Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	134	56.1	60.4	60.4
	Yes to some extent	67	28.0	30.2	90.5
	No	21	8.8	9.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.61 illustrates that 56.1% of the respondents agreed that a family member or someone else close to them was “definitely” given the opportunity to speak to a doctor is they wished to, while 28.0% reported that they were given such an opportunity “to some extent”, 8.8% said that they were not given enough opportunity, and 7.1% of the respondents did not answer this question.

Table 6.62Access to care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment? - Dispersion of Respondents

Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	149	62.3	67.1	67.1
	Yes to some extent	59	24.7	26.6	93.7
	No	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.62 shows that 62.3% of the respondents said that there were “definitely” involved as much as they wanted to be in their care and treatment,24.7% were involved “to some extent”, 5.9% were not involved as much as they wanted to be, and 7.1% of the respondents did not answer this question.

Table 6.63 When you had important questions to ask a doctor, did you get answers that you could understand? - Dispersion of Respondents

When you had important questions to ask a doctor, did you get answers that you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes always	138	57.7	62.2	62.2
	Yes sometimes	72	30.1	32.4	94.6
	No	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.63reveals that 57.7% of the respondents said that they “always” got answers they could understand, 30.1% said that they “sometimes” received answers they could understand, 5.0% said that they did not receive answers they could understand, and 7.1% of the respondents did not answer this question.

Table 6.64When you had important questions to ask a doctor, did you get answers that you could understand? - Dispersion of Respondents

When you had important questions to ask a nurse, did you get answers that you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes always	158	66.1	71.2	71.2
	Yes sometimes	49	20.5	22.1	93.2
	No	15	6.3	6.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.64 illustrates that66.1% of the respondents answered “yes, always” to this question, 20.5% answered “sometimes”, 6.3% answered “no”, and 7.1% of the respondents did not answer this question.

Table 6.65Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? - Dispersion of Respondents

Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	149	62.3	67.1	67.1
	Yes to some extent	43	18.0	19.4	86.5
	No	30	12.6	13.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.65 shows that62.3% of the respondents stated that a member of staff “definitely” explained the purpose of the medicine they were to take at home in a way they could understand, while 18.0% said this occurred “to some extent” 12.6% said it did not, and 7.1% of the respondents did not answer this question.

Table 6.66Did a member of staff tell you about any medication side effects to watch for when you went home? - Dispersion of Respondents

Did a member of staff tell you about any medication side effects to watch for when you went home?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	131	54.8	59.0	59.0
	Yes to some extent	50	20.9	22.5	81.5
	No	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.66 illustrates that54.8% of the respondents answered “yes, definitely” to this question, followed by 20.9% who answered “yes, to some extent”, and 17.2% who answered “no”, with 7.1% of the respondents not answering this question.

Table 6.67 Did a member of staff tell you about any danger signals you should watch for after you went home? Dispersion of Respondents

Did a member of staff tell you about any danger signals you should watch for after you went home?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	118	49.4	53.2	53.2
	Yes to some extent	68	28.5	30.6	83.8
	No	36	15.1	16.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.67reveals that 49.4% of the respondents reported that they were “definitely” told about of any danger signals they should watch out for when they went home, 28.5% said that they had been warned “to some extent”, 15.1% claimed that they had not been told, and 7.1% of the respondents did not answer this question.

Table 6.68 Did the doctor or nurses give your family or someone close to you all the information they needed to help you recover?- Dispersion of Respondents

Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	65	27.2	29.3	29.3
	Yes to some extent	82	34.3	36.9	66.2
	No	75	31.4	33.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.68 illustrates that 27.2% of the respondents answered “yes, definitely” to this question, 34.4% answered “yes, to some extent”, 31.4% answered “no”, and 7.1% of the respondents did not answer this question.

Table 6.69 Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you? - Dispersion of Respondents

Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes often	109	45.6	49.1	49.1
	Yes sometimes	56	23.4	25.2	74.3
	No	57	23.8	25.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.69 shows that 45.6% of the respondents reported that there were “often” discrepancies in coordination of care, 23.8% said there were no discrepancies, 23.4% said there were “sometimes” discrepancies, and 7.1% of the respondents did not answer this question.

Table 6.70 Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?- Dispersion of Respondents

Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	49	20.5	22.1	22.1
	Yes to some extent	26	10.9	11.7	33.8
	No	147	61.5	66.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.70 reveals that only 20.5% of the respondents "definitely" found someone on the hospital staff to talk to about their worries and fears, 10.9% found such support "to some extent", 61.5% did not receive such support, and 7.1% of the respondents did not answer this question.

Table 6.71The food and the way it was presented was good - Dispersion of Respondents

The food and the way it was presented was good

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	28	11.7	12.6	12.6
	Disagree	22	9.2	9.9	22.5
	Uncertain	16	6.7	7.2	29.7
	Agree	85	35.6	38.3	68.0
	Strongly Agree	71	29.7	32.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.71 illustrates that 35.6% of the respondents agreed with this statement, 29.7% strongly agreed, 11.7% strongly disagreed, 9.2% disagreed, 6.7% were uncertain, and 7.1% of the respondents did not answer this question.

Table 6.72 Eating utensils e.g. spoons, were provided with your meals - Dispersion of Respondents

Table …**Eating utensils e.g spoons were provided with your meals**

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	29	12.1	13.1	13.1
	Disagree	29	12.1	13.1	26.1
	Uncertain	17	7.1	7.7	33.8
	Agree	78	32.6	35.1	68.9
	Strongly Agree	69	28.9	31.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.72shows that 32.6% of the respondents agreed with this statement, 28.9% strongly agreed, 12.1% strongly disagreed, 12.1% disagreed, 7.1% were uncertain, and 7.1% of the respondents did not answer this question.

Table 6.73 Are visiting hours convenient to the community? - Dispersion of Respondents

Do you agree that the visiting hours are convenient to the community?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	33	13.8	14.9	14.9
	Disagree	34	14.2	15.3	30.2
	Uncertain	15	6.3	6.8	36.9
	Agree	81	33.9	36.5	73.4
	Strongly Agree	59	24.7	26.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.73 illustrates that33.9% agreed with this statement, 24.7% strongly agreed, 14.2% disagreed, at 13.8% strongly disagreed, 6.3% were uncertain, and 7.1% of the respondents did not answer this question.

Table 6.74 During your stay at the hospital, were you offered pyjamas/nighties daily? - Dispersion of Respondents

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	31	13.0	14.0	14.0
	Disagree	28	11.7	12.6	26.6
	Uncertain	42	17.6	18.9	45.5
	Agree	74	31.0	33.3	78.8
	Strongly Agree	47	19.7	21.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.74reveals that 31.0% of the respondents agreed with this statement, 19.7% strongly agreed, 17.6% were uncertain, 13.0% strongly disagreed, and 11.7% disagreed, while 7.1% of the respondents did not answer this question.

Table 6.75 Were you and your family advised about changes in your condition? - Dispersion of Respondents

You and your family were advised about changes in your condition

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	20	8.4	9.0	9.0
	Disagree	19	7.9	8.6	17.6
	Uncertain	42	17.6	18.9	36.5
	Agree	92	38.5	41.4	77.9
	Strongly Agree	49	20.5	22.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.75 shows that 38.5% of the respondents agreed that they and their family were advised about changes in their condition, 20.5% strongly agreed, 17.6% were uncertain, 8.4% strongly disagreed, 7.9% disagreed, and 7.1% of the respondents did not answer this question.

Table 6.76The hospital staff assisted you in making arrangements for you when you were discharged - Dispersion of Respondents

The hospital staff assisted you in making arrangements for you when you were discharged

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	19	7.9	8.6	8.6
	Disagree	16	6.7	7.2	15.8
	Uncertain	43	18.0	19.4	35.1
	Agree	83	34.7	37.4	72.5
	Strongly Agree	61	25.5	27.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.76 illustrates that34.7% of the respondents agreed with this statement, 25.5% strongly agreed, 18.0% were uncertain, 7.9% strongly disagreed, and 6.7% disagreed, with 7.1% of the respondents not answering this question.

Table 6.77At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home? - Dispersion of Respondents

At the time of your discharge, you had enough knowledge about your illness to take care of yourself at home

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	17	7.1	7.7	7.7
	Disagree	22	9.2	9.9	17.6
	Uncertain	22	9.2	9.9	27.5
	Agree	81	33.9	36.5	64.0
	Strongly Agree	80	33.5	36.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.77shows that 33.9% of the respondents agreed that upon their discharge, they had enough knowledge about how to take care of themselves at home, while 33.5% strongly agreed, 9.2% disagreed, 9.2% were uncertain, and 7.1% strongly disagreed, with 7.1% of the respondents not answering this question.

Table 6.78 Would you return to this hospital for treatment? Dispersion of Respondents

I would return to this hospital for treatment

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	12	5.0	5.4	5.4
	Disagree	20	8.4	9.0	14.4
	Uncertain	29	12.1	13.1	27.5
	Agree	81	33.9	36.5	64.0
	Strongly Agree	80	33.5	36.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.78 reveals that 33.9% of the respondents agreed that they would return to this hospital for treatment, 33.5% strongly agreed, 12.1% were uncertain, 8.4% disagreed, and 5.0% strongly disagreed, with 7.1% of the respondents not answering this question.

Table 6.79Were you treated in a polite, courteous and friendly manner by all health professionals? - Dispersion of Respondents

I was treated in a polite, courteous and friendly manner by all health professionals

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	53	22.2	23.9	23.9
	Disagree	49	20.5	22.1	45.9
	Uncertain	40	16.7	18.0	64.0
	Agree	39	16.3	17.6	81.5
	Strongly Agree	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.79 illustrates that 22.2% of the respondents strongly disagreed with the statement that they were treated in a polite, courteous and friendly manner by all health professionals, 20.5% disagreed with this statement, 17.2% strongly agreed, 16.7% were uncertain, and only 16.3% agreed with this statement, while 7.1% of the respondents did not answer this question.

Table 6.80How long did you wait for your outpatient card? Dispersion of Respondents

How long did you wait for your outpatient card?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	64	26.8	28.8	28.8
	15-30 minutes	53	22.2	23.9	52.7
	30-45 minutes	44	18.4	19.8	72.5
	45mins -1hr	35	14.6	15.8	88.3
	1hr and more	26	10.9	11.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.80 shows that 26.8% of the respondents waited 0-15 minutes for their outpatient card, 22.2% waited for 15-30 minutes, 18.4% for 30-45 minutes, and 14.6% for between 45 minutes and an hour, while 10.9% waited for an hour and more and 7.1% of the respondents did not answer this question.

Table 6.81How long did you wait to be treated by a nurse? Dispersion of Respondents

How long did you wait to be treated by a nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	52	21.8	23.4	23.4
	15-30 minutes	42	17.6	18.9	42.3
	30-45 minutes	42	17.6	18.9	61.3
	45mins -1hr	36	15.1	16.2	77.5
	1hr and more	50	20.9	22.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.81reveals that 21.8% of the respondents reported waiting for 0-15 minutes to be seen by a nurse, 20.9% waited an hour or more, 17.6% waited for 15-30 minutes, the same per centage waited for 30-45 minutes, and 15.1% waited for 45 minutes to an hour, with 7.1% of the respondents not answering this question.

Table 6.82How long did you wait to be treated by a doctor? - Dispersion of Respondents

How long did you wait to be treated by a doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	37	15.5	16.7	16.7
	15-30 minutes	39	16.3	17.6	34.2
	30-45 minutes	55	23.0	24.8	59.0
	45mins -1hr	46	19.2	20.7	79.7
	1hr and more	45	18.8	20.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.82 illustrates that 23.0% of the respondents stated that they waited for 30-45 minutes to see a doctor,19.2% waited for 45 minutes to an hour, and 18.8% waited an hour or more, while 16.3% waited 15-30 minutes, and 15.5% waited 0-15 minutes, with 7.1% of the respondents not answering this question.

Table 6.83How long did you wait for medication in the pharmacy department? - Dispersion of Respondents

How long did you wait for medication in the pharmacy department?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	41	17.2	18.5	18.5
	15-30 minutes	47	19.7	21.2	39.6
	30-45 minutes	63	26.4	28.4	68.0
	45mins -1hr	40	16.7	18.0	86.0
	1hr and more	31	13.0	14.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.83 shows that 26.4% of the respondents waited 30-45 minutes in the pharmacy department for their medicine, 19.7% waited 15-30 minutes, 17.2% waited 0-15 minutes, 16.7% waited 45 minutes to an hour, and 13.0% waited for an hour or more, with 7.1% of the respondents not answering this question.

Table 6.84 How long was the waiting time to get a folder? - Dispersion of Respondents

How long was the waiting time to get a folder?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	38	15.9	17.1	17.1
	15-30 minutes	37	15.5	16.7	33.8
	30-45 minutes	53	22.2	23.9	57.7
	45mins -1hr	42	17.6	18.9	76.6
	1hr and more	52	21.8	23.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.84reveals that 22.2% of the respondents waited 30-45 minutes to get a folder, 21.8% waited an hour or more, 17.6% waited 45 minutes to an hour, 15.9% waited 0-15 minutes, and 15.5% waited 15-30 minutes, with 7.1% of the respondents not answering this question.

Table 6.85How long was the waiting time in the outpatient department? - Dispersion of Respondents

How long was the waiting time in the outpatient department?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	47	19.7	21.2	21.2
	15-30 minutes	41	17.2	18.5	39.6
	30-45 minutes	40	16.7	18.0	57.7
	45mins -1hr	35	14.6	15.8	73.4
	1hr and more	59	24.7	26.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.85 illustrates that 24.7% of the respondents reported waiting an hour or more in the outpatient department, 19.7% waited 0-15 minutes, 17.2% waited 15-30 minutes, 16.7% waited 30-45 minutes, and 14.6% waited 45 minutes to an hour, with 7.1% of the respondents not answering this question.

Table 6.86 How long did you wait for a doctor to discharge you on the last day at hospital? - Dispersion of Respondents

How long did you wait for a doctor to discharge you on the last day at hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	149	62.3	67.1	67.1
	15-30 minutes	55	23.0	24.8	91.9
	30-45 minutes	14	5.9	6.3	98.2
	45mins -1hr	1	.4	.5	98.6
	1hr and more	3	1.3	1.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.86 shows that 62.3% of the respondents only waited 0-15 minutes for a doctor to discharge them on their last day at hospital, 23.0% waited 15-30 minutes, 5.9% waited 30-45 minutes, 1.3% waited an hour or more and .4% waited 45 minutes to an hour, with 7.1% of the respondents not answering this question.

Table 6.87Importance of not having to wait too long to receive doctor assistance - Dispersion of Respondents

Not having to wait too long to receive doctor assistance

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	153	64.0	68.9	68.9
	Important	63	26.4	28.4	97.3
	Not important	6	2.5	2.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.87reveals that with the majority of patients (64.0%) rated not having to wait too long for doctor assistance “very important”, 26.4% rated it “important”, and only 2.5% raised it “not important”, with 7.1% of the respondents not answering this question.

Table 6.88Importance of not having to wait too long to receive a nurse's assistance - Dispersion of Respondents

Not having to wait too long to receive a nurse's assistance

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	135	56.5	61.1	61.1
	Important	75	31.4	33.9	95.0
	Not important	11	4.6	5.0	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

Table 6.88 illustrates that the majority of the respondents (56.5%) rated not having to wait too long to receive assistance from a nurse as "very important", followed by 31.4% who rated it "important", and only 4.6% who rated it as "not important", with 7.1% of the respondents not answering this question.

Table 6.89 Importance of not having to wait too long for my surgical procedure - Dispersion of Respondents

Not having to wait too long for my surgical procedure

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	131	54.8	59.0	59.0
	Important	77	32.2	34.7	93.7
	Not important	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.89 shows that 54.8% of the respondents felt that it was “very important” that they should not have to wait too long for a surgical procedure, while 32.2% felt it was “important” and only 5.9% felt it was “not important”, with 7.1% of the respondents not answering this question.

Table 6.90 Importance of not having to wait too long for my medication - Dispersion of Respondents

Importance of not having to wait too long for my medication

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	115	48.1	51.8	51.8
	Important	84	35.1	37.8	89.6
	Not important	23	9.6	10.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.90reveals that 48.1% of the respondents felt that it was “very important” that they should not have to wait too long for their medication, while 35.1% felt it was “important”, and only 9.6% felt it was “not important”, with 7.1% of the respondents not answering this question.

Table 6.91 Importance of receivingadequate information prior to anaesthesia and surgery - Dispersion of Respondents

Importance of receiving adequate information prior to anaesthesia and surgery

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	120	50.2	54.1	54.1
	Important	84	35.1	37.8	91.9
	Not important	18	7.5	8.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.91illustrates that 50.2% of the respondents felt that it was “very important” that they receive adequate information prior to anaesthesia or surgery, with 35.1% rating this as “important”, and 7.5% rating it “not important”, and 7.1% of the respondents not answering this question.

Table 6.92 Importance ofadequate friendliness and courtesy - Dispersion of Respondents

Importance of adequate friendliness and courtesy

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	135	56.5	60.8	60.8
	Important	65	27.2	29.3	90.1
	Not important	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.92 shows that 56.5% of the respondents felt that adequate friendliness and courtesy was “very important”, 27.2% felt that it was “important”, 9.2% felt it was “not important”, and 7.1% of the respondents did not answer this question.

Table 6.93 Friendliness and courtesy shown to you by nurse - Dispersion of Respondents

Friendliness and courtesy shown to you by nurse

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	72	30.1	32.4	32.4
	Very good	64	26.8	28.8	61.3
	Good	61	25.5	27.5	88.7
	Fair	15	6.3	6.8	95.5
	Poor	10	4.2	4.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.93reveals that 30.1% of the respondents rated the friendliness and courtesy shown towards them by the nurse as “excellent”, 26.8% rated it “very good”, 25.5% rated it “good”, 6.3% felt it was “fair”, 4.2% rated it “poor” and 7.1% of the respondents did not answer this question.

Table 6.94 Friendliness and courtesy shown to you by Clerks - Dispersion of Respondents

Friendliness and courtesy shown to you by Clerks

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	52	21.8	23.4	23.4
	Very good	63	26.4	28.4	51.8
	Good	65	27.2	29.3	81.1
	Fair	33	13.8	14.9	95.9
	Poor	9	3.8	4.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.94 illustrates that 27.2% rated the friendliness and courtesy shown to them by the clerks as “good”, 26.4% rated it “very good”, 21.8% “excellent”, 13.8% felt it was “fair”, 3.8% rated it “poor”, and 7.1% of the respondents did not answer this question.

Table 6.95Friendliness and courtesy shown to you by other staff - Dispersion ofRespondents

Friendliness and courtesy shown to you by other staff

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	74	31.0	33.3	33.3
	Very good	69	28.9	31.1	64.4
	Good	58	24.3	26.1	90.5
	Fair	13	5.4	5.9	96.4
	Poor	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.95 shows that 31.0% of the respondents rated thefriendliness and courtesy shown to them by other staff dispersion “excellent”, 28.9% rated it ”very good”, 24.3% felt it was ‘good”, 5.4% rated it “fair” and 3.3% rated it “poor”, with 7.1% of the respondents not answering this question.

Table 6.96The thoroughness of care you received from your doctor - Dispersion of Respondents

The thoroughness of care you received from your doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	59	24.7	26.6	26.6
	Very good	61	25.5	27.5	54.1
	Good	62	25.9	27.9	82.0
	Fair	24	10.0	10.8	92.8
	Poor	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.96reveals that 25.9% of the respondents described the thoroughness of care they received from their doctor as “very good”, followed closely by 25.5% who rated it “very good” and 24.7% who felt it was “excellent”. Furthermore, 10.0% of the respondents described the thoroughness of care they received from the doctor as “fair” and 6.7% felt it was “poor”, with 7.1% of the respondents not answering this question.

Table 6.97The amount of time spent with your doctor - Dispersion of Respondents

The amount of time spent with your doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	67	28.0	30.2	30.2
	Very good	66	27.6	29.7	59.9
	Good	52	21.8	23.4	83.3
	Fair	25	10.5	11.3	94.6
	Poor	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.97 shows that28.0% of the respondents rated the amount of time spent with the doctor as “excellent”, with 27.6% rating it “very good”; 21.8% felt it was “good”, 10.5% of the respondents rated it “fair” and 5.0% said it was “poor”; and 7.1% of the respondents did not answer this question.

Table 6.98How well were your questions answered by your doctor? - Dispersion of Respondents

How well were your questions answered by your doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	61	25.5	27.5	27.5
	Very good	66	27.6	29.7	57.2
	Good	61	25.5	27.5	84.7
	Fair	27	11.3	12.2	96.8
	Poor	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.98 illustrates that 27.6% of the respondents rated the way their questions were answered by the doctor as “very good”, while 25.5% rated it “excellent” and “good” respectively, 11.3% felt it was “fair”, 2.9% “poor” and 7.1% of the respondents did not answer this question.

Table 6.99 How well were your questions answered by your nurse? - Dispersion of Respondents

How well were your questions answered by your nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	52	21.8	23.4	23.4
	Very good	52	21.8	23.4	46.8
	Good	61	25.5	27.5	74.3
	Fair	33	13.8	14.9	89.2
	Poor	24	10.0	10.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 6.99 reveals that 25.5% of the respondents rated the way the nurse handled their questions as “good”, 21.8% rated it “excellent” and “very good” respectively, 13.8% felt it was “fair”, 10.0% rated it “poor” and 7.1% of the respondents did not answer this question.

Table 6.100The overall service and care you received - Dispersion of Respondents

The overall service and care you received

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	69	28.9	28.9	28.9
	Very good	170	71.1	71.1	100.0
	Total	239	100.0	100.0	

Table 6.100 shows that the large majority of the respondents (71.1%) rated the overall care and service they received as “very good”, while 28.9% rated it “excellent”.

STAFF RESPONSES

Table 6.101 To what extent do you agree with the following? I often think about leaving my current employer - Dispersion of Respondents

To what extent do you agree with the following: I often think about leaving my current employer?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	79	33.1	33.1	33.1
	Disagree	88	36.8	36.8	69.9
	Uncertain	72	30.1	30.1	100.0
	Total	239	100.0	100.0	

Table 6.101 illustrates that 36.8% of the respondents disagreed with this statement, 33.1% strongly disagreed and 30.1% were uncertain.

Table 6.102I will probably look for a new job in the next year - Dispersion of Respondents

I will probably look for a new job in the next year

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	38	15.9	15.9	15.9
	Disagree	66	27.6	27.6	43.5
	Uncertain	37	15.5	15.5	59.0
	Agree	66	27.6	27.6	86.6
	Strongly Agree	32	13.4	13.4	100.0
	Total	239	100.0	100.0	

Table 6.102 reveals that respondents were fairly evenly split on this issue, with 27.6% both disagreeing and agreeing with this statement respectively, 15.9% strongly disagreeing, 15.5% being uncertain and 13.4% strongly agreeing.

Table 6.103As soon as I can find another job, I will leave my current employer - Dispersion of Respondents

As soon as I can find another job, I will leave my current employer

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	41	17.2	17.2	17.2
	Disagree	81	33.9	33.9	51.0
	Uncertain	27	11.3	11.3	62.3
	Agree	49	20.5	20.5	82.8
	Strongly Agree	41	17.2	17.2	100.0
	Total	239	100.0	100.0	

Table 6.103 shows that 33.9% of the respondents disagreed with this statement, 20.5% agreed, 17.2% strongly disagreed and strongly agreed respectively, and 11.3% were uncertain.

Table 6.104I am involved in deciding on the changes introduced that affect my work area/team/department – Dispersion of Respondents

I am involved in deciding on the changes introduced that affect my work area/team/department

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	33	13.8	13.8	13.8
	Disagree	70	29.3	29.3	43.1
	Uncertain	18	7.5	7.5	50.6
	Agree	73	30.5	30.5	81.2
	Strongly Agree	45	18.8	18.8	100.0
	Total	239	100.0	100.0	

Table 6.104 illustrates that 30.5% of the respondents agreed with this statement, 29.3% disagreed, 18.8% strongly agreed, 13.8% strongly disagreed and 7.5% were uncertain.

Table 6.105I am consulted about the changes that affect my work area/team/department - Dispersion of Respondents

I am consulted about the changes that affect my work area/team/department

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	41	17.2	17.2	17.2
	Disagree	90	37.7	37.7	54.8
	Uncertain	31	13.0	13.0	67.8
	Agree	67	28.0	28.0	95.8
	Strongly Agree	10	4.2	4.2	100.0
	Total	239	100.0	100.0	

Table 6.105 reveals that 37.7% of the respondents disagreed that they are consulted about changes that affect their work area or department, 28.0% agreed, 17.2% strongly disagreed, 13.0% were uncertain and 4.2% strongly agreed.

Table 6.106 Manager/supervisor asks for my opinion before making decisions that affect my work -Dispersion of Respondents

Managers/supervisor asks for my opinion before making decisions that affect my work

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	50	20.9	20.9	20.9
	Disagree	70	29.3	29.3	50.2
	Uncertain	24	10.0	10.0	60.3
	Agree	82	34.3	34.3	94.6
	Strongly Agree	13	5.4	5.4	100.0
	Total	239	100.0	100.0	

Table 6.106 shows that 34.3% of the respondents agreed that their manager/supervisor asks their opinion before making changes that affect their work, while 29.3%, disagreed, 20.9% strongly disagreed, 10.0% were uncertain, and 5.4% strongly agreed.

Table 6.107Managers here try to involve staff in important decisions - Dispersion of Respondents

Managers here try to involve staff in important decisions

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	67	28.0	28.0	28.0
	Disagree	60	25.1	25.1	53.1
	Uncertain	36	15.1	15.1	68.2
	Agree	61	25.5	25.5	93.7
	Strongly Agree	15	6.3	6.3	100.0
	Total	239	100.0	100.0	

Table 6.107 illustrates that the majority (28.0%) of the respondents strongly disagree that their managers try to involve staff in important decisions, while 25.5% agree with the statement, 25.1% disagree, 15.1% were uncertain and 6.3% strongly agree.

Table 6.108 Managers encourage staff to suggest new ideas for improving services - Dispersion of Respondents

Managers encourage staff to suggest new ideas for improving services

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	53	22.2	22.2	22.2
	Disagree	59	24.7	24.7	46.9
	Uncertain	32	13.4	13.4	60.3
	Agree	77	32.2	32.2	92.5
	Strongly Agree	18	7.5	7.5	100.0
	Total	239	100.0	100.0	

Table 6.108reveals that 32.2% of the respondents agreed with the statement that the managers encourage staff to suggest new ideas for improving services, 24.7% disagreed, 22.2% strongly disagreed, 13.4% were uncertain and 7.5% strongly agreed.

Table 6.109 Communication between managers and staff is effective - Dispersion of Respondents

Communication between managers & staff is effective

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	50	20.9	20.9	20.9
	Disagree	60	25.1	25.1	46.0
	Uncertain	32	13.4	13.4	59.4
	Agree	80	33.5	33.5	92.9
	Strongly Agree	17	7.1	7.1	100.0
	Total	239	100.0	100.0	

Table 6.109 shows that 33.5% of the respondents agreed that communication between managers and staff is effective, while 25.1% disagreed, 20.9%, strongly disagreed, 13.4% were uncertain, and 7.1% strongly agreed.

Table 6.110 On the whole, the different parts of the organization communicate effectively with one another - Dispersion of Respondents

On the whole, the different parts of the organization communicate effectively with one another

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	43	18.0	18.0	18.0
	Disagree	63	26.4	26.4	44.4
	Uncertain	41	17.2	17.2	61.5
	Agree	77	32.2	32.2	93.7
	Strongly Agree	15	6.3	6.3	100.0
	Total	239	100.0	100.0	

Table 6.110 illustrates that 32.2% of the respondents agreed with this statement, 26.4% disagreed, 18.0% strongly disagreed, 17.2% were uncertain, and 6.3% strongly agreed.

CORRELATIONS ANALYSIS

Correlations

		Age in years	Principal language spoken at home
Age in years	Pearson Correlation	1	.374**
	Sig. (2-tailed)		.000
	N	222	222
Principal language spoken at home	Pearson Correlation	.374**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between age in years and principal language spoken is 0.374. This coefficient shows that there is a strong and positive relationship between the age in years and principal language spoken. The probability (p) of this correlation coefficient which is 0.000 is less than 0.05 thus implying that there is statistically significant relationship (r=-0.374, p>0.05).

Correlations

		Were there visible security personnel at the hospital gates and inside the hospital?	Were signs to the OPD clear?
Were there visible security personnel at the hospital gates and inside the hospital?	Pearson Correlation	1	.801**
	Sig. (2-tailed)		.000
	N	239	239
Were signs to the OPD clear?	Pearson Correlation	.801**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the presence of visible security personnel at the hospital gates and inside the hospital and clear signs to the OPD is 0.801. This coefficient shows that there is a strong and positive relationship between visible security personnel at the hospital gates and inside the hospital and clear signs to the OPD. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant

relationship(r=-0.801, p>0.05).

Correlations

		Were signs to the wards clear?	Was it easy to find the disabled parking bay/wheel chair ramp?
Were signs to the wards clear?	Pearson Correlation	1	.585**
	Sig. (2-tailed)		.000
	N	239	239
Was it easy to find the disabled parking bay/wheel chair ramp?	Pearson Correlation	.585**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between clear signs to the wards and whether it was easy to find the disabled parking bay/wheel chair rampis 0.585. This coefficient shows that there is a strong and positive relationship between clear signs to the wards and whether it was easy to find the disabled parking bay/wheel chair ramp. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.585, p>0.05).

Correlations

		Signage to indicate where the toilets are clear?	Signage to different areas of the hospital is clear?
Signage to indicate where the toilets are clear?	Pearson Correlation	1	.442**
	Sig. (2-tailed)		.000
	N	239	239
Signage to different areas of the hospital is clear?	Pearson Correlation	.442**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between clear signage to indicate where the toilets are and clear signage to different areas of the hospital is 0.442. This coefficient shows that there is a positive relationship between clear signage to indicate where the toilets are and clear signage to

different areas of the hospital. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.442, p>0.05).

Correlations

		Did the following staff who attended to you wear a badge: Security personnel?	Did the following staff who attended to you wear a badge: Clerk?
Did the following staff who attended to you wear a badge: Security personnel?	Pearson Correlation	1	.495**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended to you wear a badge: Clerk?	Pearson Correlation	.495**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the following staff who attended to you wear a badge: Security personnel?” and “did the following staff who attended to you wear a badge: Clerk?” is 0.495. This coefficient shows that there is a positive relationship between “did the following staff who attended to you wear a badge: Security personnel?” and “did the following staff who attended to you wear a badge: Clerk?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.495, p>0.05).

Correlations

		Did the following staff who attended to you wear a badge: Nurse?	Did the following staff who attended to you wear abadge:Doctor?
Did the following staff who attended to you wear a badge: Nurse?	Pearson Correlation	1	.563**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended to you wear abadge:Doctor?	Pearson Correlation	.563**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the following staff who attended to you wear a badge: Nurse?” and “did the following staff who attended to you wear a badge:Doctor?” is 0.563. This coefficient shows that there is a positive relationship between “did the following staff who attended to you wear a badge: Nurse?” and “did the following staff who attended to you wear a badge:Doctor?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.563, p>0.05).

Correlations

		Did the following staff who attended to you wear a badge: Pharmacy personnel?	Did the following staff who attended to you wear a badge: Other?
Did the following staff who attended to you wear a badge: Pharmacy personnel?	Pearson Correlation	1	.372**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended to you wear a badge: Other?	Pearson Correlation	.372**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the following staff who attended to you wear a badge: Pharmacy personnel?” and “did the following staff who attended to you wear a badge: Other?” is 0.372. This coefficient shows that there is a high strength and positive relationship between “did the following staff who attended to you wear a badge: Pharmacy personnel?” and “did the following staff who attended to you wear a badge: Other?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship($r=-0.372$, $p>0.05$).

Correlations

		Were you able to communicate with staff in your language?	Where necessary were the services of an interpreter arranged?
Were you able to communicate with staff in your language?	Pearson Correlation	1	.526**
	Sig. (2-tailed)		.000
	N	239	239
Where necessary were the services of an interpreter arranged?	Pearson Correlation	.526**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were you able to communicate with staff in your language?" and "where necessary were the services of an interpreter arranged?" is 0.526. This coefficient shows that there is a positive relationship between "were you able to communicate with staff in your language?" and "where necessary were the services of an interpreter arranged?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.526, p>0.05).

Correlations

		During your treatment were the procedures explained to you?	Were the questions and queries you made dealt with satisfactorily?
During your treatment were the procedures explained to you?	Pearson Correlation	1	.464**
	Sig. (2-tailed)		.000
	N	239	239
Were the questions and queries you made dealt with satisfactorily?	Pearson Correlation	.464**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "during your treatment were the procedures explained to you?" and "were the questions and queries you made dealt with satisfactorily?" is 0.464. This coefficient shows that there is a positive relationship between "during your treatment were

the procedures explained to you?" and "were the questions and queries you made dealt with satisfactorily?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.464, p>0.05).

Correlations

		Were you treated politely by the following staff members: Security personnel?	Were you treated politely by the following staff members: Clerk?
Were you treated politely by the following staff members: Security personnel?	Pearson Correlation	1	.547**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Clerk?	Pearson Correlation	.547**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were you treated politely by the following staff members: Security personnel?" and "were you treated politely by the following staff members: Clerk?" is 0.547. This coefficient shows that there is a positive relationship between "were you treated politely by the following staff members: Security personnel?" and "were you treated politely by the following staff members: Clerk?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.547, p>0.05).

Correlations

		Were you treated politely by the following staff members: Nurse?	Were you treated politely by the following staff members: Doctor?
Were you treated politely by the following staff members: Nurse?	Pearson Correlation	1	.491**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Doctor?	Pearson Correlation	.491**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were you treated politely by the following staff members: Nurse?" and "were you treated politely by the following staff members: Doctor?" is 0.491. This coefficient shows that there is a positive relationship between "were you treated politely by the following staff members: Nurse?" and "were you treated politely by the following staff members: Doctor?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.491, p>0.05).

Correlations

		Were you treated politely by the following staff members: Pharmacy personnel?	Were you treated politely by the following staff members: Other?
Were you treated politely by the following staff members: Pharmacy personnel?	Pearson Correlation	1	.321**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Other?	Pearson Correlation	.321**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were you treated politely by the following staff members: Pharmacy personnel?" and "were you treated politely by the following staff members:

Other?" is 0.321. This coefficient shows that there is a positive relationship between "were you treated politely by the following staff members: Pharmacy personnel?" and "were you treated politely by the following staff members: Other?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.321, p>0.05).

Correlations

		The nurse explained the findings before I saw the doctor respectful	The doctor asked for permission before the examination
The nurse explained the findings before I saw the doctor	Pearson Correlation	1	.588**
	Sig. (2-tailed)		.000
	N	239	239
The doctor asked for permission before the examination	Pearson Correlation	.588**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "the nurse explained the findings before I saw the doctor" and "the doctor asked for permission before the examination" is 0.588. This coefficient shows that there is a positive relationship between "the nurse explained the findings before I saw the doctor" and "the doctor asked for permission before the examination". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.588, p>0.05).

Correlations

		Doctor explained my condition to me	Advice was given on how to improve my health status
Doctor explained my condition to me	Pearson Correlation	1	.417**
	Sig. (2-tailed)		.000
	N	239	239
Advice was given on how to improve my health status	Pearson Correlation	.417**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the doctor explained my condition to me” and “advice was given on how to improve my health status” is 0.417. This coefficient shows that there is a positive relationship between “the doctor explained my condition to me” and “advice was given on how to improve my health status”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.417, p>0.05).

Correlations

		Were you treated in a respectful manner?	Advice was given on how to improve my health status
Were you treated in a respectful manner	Pearson Correlation	1	.398**
	Sig. (2-tailed)		.000
	N	239	239
Advice was given on how to improve my health status	Pearson Correlation	.398**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were you treated in a respectful manner?” and “advice was given on how to improve my health status” is 0.398. This coefficient shows that there is a positive relationship between “were you treated in a respectful manner?” and “advice was given on how to improve my health status”. The probability (p) of this correlation coefficient

which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.398, p>0.05).

Correlations

		The outpatient department was clean	The Pharmacy department was clean
The outpatient department was clean	Pearson Correlation	1	.440**
	Sig. (2-tailed)		.000
	N	239	239
The Pharmacy department was clean	Pearson Correlation	.440**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the outpatient department was clean” and “the Pharmacy department was clean” is 0.440. This coefficient shows that there is a positive relationship between “the outpatient department was clean” and “the Pharmacy department was clean”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.440, p>0.05).

Correlations

		The toilets were clean	There was toilet paper in the toilet
The toilets were clean	Pearson Correlation	1	.526**
	Sig. (2-tailed)		.000
	N	239	239
There was toilet paper in the toilet	Pearson Correlation	.526**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the toilets were clean” and “there was toilet paper in the toilet” is 0.526. This coefficient shows that there is a positive relationship between “the toilets were clean” and “there was toilet paper in the toilet”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.526, p>0.05).

Correlations

		There was soap to wash hands in the toilet	There were paper towels/air dryer to dry hands in the toilet
There was soap to wash hands in the toilet	Pearson Correlation	1	.360**
	Sig. (2-tailed)		.000
	N	239	239
There were paper towels/air dryer to dry hands in the toilet	Pearson Correlation	.360**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “there was soap to wash hands in the toilet and “there were paper towels/air dryer to dry hands in the toilet” is 0.360. This coefficient shows that there is a positive relationship between “there was soap to wash hands in the toilet” and “there were paper towels/air dryer to dry hands in the toilet”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.360, p>0.05).

Correlations

		Did the staff wash/spray their hands before & after examining you?	Were you happy with overall cleanliness of the hospital?
Did the staff wash/spray their hands before & after examining you?	Pearson Correlation	1	.349**
	Sig. (2-tailed)		.000
	N	239	239
Were you happy with overall cleanliness of the hospital?	Pearson Correlation	.349**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the staff wash/spray their hands before and after examining you?” and “were you happy with overall cleanliness of the hospital?” is 0.349. This

coefficient shows that there is a positive relationship between “did the staff wash/spray their hands before and after examining you?” and “were you happy with overall cleanliness of the hospital?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.349, p>0.05).

Correlations

		Were the following areas in hospital clean: Grounds?	Were the following areas in hospital clean: Corridors?
Were the following areas in hospital clean? Grounds?	Pearson Correlation	1	.640**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in hospital clean: Corridors?	Pearson Correlation	.640**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were the following areas in hospital clean: Grounds?” and “were the following areas in hospital clean: Corridors?” is 0.640. This coefficient shows that there is a positive relationship between “were the following areas in hospital clean: Grounds?” and “were the following areas in hospital clean: Corridors?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.640, p>0.05).

Correlations

		Were the following areas in the hospital clean: Buildings?	Were the following areas in the hospital clean: Ablution facilities?
Were the following areas in the hospital clean: Buildings?	Pearson Correlation	1	.602**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in the hospital clean: Ablution facilities?	Pearson Correlation	.602**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were the following areas in the hospital clean: Buildings?" and "were the following areas in the hospital clean: Ablution facilities?" is 0.602. This coefficient shows that there is a positive relationship between "were the following areas in the hospital clean: Buildings?" and "were the following areas in the hospital clean: Ablution facilities?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.602, p>0.05).

Correlations

		Were the following areas in the hospital clean: Was the bed linen clean?	Were the following areas in the hospital clean: Was the ward free of pests?
Were the following areas in the hospital clean: Was the bed linen clean?	Pearson Correlation	1	.405**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in the hospital clean: Was the ward free of pests?	Pearson Correlation	.405**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were the following areas in the hospital clean: Was the bed linen clean?” and “were the following areas the in hospital clean: Was the ward free of pests?” is 0.405. This coefficient shows that there is a positive relationship between “were the following areas in the hospital clean: Was the bed linen clean?” and “were the following areas in the hospital clean: Was the ward free of pests?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.405, p>0.05).

Correlations

		Did the hospital staff draw your attention to patients’ rights & responsibilities?	Did your consultation with the nurse or doctor take place in a private manner?
Did the hospital staff draw your attention to patients’ rights & responsibilities?	Pearson Correlation	1	.477**
	Sig. (2-tailed)		.000
	N	239	239
Did your consultation with the nurse or doctor take place in a private manner?	Pearson Correlation	.477**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the hospital staff draw your attention to patients’ rights and responsibilities?” and “did your consultation with the nurse or doctor take place in a private manner?” is 0.477. This coefficient shows that there is a positive relationship between “did the hospital staff draw your attention to patients’ rights and responsibilities?” and “did your consultation with the nurse or doctor take place in a private manner?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.477, p>0.05).

Correlations

		Was a bench/chair provided for you to sit on while you waited?	Did your consultation with the nurse or doctor take place in a private manner?
Was a bench/chair provided for you to sit on while you waited?	Pearson Correlation	1	.347**
	Sig. (2-tailed)		.000
	N	239	239
Did your consultation with the nurse or doctor take place in a private manner?	Pearson Correlation	.347**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “was a bench/chair provided for you to sit on while you waited?” and “did your consultation with the nurse or doctor take place in a private manner?” is 0.437. This coefficient shows that there is a positive relationship between “was a bench/chair provided for you to sit on while you waited?” and “did your consultation with the nurse or doctor take place in a private manner?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.347, p>0.05).

Correlations

		Did you have a complaint?	If you had a complaint, did you report it?
Did you have a complaint?	Pearson Correlation	1	.564**
	Sig. (2-tailed)		.000
	N	239	239
If you had a complaint, did you report it?	Pearson Correlation	.564**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did you have a complaint?” and “if you had a complaint, did you report it?” is 0.564. This coefficient shows that there is a positive relationship between “did

you have a complaint?" and "if you had a complaint, did you report it?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.564, p>0.05).

Correlations

		At night was the nurse available when you called?	Did you feel safe in the hospital?
At night was the nurse available when you called?	Pearson Correlation	1	.491**
	Sig. (2-tailed)		.000
	N	239	239
Did you feel safe in the hospital?	Pearson Correlation	.491**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "at night was the nurse available when you called?" and "did you feel safe in the hospital?" is 0.491. This coefficient shows that there is a positive relationship between "at night was the nurse available when you called?" and "did you feel safe in the hospital?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.491, p>0.05).

Correlations

		Were you issued with the medication that the doctor prescribed for you?	Were instructions regarding medication/ follow up provided?
Were you issued with the medication that the doctor prescribed for you?	Pearson Correlation	1	.637**
	Sig. (2-tailed)		.000
	N	239	239
Were instructions regarding medication /follow up provided?	Pearson Correlation	.637**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were you issued with the medication that the doctor prescribed for you?” and “were instructions regarding medication/follow up provided?” is 0.637. This coefficient shows that there is a positive relationship between “were you issued with the medication that the doctor prescribed for you?” and “were instructions regarding medication /follow up provided?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.637, p>0.05).

Correlations

		Instructions regarding medication /follow up were provided	Was the instruction communicated in the language you understand?
Instructions regarding medication /follow up were provided	Pearson Correlation	1	.314**
	Sig. (2-tailed)		.000
	N	239	239
Was the instruction communicated in the language you understand?	Pearson Correlation	.314**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “instructions regarding medication /follow up were provided” and “was the instruction communicated in the language you understand?” is 0.314. This coefficient shows that there is a positive relationship between “instructions regarding medication /follow up were provided” and “was the instruction communicated in the language you understand?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.314, p>0.05).

Correlations

		Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?
Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	Pearson Correlation	1	.584**
	Sig. (2-tailed)		.000
	N	239	239
Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?	Pearson Correlation	.584**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) access to care (single item): “If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?” and patient engagement in care (single item): “Were you involved as much as you wanted to be in decisions about your care and treatment?”is 0.584. This coefficient shows that there is a positive relationship between access to care (single item): “If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?” and patient engagement in care (single item): “Were you involved as much as you wanted to be in decisions about your care and treatment?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.584, p>0.05).

Correlations

		When you had important questions to ask a doctor, did you get answers that you could understand?	When you had important questions to ask a nurse, did you get answers that you could understand?
When you had important questions to ask a doctor, did you get answers that you could understand?	Pearson Correlation	1	.503**
	Sig. (2-tailed)		.000
	N	239	239
When you had important questions to ask a nurse, did you get answers that you could understand?	Pearson Correlation	.503**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “when you had important questions to ask a doctor, did you get answers that you could understand?” and “when you had important questions to ask a nurse, did you get answers that you could understand?” is 0.503. This coefficient shows that there is a positive relationship between “when you had important questions to ask a doctor, did you get answers that you could understand?” and “when you had important questions to ask a nurse, did you get answers that you could understand?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.503, p>0.05).

Correlations

		Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	Did a member of staff tell you about any medication side effects to watch for when you went home?
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	Pearson Correlation	1	.662**
	Sig. (2-tailed)		.000
	N	222	222
Did a member of staff tell you about any medication side effects to watch for when you went home?	Pearson Correlation	.662**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?” and “did a member of staff tell you about any medication side effects to watch for when you went home?” is 0.662. This coefficient shows that there is a positive relationship between “did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?” and “did a member of staff tell you about any medication side effects to watch for when you went home?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship ($r=-0.662$, $p>0.05$).

Correlations

		Did a member of staff tell you about any danger signals you should watch for after you went home?	Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?
Did a member of staff tell you about any danger signals you should watch for after you went home?	Pearson Correlation	1	.283**
	Sig. (2-tailed)		.000
	N	222	222
Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?	Pearson Correlation	.283**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did a member of staff tell you about any danger signals you should watch for after you went home?” and “did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?” is 0.283. This coefficient shows that there is a positive relationship between “did a member of staff tell you about any danger signals you should watch for after you went home?” and “did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship ($r=-0.283$, $p>0.05$).

Correlations

		Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?
Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Pearson Correlation	1	.025
	Sig. (2-tailed)		.716
	N	222	222
Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?	Pearson Correlation	.025	1
	Sig. (2-tailed)	.716	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between coordination of care (single item): “sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?” and Emotional support (single item): “Did you find someone on the hospital staff to talk to about your worries and fears?” is 0.025. This coefficient shows that there is a positive relationship between coordination of care (single item): “sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?” and Emotional support (single item): “Did you find someone on the hospital staff to talk to about your worries and fears?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship ($r=-0.025$, $p>0.05$).

Correlations

		The food & the way it was presented to you were good.	*Eating utensils e.g spoons were provided with your meals.*
The food and the way it was presented to you were good.	Pearson Correlation	1	*.436***
	Sig. (2-tailed)		*.000*
	N	222	*222*
Eating utensils e.g spoons were provided with your meals.	Pearson Correlation	.436**	*1*
	Sig. (2-tailed)	*.000*	
	N	*222*	*222*

***. Correlation is significant at the 0.01 level (2-tailed).*

The correlation (r) between “the food and the way it was presented to you were good” and “eating utensils e.g spoons were provided with your meals”is 0.436. This coefficient shows that there is a positive relationship between “the food and the way it was presented to you were good” and “eating utensils e.g spoons were provided with your meals”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.436, p>0.05).

Correlations

		Do you agree that the visiting hours are convenient to the community?	During your stay at the hospital were you offered pyjamas/nighties daily?
Do you agree that the visiting hours are convenient to the community?	Pearson Correlation	1	.513**
	Sig. (2-tailed)		.000
	N	222	222
During your stay at the hospital were you offered pyjamas/nighties daily?	Pearson Correlation	.513**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlations (r) between “do you agree that the visiting hours are convenient to the community?” and “during your stay at the hospital were offered pyjamas/nighties daily?” is 0.513. This coefficient shows that there is positive relationships between “do you agree that the visiting hours are convenient to the community?” and “during your stay at the hospital were you offered pyjamas/nighties daily?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.513, p>0.05).

Correlations

		You and your family were advised about changes in your condition?	The hospital staff assisted you in making arrangements for you when you were discharged?
You and your family were advised about changes in your condition?	Pearson Correlation	1	.635**
	Sig. (2-tailed)		.000
	N	222	222
The hospital staff assisted you in making arrangements for you when you were discharged?	Pearson Correlation	.635**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “you and your family were advised about changes in your condition” and “the hospital staff assisted you in making arrangements for you when you were discharged” is 0.635. This coefficient shows that there is a positive relationship between “you and your family were advised about changes in your condition” and “the hospital staff assisted you in making arrangements for you when you were discharged”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.635, p>0.05).

Correlations

		At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?	Would you return to this hospital for treatment?
At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?	Pearson Correlation	1	.559**
	Sig. (2-tailed)		.000
	N	222	222
Would you return to this hospital for treatment?	Pearson Correlation	.559**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “at the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?” and “would you return to this hospital for treatment?” is 0.559. This coefficient shows that there is a positive relationship between “at the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?” and “would you return to this hospital for treatment?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.559, p>0.05).

Correlations

		Were you treated in a polite, courteous & friendly manner by all health professionals?	Would you return to this hospital for treatment?
Were you treated in a polite, courteous & friendly manner by all health professionals?	Pearson Correlation	1	.000
	Sig. (2-tailed)		.994
	N	222	222
Would you return to this hospital for treatment?	Pearson Correlation	.000	1
	Sig. (2-tailed)	.994	
	N	222	222

The correlation (r) between “were you treated in a polite, courteous and friendly manner by all health professionals?” and “would you return to this hospital for treatment?” is 0.000. This coefficient shows that there is a weak but positive relationship between “were you treated in a polite, courteous and friendly manner by all health professionals?” and “would you return to this hospital for treatment?” The probability (p) of this correlation coefficient which is 0.994 is greater than 0.05, thus implying that there is no statistically significant relationship(r=-0.000, p>0.05)

Correlations

		How long did you wait for your outpatient card?	How long did you wait to be treated by a nurse?
How long did you wait for your outpatient card?	Pearson Correlation	1	.550**
	Sig. (2-tailed)		.000
	N	222	222
How long did you wait to be treated by a nurse?	Pearson Correlation	.550**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “how long did you wait for your outpatient card?” and “how long did you wait to be treated by a nurse?” is 0.550. This coefficient shows that there is a positive relationship between “how long did you wait for your outpatient card?” and “how long did you wait to be treated by a nurse?” The probability (p) of this correlation coefficient which is

0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.550, p>0.05).

Correlations

		How long did you wait to be treated by a doctor?	How long did you wait for medication in the pharmacy department?
How long did you wait to be treated by a doctor?	Pearson Correlation	1	.606**
	Sig. (2-tailed)		.000
	N	222	222
How long did you wait for medication in the pharmacy department?	Pearson Correlation	.606**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “how long did you wait to be treated by a doctor?” and “how long did you wait for medication in the pharmacy department?” is 0.606. This coefficient shows that there is a positive relationship between “how long did you wait to be treated by a doctor?” and “how long did you wait for medication in the pharmacy department?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.606, p>0.05).

Correlations

		How long was the waiting time to get a folder?	How long was the waiting time in the outpatient department?
How long was the waiting time to get a folder?	Pearson Correlation	1	.471**
	Sig. (2-tailed)		.000
	N	222	222
How long was the waiting time in the outpatient department?	Pearson Correlation	.471**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "how long was the waiting time to get a folder?" and "how long was the waiting time in the outpatient department?" is 0.471. This coefficient shows that there is a positive relationship between "how long was the waiting time to get a folder?" and "how long was the waiting time in the outpatient department?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.471, p>0.05).

Correlations

		How long did you wait for a doctor to discharge you on the last day at hospital?	Not have to wait too long to receive doctor's assistance
How long did you wait for a doctor to discharge you on the last day at hospital?	Pearson Correlation	1	.364**
	Sig. (2-tailed)		.000
	N	222	222
Not have to wait too long to receive doctor's assistance	Pearson Correlation	.364**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "how long did you wait for a doctor to discharge you on the last day at hospital?" and "not have to wait too long to receive doctor's assistance" is 0.364. This coefficient shows that there is a positive relationship between "how long did you wait for a

doctor to discharge you on the last day at hospital?" and "not have to wait too long to receive doctor's assistance". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.364, p>0.05).

Correlations

		Not have to wait too long to receive doctor's assistance	Not have to wait too long to receive nurse's assistance
Not have to wait too long to receive doctor's assistance	Pearson Correlation	1	.497**
	Sig. (2-tailed)		.000
	N	222	222
Not have to wait too long to receive nurse's assistance	Pearson Correlation	.497**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "not have to wait too long to receive doctor's assistance" and "not have to wait too long to receive nurse's assistance" is 0.497. This coefficient shows that there is a positive relationship between "not have to wait too long to receive doctor's assistance" and "not have to wait too long to receive nurse's assistance". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.497, p>0.05).

Correlations

		Not wait too long for my surgical procedure	Not wait too long for my medication
Not wait too long for my surgical procedure	Pearson Correlation	1	.532**
	Sig. (2-tailed)		.000
	N	222	222
Not wait too long for my medication	Pearson Correlation	.532**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “not wait too long for my surgical procedure” and “not wait too long for my medication” is 0.532. This coefficient shows that there is a positive relationship between “not wait too long for my surgical procedure” and not wait too long for my medication”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.532, p>0.05).

Correlations

		Not wait too long for my medication	Not have to wait too long here during my visit
Not wait too long for my medication	Pearson Correlation	1	.460**
	Sig. (2-tailed)		.000
	N	222	222
Not have to wait too long here during my visit	Pearson Correlation	.460**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “not wait too long for my medication” and “not have to wait too long here during my visit” is 0.460. This coefficient shows that there is a positive relationship between “not wait too long for my medication” and “not have to wait too long here during

my visit". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.460, p>0.05).

Correlations

		Adequate information about my anaesthesia and surgery	Adequate friendliness and courtesy
Adequate information about my anaesthesia and surgery	Pearson Correlation	1	.541**
	Sig. (2-tailed)		.000
	N	222	222
Adequate friendliness and courtesy	Pearson Correlation	.541**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "adequate information about my anaesthesia and surgery" and "adequate friendliness and courtesy" is 0.541. This coefficient shows that there is a positive relationship between "adequate information about my anaesthesia and surgery" and "adequate friendliness and courtesy". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.541, p>0.05).

Correlations

		A comfortable hospital to be in	Convenience of appointment time at hospital
A comfortable hospital to be in	Pearson Correlation	1	.611**
	Sig. (2-tailed)		.000
	N	222	222
Convenience of appointment time at hospital	Pearson Correlation	.611**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between a comfortable hospital to be in and convenience of appointment time at hospital is 0.611. This coefficient shows that there is a positive relationship between a comfortable hospital to be in and convenience of appointment time at hospital. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.611, p>0.05).

Correlations

		Convenience of appointment time at hospital	Convenience of hospital location
Convenience of appointment time at hospital	Pearson Correlation	1	.647**
	Sig. (2-tailed)		.000
	N	222	222
Convenience of hospital location	Pearson Correlation	.647**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between convenience of appointment time at hospital and convenience of hospital location is 0.647. This coefficient shows that there is a medium strength and positive relationship between convenience of appointment time at hospital and convenience of hospital location. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.647, p>0.05).

Correlations

		Appearance of hospital waiting area	Hours when hospital is open
Appearance of hospital waiting area	Pearson Correlation	1	.529**
	Sig. (2-tailed)		.000
	N	222	222
Hours when hospital is open	Pearson Correlation	.529**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between appearance of hospital waiting area and hours when hospital is open is 0.529. This coefficient shows that there is a positive relationship between appearance of hospital waiting area and hours when hospital is open. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.529, p>0.05).

Correlations

		Friendliness and courtesy shown to you by nurse	Friendliness and courtesy shown to you by doctors
Friendliness and courtesy shown to you by nurse	Pearson Correlation	1	.818**
	Sig. (2-tailed)		.000
	N	222	222
Friendliness and courtesy shown to you by doctors	Pearson Correlation	.818**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by doctors is 0.818. This coefficient shows that there is a positive relationship between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by doctors. The probability (p) of this correlation coefficient which is

0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.818, p>0.05).

Correlations

		Friendliness and courtesy shown to you by nurse	Friendliness and courtesy shown to you by other staff
Friendliness and courtesy shown to you by nurse	Pearson Correlation	1	.543**
	Sig. (2-tailed)		.000
	N	222	222
Friendliness and courtesy shown to you by other staff	Pearson Correlation	.543**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by other staff is 0.543. This coefficient shows that there is a strong and positive relationship between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by other staff. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.543, p>0.05).

Correlations

		The thoroughness of care you received from your doctor	Explanation about your anesthesia and surgery
The thoroughness of care you received from your doctor	Pearson Correlation	1	.745**
	Sig. (2-tailed)		.000
	N	222	222
Explanation about your anaesthesia and surgery	Pearson Correlation	.745**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the thoroughness of care you received from your doctor and explanation about your anaesthesia and surgery is 0.745. This coefficient shows that there is a strong and positive relationship between the thoroughness of care you received from your doctor and explanation about your anaesthesia and surgery. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.745, p>0.05).

Correlations

		The amount of time spent with your doctor	How well were your questions answered by your doctor?
The amount of time spent with your doctor	Pearson Correlation	1	.557**
	Sig. (2-tailed)		.000
	N	222	222
How well were your questions answered by your doctor?	Pearson Correlation	.557**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the amounts of time spent with your doctor and “how well were your questions answered by your doctor?” is 0.557. This coefficient shows that there is a positive relationship between the amount of time spent with your doctor and “how well were your questions answered by your doctor?” The probability (p) of this correlation coefficient

which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.557, p>0.05).

Correlations

		How well were your questions answered by your doctor?	How well were your questions answered by your nurse?
How well were your questions answered by your doctor?	Pearson Correlation	1	.514**
	Sig. (2-tailed)		.000
	N	222	222
How well were your questions answered by your nurse?	Pearson Correlation	.514**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “how well were your questions answered by your doctor?” and “how well were your questions answered by your nurse?” is 0.514. This coefficient shows that there is a positive relationship between “how well were your questions answered by your doctor?” and “how well were your questions answered by your nurse?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.514, p>0.05).

Correlations

		How long did you wait to see the doctor after arriving at the hospital?	The overall service and care you received
How long did you wait to see the doctor after arriving at the hospital?	Pearson Correlation	1	-.034
	Sig. (2-tailed)		.616
	N	222	222
The overall service and care you received	Pearson Correlation	-.034	1
	Sig. (2-tailed)	.616	
	N	222	239

The correlation (r) between "how long did you wait to see the doctor after arriving at the hospital?" and the overall service and care you received is 0.-034. This coefficient shows that there is a weak but positive relationship between "how long did you wait to see the doctor after arriving at the hospital?" and the overall service and care you received. The probability (p) of this correlation coefficient which is 0.661 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-034, p>0.05)

Correlations

		To what extent do you agree with the following? I often think about leaving my current employer	I will probably look for a new job in the next year
To what extent do you agree with the following? I often think about leaving my current employer	Pearson Correlation	1	-.038
	Sig. (2-tailed)		.564
	N	239	239
I will probably look for a new job in the next year	Pearson Correlation	-.038	1
	Sig. (2-tailed)	.564	
	N	239	239

The correlation (r) between to what extent do you agree with the following? "I often think about leaving my current employer" and "I will probably look for a new job in the next year"

is 0.-038. This coefficient shows that there is a weak but positive relationship between to what extent do you agree with the following? “I often think about leaving my current employer” and “I will probably look for a new job in the next year”. The probability (p) of this correlation coefficient which is 0.564 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-038 p>0.05).

Correlations

		As soon as I can find another job, I will leave my current employer.	I am involved in deciding on the changes introduced that affect my work area/team/department.
As soon as I can find another job, I will leave my current employer.	Pearson Correlation	1	.785**
	Sig. (2-tailed)		.000
	N	239	239
I am involved in deciding on the changes introduced that affect my work area/team/department.	Pearson Correlation	.785**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “as soon as I can find another job, I will leave my current employer” and “I am involved in deciding on the changes introduced that affect my work area/team/department” is 0.785. This coefficient shows that there is a positive relationship between “as soon as I can find another job, I will leave my current employer” and “I am involved in deciding on the changes introduced that affect my work area/team/department”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.785, p>0.05).

Correlations

		I am involved in deciding on the changes introduced that affect my work area/team/department.	I am consulted about the changes that affect my work area/team/department.
I am involved in deciding on the changes introduced that affect my work area/team/department.	Pearson Correlation	1	-.169**
	Sig. (2-tailed)		.009
	N	239	239
I am consulted about the changes that affect my work area/team/department.	Pearson Correlation	-.169**	1
	Sig. (2-tailed)	.009	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “I am involved in deciding on the changes introduced that affect my work area/team/department” and “I am consulted about the changes that affect my work area/team/department” is 0.-169. This coefficient shows that there is apositiverelationship between “I am involved in deciding on the changes introduced that affect my work area/team/department” and “I am consulted about the changes that affect my work area/team/department”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.-169, p>0.05).

Correlations

		Managers/supervisor asks for my opinion before making decisions that affect my work.	Managers here try to involve staff in important decisions.
Managers/supervisor asks for my opinion before making decisions that affect my work.	Pearson Correlation	1	.571**
	Sig. (2-tailed)		.000
	N	239	239
Managers here try to involve staff in important decisions.	Pearson Correlation	.571**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “managers/supervisor asks for my opinion before making decisions that affect my work” and “managers here try to involve staff in important decisions”is 0.571. This coefficient shows that there is a high strength and positive relationship between “managers/supervisor asks for my opinion before making decisions that affect my work” and “managers here try to involve staff in important decisions”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.571, p>0.05).

Correlations

		Managers here try to involve staff in important decisions.	Managers encourage staff to suggest new ideas for improving services.
Managers here try to involve staff in important decisions.	Pearson Correlation	1	.646**
	Sig. (2-tailed)		.000
	N	239	239
Managers encourage staff to suggest new ideas for improving services.	Pearson Correlation	.646**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “managers here try to involve staff in important decisions” and “managers encourage staff to suggest new ideas for improving services” is 0.646. This coefficient shows that there is a positive relationship between “managers here try to involve staff in important decisions” and “managers encourage staff to suggest new ideas for improving services”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.646, p>0.05).

Correlations

		Communication between managers & staff is effective	On the whole, the different parts of the organization communicate effectively with oneanother.
Communication between managers & staff is effective	Pearson Correlation	1	.731**
	Sig. (2-tailed)		.000
	N	239	239
On the whole, the different parts of the organization communicate effectively with one another.	Pearson Correlation	.731**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "communication between managers and staff is effective" and "on the whole, the different parts of the organization communicate effectively with one another" is 0.731. This coefficient shows that there is a positive relationship between "communication between managers and staff is effective" and "on the whole, the different parts of the organization communicate effectively with one another". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.731, p>0.05).

VALIDITY

Cronbach's Alpha is a test to determine the validity level of the questionnaire. A level above 0.7 is considered adequate to declare a question/questionnaire valid (Pallant, 2007), although Pallant goes on to say that with scales with fewer than 10 items it is common to find lower values, even as low as 0.5 Cronbach's Alpha was conducted on the questionnaire and the results are as follows:

VALIDITY - CRONBACH ALPHA

Table 6.111: Case Processing Summary

		N	%
Cases	Valid	222	92.9
	Excluded[a]	17	7.1
	Total	239	100.0

a.Deletion from list based on all variables in the procedure.

Table 6.112: Reliability Statistics

Cronbach's Alpha	N of Items
.823	121

The questions in the questionnaire were drawn up based on the literature review. Cronbach's Alpha was used to measure the issue of reliability in order to understand whether or not the questions in the questionnaire all reliably measure the same underlying variable. Tables6.111 and 6.112 above contain the results. Cronbach's Alpha was calculated at 0.919 which is above 0.7, so the scale can be considered reliable with the samples (Pallant, 2007). The Cronbach's Alpha co-efficient of 0.823 shows that the questionnaire was reliable and sound.

CHAPTER SEVEN

PRESENTATION AND ANALYSIS OF RESULTS

7.1 INTRODUCTION

In this chapter, the findings of the research survey are presented and analysed. Two sets of questionnaires were administered; firstly, to patients, andsecondly, to hospital staff doctors and nurses at three selected district hospitals in Ilembe Region and eThekwini Metropolitan Municipality in KZN.

The findings are presented in graphic form, using descriptive statistics toenhance the presentation of data and to simplify the analysis. Furthermore, theresearch study examines significant relationship between variables and presents these findings to support the key objectives presented in Chapter One. The analysis is presented using all three categories of role players, and wherever possible, a summary of each category's response iscaptured in tables and graphs.

7.2 RELIABILITY

The statistician conducted a test on the survey to gauge the level of reliability of thescores. The following table reflects the results of a reliability test after the scoreswere analysed, interpreted and grouped together. Through Cronbach's Alpha Theory, overall reliability for the different respondent groupings is depicted in the following tables. The table below is a summary of the Cronbach'sAlpha reliability scores for theservice dimensions of the customerand staffquestionnaires.

Reliability Statistics

Cronbach's Alpha	N of Items
.823	121

PATIENT RESPONSES

Residential area

The sample survey was drawn from eight different areas, each consisting of a number of different respondents. The locations chosen were representative of all social strata, and race groups, as most of the respondents from a particular area were from the same race group.
The results are presented below.

Table 7.1: Geographical residential area

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Durban North	43	18.0	19.4	19.4
	Durban East	27	11.3	12.2	31.5
	Durban South	50	20.9	22.5	54.1
	Durban West	20	8.4	9.0	63.1
	Stanger	46	19.2	20.7	83.8
	Ndwedwe	10	4.2	4.5	88.3
	Mandini	21	8.8	9.5	97.7
	Maphumulo	5	2.1	2.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

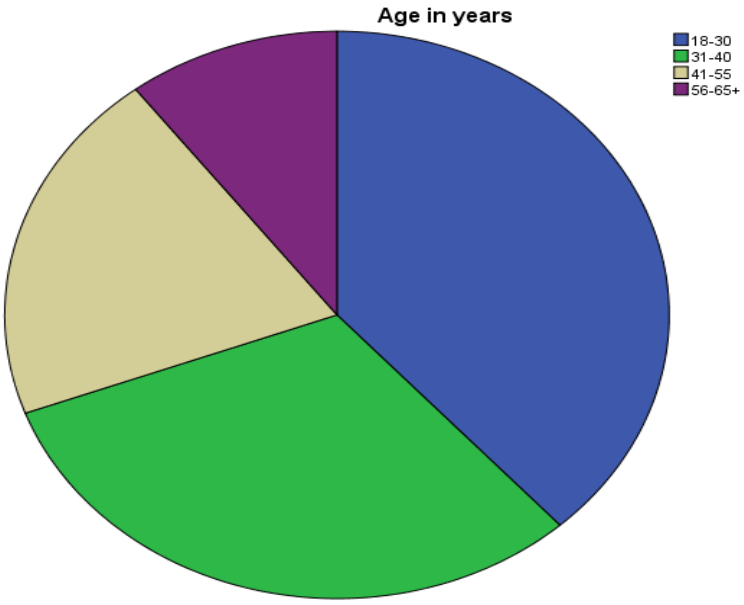


Figure 7.1: Age

Table 7.2: Age

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	18-30	85	35.6	38.3	38.3
	31-40	69	28.9	31.1	69.4
	41-55	45	18.8	20.3	89.6
	56-65+	23	9.6	10.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Of significance is that the age group 18-30 years was almost twice the size of the other age groups in the survey (35.6% of the sample). This indicates that more young people are ill and seek treatment at these hospitals.Also of significance is that this age group is generally viewed as the most economically active age group in any country. This is followed closely by the 31-40 year age group (28.9% of the sample), while approximately 18.8% of respondents were 41-55 years old.The age distribution correlates with the patient profile of the three hospitals; most patients are young and Black.

Table 7.3: Gender

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Female	154	64.4	69.4	69.4
	Male	68	28.5	30.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.2: Gender

The male to female distribution was approximately in the ratio 6: 3.This indicates that more patients are female (64.4%) than male (28.5%) in the district hospitals. This is also the result of the fact that women are in the majority in the iLembe region and eThekwini Metropolitan Municipality and that they rely heavily on the provincial health system for a number of different reasons.

Table 7.4: Marital status

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Single [Never married]	141	59.0	63.5	63.5
	Married	67	28.0	30.2	93.7
	Widowed	8	3.3	3.6	97.3
	Divorced/ separated	6	2.5	2.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

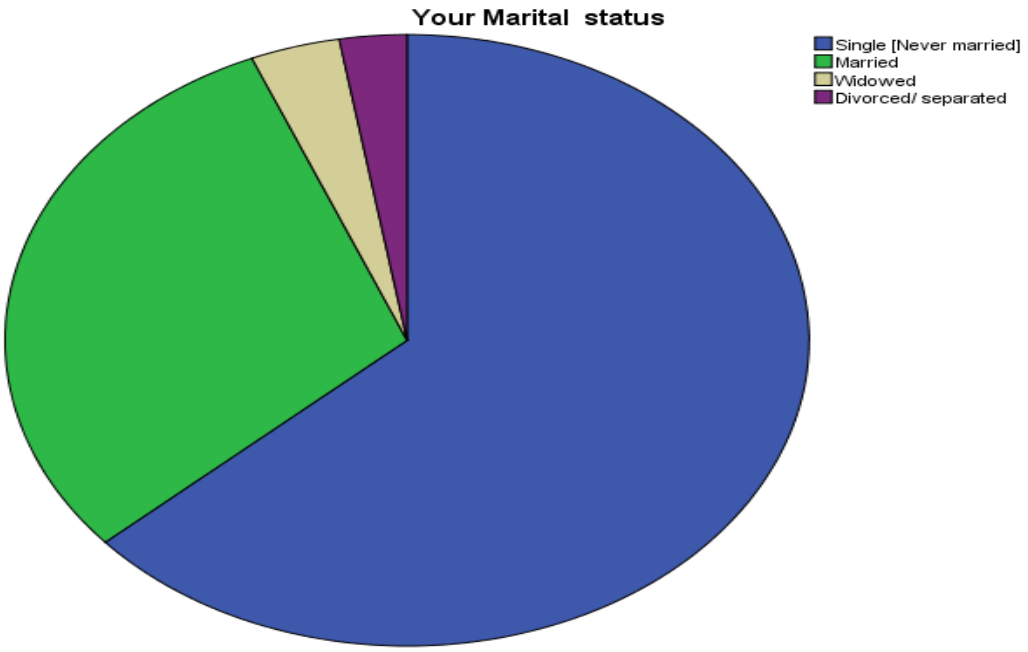


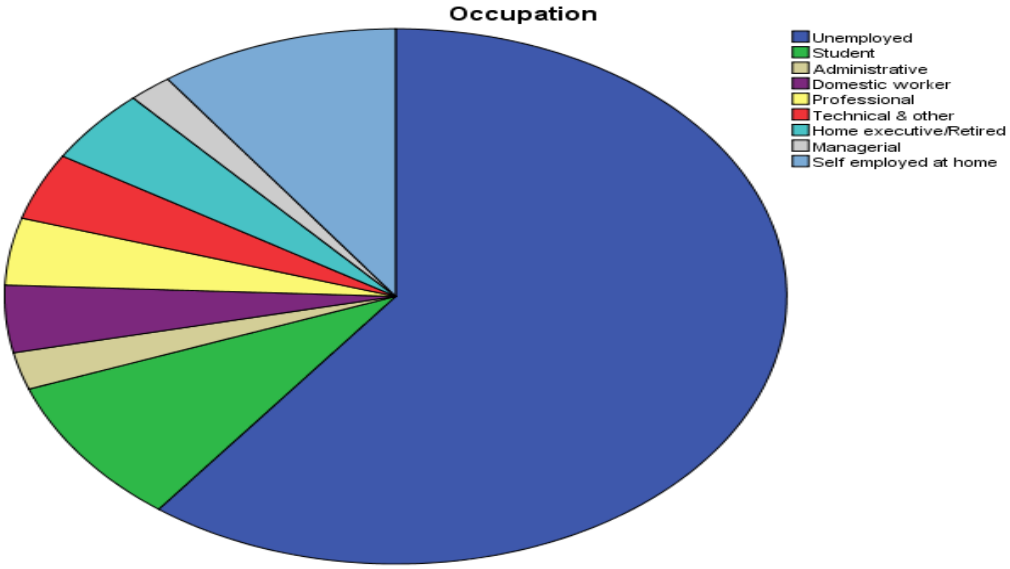
Figure 7.3: Marital Status

Fifty-nine per cent of the respondents were single, while just 28% were married. Avery small proportion (less than 4%) was widowed, while 3% were divorced or fitted into the "other" category. This could also indicate that single adults are more in need of health care due to their lifestyles.

Table 7.5 Occupation

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Unemployed	134	56.1	60.4	60.4
	Student	20	8.4	9.0	69.4
	Administrative	5	2.1	2.3	71.6
	Domestic worker	9	3.8	4.1	75.7
	Professional	9	3.8	4.1	79.7
	Technical & other	9	3.8	4.1	83.8
	Home executive/Retired	10	4.2	4.5	88.3
	Managerial	4	1.7	1.8	90.1
	Self employed at home	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.4: Occupation



The majority of respondents (56.1%) were unemployed. This would imply that they are unable to afford private health care. Students comprised 8.4% of the sample, while 9.2% were self-employed, which implies that their income is too low to attend private hospitals.

Table 7.6 Highest Education Level - Dispersion of Respondents

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Between Grade 1-7	30	12.6	13.5	13.5
	Between Grade 8-12	94	39.3	42.3	55.9
	Passed Matric	58	24.3	26.1	82.0
	Certificate	13	5.4	5.9	87.8
	Diploma	16	6.7	7.2	95.0
	Degree	2	.8	.9	95.9
	Post-graduate	2	.8	.9	96.8
	Uneducated	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

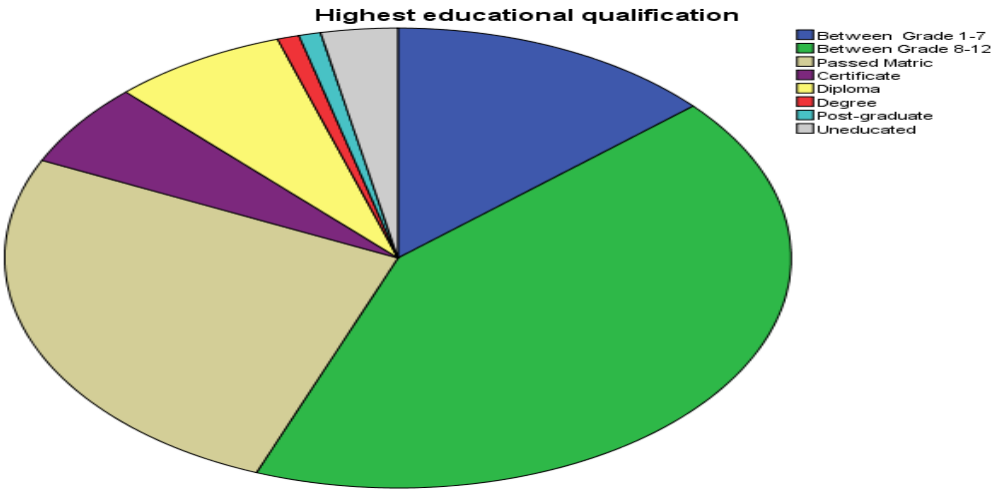


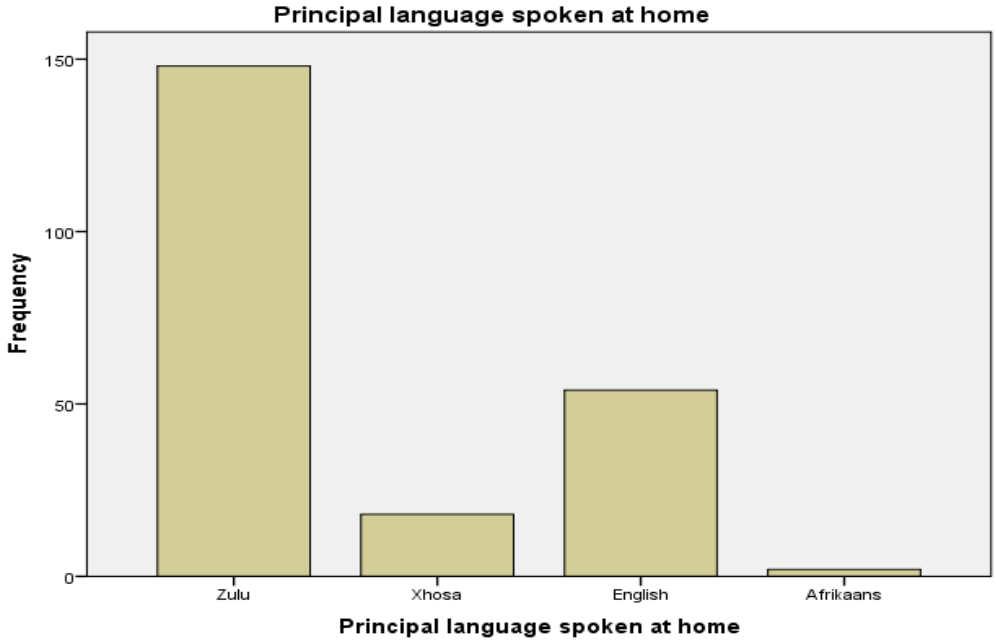
Figure 7.5: Highest Education Qualifications (pg 248)

Motsoaledi (2010) notes that, 'Bantu education' left South Africa "with a monster in our midst". South Africans compare poorly with residents in other SADC countries when it comes to education levels. Approximately 40% of the respondents were not able to progress to post-matric education. The majority of respondents (39.3%) had completed between grade 8 and 12 and only 24.3 achieved a matric, while 12.6% had not progressed beyond primary school. Although not conclusive in this study, the qualifications levels of respondents could indicate that some have greater difficulty in obtaining employmentand may depend on the state to provide health care for themselves and their families.

Table 7.7 Principal language spoken at home

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Zulu	148	61.9	66.7	66.7
	Xhosa	18	7.5	8.1	74.8
	English	54	22.6	24.3	99.1
	Afrikaans	2	.8	.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.6: Principal Language spoken at Home



Zulu-speaking respondents made up of 61.9% of the respondents. Woolard (2002: 2) notes that while poverty is not confined to any one racial group in SA, it is concentrated among Blacks and Africans in particular. The 1999 Household Survey found that 52% of Africans are poor and that while Africans make up 78% of the population, they account for 95% of the poor. The literature also demonstrates that Africans are the largest and poorest group with KZN. As a result this province is home to more Black people who depend on the overcrowded public health system. English-speaking respondents made up 22% of the sample; this represents Indians and Whites who cannot afford medical aid; the majority would be unemployed and pensioners.

Figure 7.7: Km travelled to Hospital

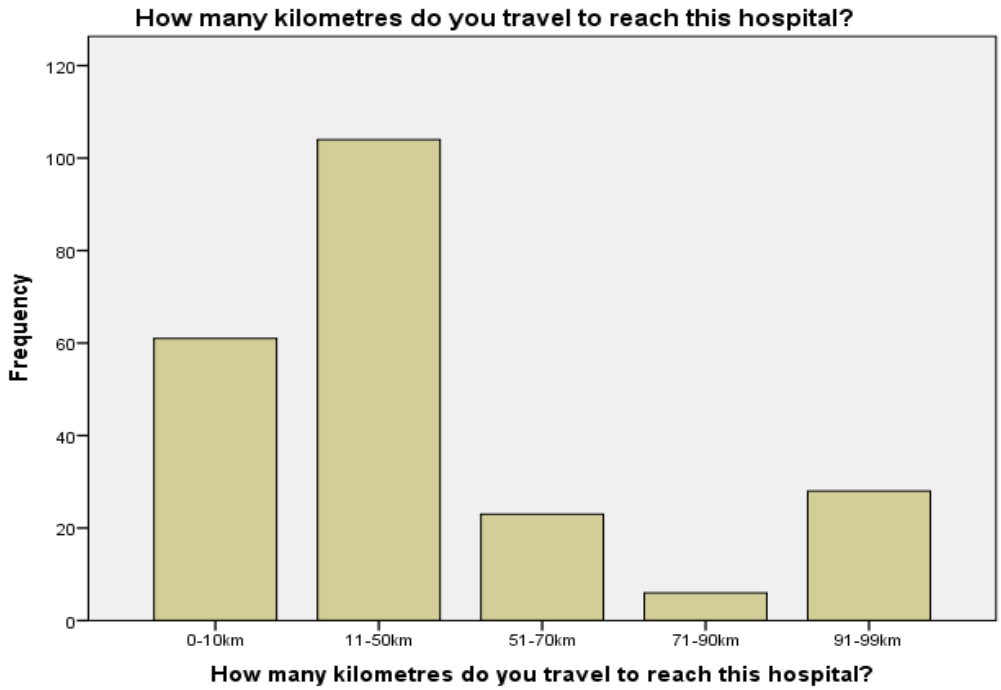


Table 7.8:How many kilometres do you travel to reach this hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0-10km	61	25.5	27.5	27.5
	11-50km	104	43.5	46.8	74.3
	51-70km	23	9.6	10.4	84.7
	71-90km	6	2.5	2.7	87.4
	91-99km	28	11.7	12.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

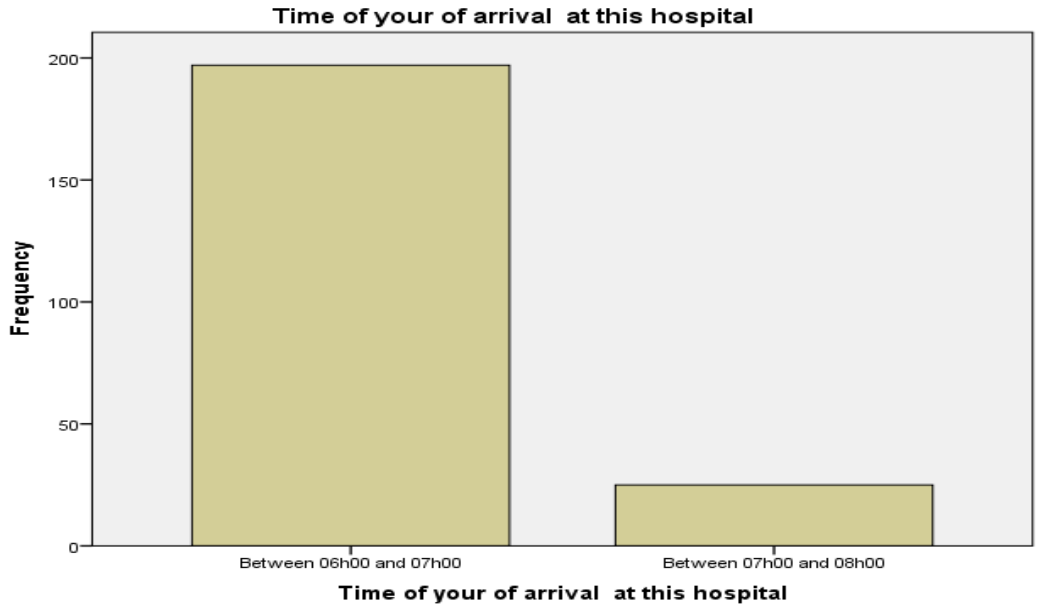
All citizens should have equal access to health services. This implies that patients who were previously disadvantaged as a result of the lack of infrastructure and barriers to access such as social, cultural, physical, communication and attitudinal factors (South Africa 1997:18)

should be enabled to access these services. The majority of the respondents (43.5%) travelled 11-50km to hospital; 25.5% travelled 0-10 km, and 11.7% travelled almost100km to hospital. This could be caused by number of factors, such as being referred to another hospital.

Table 7.9: Time of your of arrival at this hospital

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Between 06h00 and 07h00	197	82.4	88.7	88.7
	Between 07h00 and 08h00	25	10.5	11.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.8: Time of your arrival at this hospital



The results show that (82.4%) of the respondents arrived at the hospital between 06h00 and 07h00 in order to get medical attention as early as possible, while 10.5% arrived between 07h00 and 08h00 which could be caused by transport problems or other reasons such as set appointments and other issues. While the Nurses' Pledge of Service (Seerle&Pera, 1998) commits nurses to "serve the community with dignity and respect….", one participant stated

that, "*I came quite early in the morning, so that I make sure to be helped early, [but]… many times you first find the nurse drinking tea while we [the patients] have to wait*".

Table 7.10: Were there visible security personnel at the hospital gates and inside the hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	176	73.6	79.3	79.3
	No	46	19.2	20.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.9: Were there visible security personnel at the hospital gates and inside the hospital?

With regards to security, (73.6%) of the respondents agreed that there was visible security during their stay at the hospital. Security is a very important function. Security personnel give directions to patients and protect them, as well as hospital equipment. The 19.2% of the respondents who did not feel that hospital security was visible is cause for concern and needs to be addressed by hospital management.

Table 7.11: Were Signs to the OPD Clear?

		F frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	181	75.7	81.5	81.5
	No	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

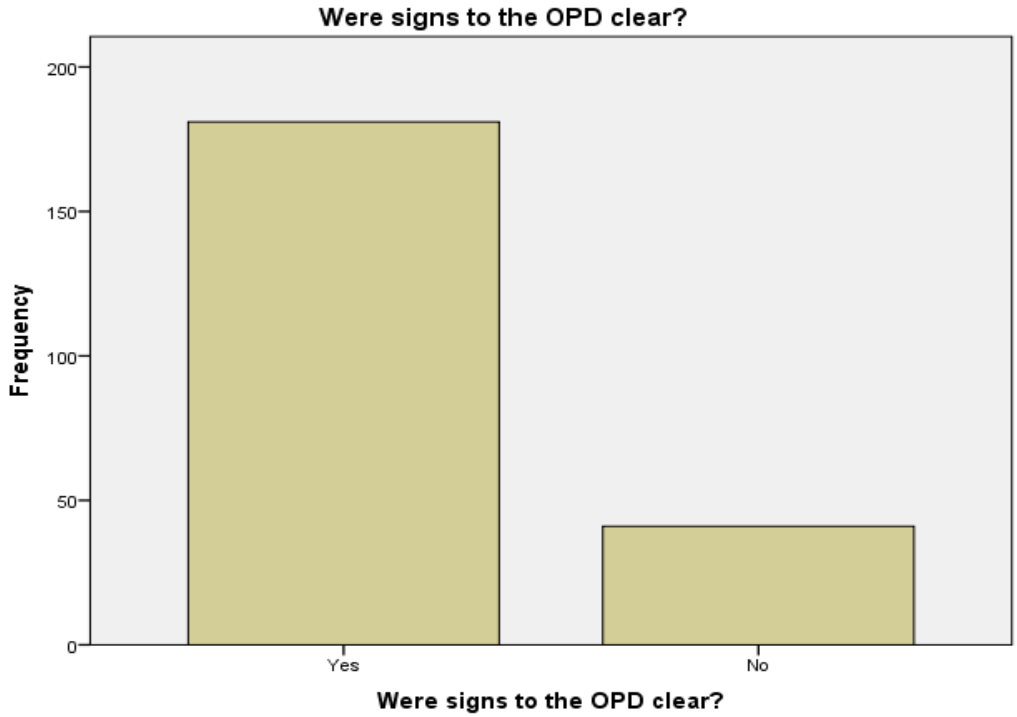


Figure 7.10: Were Signs to the OPD Clear?

Signage is very important in hospitals. The majority (75.7%) of respondents said that the OPD signs were clearly visible. However, the fact that 17.3% said that there were no clear signs needs to be addressed by hospital management. The PCC literature has identified five dimensions of the delivery care model: 1. Access to care; 2. Patient engagement in care or patient preferences; 3. Patient education of information systems; 4. Coordination of care across hospital staff; and 5. Patient emotional support (Audet*et al*., 2006; Bergeson and Dean 2006; Davis *et al*., 2004; Fiach*et al*., 2004; for similar dimensions, see Corrigan *et al*., 2001:49).

Table 7. 12: Were signs to the wards clear?

Frequency	Per cent	Valid Per cent	Cumulative Per cent
157	65.7	70.7	70.7
65	27.2	29.3	100.0
222	92.9	100.0	
17	7.1		
239	100.0		

The above table indicates that (65.7 %) of the respondents felt that the signs to the hospital wards were clear, with 27.2% reporting that they were not. The per centage indicated above (27.2 %) shows that the signs were not clear and this implies that hospital management and the DoH need to address the issue of signage in all the provincial hospitals.

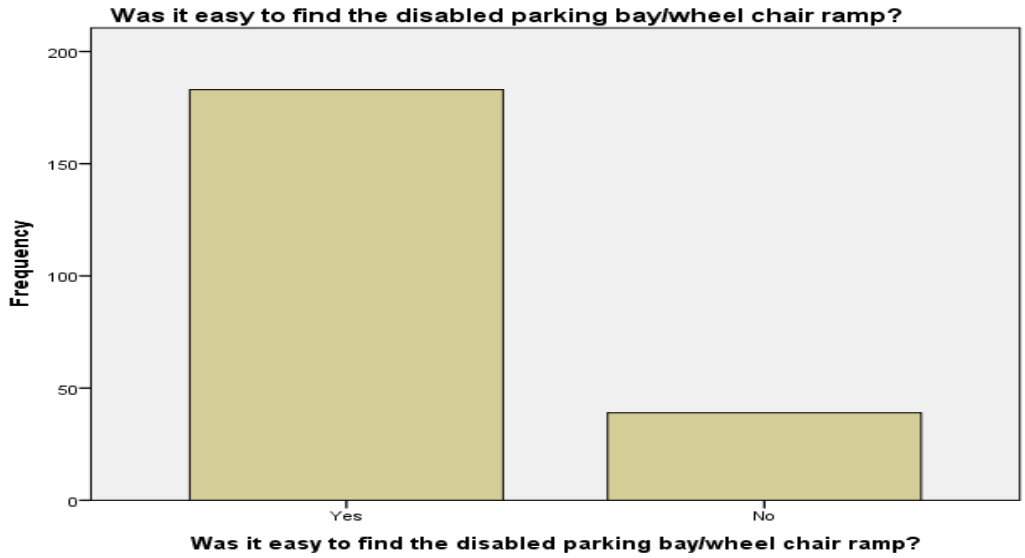


Figure 7.11: Was it easy to find the Disabled Parking Bay/Wheel Chair Ramp

Table 7.13: Was it easy to find the disabled parking bay/wheel chair ramp?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	39	16.3	17.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The above table shows that (76.6%) of the respondents agreed that it was easy to find the disabled parking bay/wheel chair ramp. However, 16.3% disagreed. The literature stresses the importance of access as a service delivery principle, including easy access to health care services to patients who were previously disadvantaged as a result of the lack of infrastructure and barriers to access such as social, culture, physical, communication and attitudinal factors (South Africa, 1997:18).

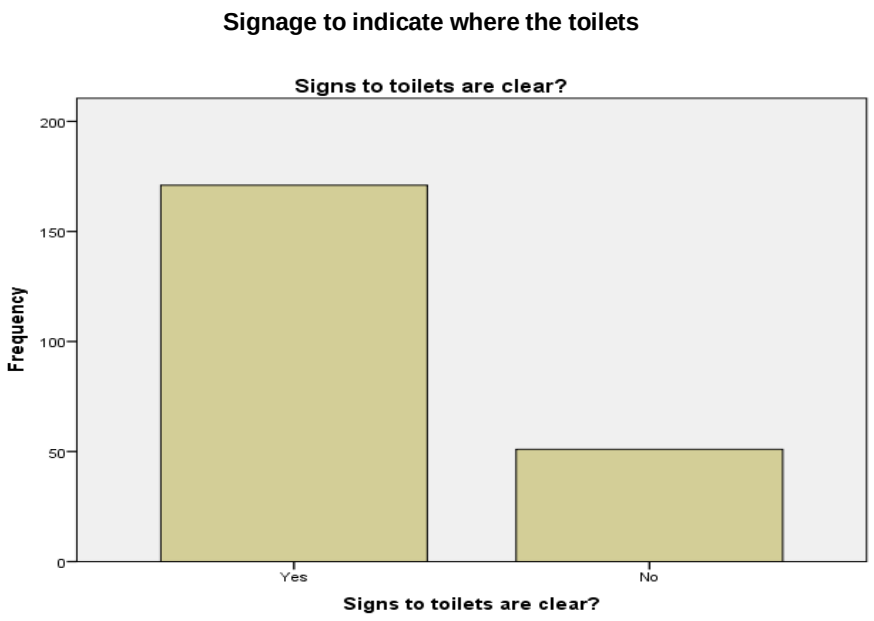


Figure 7.12 Signs to the Toilets are Clear

Table 7.14 Signs to Toilets are Clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	171	71.5	77.0	77.0
	No	51	21.3	23.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The majority of the respondents (71.5%) felt that the signs to the toilets were clear, while 21.3% indicated that these signs are not clear. Again, these results point to the need for hospital management to address this issue.

Table 7.15: Signage to Different Areas of the Hospital is Clear?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.1	81.1
	No	42	17.6	18.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.13: Signage to Different Areas of the Hospital is Clear

Hospitals normally cover very large areas, encompassing many different facilities, such as wards, staff offices and emergency areas. Signage therefore plays an important role in effective service delivery. 75.3% of the respondents indicated that the signage was clear, with 17.6% feeling that it was not. Again, hospital management needs to address this issue.

Table 7.16: Did the following staff who attended to you wear a badge: Security personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	36	15.1	16.2	87.8
	Unsure	27	11.3	12.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.14: Did the following Staff who attended to you wear a badge: Security Personnel?

The majority (66.5%) of the respondents stated that the security personnel wore badges, with 15.1% indicating that they did not and 11.3% being unsure. Badges plays a vital role in government institutions that serve the people, as staff who fail to render satisfactory customer services can then be identified and trained.

Table 7.17 Did the following staff who attended to you wear a badge: Clerk?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	193	80.8	86.9	86.9
	No	22	9.2	9.9	96.8
	Unsure	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.15 Did the following staff who attended to you wear a badge:Clerk

Public service policy states that all officials should wear badges. The majority of the respondents (80.8 %) said that the clerks in the hospitals were wearing badges, while 9.2% said that they were not and 2.9% were unsure.

Table 7.18: Did the following staff who attended to you wear a badge: Nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	164	68.6	73.9	73.9
	No	41	17.2	18.5	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.16: Did the following staff who attended to you wear a badge: Nurse?

The above table and graph indicate that (68.6%) of the nurses in the three hospitals comply with the hospital code of conduct in wearing badges so that the patients can identify them. However, 17.2% of the respondents reported that the nurses did not wear badges, and 7.1% were unsure.

Table 7.19: Did the following staff who attended to you wear a badge: Doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	121	50.6	54.5	54.5
	No	59	24.7	26.6	81.1
	Unsure	42	17.6	18.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.17: Did the following who attended to you wear a badge: Doctor?

The above table and graph indicate a problem at public hospitals, in that only half of the doctors (50.6%) were reported to wear badges. This indicates that many doctors are not complying with hospitals rules. Many patients are thus unable to identify the doctor who treated them.

Table 7.20: Did the following staff who attended to you wear a badge: Pharmacy personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	102	42.7	50.5	50.5
	No	45	18.8	22.3	72.8
	Unsure	55	23.0	27.2	100.0
	Total	202	84.5	100.0	
Missing	System	37	15.5		
Total		239	100.0		

Figure 7.18: Did the following staff who attended to you wear a badge: Pharmacy personnel?

The respondents indicated that only 42.7% of pharmacy personnel wore badges, while18.8% said that they did not and 23% were unsure. This is a serious issue that needs to be addressed by hospital management.

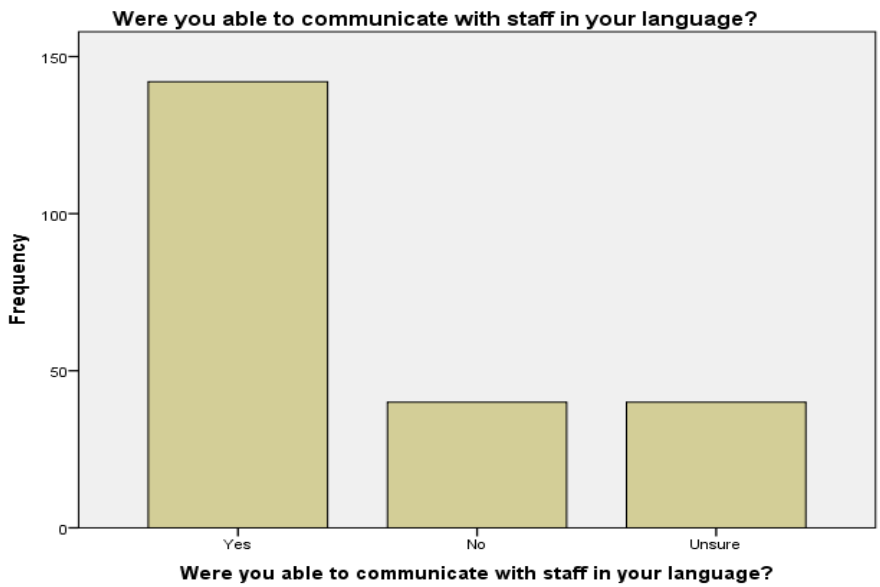


Figure 7.19: Were you able to communicate with staff in your language?

Table 7.21: Were you able to communicate with staff in your language?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	142	59.4	64.0	64.0
	No	40	16.7	18.0	82.0
	Unsure	40	16.7	18.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Almost (60%) of the respondents confirmed that they were able to communicate with staff in their own language. However, 16.7% of the respondents reported that staff did not communicate with them in their own language and 16.7% unsure. This implies that a large per centage of patients in the three hospitals were not able to communicate properly with staff, an issue that needs to be addressed by hospital management.

Table 7.22: Where necessary were the services of an interpreter arranged?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	184	77.0	82.9	82.9
	No	27	11.3	12.2	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

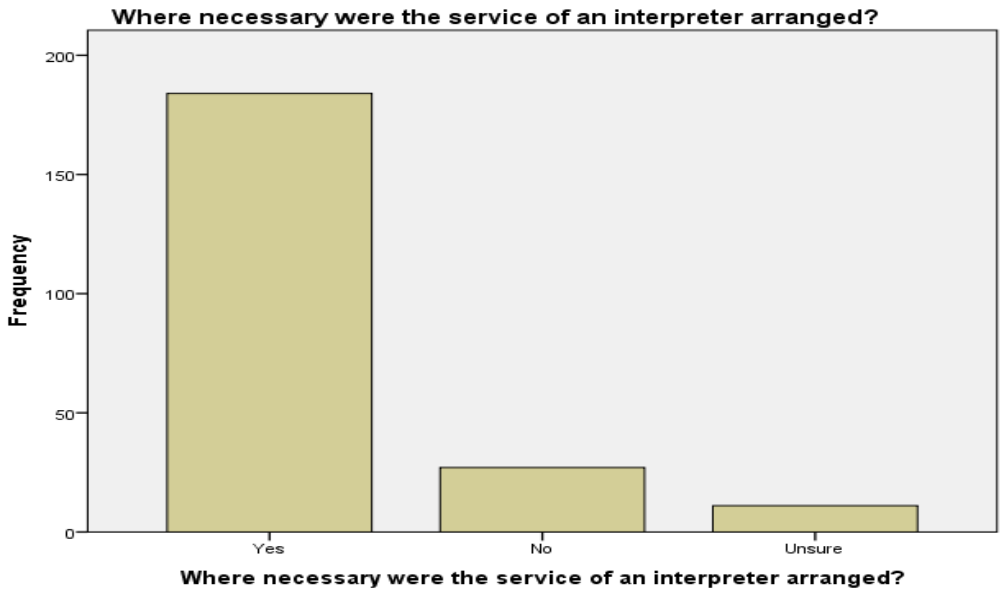


Figure 7.20: Where necessary were the services of an interpreter arranged?

The province of KZN has a large number of illiterate citizens. The majority (77%) of the respondents said that the services of an interpreter were arranged where necessary; however 11.3% said that they were not and 4.6% were unsure. Patients who are not provided with the services of an interpreter run the risk of receiving the wrong medication or treatment.

Figure 7.21: During your treatment were the procedures explained to you?

Table 7.23: During your treatment were the procedures explained to you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	167	69.9	75.2	75.2
	No	34	14.2	15.3	90.5
	Unsure	21	8.8	9.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Agulair and Stock (1996:4) observe that good customer service means meeting one's patients' needs in a way that has value and meaning for them. With regard to treatment, (69.9%) of the respondents affirmed that the procedure was explained, while 14.2% stated the opposite and 8.8% were unsure.

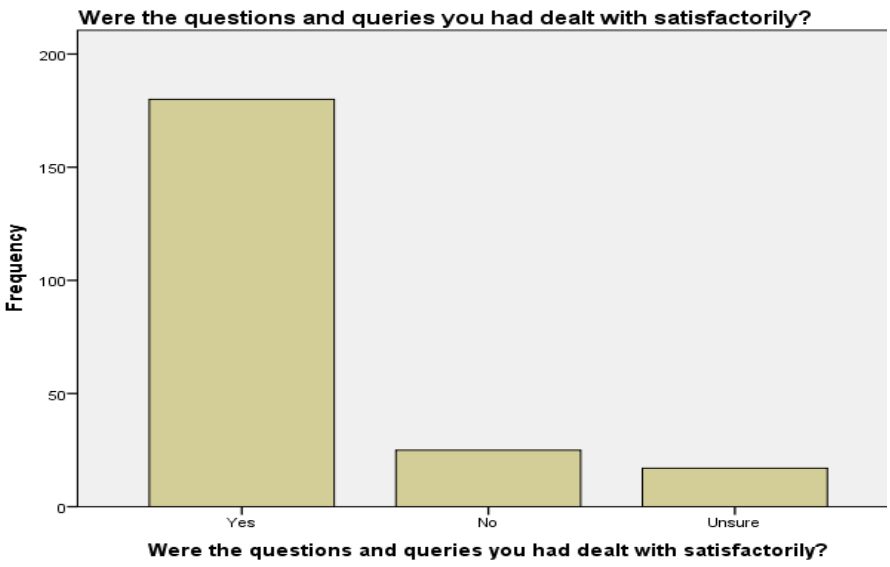


Figure 7.22: Were the questions and queries you had dealt with satisfactorily?

Table 7.24 Were the questions and queries you had dealt with satisfactorily?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.1	81.1
	No	25	10.5	11.3	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The majority (75.3%) of the respondents felt that their questions and queries were dealt with satisfactorily, but 10.5% reported that they were not and 7.1% were unsure). Andaleeb (2001) maintains that the patient's voice must play a greater role in the design of the health care service delivery processes and the emerging health care literature suggests that patient satisfaction is a primary concern that is intertwined with strategic decisions in the health services.

Patients should be treated as individuals, in an unhurried manner, with fairness, empathy, politeness, understanding, consideration and respect. Discourteous behaviour should not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioural norms to junior health care workers (South Africa, 1997:19). Courtesy is underwritten by the Bill of Rights and the PRC. The following questions deals with politeness by: security personnel, clerks, doctors, nurses and other hospital officials.

Table 7.25: Were you treated politely by the following staff members: Security personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	158	66.1	71.2	71.2
	No	37	15.5	16.7	87.8
	Unsure	27	11.3	12.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

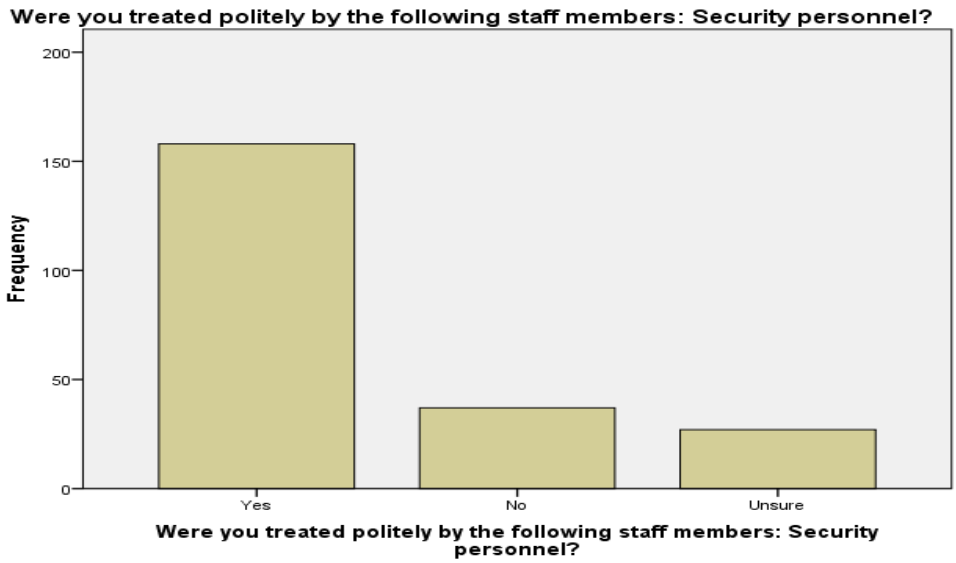


Figure 7.23,(pg 269): Were you treated politely by the following staff member: Security personnel?

The above figures indicates that more than (66%) of the patients were happy with the treatment received from security personnel during their visit to the hospital and only 15% felt that the security personnel did not treat them politely.

Table 7.26: Were you treated politely by the following staff members: Clerk?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	189	79.1	85.1	85.1
	No	25	10.5	11.3	96.4
	Unsure	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

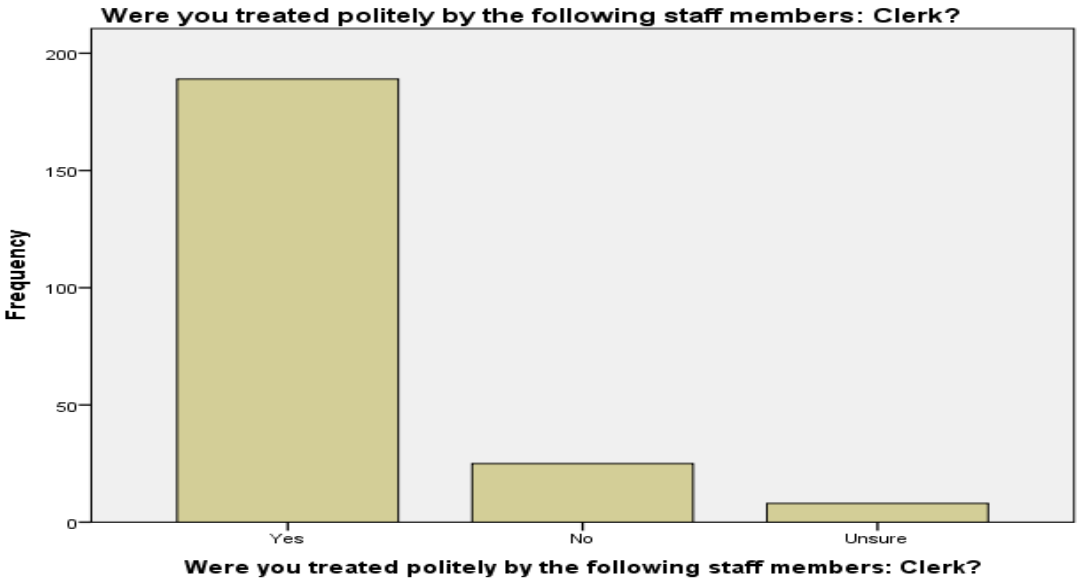


Figure 7.24: Were you treated politely by the following staff members: Clerk?

Clarks are at the coalface of service delivery as they are the link between the patients and the doctors and nurses in terms of access to hospital facilities and medical treatment. The majority (79.1%) of the respondents felt that the clerks in the hospitals treated them politely, while 10% were unhappy with levels of politeness.

Table 7.27: Were you treated politely by the following staff members: Nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	180	75.3	81.4	81.4
	No	29	12.1	13.1	94.6
	Unsure	12	5.0	5.4	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

Figure 7.25: Were you treated politely by the following staff members: Nurse?

In terms of politeness on the part of nurses, the respondents reported an approval rate of

(75.3 %,) while just over 12% stated that nurses did not treat them politely.

Table 7.28: Were you treated politely by the following staff members: Doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	141	59.0	63.5	63.5
	No	36	15.1	16.2	79.7
	Unsure	45	18.8	20.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.26: Were you treated politely by the following staff members: Doctor?

Approximately (60%) of the respondents reported that their doctor treated them politely, while 40% said that that their doctor was not polite. It is evident that doctors' poor attitude towards patients at the three hospitals could compromise their health care.

Table 7.29 Were you treated politely by the following staff members: Pharmacy personnel?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	109	45.6	53.2	53.2
	No	48	20.1	23.4	76.6
	Unsure	48	20.1	23.4	100.0
	Total	205	85.8	100.0	
Missing	System	34	14.2		
Total		239	100.0		

Pharmacy personnel perform the critical function of dispensing medication to patients. In most cases, they are dealing with people who are in pain. Only (45.6 %,) of the respondents reported that pharmacy personnel were polite, while 20.1% indicated that they were not. Hospital management needs to find ways to improve this situation.

Figure7.27: Were you treated politely by the following staff members: Pharmacy personnel?

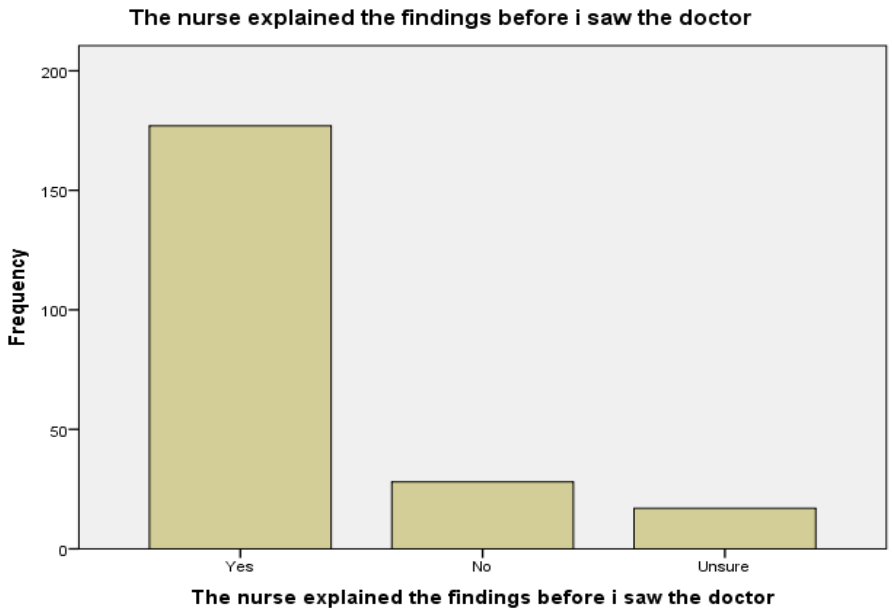


Figure 7.28: The nurse explained the findings before I saw the doctor

Table 7.30: The nurse explained the findings before I saw the doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	177	74.1	79.7	79.7
	No	28	11.7	12.6	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Overall, (74.1%) of the respondents said that the nurse had explained the findings before they saw the doctor. This is a positive sign that nurses are playing their part in health service delivery. However, 11.7% of the respondents reported that the nurse did not explain the findings before they saw the doctor; this needs to be addressed by hospital management.

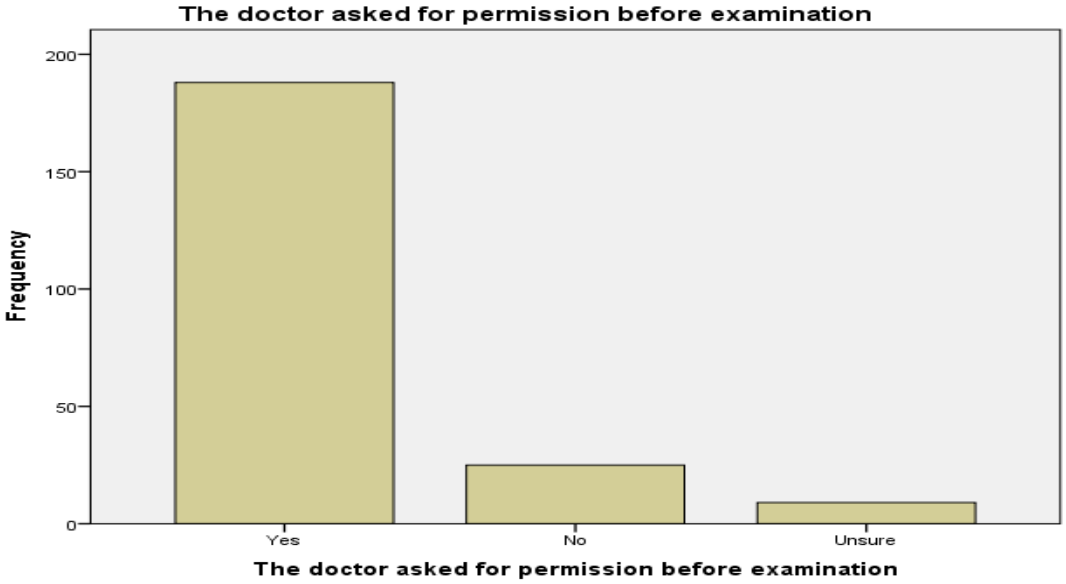


Figure 7.29: The doctor asked for permission before examination

Table 7.31: The doctor asked for permission before examination

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	188	78.7	84.7	84.7
	No	25	10.5	11.3	95.9
	Unsure	9	3.8	4.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Carr-Hill (1992:242) concludes that patient satisfaction is considerably higher if the physical examination if friendly and the patient's expectations are met. Friedman (1997:31) concurs with these findings, and argues that patients need to feel comfortable with the physical examination, since this is an important part of the healing process. It is against the above background that the aims and principles of the *Batho Pele* White Paper are relevant to the improvement of the National Health System in South Africa. The majority of the respondents

(78.7%) agreed that the doctor asked permission before examining them; while 10.5% said that they did not and 3.8% were unsure.

Figure 7:30: Doctor explained my condition to me

Table 7.32: Doctor explained my condition to me

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	28	11.7	12.6	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

It is a standard requirement that doctors explain a patient's condition to them. (76.6%) of the respondents reported that their doctor explained their condition to them, while 11.7% reported the opposite and 4.6% were unsure. It is of concern that this means that approximately 15% of the respondents were treated by a doctor who did not explain their

condition to them; this should be attended to by the DoH, as it indicates the need for more training.

Figure 7.31: Advice was given on how to improve my health status

The above figure indicates the level of communication between the patient and hospital officials the doctors and the nurses regarding giving the patients advices as to how to improve their health status after leaving the hospital or after being discharged from the hospital. As the figure clearly indicates that most of the patients were given advices on how to improve health status and this study also shows that some on the inpatient were not given any advices and others were unsure. As indicated in the study literature, The White Paper on the Transformation of the Public Service (South Africa, 1997) states that the delivery of healthcare should be guided by the principles contained in the framework of *Batho Pele*, a Sotho term meaning "People First".

Three principle values capture *Batho Pele*: belonging, caring and service. This implies that the healthcare service must be transformed to become representative, coherent, transparent, efficient, effective, accountable and responsive to the need of patients/clients as the consumers of healthcare. Healthcare institutions are called upon to deliver people-centered

and people-driven services that are characterized by equity, quality, timeousness and a strong code of ethics (South Africa, 1997).

Table 7.33: Advice was given on how to improve my health status

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	20	8.4	9.0	91.0
	Unsure	20	8.4	9.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 7.33: Advice was given on how to improve my health status

The majority (76.2%) of the respondents said that they were given advice on how to improve their health status, while 8.2% said that they were not and 8.4% were unsure. Health care authorities should focus on the 16% of respondents who indicated their unhappiness and uncertainty regarding this particular service. Katz and Green (1992:18) observe that patients have certain basic expectations of a particular service and expect to be “served in a respectful and meaningful way”.

Table 7.34: The outpatient department was clean

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	168	70.3	75.7	75.7
	No	25	10.5	11.3	86.9
	Unsure	29	12.1	13.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

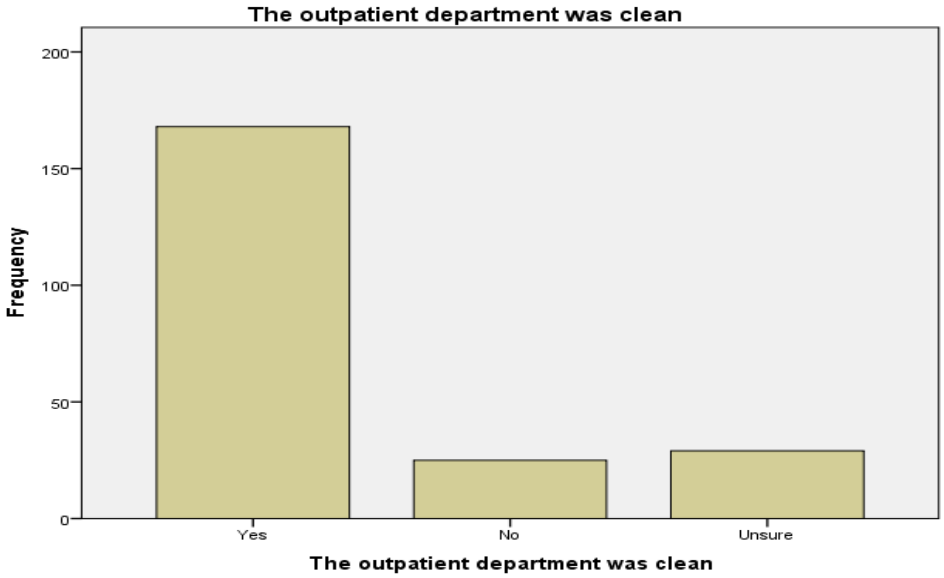


Figure 7.32: The outpatient department was clean

Motsoaledi (2010) maintained that hospital hygiene and infection control in South Africa are "dismal", and that there is a dire lack of minimum standards. Most of the respondents (70.3%) ranked the hygiene at the three hospitals highly, with 10% indicating a need for improvement. It should be noted that at the time of this research study renovations were underway in these hospitals.

Table 7.35: The Pharmacy department was clean

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	172	72.0	77.5	77.5
	No	38	15.9	17.1	94.6
	Unsure	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

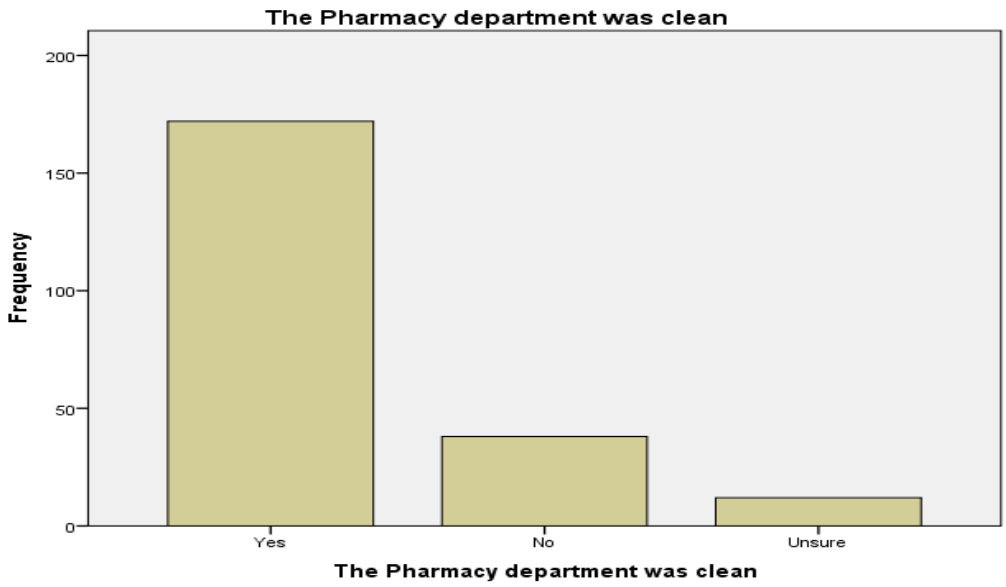


Figure 7.33: The Pharmacy department was clean

The majority of the respondents (72.0%) felt that the pharmacy department very clean, with 15.9% stating that it was not. Clearly this is an issue for concern, as unhygienic conditions can constitute health hazards, as has been witnessed in hospitals in provinces such as the Eastern Cape, where they resulted in a high infant mortality rate.

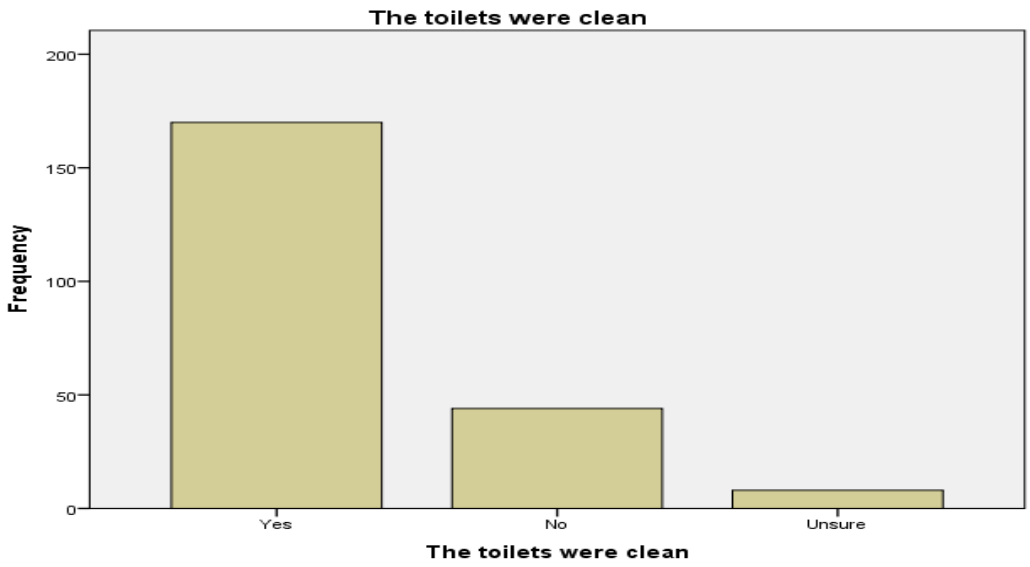


Figure 7.34: The toilets were clean

Table 7.36:The toilets were clean

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	170	71.1	76.6	76.6
	No	44	18.4	19.8	96.4
	Unsure	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

While(71.1%) of the respondents indicated that toilets were clean, 18.4% said that they were not. Toilets are a very important space at any environment and can pose serious health hazards if not cleaned properly. The health care authorities must ensure that toilets are always clean.

Table 7.37 There was toilet paper in the toilet

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	151	63.2	68.0	68.0
	No	49	20.5	22.1	90.1
	Unsure	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

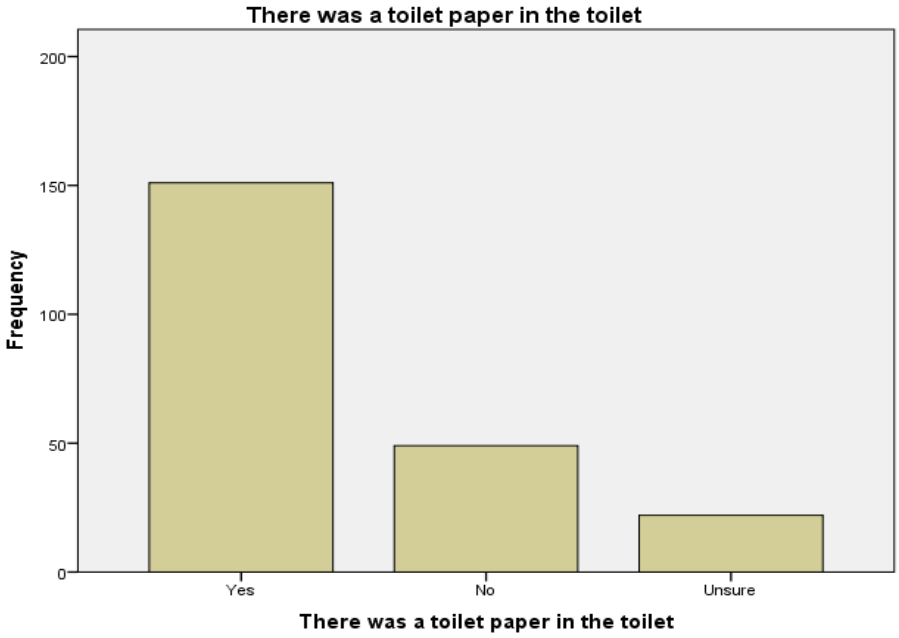


Figure 7.35: There was toilet paper in the toilet

The majority (63%) of the respondents indicated that when they were using the toilets facilities, toilet paper was provided; however just above 20% stated that there was no toilet paper and almost 30% were unsure. In order to improve services the hospital management must address this issue.

Table 7.38: There was soap to wash hands in the toilet

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	137	57.3	61.7	61.7
	No	68	28.5	30.6	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.36: There was soap to wash hands in the toilet

Just over half (57.3%) of the respondents stated that soap was available to wash their hands after using the toilet; 28.5% indicated that there was no soap and the rest were unsure. Hospital management should be concerned that almost 40% of patients either did not find soap in the toilets or were uncertain whether or not it was available.

Table 7.39: There was paper towels/air dryer to dry hands in the toilet

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	183	76.6	82.4	82.4
	No	23	9.6	10.4	92.8
	Unsure	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

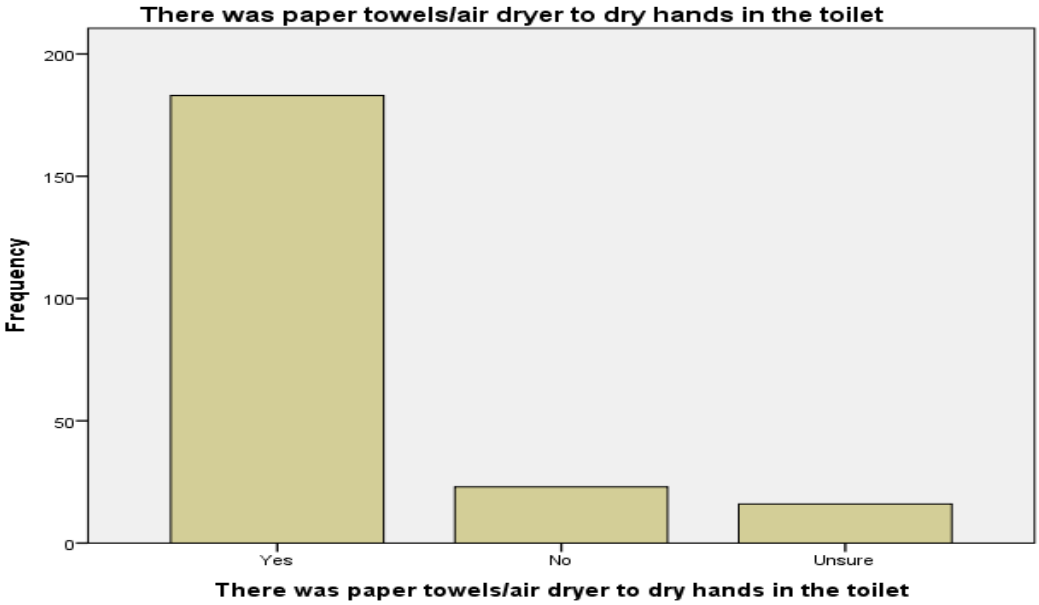


Figure 7.37: There was paper towel/air dryer to dry hands in the toilet

The majority (76.6%) of the respondents confirmed that the three hospitals provided paper towels and air dryers for patients in the hospital toilets, while 9.6% did not find these facilities and 6.7% were unsure. It is not acceptable that almost 20% of respondents either reported that there were no facilities to dry their hands or were uncertain if these facilities were available.

Table 7.40: Did the staff wash/spray their hands before & after examining you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	161	67.4	72.5	72.5
	No	33	13.8	14.9	87.4
	Unsure	28	11.7	12.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.38 Did the staff wash/spray their hands before and after examining you?

The majority of the respondents (67.4%) stated that hospital staff did wash/spray their hands before examining them; however13.8% stated that they did not and 11.7% were unsure. Considering that this is a basic hygiene requirement, this should be a matter for concern.

Table 7.41: Were the following areas in the hospital clean: Corridors?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	160	66.9	72.1	72.1
	No	38	15.9	17.1	89.2
	Unsure	24	10.0	10.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

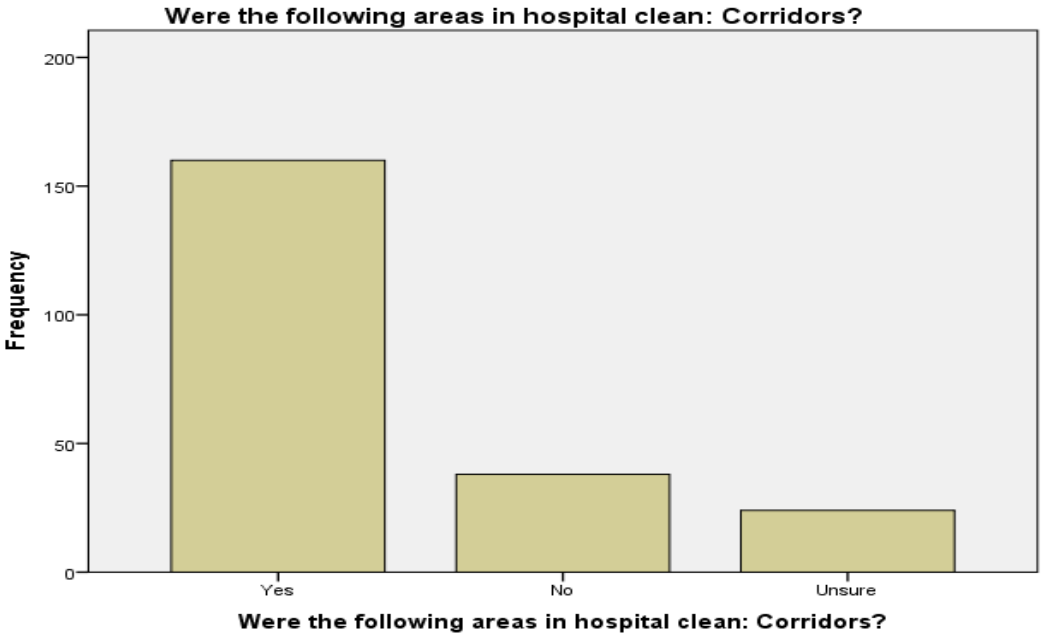


Figure 7.39: Were the following areas in hospital clean: Corridors?

Dyck (1996:541-549) asserts that knowing what clients' expectations are, is the first and most critical step in delivering quality care. She further indicates that the degree of service quality can be determined by measuring the extent of the difference between clients' expectations or desires and their perception of the services they receive; premises upon which the current research study is founded. 66.9% of the study respondents indicated that the corridors in the hospitals were clean, while 15.9% felt that they were not, with 10% unsure. It should be of

concern to hospital management that a total of almost30% of the respondents either felt that corridors were dirty or were not sure that they were clean.

Table 7.42: Were the following areas in hospital clean: Buildings?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	149	62.3	67.1	67.1
	No	41	17.2	18.5	85.6
	Unsure	32	13.4	14.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

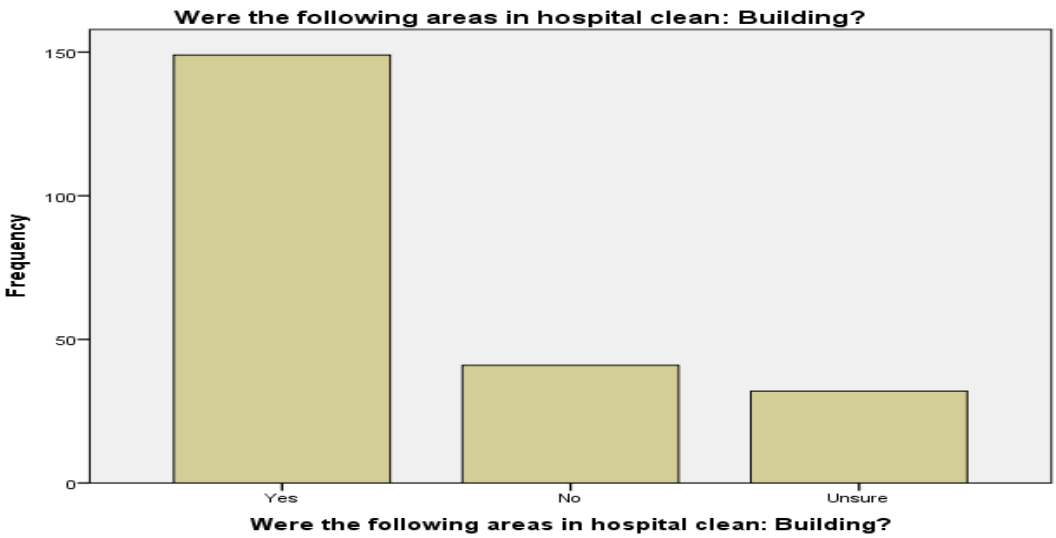


Figure 7.40: Were the following areas in hospitals clean: Buildings?

During the course of this research, renovations were taking place in the three hospitals; however 62.3% of the respondents indicated that the buildings were clean, with 17.2% disagreeing. Again, the hospital management should focus on the negative responses to improve cleanliness in the hospitals.

Table 7.43: Were the following areas in hospital clean: Ablution facilities?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	41	17.2	18.5	90.1
	Unsure	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

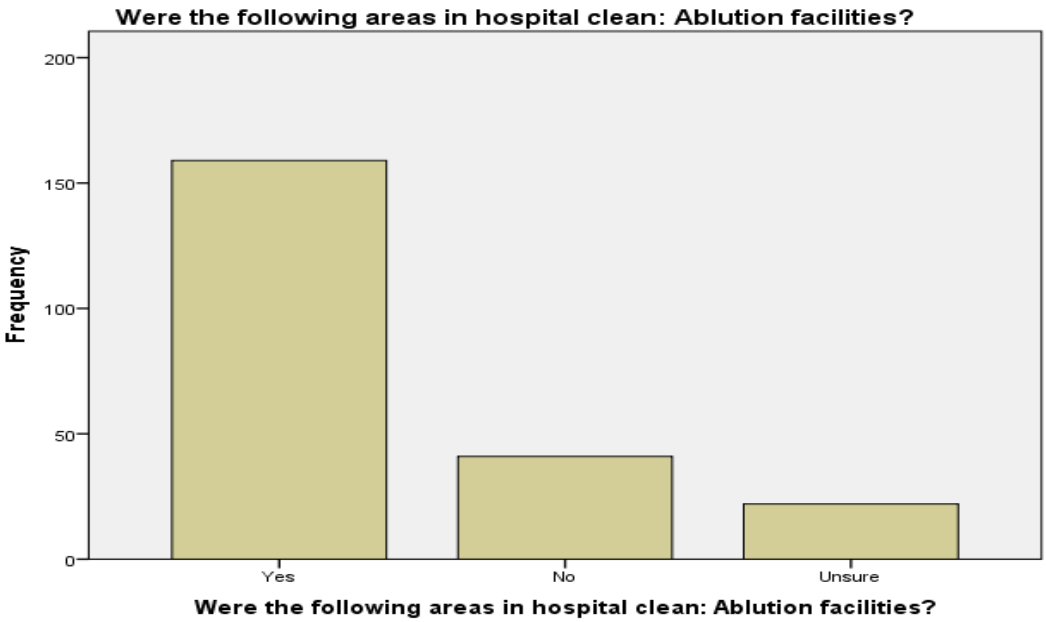


Figure 7.41: Were the following areas in hospital clean: Ablution facilities?

66.5% of the respondents confirmed that the ablution facilities were clean, while 17.2% felt that they were not. The focus yet again should be on improving hospital services, including facilities.

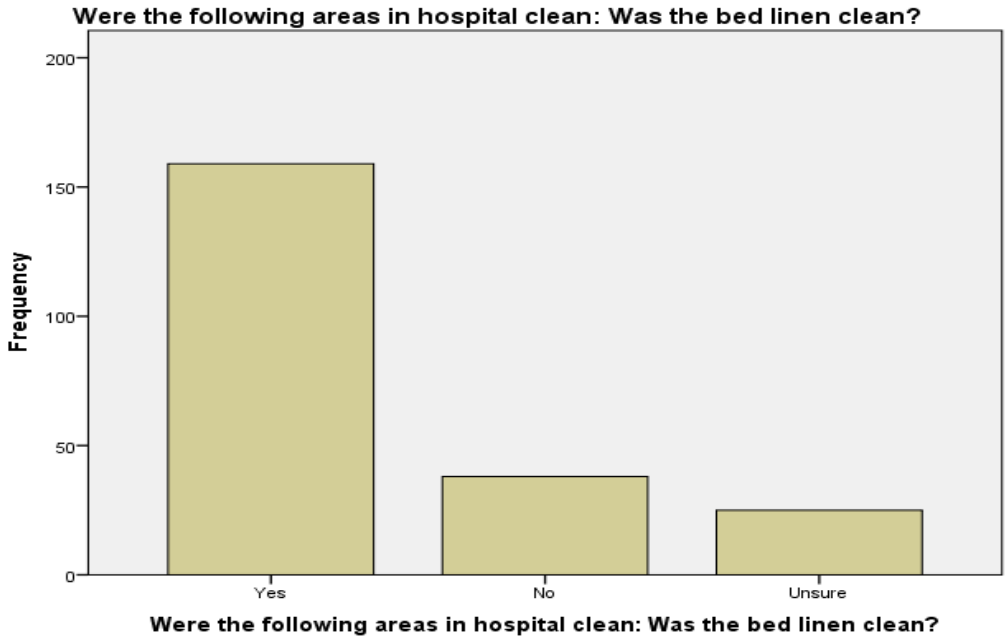


Figure 7.42: Were the following areas in the hospital clean: Was the bed linen clean?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	159	66.5	71.6	71.6
	No	38	15.9	17.1	88.7
	Unsure	25	10.5	11.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 7.44: Were the following areas in the hospital clean: Was the bed linen clean?

The above table and figure indicates that the majority of the respondents (66.5%) said that the hospital bed linen was clean during their stay while 15.9% said it was not clean. The literature notes that customer-oriented service means placing the patient's needs before those of the institution, a notion also reflected in the phrase: "Batho Pele", the guiding philosophy

of public service delivery (Abbott &Lewry, 1999:83; South Africa, 1997). Any suspicion on the part of the patient that the priorities in terms of service delivery are the other way round is likely to be counter-productive, and does not facilitate a caring and ethical service delivery environment.

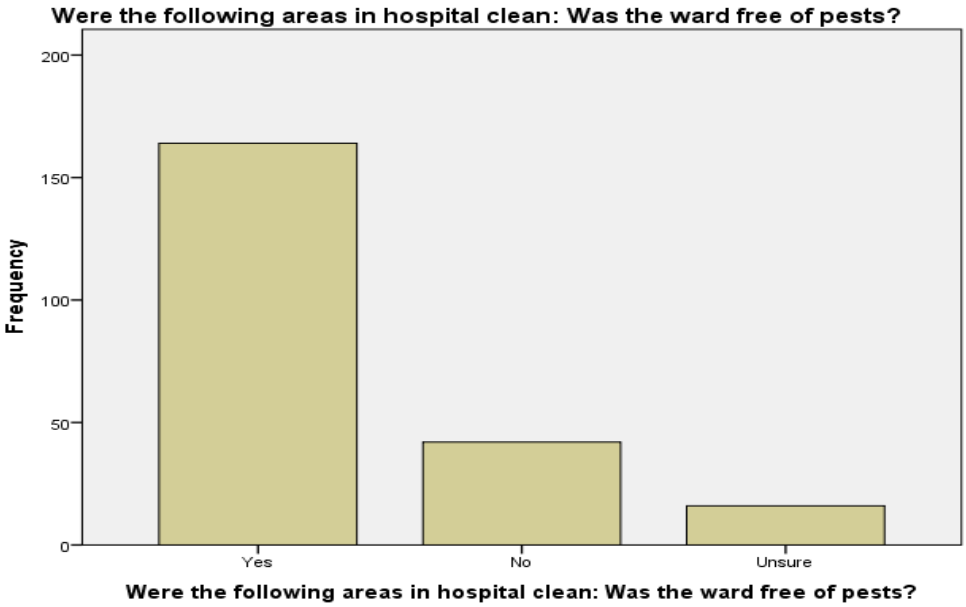


Figure 7.43: Were the following areas in hospital clean: Was the ward free of pests?

Table 7.45: Were the following areas in the hospital clean: Was the ward free of pests?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	164	68.6	73.9	73.9
	No	42	17.6	18.9	92.8
	Unsure	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The majority of the respondents (68.6%) in the above table and figure reported that the ward was free of pests, while 17.6% indicated that the hospital was not pest free. This should be of concern to hospital management, as pests contribute to unhygienic conditions in hospitals.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	169	70.7	76.1	76.1
	No	36	15.1	16.2	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 7.46 Did the hospital staff draw attention to patient's rights and responsibilities?

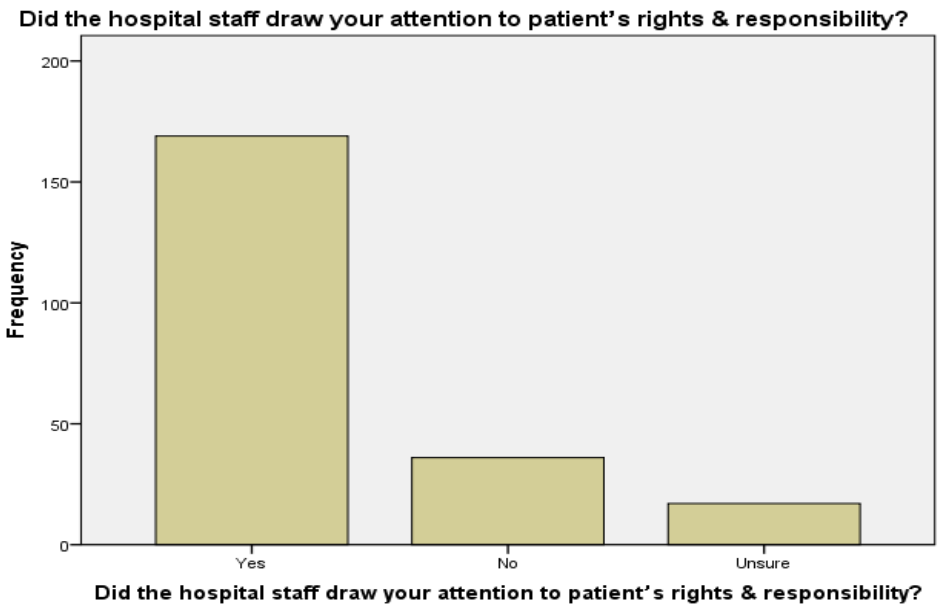


Figure 7.44: Did the hospital staff draw attention to patient's rights and responsibilities?

In relation to the service encounter, Band's research shows that consumers are more tolerant with regard to problems experienced with services if they are treated with respect (Band, 1991:25). The Patients' Rights Charter states that everyone has the right of access to health care services that embrace "...courtesy, human dignity, patience, empathy and tolerance" on the part of health care workers (sec 3(vi)). It further points out that where such respect is subverted by bad service and dehumanizing treatment, a person can, and should, exercise the "... right to complain" (sec 12; cf. South Africa, 1997: sec 1.2.2,4.7).

The provincial hospital management seems to be doing a good job in ensuring that patients' rights are adhered too, with 70.7% of respondents confirming that staff drew their attention to their rights as patients, and just over 15% indicating that staff did not do so. This is a critical issue and hospital officials need to make sure patients' rights are explained at all times.

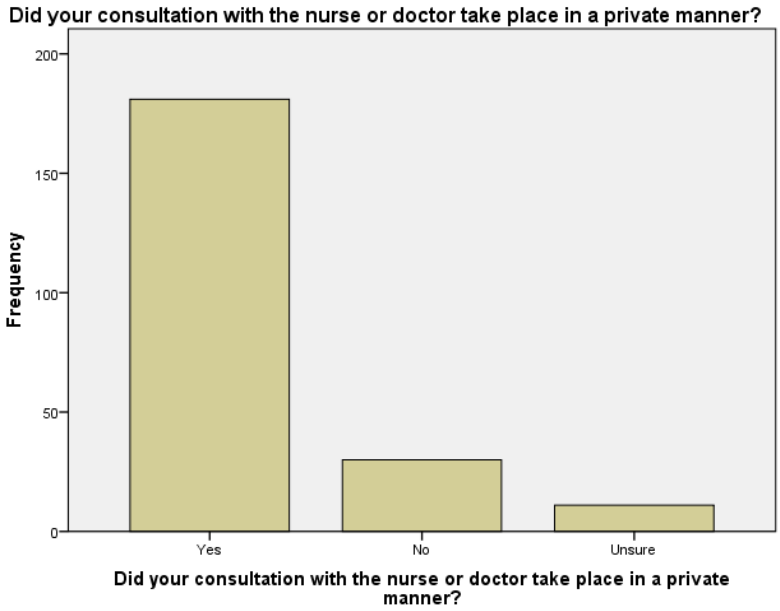


Figure 7.45: Did your consultation with the nurse or doctor take place in a private manner?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	181	75.7	81.5	81.5
	No	30	12.6	13.5	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table: 7.47: Did your consultation with the nurse of doctor take place in a private manner?

Privacy is a fundamental right that every patient is entitled to. The above table and figure shows that 75.7% of the respondents indicated that their consultation was done in a private manner. This shows a level of respect for patients' privacy and their right to dignity. Only 12.6% of the respondents felt that their consultations were not conducted in a private manner.

The health profession and hospitals need to find solutions to improve the quality of service offered in the three hospitals.

Table 7.48:Was a bench/chair provided for you to sit on while you waited?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	92	38.5	41.4	41.4
	No	116	48.5	52.3	93.7
	Unsure	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

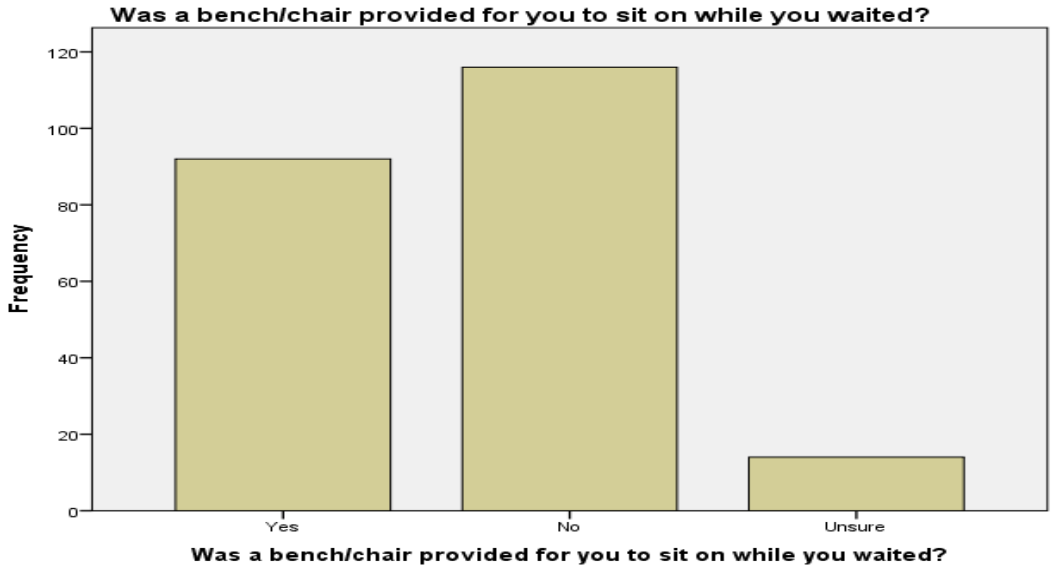


Figure 7.46: Was a bench/chair provided for you to sit on while you waited?

Service standards cannot be achieved in the absence of resources and infrastructure (South Africa, 1997:16-17). The above table and graph indicate that 48.5% of the respondents stated that benches and chairs were not provided for them to sit on while they waited, and only 38.5% said that they were provided. Satisfying patients' needs could save hospitals money in terms of reducing the amount of time spend resolving complaints (Press *et al.,* 1991*)*.The

quality of health care can be improved by establishing patient preferences and customizing care to meet their needs (Macario*et al.*, 1999).

Table: 7.49: Did you have a complaint?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	119	49.8	53.6	53.6
	No	85	35.6	38.3	91.9
	Unsure	18	7.5	8.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

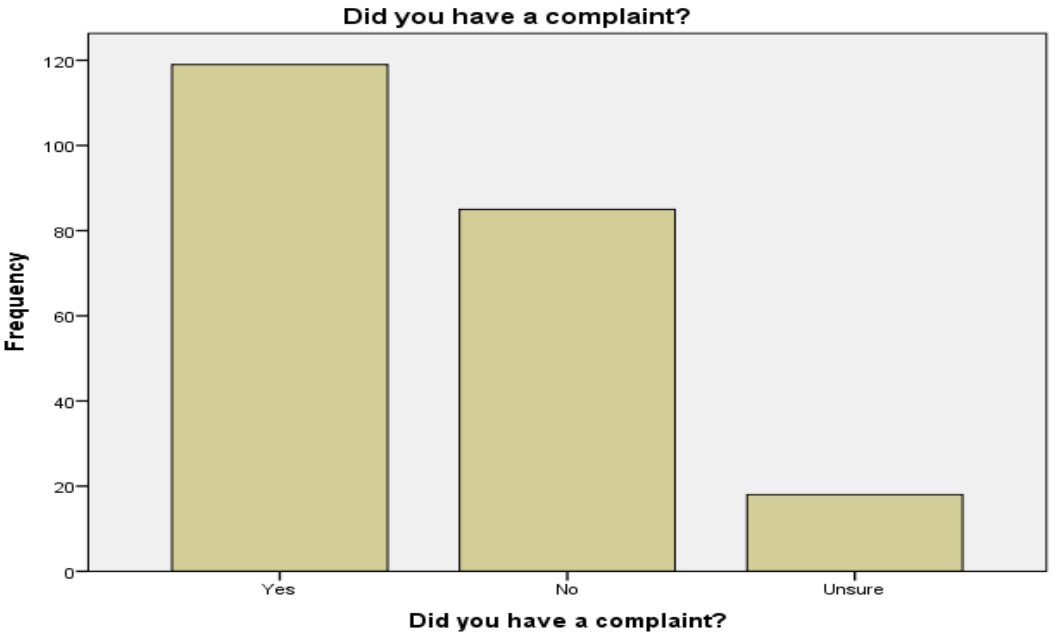


Figure 7.47: Did you have a complaint?

Bearden *et al.*(1995:123) note that, while most dissatisfied consumers do not lodge their complaints directly with the institution rendering the service, consumers who do complain should not be ignored, since they talk to, and influence other prospective consumers. Half of

the respondents said that they had had a complaint, while 35.6% did not have any complaints at the time the research was conducted.

Figure 7.48: If you had a complaint, did you report it?

Table 7.50: If you had a complaint, did you report it?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	141	59.0	63.8	63.8
	No	55	23.0	24.9	88.7
	Unsure	25	10.5	11.3	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

59% of the respondents said that they registered their complaints and 23% did not, while 10.5% were unsure. The national Department of Health and other institutions should encourage patients to voice their views on the quality of care received. This study seeks to evaluate patients' perceptions of the services they received and make recommendations on improvements in the provision such services in the provincial hospitals. These recommendations could also assist hospitals in other provinces.

Table 7.51: If you had a complaint were you satisfied with the way it was handled?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	168	70.3	75.7	75.7
	No	43	18.0	19.4	95.0
	Unsure	11	4.6	5.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

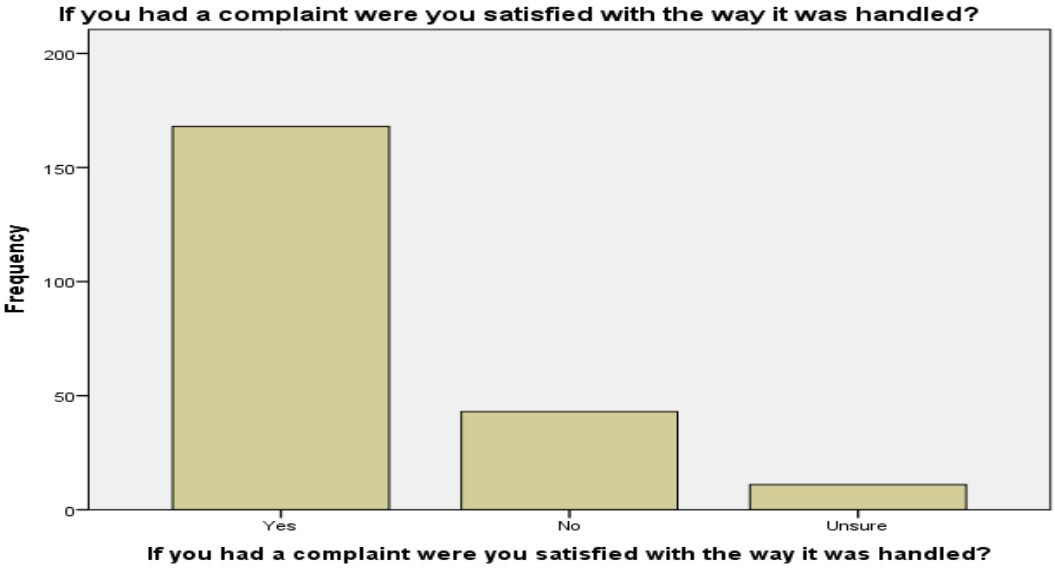


Figure 7.49: If you had a complaint were you satisfied with the way it was handled?

The literature notes that hospitals should have a strategy to provide feedback about complaints that will serve as a training opportunity for health care providers. All staff must know the procedure for handling complaints (South Africa: 1997). 70% of the respondents were satisfied with the way the hospital handled their complaint. This is encouraging and implies that management at the three hospitals has a good system in place to deal with complaints. However, 18% of the respondents felt that their complaints were not properly handled. Hospital management needs to pay attention to the fact that of 30% of respondents

were either dissatisfied with the way their complaints were handled or were unsure that it had been handled well.

Table 7.52: At night was the nurse available when you called?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	184	77.0	82.9	82.9
	No	25	10.5	11.3	94.1
	Unsure	13	5.4	5.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

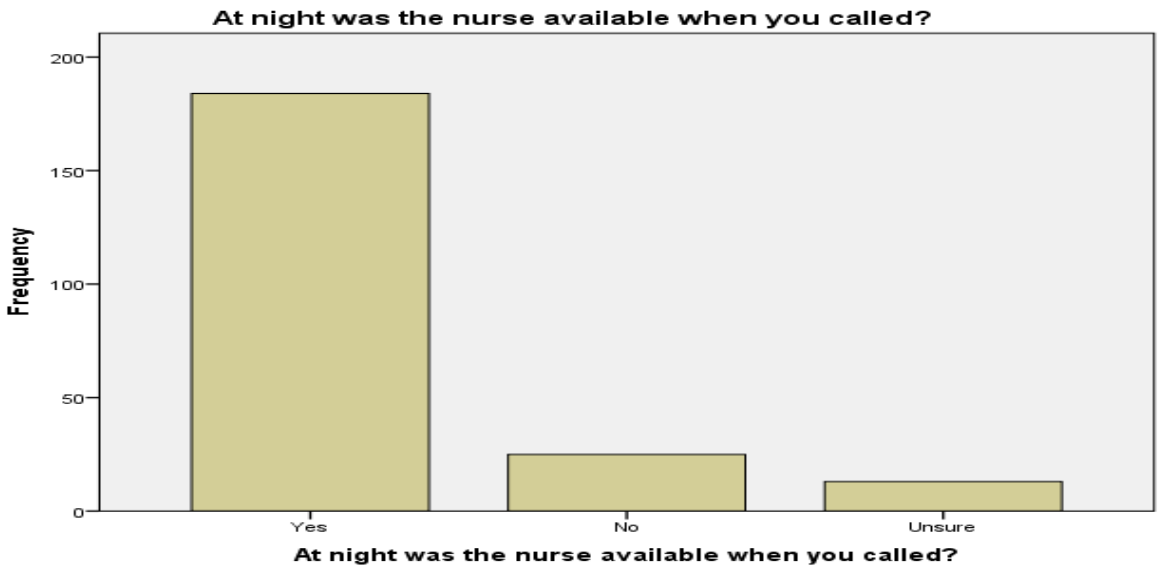


Figure 7.50: At night was the nurse available when you called?

The importance of nurses being available in the wards to support patients at night and assist them in taking their medication, going to the toilet, and turning them when they are tired of sleeping on one side is attested to in the literature. 77% of the respondents agreed that nurses were available at night to help them, while a small fraction of just above 10% said that they were not. This should nonetheless be of concern to hospital management.

Figure 7.51: Did you feel safe in the hospital?

Table 7.53: Did you feel safe in the hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	26	10.9	11.7	93.7
	Unsure	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Safety in hospitals has come under serious scrutiny in the past. The table and graph reveal that 76.2% of respondents felt safe in the hospital. Safety would encompass visible security personnel, guards patrolling the wards and other areas as night and protection from other patients who might put another patient's life at risk. 10.9% of the respondents said they did not feel safe at the hospital.

Table 7.54: Were you issued with the medication that the doctor prescribed for you?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	182	76.2	82.0	82.0
	No	23	9.6	10.4	92.3
	Unsure	17	7.1	7.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

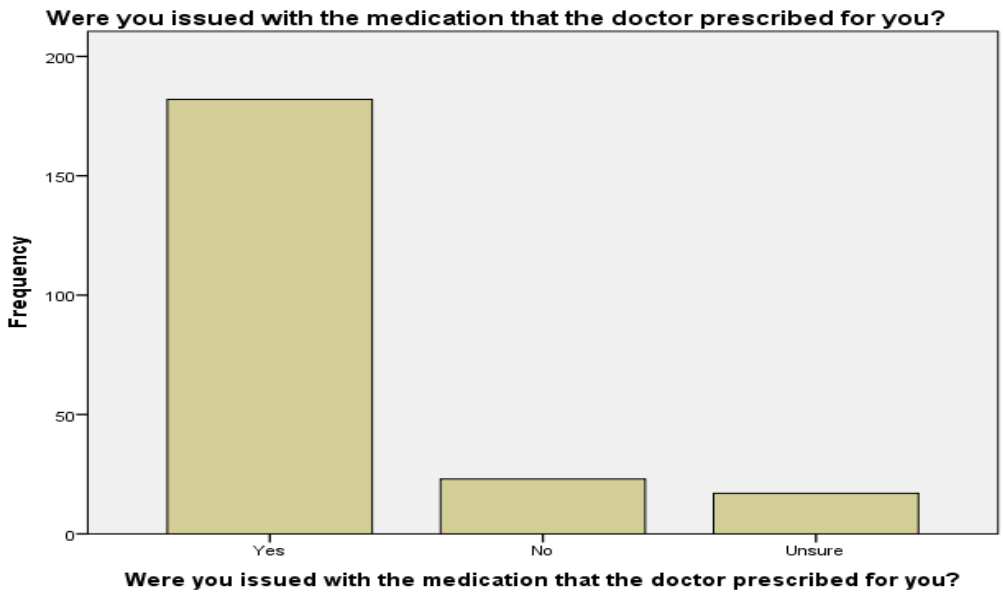


Figure 7.52: Were you issued with the medication that the doctor prescribed for you?

The majority (76.2%) of the respondents indicated that they were issued with the medication that the doctor prescribed for them, while only (9.6%) indicated that they were not. Just less than 25% either indicated that they were not issued with the medication the doctor prescribed or were unsure. This suggests that these patients were given the wrong medication or that the medication prescribed by the doctor was not available. This could put their lives at risk.

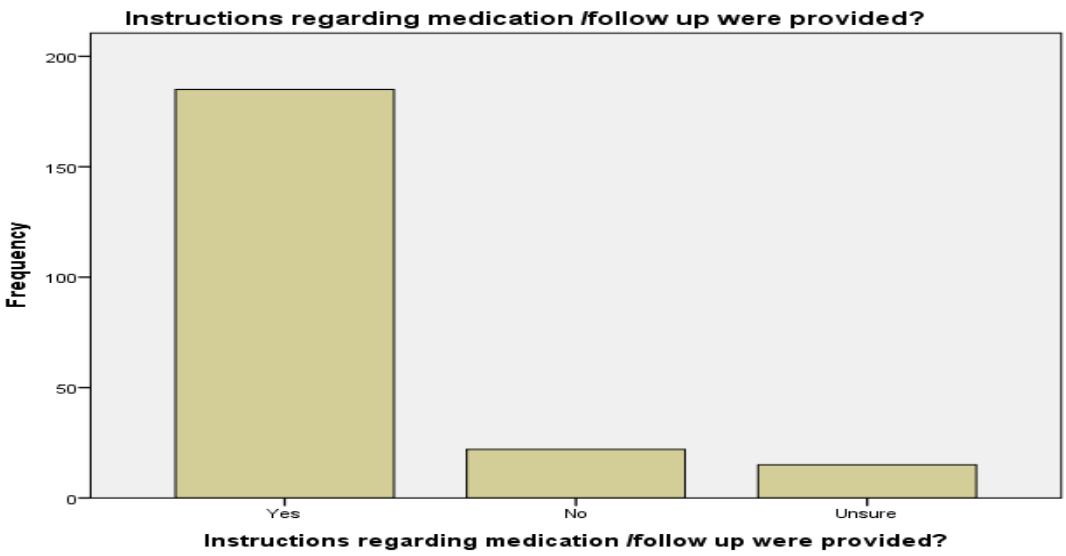


Figure 7.53: Instructions regarding medication/follow up were provided?

The above figure shows that 77.4% of the respondents were given instructions as to how to use the medication after consultations with the doctors. This figure also indicates that 9.2% indicated that they did not receive instructions regarding medication and follow up were no provided. With this question there were 6.3% who were unsure where medication instructions were give or no. Only about 8.1% of the respondents did not answer the questions.

In the literature reviews on this study it is indicated that Patients Care Centre (PCC) is founded on the notion that information should be shared between physicians and patients and, more importantly, that decision making is based on patient involvement so that viable treatment or medication options take into account patient preferences and perspectives (Davis *et al*., 2005; Corrigan *et al*., 2001)

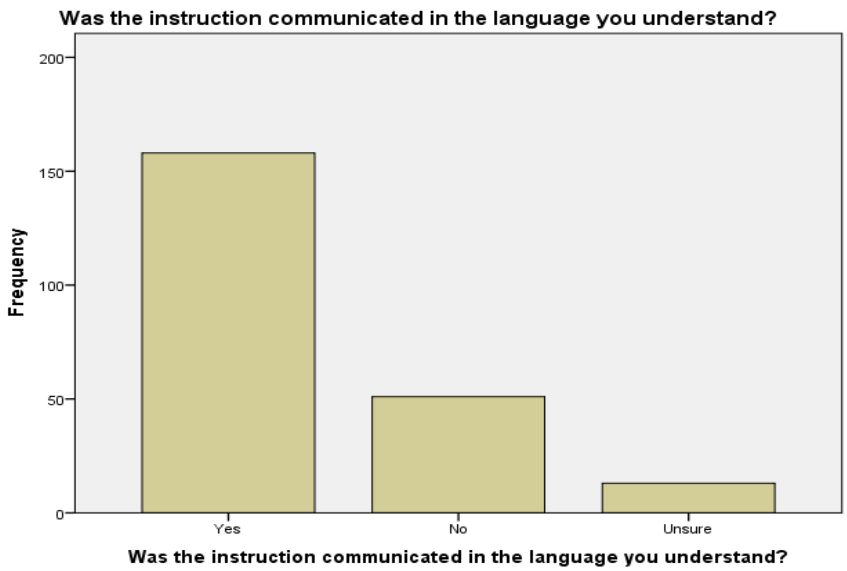


Figure: 7.54 Was the instruction communicated in the language you understand?

Table 7.55 Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	134	56.1	60.4	60.4
	Yes to some extent	67	28.0	30.2	90.5
	No	21	8.8	9.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

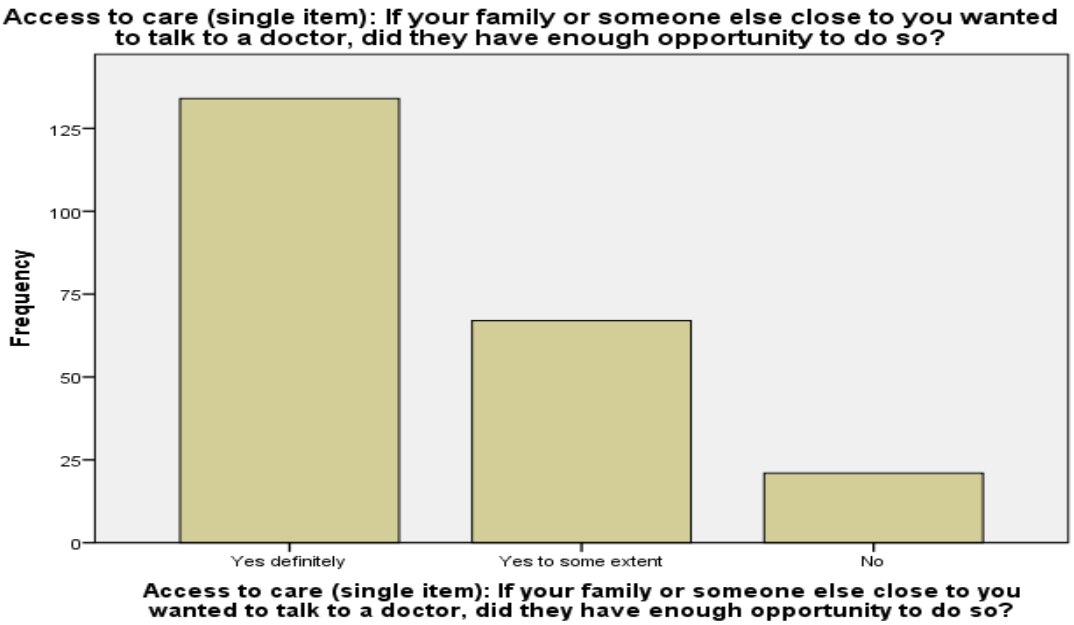


Figure 7.55: Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

Just over half (56.1%) of the respondents indicated they their family members or others close to them were definitely able to talk to a doctor if they needed to, while 28% reported that this was possible to some extent, and 8.8% said it was not possible. It was not clear whether doctors were not available to speak to family members or whether family members could not see the doctor treating the patient during the period of the research.

Table 7.56: Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	149	62.3	67.1	67.1
	Yes to some extent	59	24.7	26.6	93.7
	No	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

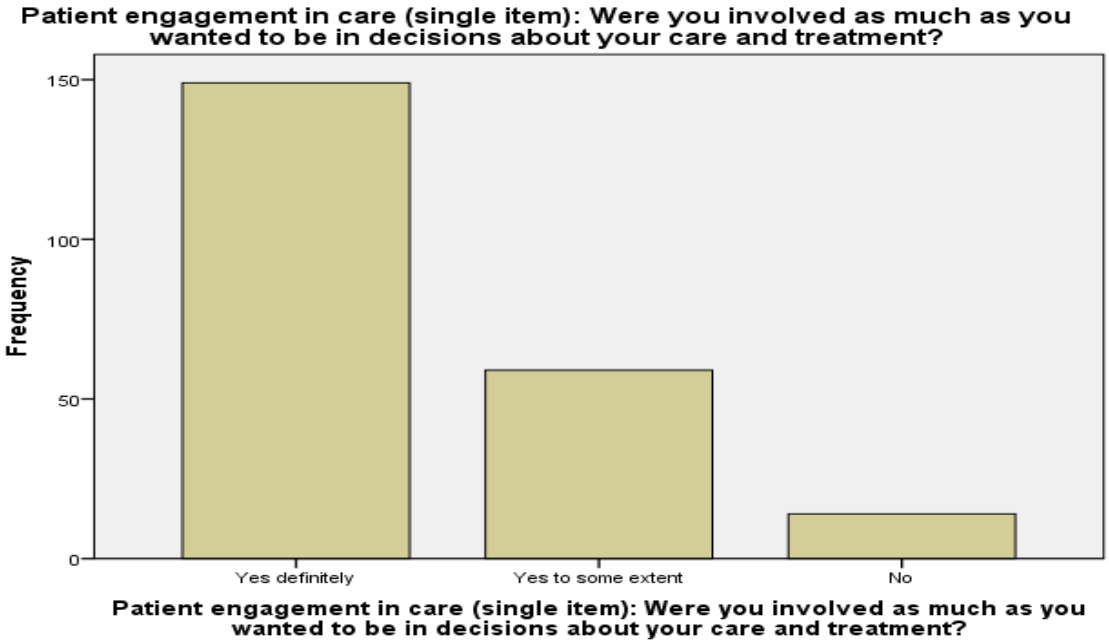


Figure 7.56: Patients engagement in care (Single item): Were you involved as much as you wanted to be in decisions about your care and treatment?

Most of the respondents (62.3%) stated that they were definitely involved as much as they wanted to be in decisions about their care and treatment at the hospital, while 24.7% said that this was true to some extent and 5.6% reported that they were not involved as much as they wanted to be. Although this question elicited fairly positive responses from patients, it is

important that the hospitals address the issue of why some patients did not feel that they were able to be actively involved in their treatment.

Table 7.57: When you had important questions to ask a doctor, did you get answers that you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes always	138	57.7	62.2	62.2
	Yes sometimes	72	30.1	32.4	94.6
	No	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.57: When you had important questions to ask a doctor, did you get answers that you could understand?

The table and graph show that 57.7% of the respondents indicated that when they had important questions to ask a doctor they always got answers that they understood; however, a

substantial number (30.1) reported that they only sometimes received answers that they could understand and 5% stated that they did not get answers they could understand.

Table 7.58: When you had important questions to ask a nurse, did you get answers that you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes always	158	66.1	71.2	71.2
	Yes sometimes	49	20.5	22.1	93.2
	No	15	6.3	6.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

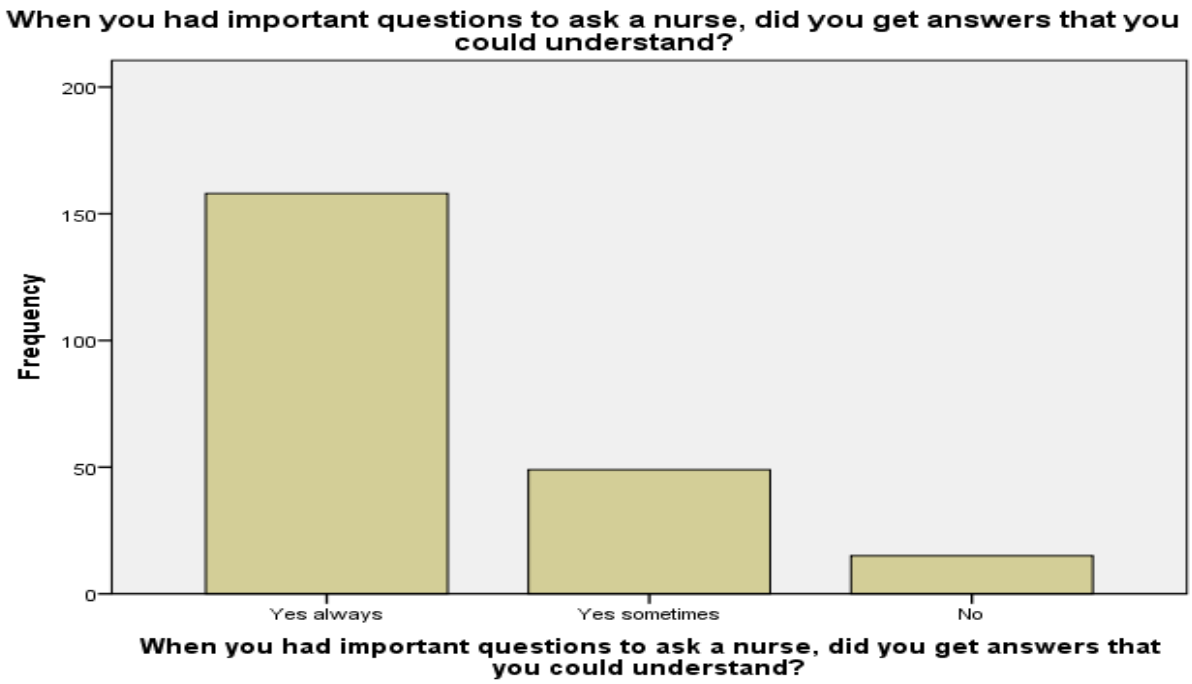


Figure 7.58: When you had important questions to ask a nurse, did you get answers that you could understand?

66.1% of the respondents indicated that when they had important questions to ask a nurse they always got answers that they understood, while 20.5% stated that they sometimes received answers they could understand, and 6.3% responded that when they had an important question, the nurse did not provide answers they could understand. In essence 87% of the respondents indicated that they were given answers that they could understand; this is a positive sign that nurses are properly trained to serve patients and assist where necessary. The focus should, however, be on the 13% of respondents who did not receive answers they could understand from the nurses.

Table 7.59: Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	149	62.3	67.1	67.1
	Yes to some extent	43	18.0	19.4	86.5
	No	30	12.6	13.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

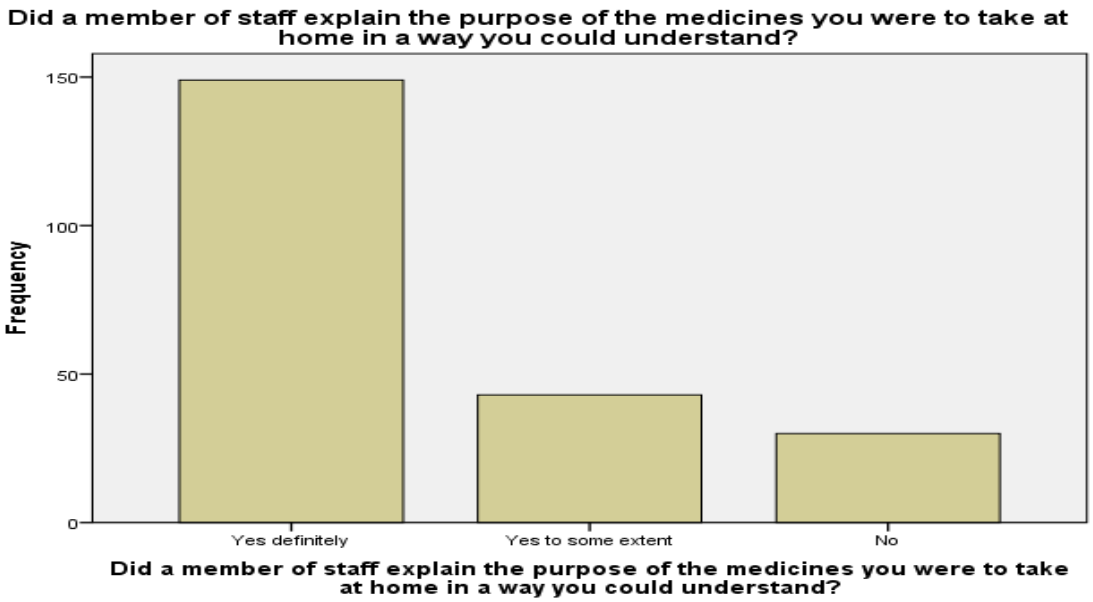


Figure 7.59: Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

The table and graph indicate that 62.3% of the respondents definitely received clear information on the purpose of the medicine they were to take at home, while 18% indicated that this occurred to some extent, and 12.6% did not receive information they could understand on the medicine they were to take at home. Since medication can be complicated and cause serious harm to patients if not taken correctly, hospital management needs to find ways to improve the quality of services provided by staff members in this regard.

Table 7.60: Did a member of staff tell you about any medication side effects to watch for when you went home?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	131	54.8	59.0	59.0
	Yes to some extent	50	20.9	22.5	81.5
	No	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

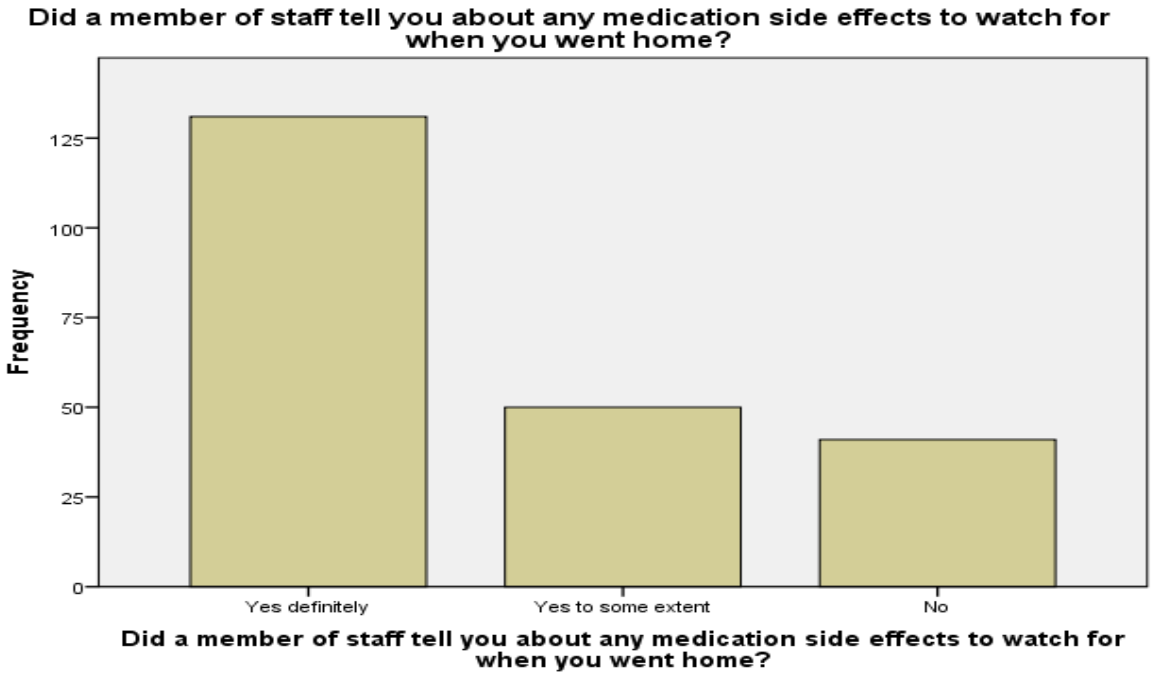


Figure 7.60: Did a member of the staff tell you about any medication side effect to watch for when you went home?

While 54.8% of the respondents said that they definitely received information about the side effects of their medication, 20.9% reported that this only occurred to some extent, and 17.2% were not informed about side effects. This places patients' lives at risk and should be of serious concern to the DoH and hospital management.

Table 7.61: Did a member of staff tell you about any danger signals you should watch for after you went home?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	118	49.4	53.2	53.2
	Yes to some extent	68	28.5	30.6	83.8
	No	36	15.1	16.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

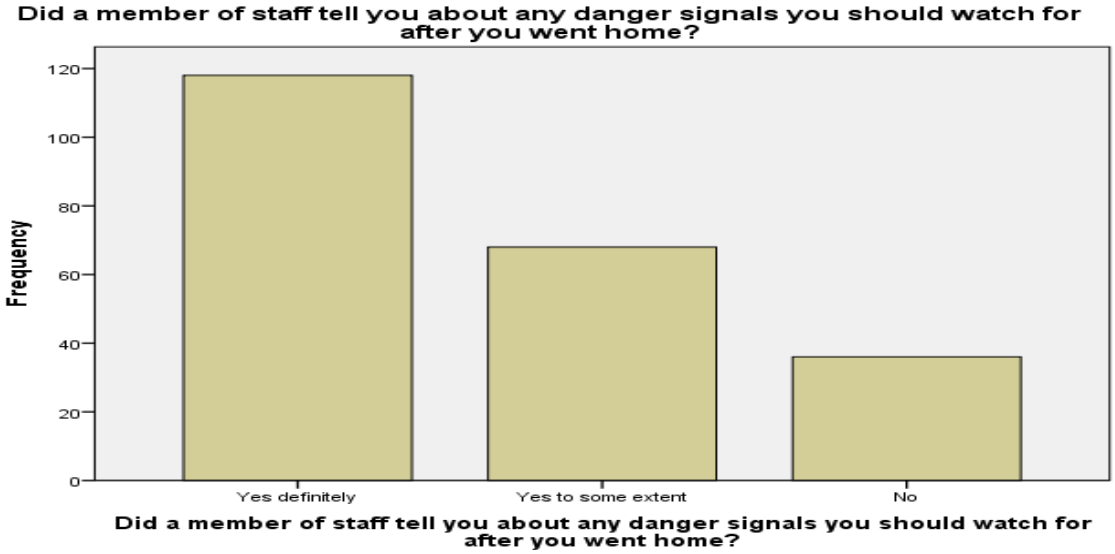


Figure 7.61: Did a member of staff tell you about any danger signals you should watch for after you went home?

Just under half (49.4%) of the respondents stated that they were definitely informed about danger signals to watch for after they were discharged, while 28.5% said they were warned to some extent and 15.1% claimed to have received no information at all. Again, it should be of concern to hospital management that some patients are sent home without being informed about danger signals to watch out for. Dyck (1996:541-549) asserts that knowing what clients expect is the first and most critical step in delivering quality care. The degree of service

quality can be determined by measuring the extent of the difference between clients' expectations or desires and their perceptions of the service they receive; premises upon which the current research project is founded.

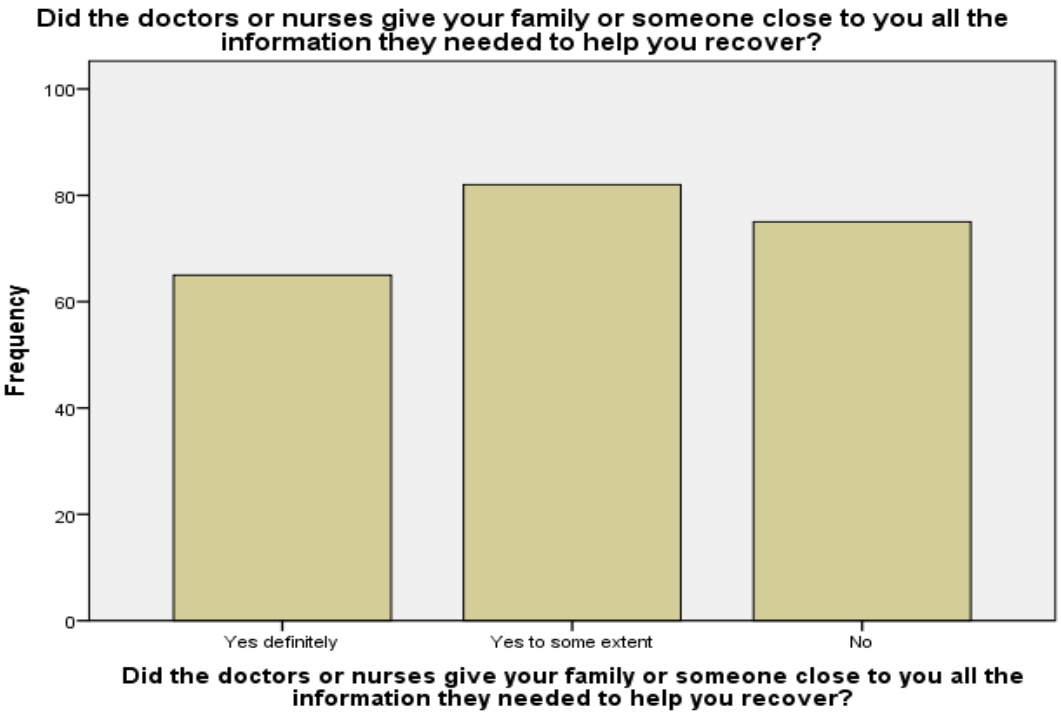


Figure 7.62: Did the doctor or nurse give your family or someone close to you all the information they needed to help you recover?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	65	27.2	29.3	29.3
	Yes to some extent	82	34.3	36.9	66.2
	No	75	31.4	33.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Table 7.62: (pg 312)Did the doctor of nurse give your family or someone close to you all the information they needed to help you recover?

The table and figure indicate that only 27.2% o222f respondents confirmed that their family members were definitely given the information they needed to help them recover, while 34.3% said that this was true to some extent. Shockingly, 31.4% of the respondents indicated that their family members were not given the information they needed to help them recover after they were discharged. This is a serious indication of poor service at these hospitals.

Table 7.63: Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes definitely	49	20.5	22.1	22.1
	Yes to some extent	26	10.9	11.7	33.8
	No	147	61.5	66.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

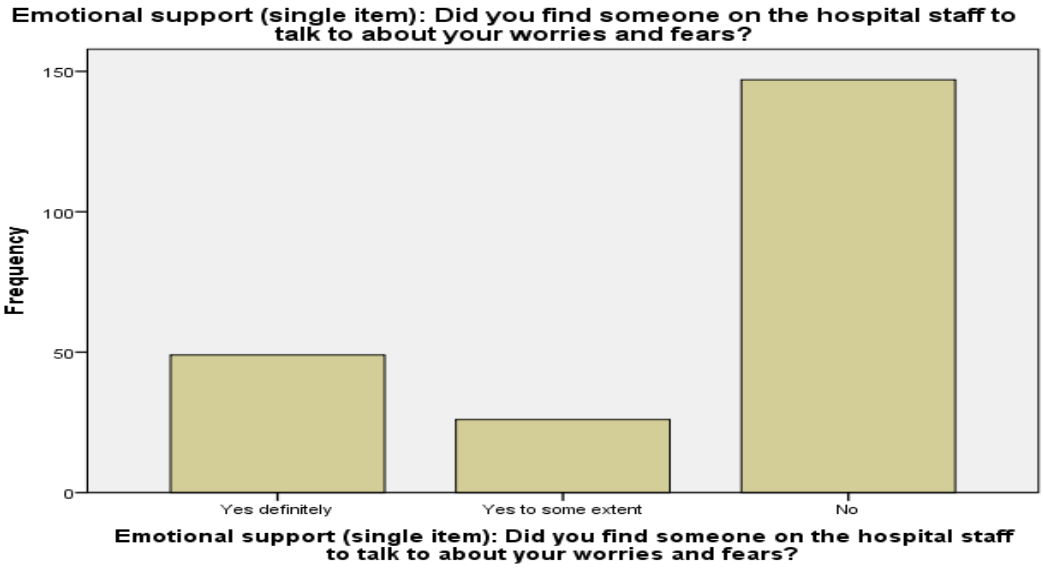


Figure 7.63: Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?

More than 60% of the respondents stated that they did not find a member of staff to talk to about their worries and fears, with only 20.5% indicated that they definitely did so, and 10.9% saying that this occurred to some extent.

Searle and Pera (1998) observe that patients' negative experience of the quality of service delivery includes a lack of service commitment; a culture of non-caring and inhospitality; powerlessness related to a lack of information; violence expressed through aggressive language, frustration and uncertainty; an unfriendly, unsafe and non-enabling environment; dehumanization and a lack of consideration for the patient.

The current study confirms the importance of service delivery reflecting the work of multi-disciplinary team of doctors, nurses, physiotherapists, laboratory technicians and pharmacists; as reflected in *Batho Pele*.

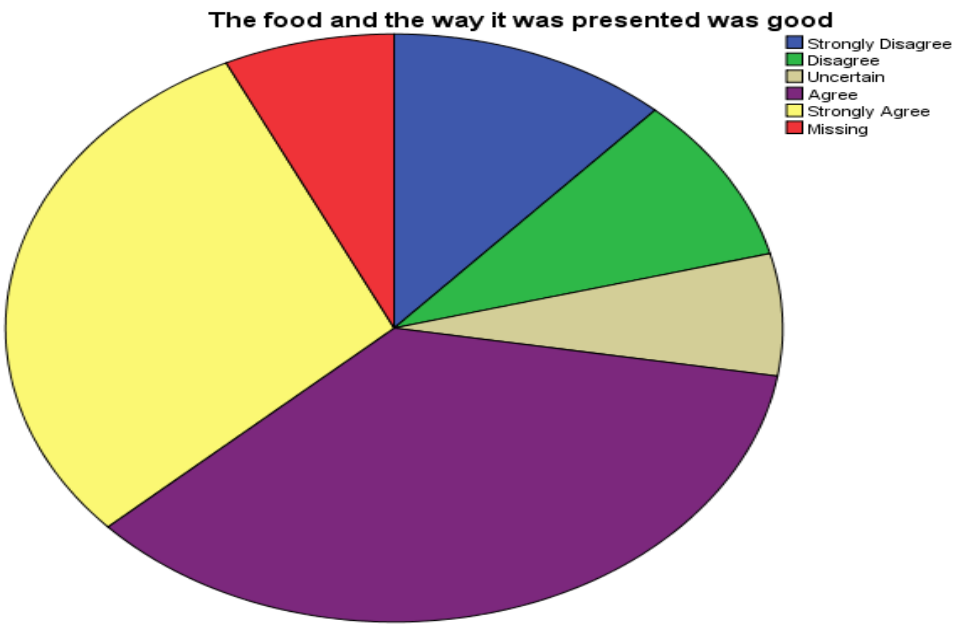


Figure 7.64: The food and the way it was presented was good

Table 7.64: The food the way it was presented was good

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	28	11.7	12.6	12.6
	Disagree	22	9.2	9.9	22.5
	Uncertain	16	6.7	7.2	29.7
	Agree	85	35.6	38.3	68.0
	Strongly Agree	71	29.7	32.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Muller *et al*. (2006:534) indicate that the quality of services is measured by the degree of excellence or extent to which an organization meets its clients' needs and exceeds their expectations.

In the context of this study, this refers to the health care rendered in a public hospital in line with official government and hospital policies. The above table and figure show that 35.6% of the respondents agreed, and 29.7% strongly agreed that the food and the way it was presented to the patients were good. In contrast, 11.7% of the respondents strongly disagreed and 9.2% disagreed. This means that nearly 20% of the respondents were not happy with the quality of the food and the way it was presented. Hospital management, together with the health authorities needs to address the quality of food in these hospitals.

Table 7.65: Eating utensils e.g spoons were provided with your meals

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	29	12.1	13.1	13.1
	Disagree	29	12.1	13.1	26.1
	Uncertain	17	7.1	7.7	33.8
	Agree	78	32.6	35.1	68.9
	Strongly Agree	69	28.9	31.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The table reveals that 28.9% of the respondents strongly agreed and 32.6% agreed with this statement, while 12.1% strongly disagreed and disagreed respectively. It should be of serious concern to the authorities at these hospitals that nearly a quarter of the respondents indicated that they ate their meals without utensils.

Table 7.66: Do you agree that the visiting hours are convenient to the community?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	33	13.8	14.9	14.9
	Disagree	34	14.2	15.3	30.2
	Uncertain	15	6.3	6.8	36.9
	Agree	81	33.9	36.5	73.4
	Strongly Agree	59	24.7	26.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

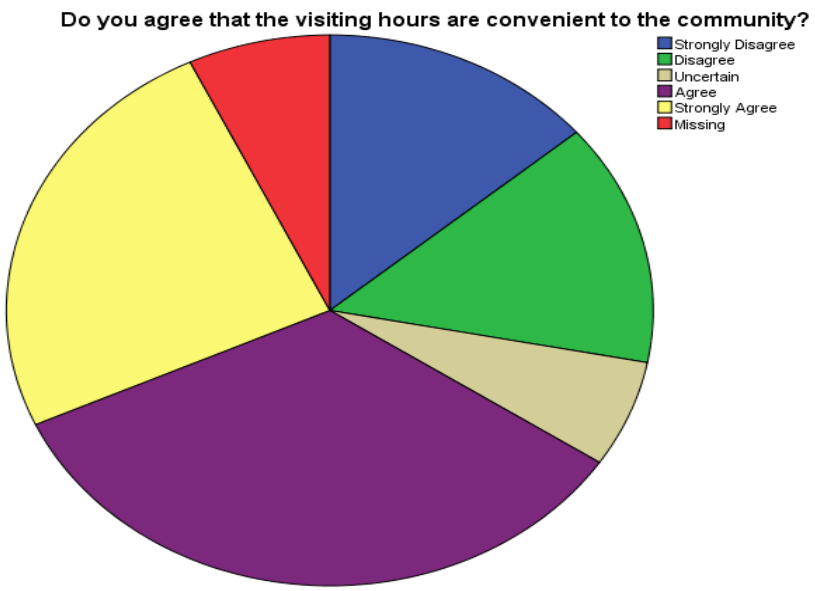


Figure 7.65:Do you agree that the visiting hours are convenient to the community?

33.9% of the respondents agreed and 24.7% strongly agreed that the visiting hours are convenient for the community, while 14.2% disagreed and 13.8% strongly disagreed. This

means that approximately 28% of the respondents would like the visiting hours to be adjusted. Hospital management should look into this issue to make sure that patients and other members of the public are satisfied with this service.

Table 7.67: During your stay at the hospital you were offered pyjamas/nighties daily

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	31	13.0	14.0	14.0
	Disagree	28	11.7	12.6	26.6
	Uncertain	42	17.6	18.9	45.5
	Agree	74	31.0	33.3	78.8
	Strongly Agree	47	19.7	21.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The majority of the respondents were offered pyjamas/nighties daily during their stay at the hospital, (31% agreed with this statement and 19.7% strongly agreed). It is not clear if the 18.9% who were uncertain understood the question or if they had their own pyjamas/nighties. 13% and 11.7%, respectively, strongly disagreed and disagreed that they were provided with pyjamas/nighties. The assumption would be they had their own night clothes and it is not clear how long they used their own pyjamas/nighties during their stay at the hospital or if this only occurred on the day they were admitted.

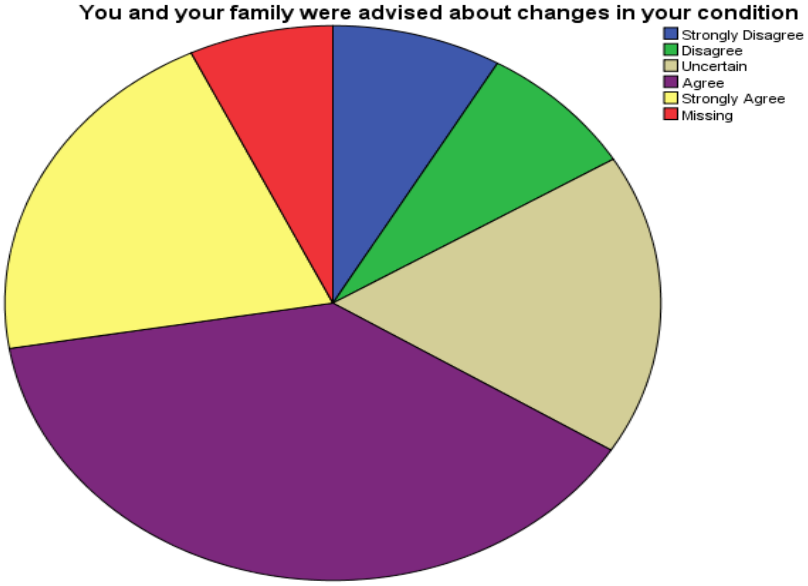


Figure: 7.66: You and your family were advised about changes in your condition

Table 7.68: You and your family were advised about changes in your condition

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	20	8.4	9.0	9.0
	Disagree	19	7.9	8.6	17.6
	Uncertain	42	17.6	18.9	36.5
	Agree	92	38.5	41.4	77.9
	Strongly Agree	49	20.5	22.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

With regard to whether the patient and their family were advised on changes in their condition, the table and the figure above show that 38.5% of the respondents agreed with this statement, and 20.5% strongly agreed.17.6% of the respondents were uncertain; this could be because they were not part of the discussion or they were in too much pain to pay attention when the doctors were talking family members. 8.4% and 7.4% of the respondents respectively strongly disagreed and disagreed with this statement, indicating that they and their family members were not informed about changes in their condition. This area of communication should be one that hospitals focus on because patients themselves and members of their family play a very important role in recovery from illness.

Table 7.69: The hospital staff assisted you in making arrangements for when you were discharged

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	19	7.9	8.6	8.6
	Disagree	16	6.7	7.2	15.8
	Uncertain	43	18.0	19.4	35.1
	Agree	83	34.7	37.4	72.5
	Strongly Agree	61	25.5	27.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The results show that 34.7% and 25.5% of the respondents respectively agreed and strongly agreed with this statement while 7.9% and 6.7% strongly disagreed and agreed respectively and 18% were unsure. This issue should be an area of concern for hospital management.

Table 7.70: At the time of your discharge you felt you had enough knowledge about your illness to take care of yourself at home

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	17	7.1	7.7	7.7
	Disagree	22	9.2	9.9	17.6
	Uncertain	22	9.2	9.9	27.5
	Agree	81	33.9	36.5	64.0
	Strongly Agree	80	33.5	36.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The survey indicated that 33.5% of the respondents strongly agreed and 33.9% agreed that at the time of their discharge they felt that they had enough knowledge about their illness to take care of themselves at home.

Only 9.2% were uncertain, with another 9.2% disagreeing and 7.1% totally disagreeing with this statement. Combining the negative responses, almost 30% of the respondents felt that they did not know enough about their illness to take care of themselves at home.

Berry &Parasuraman (1991:57) and Dyck (1996:541-549) observe that consumers' experience of service quality may be assessed by comparing what they want, need or expert from service providers with their perception of what they have received and whether or not they are satisfied.

Table 7.71:I would return to this hospital for treatment

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	12	5.0	5.4	5.4
	Disagree	20	8.4	9.0	14.4
	Uncertain	29	12.1	13.1	27.5
	Agree	81	33.9	36.5	64.0
	Strongly Agree	80	33.5	36.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The above table shows that at the time the research was conducted, 33.5% of the respondents strongly agreed and 33.9% agreed that they would be happy to return to the hospital for treatment; this could mean that the quality of service delivery is improving in provincial hospitals. However, 12.1% of the respondents were uncertain if they would return; combined with the 8.4% who disagreed with this statement and the 5% who strongly disagreed, this means that just over a quarter (25%) of the respondents would not choose to return to the hospital for treatment. This indicates that there is room for improvement in provincial hospitals.

Table : 7.72: I was treated in a polite, courteous & friendly manner by all health professionals

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	53	22.2	23.9	23.9
	Disagree	49	20.5	22.1	45.9
	Uncertain	40	16.7	18.0	64.0
	Agree	39	16.3	17.6	81.5
	Strongly Agree	41	17.2	18.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Politeness and courtesy are displayed in many ways and manifest themselves in lay terms as good manners. In response to this statement, almost 43% (22.2% and 20.5) of the respondents responded negatively, with fewer respondents (16.3% and 17.2%) agreeing than disagreeing. This means that the majority of the respondents are unhappy with the attitude of staff members.

The White Paper on Transforming Public Service delivery, was published in 1997. It requires departments to improve their service delivery in order to *ensure higher levels of courtesy.*

Citizens should be treated with courtesy and consideration. This is a basic and easily achievable principle, yet it is very important to public service customers. Departments should undertake regular customer satisfaction surveys as part of an integrated monitoring and evaluation strategy. Such surveys should place strong emphasis on courtesy (Public Service Commission, 2000).

Table 7.73: How long did you wait for your outpatient card?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	64	26.8	28.8	28.8
	15-30 minutes	53	22.2	23.9	52.7
	30-45 minutes	44	18.4	19.8	72.5
	45mins -1hr	35	14.6	15.8	88.3
	1hr and more	26	10.9	11.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The above table indicates that 26.8% of the respondents waited for 0-15 minutes for their outpatient card, while 22.2% waited 15-30 minutes, 18.4% waited 30-45 minutes,14.6% waited between 45 minutes and an hour and 10.6% waited more than an hour.

The waiting period in hospitals has always been a challenge; however these results indicate an improvement, as more respondents than any other category waited for up to only 15 minutes for their outpatient card. While the fact that only 10.6% waited for more than an hour also reflects improvements, it is this section that the hospitals should focus on in order to provide efficient and quick service.

Table 7.74: How long did you wait to be treated by a nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	52	21.8	23.4	23.4
	15-30 minutes	42	17.6	18.9	42.3
	30-45 minutes	42	17.6	18.9	61.3
	45mins -1hr	36	15.1	16.2	77.5
	1hr and more	50	20.9	22.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7:67: How long did you wait to be treated by a nurse?

The above table shows that 21.8% of the respondents waited to see a nurse for less than 15 minutes, while 20.9% waited for more than an hour. This could be caused by a number of factors; for example, when there was a shortage of staff, or when the shifts changed, the waiting time was increased. 17.6% of the respondents indicated that they waited for 15-30 and 30-45 minutes to see a nurse respectively and 15.1% reported waiting between 45

minutes and an hour. These long waiting periods underscore allegations that provincial hospitals are no tproviding health care in line with the South African Constitution and the Patients' Rights Charter (Jager, 2004).

Table 7.75: How long did you wait to be treated by a doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	37	15.5	16.7	16.7
	15-30 minutes	39	16.3	17.6	34.2
	30-45 minutes	55	23.0	24.8	59.0
	45mins -1hr	46	19.2	20.7	79.7
	1hr and more	45	18.8	20.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

In many cases hospital, doctors work shifts and travel between different hospitals. The demand for healthcare services and the shortage of doctors at public hospitals play a role in the time that patients wait to see a doctor. The table above shows that 15.5% of the respondents indicated that it took at least less than 15 minutes to see a doctor, while 16.3% said that they waited 15-30 minutes; 23.0% waited 30-45 minutes and 19.2% waited between 45 minutes and an hour and 18.8% waited an hour or more. Long waiting times are cause for serious concern, as many poor people depend on the public healthcare system. Ngwenya and Friedman (1995: Online) emphasize the need for public participation in the NHS. They suggested that disadvantaged communities (the focus of the RDP) are "very eager to become actively involved in their own health care", and they lament the death of institutionalized enabling mechanisms. In contrast, Verba, Nie, & Kim (1978) observe that participation is a function of socio-economic status (SES;i.e., the higher one's economic status, the higher the likelihood of participation in order to influence issues that might affect one). They, too, draw attention to the need for increased citizen participation in matters of government and

administration. Based on these arguments, it is important that communities participate and be enabled to do so, in the development of the NHS, and that their real, rather than imagined, needs are investigated, discovered, and taken into account *(cf.* Patients' Rights Charter, sec. 2) The current research study to some degree attempts to enable such participation.

Table 7.76: How long did you wait for medication in the pharmacy department?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	41	17.2	18.5	18.5
	15-30 minutes	47	19.7	21.2	39.6
	30-45 minutes	63	26.4	28.4	68.0
	45mins -1hr	40	16.7	18.0	86.0
	1hr and more	31	13.0	14.0	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Pharmacy departments in public hospitals are often crowded, with many patients sitting on the benches waiting their turn to collect their medication. This process is frustrating for those who are in pain and suffering from ill-health. The study revealed that 17.2% of the respondents waited for less than 15 minutes to collect their medication at the pharmacy department, while 19.2% waited for 15-30 minutes, 26.4% waited for 30-45 minutes, 16.7% waited between 45 minutes and an hour, and 30% waited for an hour or more.

Table 7.77: How long was the waiting time to get a folder?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	38	15.9	17.1	17.1
	15-30 minutes	37	15.5	16.7	33.8
	30-45 minutes	53	22.2	23.9	57.7
	45mins -1hr	42	17.6	18.9	76.6
	1hr and more	52	21.8	23.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure: 7.68: How long was the waiting time to get a folder?

15.9% of the respondents reported that they up to 15 minute to receive their files, while 15.5% waited 15-30 minutes, 22.2% (the majority) waited between 30 and 45 minutes.21.8% of the respondents waited for their file for more than an hour, and 17.6% waited between 45 minutes and an hour.

Table 7.78: How long was the waiting time in the outpatient department?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	47	19.7	21.2	21.2
	15-30 minutes	41	17.2	18.5	39.6
	30-45 minutes	40	16.7	18.0	57.7
	45mins -1hr	35	14.6	15.8	73.4
	1hr and more	59	24.7	26.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Improving service delivery is a major factor in the quality of health care. The above table reveals that 24.7% of respondents waited for more than hour in the outpatient department to be attended to. 19.7% waited up to 15 minutes, 17.2% waited 15-30 minutes 16.7% waited 30-45 minutes and 14.6% of the respondents waited between 45 minutes and an hour. Hospital management needs to establish whether or not prolonged waiting periods are due to staff shortages or other factors. The study of the effects of patient-centred care on patient and employee outcomes draws on a growing body of literature on the organization of work in healthcare.

Table 7.79: How long did you wait for a doctor to discharge you on the last day at hospital?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	0 -15 minutes	149	62.3	67.1	67.1
	15-30 minutes	55	23.0	24.8	91.9
	30-45 minutes	14	5.9	6.3	98.2
	45mins -1hr	1	.4	.5	98.6
	1hr and more	3	1.3	1.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

As indicated in this literature review chapter that some researchers have examined the relationship between a variety of work arrangements and patient care indicators. For example, they have studied the relationship between human resources management (HRM) practices, teamwork and relational coordination, and quality of patient care (e.g., see Gittell*et al*., 2010; Gittel*et al*., 2008; West *et al*. 2006; Preuss 2003; *West et al*., 2002; Borrill*et al*., 2000; Aiken *et al*., 1994). West *et al*. (2002:1305) provided one of the first comprehensive analyses of the link between work practice and healthcare-related performance outcomes.

The table below and the above figure show that the majority of the respondents (62.3%) indicated that the doctor took less than 15minutes to discharge them, a very positive result indeed. Another 23% stated that there were discharged in less than 30 minutes, while a very small portion (5.9%) were discharged after 30-45 minutes and 4% indicated that this was done after 45 minutes to an hour and 1% waited more than an hour to be discharged.

The table below and the above figure show that the majority of the respondents (62.3%) indicated that the doctor took less than 15minutes to discharge them, a very positive result indeed. Another 23% stated that there were discharged in less than 30 minutes, while a very small portion (5.9%) were discharged after 30-45 minutes and 4% indicated that this was done after 45 minutes to an hour and 1% waited more than an hour to be discharged.

Table 7.80: Not having to wait too long to receive doctor's assistance

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	153	64.0	68.9	68.9
	Important	63	26.4	28.4	97.3
	Not important	6	2.5	2.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

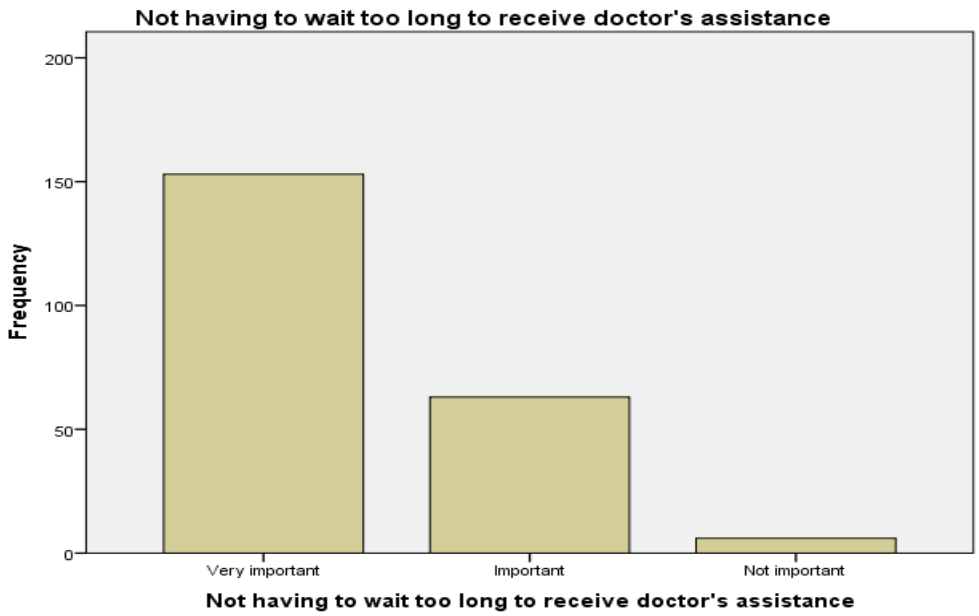


Figure: 7.69: Not having to wait too long to receive doctor's assistance

Ill and in pain, patients should not have to wait too long to see a doctor. This is borne out by the fact that 64% of the respondents indicated that it is very important not to have wait too long for a doctor's assistance and 24% said that it was important. Only 2.5% felt this was not important. The hospital management must focus on improving this service.

Table 7.81: Not having to wait too long to receive nurse's assistance

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	135	56.5	61.1	61.1
	Important	75	31.4	33.9	95.0
	Not important	11	4.6	5.0	100.0
	Total	221	92.5	100.0	
Missing	System	18	7.5		
Total		239	100.0		

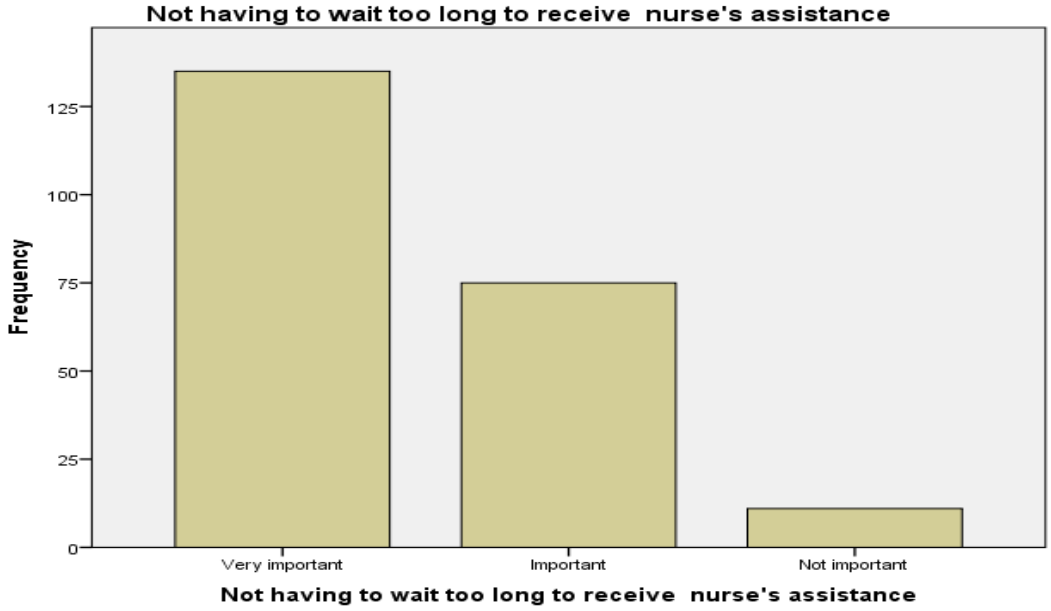


Figure 7.70: Not having to wait too long to receive nurse's assistance

The majority of the respondents (88% = 56.5% + 31.4%) indicated that it is important for patients not to wait too long to receive assistance from a nurse, and only 4.6% felt it was not important. This underscores for hospital management how important it is not to keep patients waiting too long until they receive assistance from a nurse.

Table 7.82: Not waiting too long for my surgical procedure

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	131	54.8	59.0	59.0
	Important	77	32.2	34.7	93.7
	Not important	14	5.9	6.3	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

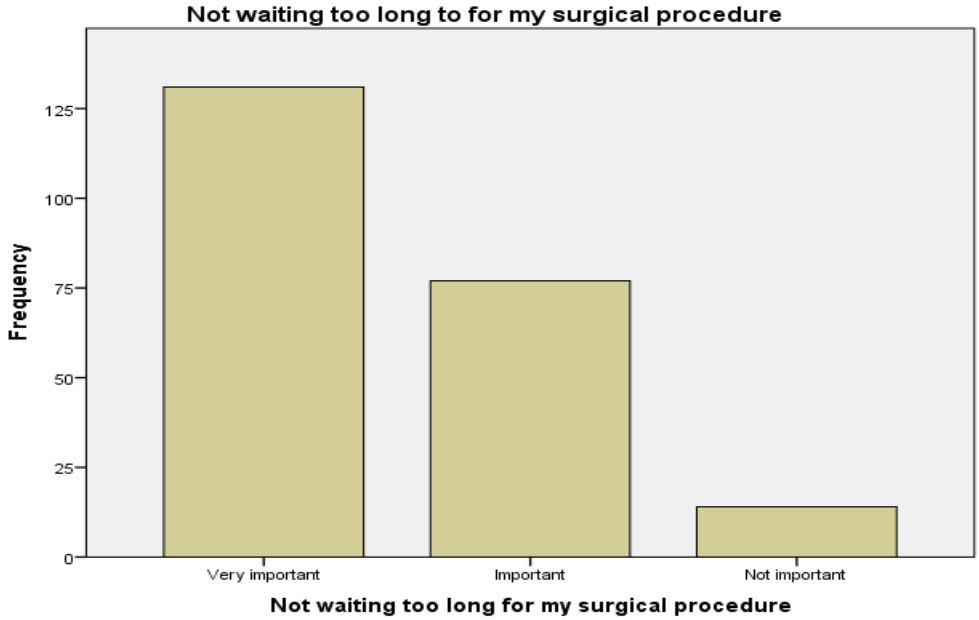


Figure 7.71: Not waiting too long for my surgical procedure

The study revealed that 54.8 % of the respondents felt it was very important and 32.2% felt it was important that they not wait too long for their surgical procedure. Only 5.9% of the respondents did not feel this was important. Hospitals need to ensure that surgical procedures are provided as quickly as possible.

Table 7.83: Not having to wait too long for my medication

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	115	48.1	51.8	51.8
	Important	84	35.1	37.8	89.6
	Not important	23	9.6	10.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

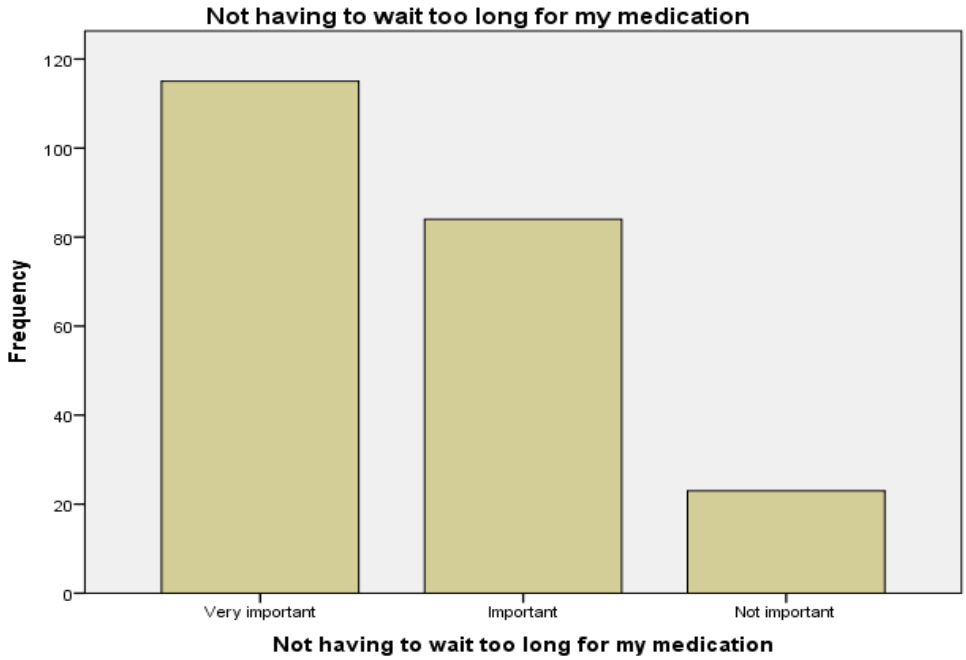


Figure 7.72: Not having to wait too long for my medication

When patients are in pain or have been discharged they would not want to wait for medication. This is confirmed by the fact that 48.1% of the respondents felt it was very important and 35.1% said it was important that they not wait too long for their medication. Only 9.6% of the respondents were of the opinion that this was not important. This also indicates an area of improvement that hospital management should consider.

Table 7.84: Adequate information about my anaesthesia and surgery

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	120	50.2	54.1	54.1
	Important	84	35.1	37.8	91.9
	Not important	18	7.5	8.1	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

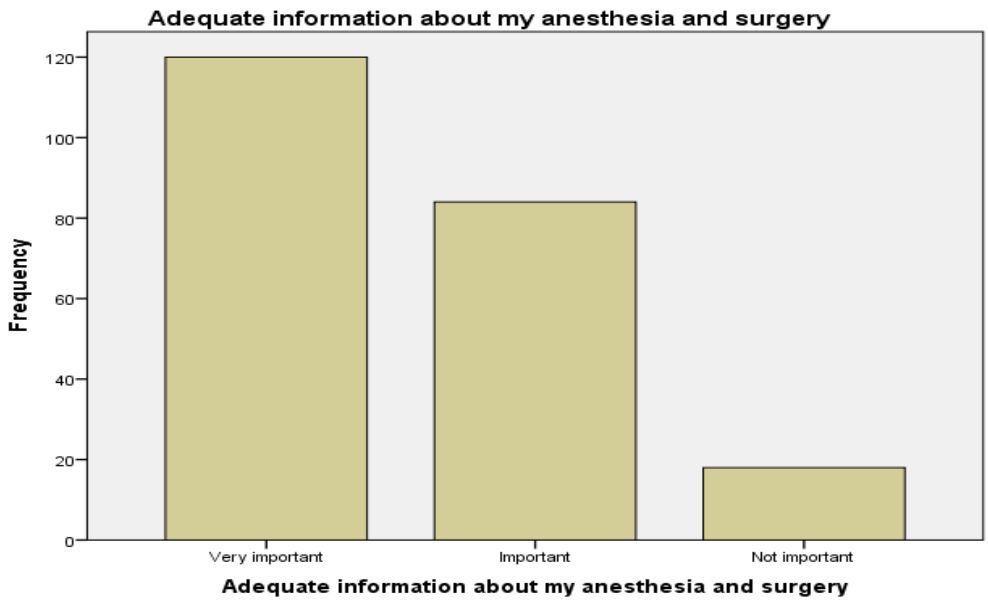


Figure 7.73: Adequate information about my anaesthesia and surgery

Patients will always want to know more about their illness. A total of 85% (50.2% + 35.1%) of the respondents felt that it was important their they be provided with adequate information about their anaesthesia and surgery, which means the hospital management will have to make sure this information is provided to patients and their families. Only 7.5% of the respondents indicated that this information was not important. The literature notes that PCC is founded on the notion that information should be shared between physicians and patients and, more importantly, that decision making is based on patient involvement so that viable treatment or

medication options take into account patient preferences and perspectives (Davis *et al*., 2005; Corrigan *et al*., 2001).

Table 7.85: Adequate friendliness and courtesy

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Very important	135	56.5	60.8	60.8
	Important	65	27.2	29.3	90.1
	Not important	22	9.2	9.9	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The above table show how the patients view the services regarding the friendliness and courtesy received by the patients while being admitted to the hospitals.

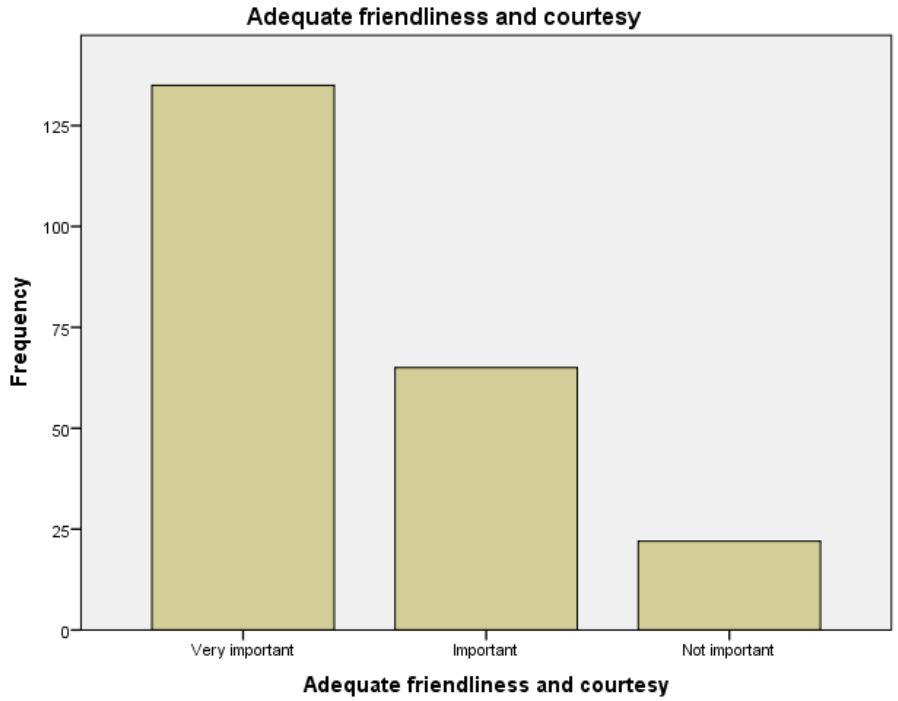


Figure 7.74, (pg. 337): Adequate friendliness and courtesy

Adequate friendliness and courtesy is very important according to more than 80% of the respondents (56.5% + 27.2%). A small fraction of 9.2% felt this was not important. The literature indicates that patients should be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding, as well as with consideration and respect and that discourtesy should not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioural norms to junior health care workers (South Africa, 1997:19). Courtesy is underwritten by the Bill of Rights and the PRC.

Table 7.86: Friendliness and courtesy shown to you by nurse

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	72	30.1	32.4	32.4
	Very good	64	26.8	28.8	61.3
	Good	61	25.5	27.5	88.7
	Fair	15	6.3	6.8	95.5
	Poor	10	4.2	4.5	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

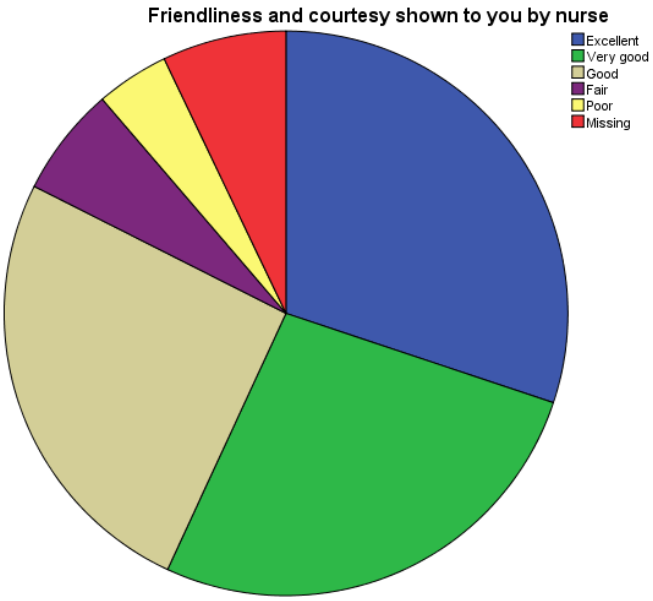


Figure 7.75:Friendliness and courtesy shown to you by nurse

Overall, respondents reported good levels of friendliness and courtesy on the part of nurses; 30.1% said the friendliness and courtesy shown by the nurses were excellent, (26.2%) stated that it was very good, 25.5% rated it good, 6.3% felt it was fair and only 4.2% indicated that friendliness and courtesy were poor. Hill and McCrory (1997:231) suggest that if a consumer

believes any service attribute to be important he/she would expect the quality of that attribute to be high, and hence will rate that attribute highly.

Table 7.87: Friendliness and courtesy shown to you by other staff

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	74	31.0	33.3	33.3
	Very good	69	28.9	31.1	64.4
	Good	58	24.3	26.1	90.5
	Fair	13	5.4	5.9	96.4
	Poor	8	3.3	3.6	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

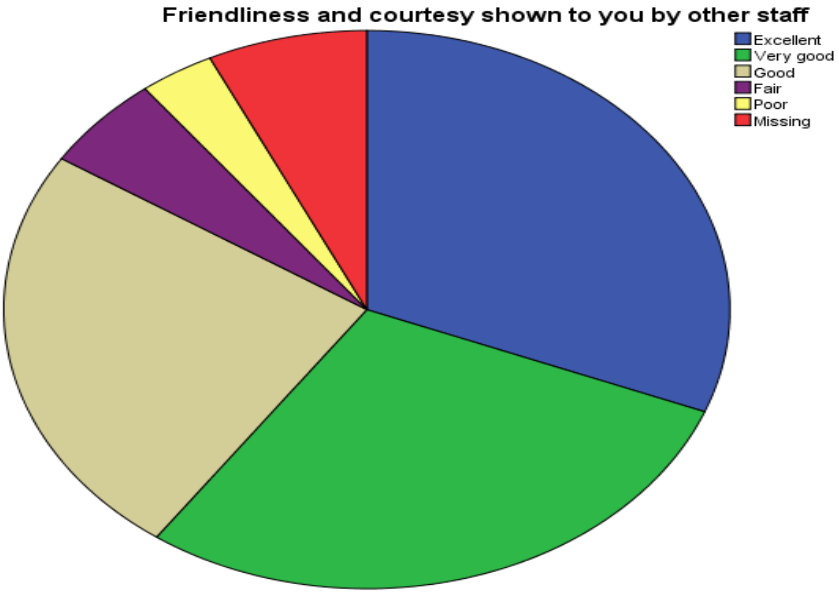


Figure 7:76: Friendliness and courtesy shown to you by other staff

Again, the respondents rated the levels of friendliness and courtesy of other staff well; 31% indicated that the levels were excellent, 28.9% stated that they were good, 24.3% said that

they were good, while 5.4% of the respondents rated the levels of friendliness and courtesy as fair and only 3.3% said they were poor. Hospital management should aim to achieve a 100% positive response to this question.

Table 7.88: The thoroughness of care you received from your doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	59	24.7	26.6	26.6
	Very good	61	25.5	27.5	54.1
	Good	62	25.9	27.9	82.0
	Fair	24	10.0	10.8	92.8
	Poor	16	6.7	7.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7:77 (pg. 341): The thoroughness of care you received from your doctor

Doctors play a critical role in delivering an excellent service in hospitals. Combining the three positive responses (excellent, 24.7%; very good, 25.5% and good, 29.9%) it is clear that the respondents feel that the doctors are doing their work very well. Only 10% of the respondents indicated that the thoroughness of doctors was fair and 6.7% stated that it was poor. The hospitals need to address the perceptions of those patients who felt the doctors' thoroughness was not up to scratch.

Table 7.89: The amount of time spent with your doctor

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	67	28.0	30.2	30.2
	Very good	66	27.6	29.7	59.9
	Good	52	21.8	23.4	83.3
	Fair	25	10.5	11.3	94.6
	Poor	12	5.0	5.4	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

Figure 7.78:The amount of time spent with your doctor

Every patient wants to spend as much time as they can with their doctor. 28% of the respondents rated the amount of time spent with their doctor as excellent, 27.6% said it was very good and 21.8% felt it was good. Only10.5% of the respondents stated that the amount of time spent with their doctor was fair and 5% indicated that it was poor, which means the

patients felt that the doctors did not spend enough time with them. The managers in these three hospitals should focus on the 15% of respondents who were not happy with the amount of time the doctors spent with them in order to improve the situation.

Table 7.90: How well were your questions answered by your doctor?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	61	25.5	27.5	27.5
	Very good	66	27.6	29.7	57.2
	Good	61	25.5	27.5	84.7
	Fair	27	11.3	12.2	96.8
	Poor	7	2.9	3.2	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The results indicate that 25.5% rated their doctors' ability to answer their questions as excellent, 27.6% said they were very good, 25.5% stated they were good, 11.3% felt the doctors' responses were fair and 2.9% felt that their doctors did not respond well to their questions.

Table 7.91: How well were your questions answered by your nurse?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	52	21.8	23.4	23.4
	Very good	52	21.8	23.4	46.8
	Good	61	25.5	27.5	74.3
	Fair	33	13.8	14.9	89.2
	Poor	24	10.0	10.8	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

The combined results (21.8% excellent, 21.8% very good and 25.5% good) show that most respondents were satisfied with the way nurses answered their questions, whilst 13.8% felt the responses were fair and 10% indicated their unhappiness with the inability of nurses to answer questions. The hospitals should aim to achieve a 100% positive response.

Table 7.92: The overall service and care you received

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Excellent	69	28.9	28.9	28.9
	Very good	170	71.1	71.1	100.0
	Total	239	100.0	100.0	

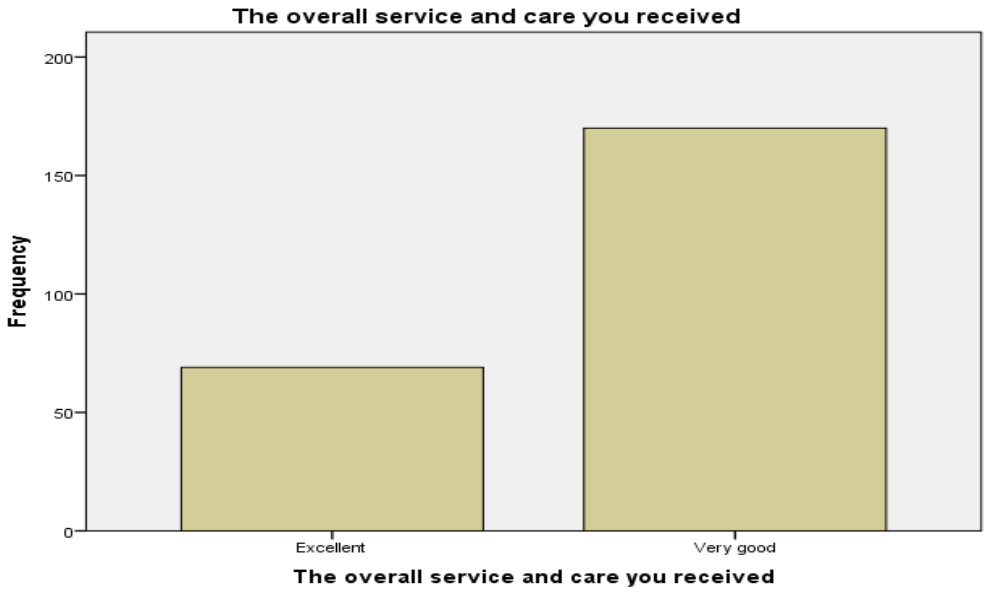


Figure 7.79: The overall service and care you received

Consumers look for value for money. The National Department of Health White Paper of 1997 states that services should be cost effective and delivery should be made within departmental resource allocations. Procedures should be simplified and waste and inefficiency must be eliminated (South Africa, 1997:22). The respondents indicated that the overall services and care they received were excellent (71.1%) or very good (28.9%). PCC literature has identified five dimensions of the delivery care model: 1. Access to care; 2. Patient engagement in care or patient preferences; 3. Patient education of information systems; 4. Coordination of care across hospital staff; and 5. Patient emotional support (Audet*et al*., 2006; Bergeson and Dean 2006; Davis *et al*., 2004; Fiach*et al*., 2004; for similar dimensions, see Corrigan *et al*., 2001:49).

Table 7.93:Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes Often	109	45.6	49.1	49.1
	Yes sometimes	56	23.4	25.2	74.3
	No	57	23.8	25.7	100.0
	Total	222	92.9	100.0	
Missing	System	17	7.1		
Total		239	100.0		

When the responses are combined almost 70% of the respondents (45.6% + 23.4%) stated that in most cases/sometimes hospital staff members will say one thing and another will say something quite different. This creates confusion and a communication breakdown between the patient and hospital staff. Only 23.8% of the respondents reported that this was not their experience.

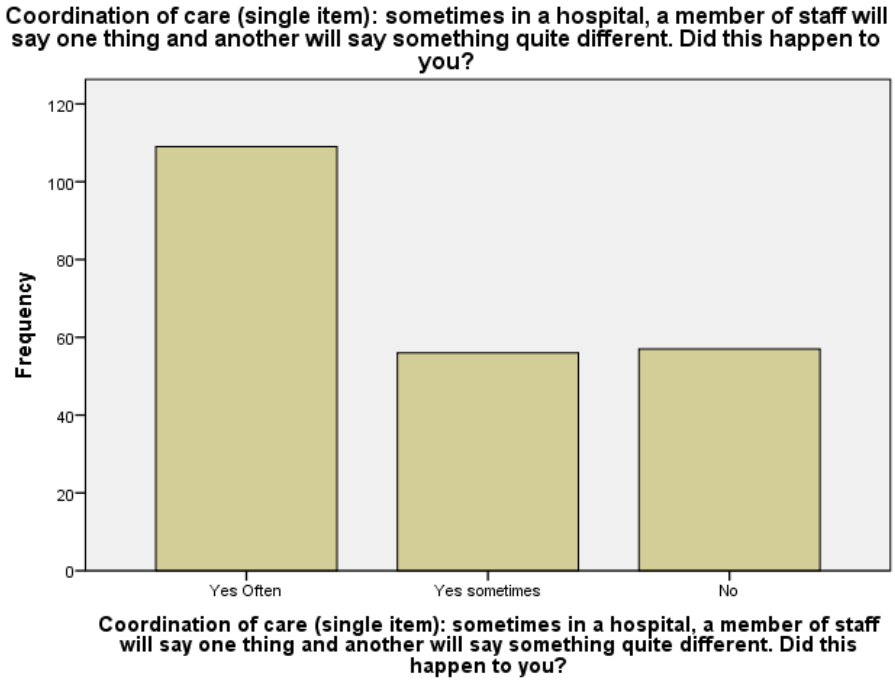


Figure 7.80: Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

Zeithaml and Bitner (1996) and Devlin and Dong (1994) are in agreement that organizations have to pay attention to the expectations of clients as well as their perceptions of the organization's and its employees' (i.e., service providers) character traits such as reliability, willingness to help, product knowledge, courtesy, client centeredness, communication and the accessibility of services. Band (1991) and Donabedian (1988) consider the above elements representative of a clear definition of service quality. This is in keeping with the Batho Pele White Paperand the goals of the Patients' Rights Charter; hence they inform the premises of the current study.

STAFF RESPONSES

Table 7.94: To what extent do you agree with the following: I often think about leaving my current employer?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	79	33.1	33.1	33.1
	Disagree	88	36.8	36.8	69.9
	Uncertain	72	30.1	30.1	100.0
	Total	239	100.0	100.0	

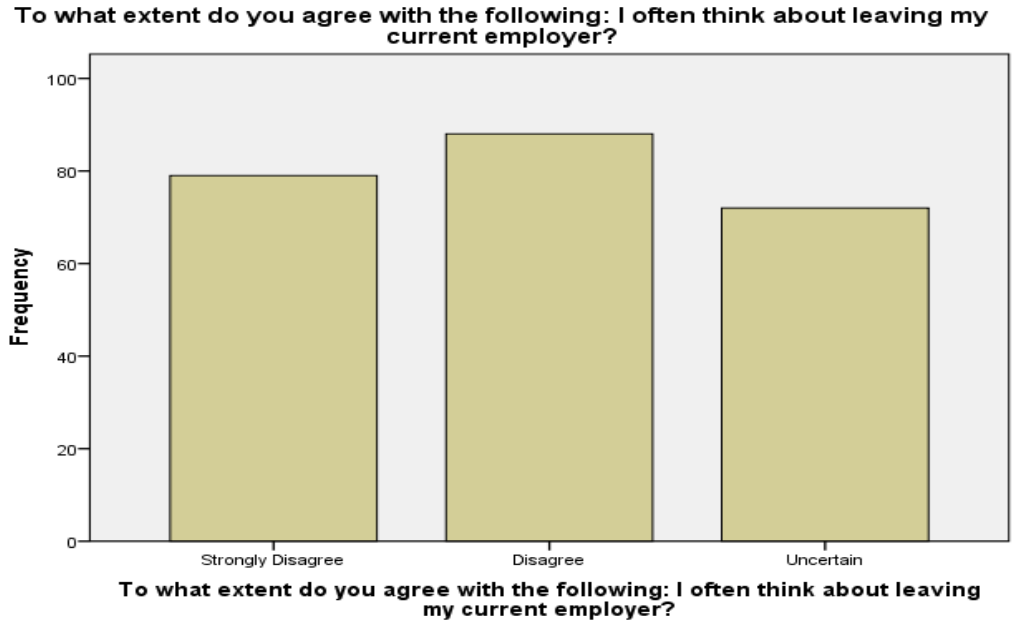


Figure 7.81: To what extent do you agree with the following: I often think about leaving my current employer?

Changing jobs is normal as individuals always look for better pay and opportunities for personal growth. 69% of the respondents who were hospital staff members indicated that they did not often think about leaving their current employer, and 31% were uncertain. The high level of uncertainty suggests the need for the DoH to examine the issues underlying it in order to ensure that it does not lose staff, as this would adversely affect the provision of effective healthcare services.

Table 7.95: I will probably look for a new job in the next year

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	38	15.9	15.9	15.9
	Disagree	66	27.6	27.6	43.5
	Uncertain	37	15.5	15.5	59.0
	Agree	66	27.6	27.6	86.6
	Strongly Agree	32	13.4	13.4	100.0
	Total	239	100.0	100.0	

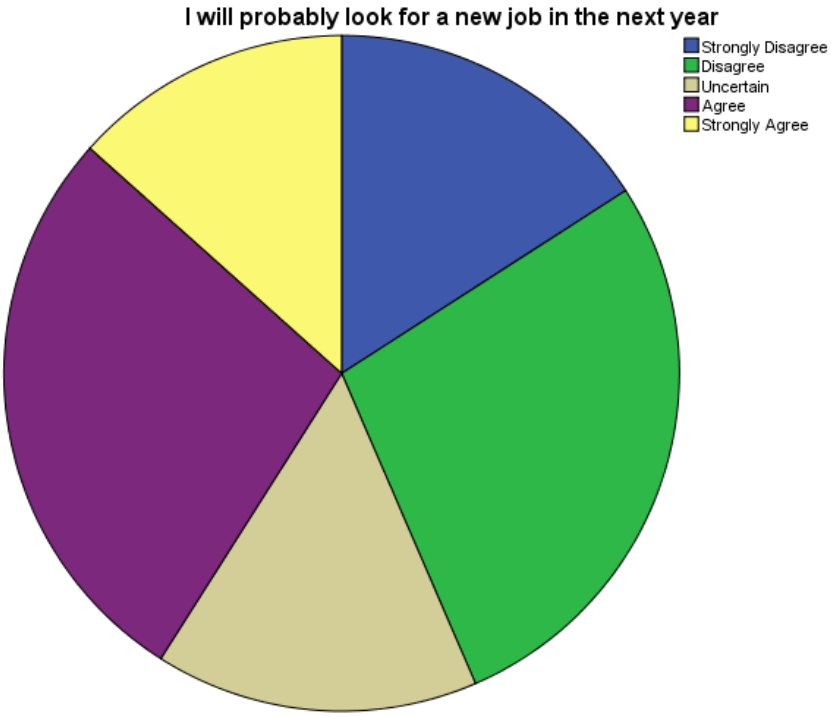


Figure 7.82: I will probably look for a new job in the next year

The table and graph indicate that 27.6% of the respondents disagreed and 15.9% strongly disagreed that they would be looking for new jobs in the following year, while 15.6% were uncertain, and 27.6% agreed and 13.4% strongly agreed that they would be looking for other opportunities and which means they are not happy working at these hospitals. The DoH

should focus on the negative responses in order to understand why so many employees are not happy in their current jobs.

Table 7.96: As soon as I can find another job, I will leave my current employer

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	41	17.2	17.2	17.2
	Disagree	81	33.9	33.9	51.0
	Uncertain	27	11.3	11.3	62.3
	Agree	49	20.5	20.5	82.8
	Strongly Agree	41	17.2	17.2	100.0
	Total	239	100.0	100.0	

Figure 7.83: As soon as I can find another job, I will leave my current employer

Just less than 40% (20.5% and 17.2%) of the doctors and nurses who participated in the study indicated that as soon as an opportunity presented itself they would leave the hospital. On the positive side, more than 50% (33.9% and 17.2%) of the respondents indicated that they were not thinking of leaving and 11.3% were uncertain.

The literature indicates that a motivated, loyal, committed, dedicated, knowledgeable, skilled and trained workforce that is able to adapt positively to an ever-changing environment is critical

to the delivery of effective public health care. The United Nations Committee of Experts on Public Administration (2002:3) stated that building public sector human capacity in terms of knowledge, skills, motivation and commitment, networks and mastery of information technology is fundamental to the effective and efficient translation of the values, objectives and goals of a government.

The South African government has reaffirmed its commitment to help its employees develop effectively, adapt to the ever-changing environment and execute their functions efficiently. The four principles it resolved to undertake include commitment, planning, action and evaluation.

Table 7.97: I am involved in deciding on the changes introduced that affect my work area/team/department

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	33	13.8	13.8	13.8
	Disagree	70	29.3	29.3	43.1
	Uncertain	18	7.5	7.5	50.6
	Agree	73	30.5	30.5	81.2
	Strongly Agree	45	18.8	18.8	100.0
	Total	239	100.0	100.0	

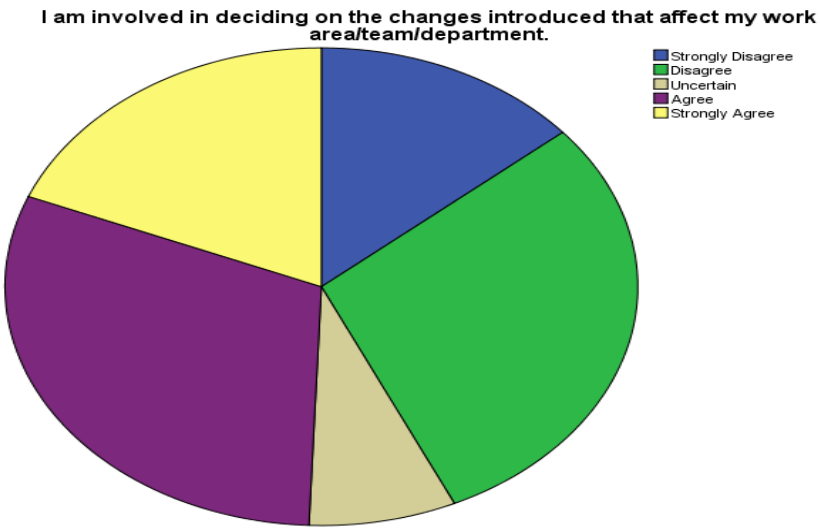


Figure 7.84: I am involved in deciding on the changes introduced that affect my work area/team/department

Almost half (30.5% + 18.5%) of the respondents felt that they are involved in deciding on changes introduced that might affect their work area/ team/ department. Approximately 44% (29.3% + 13.8%) felt that they were not consulted and not party to such changes; only 7.5% were uncertain. Constantino-David (2004:10) observes that certain factors hamper effective service delivery, including the fact that human resources tend to be the largest cost factor within government; public employees are sometimes not viewed as assets and as such are not consulted on changes in their working environment, leading to demoralization, ineffectiveness, lack of commitment and apathy; the public themselves view government as incompetent and highly corrupt.

Table 7.98: I am consulted about the changes that affect my work area/team/department

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	41	17.2	17.2	17.2
	Disagree	90	37.7	37.7	54.8
	Uncertain	31	13.0	13.0	67.8
	Agree	67	28.0	28.0	95.8
	Strongly Agree	10	4.2	4.2	100.0
	Total	239	100.0	100.0	

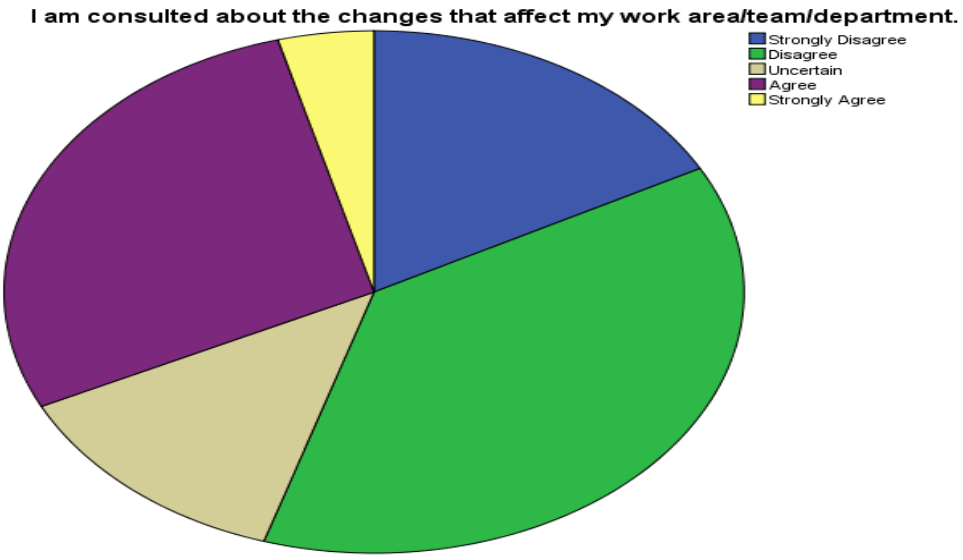


Figure 7.85: I am consulted about the changes that affect my work area/team/department

This survey revealed negative perceptions about the level of consultation, with more than 50% (37.2% + 17.2%) of the respondents stating that they were not consulted regarding changes in their working environment, and just above 32% (28% + 4.2%) saying that they were; 13% of the respondents were uncertain. The literature shows that performance and productivity can be improved when organizations become learning institutions.Boonstra (2004:104) outlines the requirements for becoming a learning and training organization in the

form of *Ten Commandments* and suggest that managers and leaders consider these commandments as prerequisites for developing effective learning organizations. These are:

- Welcome new ideas-especially from below.
- Insist that people need approval from only one level.
- Praise when praise is due and only criticize constructively.
- Encourage open debate ending in consensus on suggestions.
- Treat problems as opportunities.
- Use trust, not supervision as the main instrument of control.
- Operate a freedom of information policy.
- Institute change after consultation with those affected.
- Take, announce and implement unpleasant decisions in person.
- Share knowledge with others and share theirs.

Table 7.99: Managers/supervisor asks for my opinion before making decisions that affect my work

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	50	20.9	20.9	20.9
	Disagree	70	29.3	29.3	50.2
	Uncertain	24	10.0	10.0	60.3
	Agree	82	34.3	34.3	94.6
	Strongly Agree	13	5.4	5.4	100.0
	Total	239	100.0	100.0	

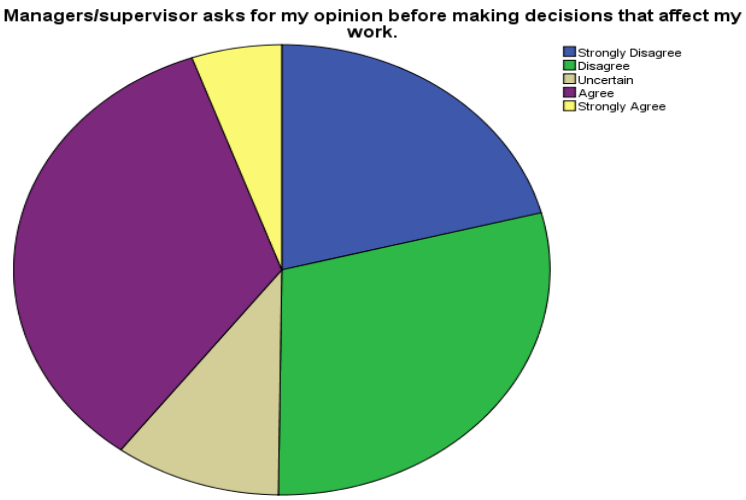


Figure 7.86: Managers/supervisor asks for my opinion before making decisions that affect my work

More than 50% of the respondents strongly disagreed that manager and supervisors asked for their opinions before making or taking decisions that affect their work, while about 39% said they were consulted, and 10% were uncertain. In interpreting these results it is quite clear that there is a lack of consultation between the management and the hospital doctors and nurses. This also indicates a lack of organizational development. Harri-Augstein, *et al*. (1995:2) defines organizational development as a "... complex educational strategy intended to change the beliefs, attributes, values, and structure of organizations so that they can better adapt to new technologies, markets and challenges in changing environments''. It is a planned and calculated attempt to move the organization as a unit to a behavioural, open and organic model. To develop a learning organization, human resources managers and leaders need to make decisions on the basis of competence rather than authority. In addition, they must develop a communication system to encourage mutual openness and candour in facing organizational challenges.

Table 7.100: Managers here try to involve staff in important decisions

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	67	28.0	28.0	28.0
	Disagree	60	25.1	25.1	53.1
	Uncertain	36	15.1	15.1	68.2
	Agree	61	25.5	25.5	93.7
	Strongly Agree	15	6.3	6.3	100.0
	Total	239	100.0	100.0	

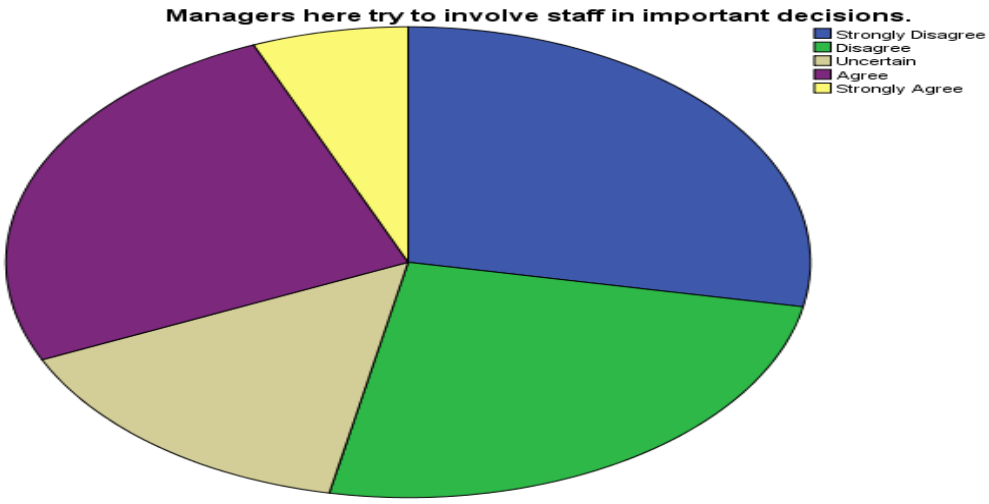


Figure 7.87: Managers here try to involve staff in important decisions

Almost (53%) of the respondents indicated that managers did not involve staff in important decision, which will obviously impact on their performance and working environment. Only approximately 31% of the respondents stated that managers involved them in important decisions and 10% were uncertain. This indicates a very week internal communication strategy.

The literature confirms the importance of employer and employees' ability to work as a team to achieve effective service delivery; according to Pinchot and Pinchot (1993), institutions are

changing as the relationship between employee and employer alters in deep and permanent ways in response to the need for all to contribute their intelligence, creativity, and responsibility to society.

It is now expected that employees in boththe public and private sectors should be innovative, care for customers, work in teams and collaborate with others as well as take own initiative rather than just following orders. The situation in the public service is, however, complex and fraught with anomalies - while member of the public are, on the one hand, the public sector's customers, on the other hand, as tax payers, they are the employers of all public agencies.

Table 7.101: Managers encourage staff to suggest new ideas for improving services

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	53	22.2	22.2	22.2
	Disagree	59	24.7	24.7	46.9
	Uncertain	32	13.4	13.4	60.3
	Agree	77	32.2	32.2	92.5
	Strongly Agree	18	7.5	7.5	100.0
	Total	239	100.0	100.0	

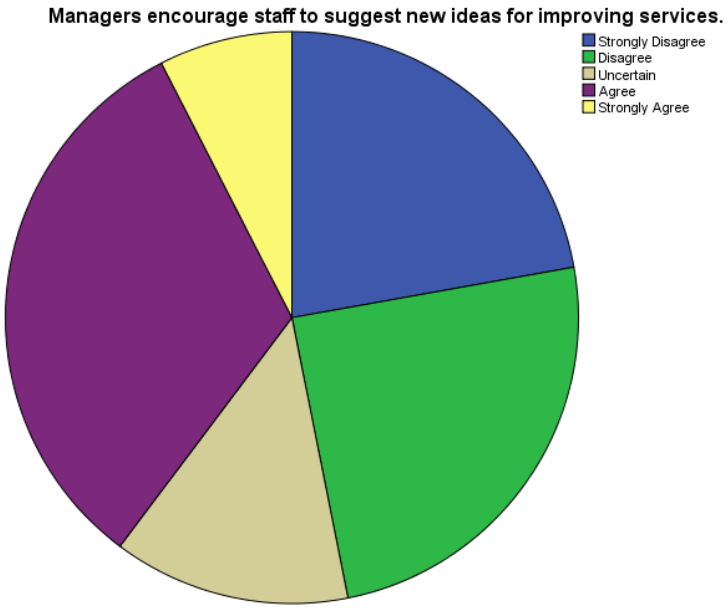


Figure 7.88: Managers encourage staff to suggest new ideas for improving services

Again the responses to this question reveal a very weak relationship between management and stuff. Almost 50% of the staff who participated in the study (22.2% strongly disagree and 29.3% disagree) indicated that managers does not encourage staff members to suggest new ideas for improving services, which means that some staff members feel that their ideas are being ignored. Just below 40% (32.2% + 7.5%) indicated that they have been encouraged by management to suggest new ideas for improving services, while 7.5% were uncertain.

In an address to the African Management Development Institute Network Conference, the former Minister for Public Service and Administration in South Africa, Ms Geraldine Fraser-Moleketi, (2007) underscored the importance of knowledge management in the African civil service of the 21st century. Fraser-Moleketi asserted:

> The 21st Century African public service has to be a learning organization, a learning organization in which people at all levels, individually and collectively, are continually increasing their capacity to produce the result they really care about, where the organization encourages new ways of thinking, where the collective vision of creating the best is liberated, and where everybody continuously learns how to work together. If the African civil service is to lead Africa to attain its commitments to the Millennium Development Goals, new ways of doing business and continuously solving problems is essential (Fraser-Moleketi, 2007).

Table 7.102: Communication between managers & staff is effective

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	50	20.9	20.9	20.9
	Disagree	60	25.1	25.1	46.0
	Uncertain	32	13.4	13.4	59.4
	Agree	80	33.5	33.5	92.9
	Strongly Agree	17	7.1	7.1	100.0
	Total	239	100.0	100.0	

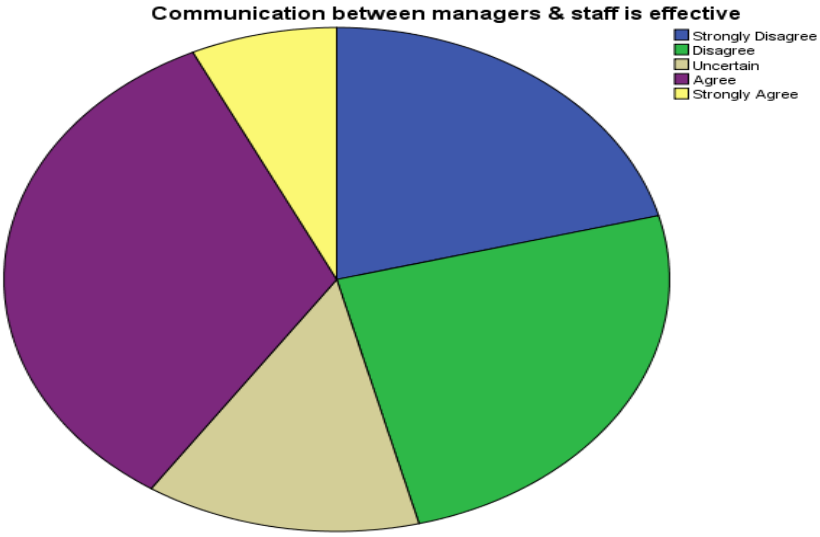


Figure 7.89:Communication between managers & staff is effective

Effective communication between staff members and the management will always make a working environment a desirable place to be. Almost 50% of the respondents (20.9% + 25.1%) disagreed that the communication between staff and management was effective. However, just less than 40% (33.5% + 7.1%) felt that managers did communicate with staff effectively. The literature indicates that, in order to improve communication and co-ordination among key role-players, political office bearers, municipal officials, community organizations and residents should liaise more freely with one another in order to learn more

from one another and to strengthen their coordinated attempts to bring about more effective, efficient and economical local public service delivery. This can only be realized through more effective communication by means of newsletters, brochures, open days/launches and effective assistance from the mass media by focusing on important issues identified by citizens and promoting grassroots democracy and popular participation in development (*City Press*, 2005/11/27:On-line).

Table 7.103: On the whole, the different parts of the organization communicate effectively with each other

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Strongly Disagree	43	18.0	18.0	18.0
	Disagree	63	26.4	26.4	44.4
	Uncertain	41	17.2	17.2	61.5
	Agree	77	32.2	32.2	93.7
	Strongly Agree	15	6.3	6.3	100.0
	Total	239	100.0	100.0	

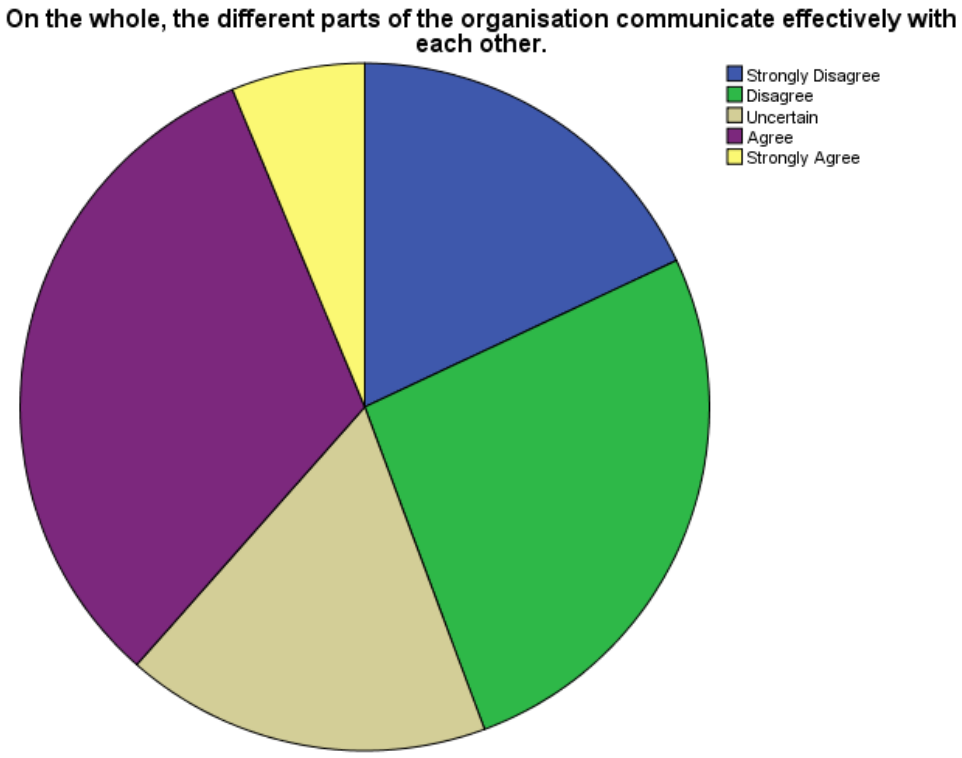


Figure 7.90:On the whole, the different parts of the organization communicate effectively with each other

The respondents reacted negatively to the DoH communication strategy. 18% totally disagreed and 26.4% disagreed that the organization's internal communications are effective, while 32.2% agreed and only 6.3% strongly agreed that they are. Communication seems to be a challenge at all three hospitals.

CORRELATIONS

Correlations

		Age in years	Principal language spoken at home
Age in years	Pearson Correlation	1	.374**
	Sig. (2-tailed)		.000
	N	222	222
Principal language spoken at home	Pearson Correlation	.374**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between age in years and principal language spoken is 0.374. This coefficient shows that there is a strong and positive relationship between age in years and principal language spoken. The probability (p) of this correlation coefficient which is 0.000 is less than 0.05, thus implying that there is statistically significant relationship (r=-0.374, p>0.05). In addition, age is significantly and positively correlated with the language spoken by the majority of patients at these hospitals as the majority is Zulu-speaking and young and middle-aged.

Correlations

		Were there visible security personnel at the hospital gates & inside the hospital?	Were signs to the OPD clear?
Were there visible security personnel at the hospital gates & inside the hospital?	Pearson Correlation	1	.801**
	Sig. (2-tailed)		.000
	N	239	239
Were signs to the OPD clear?	Pearson Correlation	.801**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between visible security personnel at the hospital gates and inside the hospital is clear, and signs to the OPD were clear 0.801. This coefficient shows that there is a

high strength and positive relationship between visible security personnel at the hospital gates and inside the hospital and clear signs to the OPD. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.801, p>0.05). The correlation between the visibility of security personnel and clear signs to the OPD shows that security personnel play a role not only in protecting patients, but also in directing them to the right places for care inside the hospitals.

Correlations

		Were signs to the wards clear?	Was it easy to find the disabled parking bay/wheel chair ramp?
Were signs to the wards clear?	Pearson Correlation	1	.585**
	Sig. (2-tailed)		.000
	N	239	239
Was it easy to find the disabled parking bay/wheel chair ramp?	Pearson Correlation	.585**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The above table shows correlation between clear signage in wards and the disabled parking bay/ wheel chair ramp. There is a clear indication that the correlation exists which is further discussed below in terms of statistical differences.

The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship between clear signs to the wards and the ease of finding the disabled parking bay/wheel chair ramp (r=-0.585, p>0.05). This strong correlation may raise concerns of same instrument bias; however, we believe that this may not be a serious problem. According to Avgar, Givan and Liu (2011), PCC and patient satisfaction are two theoretically distinguishable constructs.

Correlations

		Were you treated in a polite, courteous & friendly manner by all health professionals?	Would you return to this hospital for treatment?
Were you treated in a polite, courteous & friendly manner by all health professionals?	Pearson Correlation	1	.000
	Sig. (2-tailed)		.994
	N	222	222
Would you return to this hospital for treatment?	Pearson Correlation	.000	1
	Sig. (2-tailed)	.994	
	N	222	222

The correlation (r) between "were you treated in a polite, courteous and friendly manner by all health professionals?" and "would you return to this hospital for treatment?" is 0.000. This coefficient shows that there is a weak but positive relationship between "were you treated in a polite, courteous and friendly manner by all health professionals?" and "would you return to this hospital for treatment?" The probability (p) of this correlation coefficient which is 0.994 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.000, p>0.05). A poor attitude is positively related to poor hospital service delivery and negatively related to patients' rating of care and returning to the hospitals.

Correlations

		How long did you wait to see the doctor after arriving at the hospital?	The overall service and care you received
How long did you wait to see the doctor after arriving at the hospital?	Pearson Correlation	1	-.034
	Sig. (2-tailed)		.616
	N	222	222
The overall service and care you received	Pearson Correlation	-.034	1
	Sig. (2-tailed)	.616	
	N	222	239

The correlation (r) between "how long did you wait to see the doctor after arriving at the hospital?" and the overall service and care received is 0.-034. This coefficient shows that

there is a weak but positive relationship between “how long did you wait to see the doctor after arriving at the hospital?” and the overall service and care received. The probability (p) of this correlation coefficient which is 0.661 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-034, p>0.05).

The negative relationship between time waited to see the doctor after arrival and the overall service and care received may indicate positive hospital care services outcomes; that is, patient and doctor satisfaction may enhance each other.

Correlations

		To what extent do you agree with the following: I often think about leaving my current employer?	I will probably look for a new job in the next year
To what extent do you agree with the following: I often think about leaving my current employer?	Pearson Correlation	1	-.038
	Sig. (2-tailed)		.564
	N	239	239
I will probably look for a new job in the next year	Pearson Correlation	-.038	1
	Sig. (2-tailed)	.564	
	N	239	239

One of the ways in which service delivery in hospitals and PCC have an indirect effect on the quality of care are their emphasis on employee working conditions (e.g., Rathert and May 2007; Rathert*et al.*, 2009).The correlation (r) between “to what extent do you agree with the following: I often think about leaving my current employer?” and “I will probably look for a new job in the next year” is 0.-038. This coefficient shows that there is a weak but positive relationship between “to what extent do you agree with the following: I often think about leaving my current employer?” and “I will probably look for a new job in the next year”. The probability (p) of this correlation coefficient which is 0.564 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-038 p>0.05). The negative correlation could be a serious indication that staff members are not happy with the treatment they are receiving at the work place, especially from management and as a result would seek other opportunities.

Correlations

		I am involved in deciding on the changes introduced that affect my work area/team/department.	I am consulted about the changes that affect my work area/team/department.
I am involved in deciding on the changes introduced that affect my work area/team/department.	Pearson Correlation	1	-.169**
	Sig. (2-tailed)		.009
	N	239	239
I am consulted about the changes that affect my work area/team/department.	Pearson Correlation	-.169**	1
	Sig. (2-tailed)	.009	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “I am involved in deciding on the changes introduced that affect my work area/team/department” and “I am consulted about the changes that affect my work area/team/departments” is 0.-169. This coefficient shows that there is anegative relationship between “I am involved in deciding on the changes introduced that affect my work area/team/department” and consultation with staff about the changes that affect their work area/team/department. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.-169, p>0.05). The negative relationship between the above two items i.e the involvement of staff in decision making and changes that may affect their working environment have a negative relationship simply because most of the employees were not consulted before changes were made in their department. This resulted in a breakdown of trust between the employer and employees in these hospitals which will eventually also impact negatively on the health care provided by these hospitals.

Correlations

		Did the following staff who attended to you wear a badge: Security personnel?	Did the following staff who attended to you wear a badge: Clerk?
Did the following staff who attended to you wear a badge: Security personnel?	Pearson Correlation	1	.495**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended you to wear a badge: Clerk?	Pearson Correlation	.495**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "did the following staff who attended to you wear a badge: Security personnel?" and "did the following staff who attended to you wear a badge: Clerk?" is 0.495. This coefficient shows that there is a positive relationship between "did the following staff who attended to you wear a badge: Security personnel?" and "did the following staff who attended to you wear a badge: Clerk?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.495, p>0.05). As is evident that badges play a role in accountability, when security personnel and clerks wear badges, they are easy to identify when a patient needs help. A positive correlation was thus expected.

Correlations

		Did the following staff who attended to you wear a badge: Nurse?	Did the following staff who attended to you wear abadge:Doctor?
Did the following staff who attended to you wear a badge: Nurse?	Pearson Correlation	1	.563**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended to you wear abadge:Doctor?	Pearson Correlation	.563**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the following staff who attended to you wear a badge: Nurse?” and “did the following staff who attended to you wear abadge:Doctor?” is 0.563. This coefficient shows that there is a positive relationship between “did the following staff who attended to you wear a badge: Nurse?” and “did the following staff who attended to you wear abadge:Doctor?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.563, p>0.05). This positive correlation indicates the importance of staff wearing badges so that patients are able to identify each and every staff member.

Correlations

		Did the following staff who attended to you wear a badge: Pharmacy personnel?	Did the following staff who attended to you wear a badge: Other?
Did the following staff who attended to you wear a badge: Pharmacy personnel?	Pearson Correlation	1	.372**
	Sig. (2-tailed)		.000
	N	239	239
Did the following staff who attended to you wear a badge: Other?	Pearson Correlation	.372**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the following who staff attended to you wear a badge: Pharmacy personnel?” and “did the following staff who attended to you wear a badge: Other?” is 0.372. This coefficient shows that there is a high strength and positive relationship between “did the following staff who attended to you wear a badge: Pharmacy personnel?” and “did the following staff who attended to you wear a badge: Other?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.372, p>0.05).

Correlations

		Were you able to communicate with staff in your language?	Where necessary were the services of an interpreter arranged?
Were you able to communicate with staff in your language?	Pearson Correlation	1	.526**
	Sig. (2-tailed)		.000
	N	239	239
Where necessary were the services of an interpreter arranged?	Pearson Correlation	.526**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The literature on *Batho Pele* notes that it is important that patients be enabled to communicate in a language they understand. The correlation (r) between "were you able to communicate with staff in your language?" and "where necessary were the services of an interpreter arranged?" is 0.526. This coefficient shows that there is a positive relationship between "were you able to communicate with staff in your language?" and "where necessary were the services of an interpreter arranged?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.526, p>0.05). The positive correlation shows that patients were addressed in the language they understand in order that they could better understand the nature of their illness.

Correlations

		During your treatment were the procedures explained to you?	Were your questions and queries dealt with satisfactorily?
During your treatment were the procedures explained to you?	Pearson Correlation	1	.464**
	Sig. (2-tailed)		.000
	N	239	239
Were your questions and queries dealt with satisfactorily?	Pearson Correlation	.464**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "during your treatment were the procedures explained to you?" and "were your questions and queries dealt with satisfactorily?" is 0.464. This coefficient shows that there is a positive relationship between "during your treatment were the procedures explained to you?" and "were your questions and queries dealt with satisfactorily?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.464, p>0.05). The overarching goal of health service delivery is to provide the care that is most conducive to a patient's preferences, needs and desires (Robinson *et al.,* 2008; Wolf *et al*.,2008; Davis *et al*., 2005). The positive correlation shows the satisfactory manner in which treatment procedures were explained to the patients.

Correlations

		Were you treated politely by the following staff members" Security personnel?	Were you treated politely by the following staff members: Clerk?
Were you treated politely by the following staff members: Security personnel?	Pearson Correlation	1	.547**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Clerk?	Pearson Correlation	.547**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

As pointed out in the literature review, the evidence supports the assertion that a caring attitude on the part of health personnel improves the quality of the services delivered (Stewart *et al*., 2000; Rathert and May 2007; see also Wolf *et al*., 2008). The correlation (r) between "were you treated politely by the following staff members: Security personnel?" and "were you treated politely by the following staff members: Clerk?" is 0.547. This coefficient shows that there is a positive relationship between "were you treated politely by the following staff members: Security personnel?" and "were you treated politely by the following staff members: Clerk?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.547, p>0.05).

Correlations

		Were you treated politely by the following staff members: Nurse?	Were you treated politely by the following staff members: Doctor?
Were you treated politely by the following staff members: Nurse?	Pearson Correlation	1	.491**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Doctor?	Pearson Correlation	.491**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The Institute of Medicine maintains that the new model of patient care necessitates a particular work design aimed at increasing coordination and opportunities for patient and stuff input (Corrigan *et al.*,2001).The correlation (r) between "were you treated politely by the following staff members: Nurse?" and "were you treated politely by the following staff members: Doctor?" is 0.491. This coefficient shows that there is a positive relationship between "were you treated politely by the following staff members: Nurse?" and "were you treated politely by the following staff members: Doctor?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.491, p>0.05).

Correlations

		Were you treated politely by the following staff members: Pharmacy personnel?	Were you treated politely by the following staff members: Other?
Were you treated politely by the following staff members: Pharmacy personnel?	Pearson Correlation	1	.321**
	Sig. (2-tailed)		.000
	N	239	239
Were you treated politely by the following staff members: Other?	Pearson Correlation	.321**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were you treated politely by the following staff members: Pharmacy personnel?” and “were you treated politely by the following staff members: Other?” is 0.321. This coefficient shows that there is a positive relationship between “were you treated politely by the following staff members: Pharmacy personnel?” and “were you treated politely by the following staff members: Other?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.321, p>0.05).

Correlations

		The nurse explained the findings before I saw the doctor	The doctor asked for permission before the examination
The nurse explained the findings before I saw the doctor	Pearson Correlation	1	.588**
	Sig. (2-tailed)		.000
	N	239	239
The doctor asked for permission before the examination	Pearson Correlation	.588**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the nurse explained the findings before I saw the doctor” and“the doctor asked for permission before the examination” is 0.588. This coefficient shows that there is a positive relationship between “the nurse explained the findings before I saw the doctor” and “the doctor asked for permission before the examination”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.588, p>0.05).

Correlations

		Doctor explained my condition to me	Advice was given on how to improve my health status
Doctor explained my condition to me	Pearson Correlation	1	.417**
	Sig. (2-tailed)		.000
	N	239	239
Advice was given on how to improve my health status	Pearson Correlation	.417**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the doctor explained my condition to me” and “advice was given on how to improve my health status” is 0.417. This coefficient shows that there is a positive relationship between “the doctor explained my condition to me” and “advice was given on how to improve my health status”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.417, p>0.05).

Correlations

		Were you treated in a respectful manner?	Advice was given on how to improve my health status
Were you treated in a respectful manner?	Pearson Correlation	1	.398**
	Sig. (2-tailed)		.000
	N	239	239
Advice was given on how to improve my health status	Pearson Correlation	.398**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were you treated in a respectful manner?” and “advice was given on how to improve my health status” is 0.398. This coefficient shows that there is a positive relationship between “were you treated in a respectful manner?” and “advice was given on how to improve my health status”. The probability (p) of this correlation coefficient

which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.398, p>0.05).

Correlations

		The outpatient department was clean	The Pharmacy department was clean
The outpatient department was clean	Pearson Correlation	1	.440**
	Sig. (2-tailed)		.000
	N	239	239
The Pharmacy department was clean	Pearson Correlation	.440**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “the outpatient department was clean” and “the Pharmacy department was clean” is 0.440. This coefficient shows that there is a positive relationship between “the outpatient department was clean” and “the Pharmacy department was clean”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.440, p>0.05).

Correlations

		The toilets were clean	There was toilet paper in the toilet
The toilets were clean	Pearson Correlation	1	.526**
	Sig. (2-tailed)		.000
	N	239	239
There was toilet paper in the toilet	Pearson Correlation	.526**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlations (r) between “the toilets were clean” and “there was toilet paper in the toilet”, is 0.526. This coefficient shows that there is a positive relationship between “the toilets were clean” and “there was toilet paper in the toilet”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.526, p>0.05).

Correlations

		There was soap to wash hands in the toilet	There were paper towels/air dryer to dry hands in the toilet
There was soap to wash hands in the toilet	Pearson Correlation	1	.360**
	Sig. (2-tailed)		.000
	N	239	239
There were paper towels/air dryer to dry hands in the toilet	Pearson Correlation	.360**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “there was soap to wash hands in the toilet” and “there were paper towels/air dryer to dry hands in the toilet” is 0.360. This coefficient shows that there is a positive relationship between “there was soap to wash hands in the toilet” and “there were paper towels/air dryer to dry hands in the toilet”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.360, p>0.05).

Correlations

		Did the staff wash/spray their hands before & after examining you?	Were you happy with the overall cleanliness of the hospital?
Did the staff wash/spray their hands before & after examining you?	Pearson Correlation	1	.349**
	Sig. (2-tailed)		.000
	N	239	239
Were you happy with the overall cleanliness of the hospital?	Pearson Correlation	.349**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did the staff wash/spray their hands before and after examining you?” and “were you happy with the overall cleanliness of the hospital?” is 0.349. This coefficient shows that there is a positive relationship between “did the staff wash/spray their hands before and after examining you?” and “were you happy with the overall cleanliness of

the hospital?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.349, p>0.05).

Correlations

		Were the following areas in the hospital clean: Grounds?	Were the following areas in the hospital clean: Corridors?
Were the following areas in the hospital clean: Grounds?	Pearson Correlation	1	.640**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in the hospital clean: Corridors?	Pearson Correlation	.640**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were the following areas in hospital clean: Grounds?" and "were the following areas in the hospital clean: Corridors?" is 0.640. This coefficient shows that there is a positive relationship between "were the following areas in the hospital clean: Grounds?" and "were the following areas in the hospital clean: Corridors?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.640, p>0.05).

Correlations

		Were the following areas in the hospital clean: Buildings?	Were the following areas in the hospital clean: Ablution facilities?
Were the following areas in the hospital clean: Buildings?	Pearson Correlation	1	.602**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in the hospital clean: Ablution facilities?	Pearson Correlation	.602**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "were the following areas in the hospital clean: Buildings?" and

“were the following areas in the hospital clean: Ablution facilities?” is 0.602. This coefficient shows that there is a positive relationship between “were the following areas in the hospital clean: Buildings?” and “were the following areas in the hospital clean: Ablution facilities?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.602, p>0.05).

Correlations

		Were the following areas in the hospital clean: bed linen?	Were the following areas in the hospital clean: Was the ward free of pests?
Were the following areas in the hospital clean: bed linen?	Pearson Correlation	1	.405**
	Sig. (2-tailed)		.000
	N	239	239
Were the following areas in the hospital clean: Was the ward free of pests?	Pearson Correlation	.405**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were the following areas in the hospital clean: bed linen?” and “were the following areas in the hospital clean: Was the ward free of pests?” is 0.405. This coefficient shows that there is a positive relationship between “were the following areas in the hospital clean: bed linen?” and “were the following areas in the hospital clean: Was the ward free of pests?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.405, p>0.05).

Correlations

		Did the hospital staff draw your attention to patients' rights & responsibilities?	Did your consultation with the nurse or doctor take place in a private manner?
Did the hospital staff draw your attention to patients' rights & responsibilities?	Pearson Correlation	1	.477**
	Sig. (2-tailed)		.000
	N	239	239
Did your consultation with the nurse or doctor take place in a private manner?	Pearson Correlation	.477**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "did the hospital staff draw your attention to patients' rights and responsibilities?" and "did your consultation with the nurse or doctor take place in a private manner?" is 0.477. This coefficient shows that there is a positive relationship between "did the hospital staff draw your attention to patients' rights and responsibilities?" and "did your consultation with the nurse or doctor take place in a private manner?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.477, p>0.05).

Correlations

		Was a bench/chair provided for you to sit on while you waited?	Did your consultation with the nurse or doctor take place in a private manner?
Was a bench/chair provided for you to sit on while you waited?	Pearson Correlation	1	.347**
	Sig. (2-tailed)		.000
	N	239	239
Did your consultation with the nurse or doctor take place in a private manner?	Pearson Correlation	.347**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “was a bench/chair provided for you to sit on while you waited?” and “did your consultation with the nurse or doctor take place in a private manner?” is 0.437. This coefficient shows that there is a positive relationship between “was a bench/chair provided for you to sit on while you waited?” and “did your consultation with the nurse or doctor take place in a private manner?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.347, p>0.05).

Correlations

		Did you have a complaint?	If you had a complaint, did you report it?
Did you have a complaint?	Pearson Correlation	1	.564**
	Sig. (2-tailed)		.000
	N	239	239
If you had a complaint, did you report it?	Pearson Correlation	.564**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did you have a complaint?” and “if you had a complaint, did you report it?” is 0.564. This coefficient shows that there is a positive relationship between “did you have a complaint?”and “if you had a complaint, did you report it?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.564, p>0.05).

Correlations

		At night, was the nurse available when you called?	Did you feel safe in the hospital?
At night, was the nurse available when you called?	Pearson Correlation	1	.491**
	Sig. (2-tailed)		.000
	N	239	239
Did you feel safe in the hospital?	Pearson Correlation	.491**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “at night, was the nurse available when you called?” and “did you feel safe in the hospital?” is 0.491. This coefficient shows that there is a positive relationship between “at night, was the nurse available when you called?” and “did you feel safe in the hospital?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.491, p>0.05).

Correlations

		Were you issued with the medication that the doctor prescribed for you?	Instructions regarding medication /follow up were provided.
Were you issued with the medication that the doctor prescribed for you?	Pearson Correlation	1	.637**
	Sig. (2-tailed)		.000
	N	239	239
Instructions regarding medication /follow up were provided.	Pearson Correlation	.637**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “were you issued with the medication that the doctor prescribed for you?” and “instructions regarding medication /follow up were provided” is 0.637. This coefficient shows that there is a positive relationship between “were you issued with the medication that the doctor prescribed for you?” and “instructions regarding medication /follow up were provided”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship(r=-0.637, p>0.05).

Correlations

		Instructions regarding medication /follow up were provided.	Was the instruction communicated in the language you understand?
Instructions regarding medication /follow up were provided.	Pearson Correlation	1	.314**
	Sig. (2-tailed)		.000
	N	239	239
Was the instruction communicated in the language you understand?	Pearson Correlation	.314**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “instructions regarding medication /follow up were provided” and “was the instruction communicated in the language you understand?” is 0.314. This coefficient shows that there is a positive relationship between “instructions regarding medication /follow up were provided” and “was the instruction communicated in the language you understand?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.314, p>0.05).

Correlations

		Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?
Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	Pearson Correlation	1	.584**
	Sig. (2-tailed)		.000
	N	239	239
Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?	Pearson Correlation	.584**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) access to care (single item): “If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?” and patient engagement in care (single item): “Were you involved as much as you wanted to be in decisions about your care and treatment?”is 0.584. This coefficient shows that there is a positive relationship between access to care (single item): “If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?” and patient engagement in care (single item): “Were you involved as much as you wanted to be in decisions about your care and treatment?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.584, p>0.05).

Correlations

		When you had important questions to ask a doctor, did you get answers that you could understand?	When you had important questions to ask a nurse, did you get answers that you could understand?
When you had important questions to ask a doctor, did you get answers that you could understand?	Pearson Correlation	1	.503**
	Sig. (2-tailed)		.000
	N	239	239
When you had important questions to ask a nurse, did you get answers that you could understand?	Pearson Correlation	.503**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “when you had important questions to ask a doctor, did you get answers that you could understand?” and “when you had important questions to ask a nurse, did you get answers that you could understand?” is 0.503. This coefficient shows that there is a positive relationship between “when you had important questions to ask a doctor, did you get answers that you could understand?” and “when you had important questions to ask a nurse, did you get answers that you could understand?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.503, p>0.05).

Correlations

		Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	Did a member of staff tell you about any medication side effects to watch for when you went home?
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	Pearson Correlation	1	.662**
	Sig. (2-tailed)		.000
	N	222	222
Did a member of staff tell you about any medication side effects to watch for when you went home?	Pearson Correlation	.662**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?” and “did a member of staff tell you about any medication side effects to watch for when you went home?” is 0.662. This coefficient shows that there is a positive relationship between “did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?” and “did a member of staff tell you about any medication side effects to watch for when you went home?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.662, p>0.05).

Correlations

		Did a member of staff tell you about any danger signals you should watch for after you went home?	Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?
Did a member of staff tell you about any danger signals you should watch for after you went home?	Pearson Correlation	1	.283**
	Sig. (2-tailed)		.000
	N	222	222
Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?	Pearson Correlation	.283**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “did a member of staff tell you about any danger signals you should watch for after you went home?” and “did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?” is 0.283. This coefficient shows that there is a positive relationship between “did a member of staff tell you about any danger signals you should watch for after you went home?” and “did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.283, p>0.05).

Correlations

		Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?
Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Pearson Correlation	1	.025
	Sig. (2-tailed)		.716
	N	222	222
Emotional support (single item): Did you find someone on the hospital staff to talk to about your worries and fears?	Pearson Correlation	.025	1
	Sig. (2-tailed)	.716	
	N	222	222

The correlation (r) between coordination of care (single item): “sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?” and emotional support (single item): “Did you find someone on the hospital staff to talk to about your worries and fears?” is 0.025. This coefficient shows that there is a positive relationship between coordination of care (single item): “sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?” and emotional support (single item): “Did you find someone on the hospital staff to talk to about your worries and fears?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.025, p>0.05).

Correlations

	The food& the way it was presented to you was good	Eating utensils e.g spoons were provided with your meals

The food & the way it was presented to you was good	Pearson Correlation	1	.436**
	Sig. (2-tailed)		.000
	N	222	222
Eating utensils e.g spoons were provided with your meals	Pearson Correlation	.436**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "the food and the way it was presented to you was good" and "eating utensils e.g spoons were provided with your meals"is 0.436. This coefficient shows that there is a positive relationship between "the food and the way it was presented to you was good" and "eating utensils e.g spoons were provided with your meals". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.436, p>0.05).

Correlations

		Do you agree that the visiting hours are convenient to the community?	During your stay at the hospital, were you offered pyjamas/nighties daily?
Do you agree that the visiting hours are convenient to the community?	Pearson Correlation	1	.513**
	Sig. (2-tailed)		.000
	N	222	222
During your stay at the hospital wereyou offered pyjamas/nighties daily?	Pearson Correlation	.513**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlations (r) between "do you agree that the visiting hours are convenient to the community?" and "during your stay at the hospital were you offered pyjamas/nighties daily?" is 0.513. This coefficient shows that there is a positive relationship between "do you agree that the visiting hours are convenient to the community?" and "during your stay at the hospital were you offered pyjamas/nighties daily?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.513, p>0.05).

Correlations

		You and your family were advised about changes in your condition	The hospital staff assisted you in making arrangements for you when you were discharged
You and your family were advised about changes in your condition	Pearson Correlation	1	.635**
	Sig. (2-tailed)		.000
	N	222	222
The hospital staff assisted you in making arrangements for you when you were discharged	Pearson Correlation	.635**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “you and your family were advised about changes in your condition” and “the hospital staff assisted you in making arrangements for you when you were discharged” is 0.635. This coefficient shows that there is a positive relationship between “you and your family were advised about changes in your condition” and “the hospital staff assisted you in making arrangements for you when you were discharged”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.635, p>0.05).

Correlations

		At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?	Would you return to this hospital for treatment?
At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?	Pearson Correlation	1	.559**
	Sig. (2-tailed)		.000
	N	222	222
Would you return to this hospital for treatment?	Pearson Correlation	.559**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “at the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?” and “would you return to this hospital for treatment?” is 0.559. This coefficient shows that there is a positive relationship between “at the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?” and “would you return to this hospital for treatment?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.559, p>0.05).

Correlations

		Were you treated in a polite, courteous & friendly manner by all health professionals?	Would you return to this hospital for treatment?
Were you treated in a polite, courteous & friendly manner by all health professionals?	Pearson Correlation	1	.000
	Sig. (2-tailed)		.994
	N	222	222
Would you return to this hospital for treatment?	Pearson Correlation	.000	1
	Sig. (2-tailed)	.994	
	N	222	222

The correlation (r) between “were you treated in a polite, courteous and friendly manner by all health professionals?” and “would you return to this hospital for treatment?” is 0.000. This coefficient shows that there is a weak but positive relationship between “were you treated in a polite, courteous and friendly manner by all health professionals?” and “would you return to this hospital for treatment?” The probability (p) of this correlation coefficient which is 0.994 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.000, p>0.05).

Correlations

		How long did you wait for your outpatient card?	How long did you wait to be treated by a nurse?
How long did you wait for your outpatient card?	Pearson Correlation	1	.550**
	Sig. (2-tailed)		.000
	N	222	222
How long did you wait to be treated by a nurse?	Pearson Correlation	.550**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "how long did you wait for your outpatient card?" and "how long did you wait to be treated by a nurse?" is 0.550. This coefficient shows that there is a positive relationship between "how long did you wait for your outpatient card?" and "how long did you wait to be treated by a nurse?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.550, p>0.05).

Correlations

		How long did you wait to be treated a doctor?	How long did you wait for medication in the pharmacy department?
How long did you wait to be treated a doctor?	Pearson Correlation	1	.606**
	Sig. (2-tailed)		.000
	N	222	222
How long did you wait for medication in the pharmacy department?	Pearson Correlation	.606**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between "how long did you wait to be treated a doctor?" and "how long did you wait for medication in the pharmacy department?" is 0.606. This coefficient shows that there is a positive relationship between "how long did you wait to be treated a doctor?" and "how long did you wait for medication in the pharmacy department?" The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.606, p>0.05).

Correlations

		How long was the waiting time to get a folder?	How long was the waiting time in the outpatient department?
How long was the waiting time to get a folder?	Pearson Correlation	1	.471**
	Sig. (2-tailed)		.000
	N	222	222
How long was the waiting time in the outpatient department?	Pearson Correlation	.471**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the waiting time to get a folderand the waiting time in the outpatient department is 0.471. This coefficient shows that there is a positive relationship between the waiting time to get a folder and the waiting time in the outpatient department. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.471, p>0.05).

Correlations

		How long did you wait for a doctor to discharge you on the last day at hospital?	Not having to wait too long to receive doctor assistance
How long did you wait for a doctor to discharge you on the last day at hospital?	Pearson Correlation	1	.364**
	Sig. (2-tailed)		.000
	N	222	222
Not having to wait too long to receive doctor assistance	Pearson Correlation	.364**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between waiting time for a doctor to discharge you on the last day at hospital and not having to wait too long to receive doctor assistance is 0.364. This coefficient shows that there is a positive relationship between waiting time for a doctor to discharge you on the last day at hospital and not having to wait too long to receive doctor assistance. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.364, p>0.05).

Correlations

		Not having to wait too long to receive doctor assistance	Not having to wait too long to receive nurse assistance
Not having to wait too long to receive doctor assistance	Pearson Correlation	1	.497**
	Sig. (2-tailed)		.000
	N	222	222
Not having to wait too long to receive nurse assistance	Pearson Correlation	.497**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between not having to wait too long to receive doctor assistance and not having to wait too long to receive nurse assistance is 0.497. This coefficient shows that there is a positive relationship between not having to wait too long to receive doctor assistance and not having to wait too long to receive nurse assistance. The probability (p) of this correlation

coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.497, p>0.05).

Correlations

		Not wait too long for my surgical procedure	Notwait too long for my medication
Not wait too long for my surgical procedure	Pearson Correlation	1	.532**
	Sig. (2-tailed)		.000
	N	222	222
Not wait too long for my medication	Pearson Correlation	.532**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between not wait too long for my surgical procedure and not wait too long for my medication is 0.532. This coefficient shows that there is a positive relationship between not wait too long for my surgical procedure and not wait too long for my medication. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.532, p>0.05).

Correlations

		Not wait too long for my medication	Not wait too long here during my visit
Not wait too long for my medication	Pearson Correlation	1	.460**
	Sig. (2-tailed)		.000
	N	222	222
Not wait too long here during my visit	Pearson Correlation	.460**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between not wait too long for my medication and not wait too long here during my visitis 0.460. This coefficient shows that there is a positive relationship between not wait too long for my medication and not wait too long here during my visit. The

probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.460, p>0.05).

Correlations

		Adequate information about my anaesthesia and surgery	Adequate friendliness and courtesy
Adequate information about my anaesthesia and surgery	Pearson Correlation	1	.541**
	Sig. (2-tailed)		.000
	N	222	222
Adequate friendliness and courtesy	Pearson Correlation	.541**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between adequate information about my anaesthesia and surgery and adequate friendliness and courtesy is 0.541. This coefficient shows that there is a positive relationship between adequate information about my anaesthesia and surgery and adequate friendliness and courtesy. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.541, p>0.05).

Correlations

		A comfortable hospital to be in	Convenient appointment time at hospital
A comfortable hospital to be in	Pearson Correlation	1	.611**
	Sig. (2-tailed)		.000
	N	222	222
Convenient appointment time at hospital	Pearson Correlation	.611**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between a comfortable hospital to be in and convenient appointment time

at hospital is 0.611. This coefficient shows that there is a positive relationship between a comfortable hospital to be in and convenient appointment time at hospital. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.611, p>0.05).

Correlations

		Convenient appointment time at hospital	Convenient hospital location
Convenient appointment time at hospital	Pearson Correlation	1	.647**
	Sig. (2-tailed)		.000
	N	222	222
Convenient hospital location	Pearson Correlation	.647**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between convenient appointment time at hospital and convenient hospital location is 0.647. This coefficient shows that there is a medium strength and positive relationship between convenient appointment time at hospital and convenient hospital location. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.647, p>0.05).

Correlations

		Appearance of hospital waiting area	Hours when hospital is open
Appearance of hospital waiting area	Pearson Correlation	1	.529**
	Sig. (2-tailed)		.000
	N	222	222
Hours when hospital is open	Pearson Correlation	.529**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between appearance of hospital waiting area and hours when the hospital is open is 0.529. This coefficient shows that there is a positive relationship between appearance of hospital waiting area and hours when the hospital is open. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.529, p>0.05).

Correlations

		Friendliness and courtesy shown to you by nurse	Friendliness and courtesy shown to you by doctors
Friendliness and courtesy shown to you by nurses	Pearson Correlation	1	.818**
	Sig. (2-tailed)		.000
	N	222	222
Friendliness and courtesy shown to you by doctors	Pearson Correlation	.818**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by doctors is 0.818. This coefficient shows that there is a positive relationship between friendliness and courtesy shown to you by nurses and friendliness and courtesy shown to you by doctors. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.818, p>0.05).

Correlations

		Friendliness and courtesy shown to you by nurse	Friendliness and courtesy shown to you by other staff
Friendliness and courtesy shown to you by nurse	Pearson Correlation	1	.543**
	Sig. (2-tailed)		.000
	N	222	222
Friendliness and courtesy shown to you by other staff	Pearson Correlation	.543**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between friendliness and courtesy shown to you by nurse and friendliness

and courtesy shown to you by other staff is 0.543. This coefficient shows that there is a strong and positive relationship between friendliness and courtesy shown to you by nurse and friendliness and courtesy shown to you by other staff. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.543, p>0.05).

Correlations

		The thoroughness of care you received from your doctor	Explanation about your anaesthesia and surgery
The thoroughness of care you received from your doctor	Pearson Correlation	1	.745**
	Sig. (2-tailed)		.000
	N	222	222
Explanation about your anesthesia and surgery	Pearson Correlation	.745**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the thoroughness of care you received from your doctor and explanation about your anaesthesia and surgery is 0.745. This coefficient shows that there is a strong and positive relationship between the thoroughness of care you received from your doctor and explanation about your anaesthesia and surgery. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.745, p>0.05).

Correlations

		The amount of time spent with your doctor	How well were your questions answered by your doctor?
The amount of time spent with your doctor	Pearson Correlation	1	.557**
	Sig. (2-tailed)		.000
	N	222	222
How well were your questions answered by your doctor?	Pearson Correlation	.557**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between the amount of time spent with your doctor and “how well were your questions answered by your doctor?” is 0.557.

This coefficient shows that there is a positive relationship between the amount of time spent with your doctor and “how well were your questions answered by your doctor?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.557, p>0.05).

Correlations

		How well were your questions answered by your doctor?	How well were your questions answered by your nurse?
How well were your questions answered by your doctor?	Pearson Correlation	1	.514**
	Sig. (2-tailed)		.000
	N	222	222
How well were your questions answered by your nurse?	Pearson Correlation	.514**	1
	Sig. (2-tailed)	.000	
	N	222	222

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “how well were your questions answered by your doctor?” and “how well were your questions answered by your nurse?” is 0.514. This coefficient shows that there is a positive relationship between “how well were your questions answered by your doctor?” and “how well were your questions answered by your nurse?” The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.514, p>0.05).

Correlations

		How long did you wait to see the doctor after arriving at the hospital?	The overall service and care you received
How long did you wait to see the doctor after arriving at the hospital?	Pearson Correlation	1	-.034
	Sig. (2-tailed)		.616
	N	222	222
The overall service and care you received	Pearson Correlation	-.034	1
	Sig. (2-tailed)	.616	
	N	222	239

The correlation (r) between "how long did you wait to see the doctor after arriving at the hospital?" and the overall service and care you received is 0.-034. This coefficient shows that there is a weak but positive relationship between "how long did you wait to see the doctor after arriving at the hospital?" and the overall service and care you received. The probability (p) of this correlation coefficient which is 0.661 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-034, p>0.05)

Correlations

		To what extent do you agree with the following: I often think about leaving my current employer?	I will probably look for a new job in the next year
To what extent do you agree with the following: I often think about leaving my current employer?	Pearson Correlation	1	-.038
	Sig. (2-tailed)		.564
	N	239	239
I will probably look for a new job in the next year	Pearson Correlation	-.038	1
	Sig. (2-tailed)	.564	
	N	239	239

The correlation (r) "between to what extent do you agree with the following: I often think about leaving my current employer?" and "I will probably look for a new job in the next year" is 0.-038. This coefficient shows that there is a weak but positive relationship between "to what extent do you agree with the following: I often think about leaving my current

employer?" and "I will probably look for a new job in the next year". The probability (p) of this correlation coefficient which is 0.564 is greater than 0.05, thus implying that there is no statistically significant relationship (r=-0.-038 p>0.05).

Correlations

		As soon as I can find another job, I will leave my current employer.	I am involved in deciding on the changes introduced that affect my work area/team/department.
As soon as I can find another job, I will leave my current employer.	Pearson Correlation	1	.785**
	Sig. (2-tailed)		.000
	N	239	239
I am involved in deciding on the changes introduced that affect my work area/team/department.	Pearson Correlation	.785**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between as soon "as I can find another job, I will leave my current employer" and "I am involved in deciding on the changes introduced that affect my work area/team/department" is 0.785. This coefficient shows that there is a positive relationship between "as soon as I can find another job, I will leave my current employer" and "I am involved in deciding on the changes introduced that affect my work area/team/department". The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.785, p>0.05).

Correlations

		I am involved in deciding on the changes introduced that affect my work area/team/department.	I am consulted about the changes that affect my work area/team/department.
I am involved in deciding on the changes introduced that affect my work area/team/department.	Pearson Correlation	1	-.169**
	Sig. (2-tailed)		.009
	N	239	239
I am consulted about the changes that affect my work area/team/department.	Pearson Correlation	-.169**	1
	Sig. (2-tailed)	.009	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “I am involved in deciding on the changes introduced that affect my work area/team/department” and “I am consulted about the changes that affect my work area/team/department” is 0.-169. This coefficient shows that there is apositiverelationship between “I am involved in deciding on the changes introduced that affect my work area/team/department” and “I am consulted about the changes that affect my work area/team/department”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.-169, p>0.05).

Correlations

		Managers/supervisors ask for my opinion before making decisions that affect my work.	Managers here try to involve staff in important decisions.
Managers/supervisors ask for my opinion before making decisions that affect my work.	Pearson Correlation	1	.571**
	Sig. (2-tailed)		.000
	N	239	239
Managers here try to involve staff in important decisions.	Pearson Correlation	.571**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “managers/supervisors ask for my opinion before making decisions that affect my work” and “managers here try to involve staff in important decisions”is 0.571. This coefficient shows that there is a high strength and positive relationship between “managers/supervisors ask for my opinion before making decisions that affect my work” and “managers here try to involve staff in important decisions”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.571, p>0.05).

Correlations

		Managers here try to involve staff in important decisions.	Managers encourage staff to suggest new ideas for improving services.
Manager here try to involve staff in important decisions.	Pearson Correlation	1	.646**
	Sig. (2-tailed)		.000
	N	239	239
Managers encourage staff to suggest new ideas for improving services.	Pearson Correlation	.646**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) between “managers heretry to involve staff in important decisions” and “managers encourage staff to suggest new ideas for improving services” is 0.646. This coefficient shows that there is a positive relationship, between “managers here try to involve staff in important decisions” and “managers encourage staff to suggest new ideas for improving services”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.646, p>0.05).

Correlations

		Communication between managers & staff is effective	On the whole, the different parts of the organization communicate effectively with one another.
Communication between managers & staff is effective	Pearson Correlation	1	.731**
	Sig. (2-tailed)		.000
	N	239	239
On the whole, the different parts of the organization communicate effectively with one another.	Pearson Correlation	.731**	1
	Sig. (2-tailed)	.000	
	N	239	239

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation (r) “communication between managers and staff is effective” and “on the whole, the different parts of the organization communicate effectively with one another” is0.731. This coefficient shows that there is a positive relationship between “communication between managers and staff is effective” and “on the whole, the different parts of the organization communicate effectively with one another”. The probability (p) of this correlation coefficient which is 0.01 is less than 0.05, thus implying that there is a statistically significant relationship (r=-0.731, p>0.05).

VALIDITY

Cronbach's Alpha is a test to determine the validity level of the questionnaire. A level above 0.7 is considered adequate to declare a question/questionnaire valid (Pallant, 2007), although Pallant goes on to say that with scales with fewer than ten items it is common to find lower values, even as low as 0.5.

Cronbach's Alpha was conducted on the questionnaire and the results are as follows:

VALIDITY – CRONBACH'S ALPHA

Table 7.106: Case Processing Summary

		N	%
Cases	Valid	222	92.9
	Exclude	17	7.1
	Total	239	100.0

a. Deletion from list based on all variables in the procedure.

Table 7.107: Reliability Statistics

Cronbach's Alpha	N of Items
.823	121

The questions in the questionnaire were drawn up based on the literature review. Cronbach's Alpha was used to measure reliability in order to understand whether the questions in the questionnaire all reliably measure the same underlying variable. Tables 7.106 and 7.107above contain the results. Cronbach's Alpha was calculated at 0.919 which is above 0.7; therefore the scale can be considered reliable with the samples (Pallant, 2007). The Cronbach's Alpha co-efficient of 0.823 shows that the questionnaire was reliable and sound.

CHAPTER EIGHT

CONCLUSION AND RECOMMENDATIONS

8.1 INTRODUCTION

While the media is often accused of sensationalism in its coverage of the state of the public health care sector, this research study has shown that, from the perspective of patients at selected KZN provincial hospitals, namely Stanger,Addingtonand King Edward VII Hospitals, there is indeed reason for concern with regard to the identified service delivery goals and improving the health care system, among other disquieting issues. Although it is evident that the National Department of Health is giving attention to the development of the National Health System in post-apartheid South Africa and that the introduction of National Health Insurance holds some promise, this study has pointed to the fact that patients as consumers of hospital services are not experiencing the promised improvements. One of the main challenges facing the Department of Health is how to bridge the divide between popular pronouncements with regard to health policy and actual policy implementation; between government intentions and actual manifestation.

8.2 SUMMARY OF CHAPTERS

A literature review was undertaken to meet the objectives of the study. Themes that relate to service delivery in South Africa, *Batho Pele*, and their influence on organizational success or failure were located in existing public administration and management literature, in salient theories and other social research studies. The study aimed to build on the conceptual framework of public administration and the *Batho Pele*Principles, locating health care service delivery within this framework.

The following discussion highlights the focus of the various chapters and provides a brief summation of the fundamental issues contained therein.

Pertinent information was obtained with regard to the objectives outlined in Chapter One and key concepts were also defined. The chapter noted that the Patients'RightsCharter is a critical policy that the Department of Health must implement to achieve effective service delivery and *Batho Pele*in all hospitals in order to be responsive to the needs of citizens, deliver

various services to improve the quality of health care and to save lives. It also explored the background to the public sector service delivery context and discussed the issue of effectiveness.

Chapter Two (part one) provided insight into the conceptual and contextual framework of public administration as it relates to the public sector and service delivery in South Africa, particularly reforms of the traditional bureaucracy. Based on the rationale of the *Batho Pele* White Paper to improve the efficiency and effectiveness of public service delivery this chapter also focused on the Public Service Commission and assessed progress in implementing *Batho Pele*, the main pillars of service delivery that the provincial Department of Health should seek to achieve.

In Chapter Two (part two), the role of knowledge management in enhancing government service delivery and knowledge management in public administration were highlighted in detail as theoretical perspectives. The concepts of civil servant and civil service were examined as vehicles to achieve efficient and effective service delivery. The influence of bureaucracy was discussed as well as the civil service environment in a changing world. Knowledge management and government service delivery were raised as critical issues to indicate the importance of knowledge management in the public sector that would have a direct and positive impact on the performance of civil servants.

Efficient service delivery demands personnel that are both knowledgeable and willing to share their knowledge at all times. This chapter also presented a critical discussion on the forces of change and the practical organization of work. The concept of customer service orientated service delivery was also discussed, examining critical issues such as citizens as effective policy partners, e-government and customer-centred public administration.

A critical review of cultural factors, literacy levels in Africa, South Africa and Kenya and levels of preparedness to become a knowledge society were also presented.

In Chapter Three, the theoretical framework of service delivery in local government and national department was highlighted. A critical review of service delivery improvement strategies was also presented. The need for responsive, efficient public sector service delivery

is widely accepted. This chapter also presented a critical discussion on service delivery in provincial public hospitals. The notion of pursuing shared goals between the public healthcare sector and patients is the cornerstone of the discussion on patient-centeredness. This would result in improved health services, organization of work and superior outcomes. A patient-centred approach would measure the performance of hospitals at every level and would have a significant impact on the effectiveness and proper implementation of the National Health Scheme. As the performance of every hospital is also dependant on management capabilities, the role of employee turnover intentions was also critically examined.

This chapter also provided insight into the reasons behind poor service delivery in provincial hospitals by highlighting the problems experienced by these hospitals in South Africa, service delivery problems, service quality and healthcare in the provincial hospitals, the expectations of management and their rating. Based on the rationale of the *Batho Pele* White Paper which seeks toimprove the efficiency and effectiveness of public service delivery this chapter examined the level of satisfaction with medical management in provincial hospitals, the lack of service commitment and service-orientation in provincial hospitals, the experience of a culture of non-caring and lack of hospitality, and powerlessness related to the lack of information or choice and respect.

The chapter also focused on outpatient anger-aggression and frustration related to poor service delivery in provincial hospitals in order to examine the hospitals' performance in terms of the treatment and respect accorded to patients. A critical review was undertaken to establish the experience of a non-enabling health environment related to unfriendly staff, lack of coordination and unsafe circumstances in provincial hospitals as well as dehumanization and an unethical climate revealed in lack of consideration, professionalism and respect for patients as a critical test of the implementation of *Batho Pele* Principles in provincial hospitals.

In Chapter Four, the focus was on National Health Insurance as part of the government's commitment to improve the healthcare system in South Africa to ensure that even the poorest people and the unemployed have access to better healthcare and that lives are saved. The chapter critically reviewed the treatment plan as the main focus of NHI. A criticalreview was undertaken to establish how NHI will be implemented through redirecting resources and identifying cost drivers. The reform track record bodes ill for this initiative. This chapter also

presented a theoretical review on population coverage under NHI, and re-engineering the primary health care system.

The concepts of district clinical specialist support teams, school health services, and municipal, ward-based healthcare agents were examined. The principle behind NHI is provide healthcare for all South Africans and improve the healthcare system; this chapter also presented a critical review of healthcare benefits under NHI, the service package within the context of a district health service, and the delivery of primary health care services through private providers and hospital benefits. The chapter also focused on a critical discussion on the designation of hospitals, including district, regional, tertiary, central and specialized hospitals.

NHI will require accreditation of health care providers, an office to monitor health standards compliance, accreditation standards, payment of providers, a health coding system, and a unit to contract the services of healthcare providers. Principal funding mechanisms, the role of co-payment, the total cost of NHI, funding flows, the establishment of an NHI fund, migration from the current system into a national system and the health insurance environment still need to be established.

In order to achieve a holistic healthcare system that is competent and fully functional in order to achieve service delivery and effective implementation of *Batho Pele* Principles the DoH must have a proper human resources policy in place. A critical review was conducted of the development of the public sector human resources development strategy. This chapter also presented a critical discussion on the government as a vehicle for reform in enhancing human resources, and the effective HR training programmes in public hospitals. The need to improve the quality of services requires that the DoH also focus on developing HR training needs through organizational and training development programmes, organizational, personal and operational analysis, new learning approaches including strategic learning, action learning and the monitoring and evaluation of all these programmes to ensure their effectiveness in the development and transfer of skills.

In Chapter Five, the research methodology, research design, experimental and/or data collection procedures and the empirical layout of the field of study were highlighted. Frequency tables were used to describe the age, educational levels and professions of the

three categories of respondents. The research approach and design arose from the nature of the research project. The subjects who were part of the survey and the areas from which the survey population was drawn were described. The statistical procedures by means of which the data obtained were analysed and where appropriate, the significance levels adopted were also presented in this chapter.

In Chapter Six, data were presented and analysed using structuredquestionnaires, semi-structured interviews and various statistical tools andanalyses. The interpretation of data was enhanced by the use of tables, graphsand diagrams which provided concise summaries of the results of the empiricalstudy. Triangulation of results was undertaken and statistically significant tests were explained. This Chapter also presented the calculated values of the test statistics and the levels of significance.

Chapter Seven draws conclusions from the literature review, and provides relevant recommendations. In this chapter, the statistical results presented in the proceeding chapter are interpreted as recommendations to address the research problems presented at the commencement of this research study.

The focal point of this chapter is to reach conclusions that arejustified by this study. Furthermore, the findings of this research study raise new questions andproblems for future research and tracer studies into the extent of provincial hospitals' service delivery improvements in terms of national and international perspectives. The results of the research study show that there is a weak, non-significant, negative linear relationship between the service offered at the three provincial hospitals compared with the expectations of patients who were admitted in these hospitals during the time the research was conducted as well as with some parts of the empirical study. Therefore, given the findings of this study, there is a need for further research to be undertaken regarding the interface between public sector provincial hospital services and service delivery, and the quality of services offered by hospitals in order to comply with *Batho Pele* Principles. The research sought to analyse the impact ofservice delivery in public sector provincial hospitals in the eThekwini Metropolitan and iLembe regions. Several recommendations can be made.

8.3 KEY LESSONS

In the course of elaborating the underlying themes of this research, key lessons to be learntfrom this research study include:

- The DoH needs to play a leading role in supervising the monitoring of the service delivery strategy and the *Batho Pele* Principles;
- The multiplicity of causal factors and bureaucratic processes that slow down or impede service delivery should be modified wherever possible;
- Health workers have been accused of breaching patient confidentiality. Choi, Lui, Gou and Mandel (2006:37) report that 47% of their study respondents feared breach of confidentiality about their test results, resulting in resistance to testing for HIV. Njagi and Maharaj (2006:120) emphasize that unless clients are assured of privacy and confidentiality, the rates of voluntary counselling and testing might remain lower than expected.
- The DoH should emphasize to all hospitals that education is needed to prepare a patient for his/her results and that results should not be delayed, as this heightens anxiety;
- There is a need to increase the quality, accessibility and acceptability of service delivery standards in all provincial hospitals to achieve BPPs;
- There is a need to build community awareness and sensitization about BPPs and the Patients' Rights Charter, particularly in rural communities;
- Hospitals officials have to be developmentally focused and committed, and guard against token citizen participation in service delivery; many hospitals are now involving members of communities their through NGOs in order to improve communication;
- Through multi-dimensional interventions to address local needs, the coalescing of political power must be advocated in order to facilitate access to basic services for the poor;
- Information and on-going public dialogue is necessary to ensure that the needs of the poor are addressed;
- An increased focus on leadership and development within the public sector is important in order to ensure effective implementation of NHI.

It is advocated that future research might replicate the present research study with other populations invarious environments to contribute to a greater possibility of generalizing further findings.

Hopefully, some of the key recommendations will serve as benchmarks for replication inanalogous situations regarding the role of the public and patients in the service delivery implementation plan using the *Batho Pele* Principles with the Patients' Rights Charter, within the context of efficient, effective and adequate service delivery strategic management.

8.4 RECOMMENDATIONS

The following recommendations emanate from the literature review and theempirical study. They address the findings of the research with a view to findingsolutions. This would entail having an integrated model to enable meaningfulapplication of the results.

- **RESEARCH**

  A more extensive study should be undertaken in the same province (KZN), including other hospital wards/units and other departments that deal directly with patients. Such a study should be replicated in other regions and districts. Research and scientific evidence should form the basis for evidence-based clinical practice to secure a healthcare system in which service delivery and BPPs are central especially since the DoH is in the process of implementing the first phase of NHI.

- **Management**

  Du Preez (2002) observes that defining roles and responsibilities is integral in achieving optimum service delivery. Hospital and provincial management should demonstrate a commitment to improving the quality of service delivery and implementing BPPs by:

  a) Identifying problems areas such as respect and courtesy towards patients as well as addressing and monitoring stock and equipment shortages on a continuous basis. All levels of management should ensure that quality assurance programmes are implemented and that all levels of health care staff members are monitored;
  b) Formulating new management policies that emphasize excellent customer care. These policies should provide clear guidelines on behaviour for all employees, including medical personnel, security guards, clerks and other hospital officials;

c) Top management should show increased visibility in service delivery setting through the development of rounding schedules that take them to service sites on a routine basis; and
d) Top management should provide written feedback reports following these visits.

- **KNOWLEDGE MANAGEMENT, TRAINING AND EDUCATION**

Wig (2002) is of the opinion that knowledge management could make a significant contribution to rendering a country's public administration more effective. The implementation of the BPPs and the Patients' Rights Charter should be an integral part of human resources development programmes and care should be taken that all categories of staff are included in the training sessions. Strategies to ensure that patients are aware of and understand the BPPs and PRC should be planned, implemented and evaluated on a continuing basis. It also widely accepted that in order to achieve successful public sector service delivery, knowledge management processes must be utilized as means of gaining a competitive edge (Fowler &Pryke, 2003).

- **CUSTOMER SERVICE STANDARDS**

Customer-oriented service delivery is achieved through various initiatives introduced by government, including one-stop shops, the e-Government project and a call centre (Levin, 2004). The manner in which overall services are provided should be influenced by the BPPs. These principles seek to ensure that service delivery is citizen-centred. New customer service standards should not only be adopted, but evidence of their implementation should also be collected.

- **CUSTOMER SERVICE STANDARDS SHOULD REFLECT A STATEMENT OF THE FOLLOWING PRINCIPLES:**
  a) Patient safety;
  b) Courtesy;
  c) Professional conduct and presentation;

d) Efficiency; and
e) Trust.

- **MISSION AND VISION**

The above-mentioned service standards should be reflected in a mission and vision statement that is clearly visible to staff and patients.

- **CUSTOMER SERVICE CONTRACTS**

A customer service contract should be formulated and all employees should be requested to sign it in line with reasonable labour practice and BPPs.

- **EMPLOYEE ORIENTATED PROCESSES**

A new monthly employee orientated process/in-service education programme should be adopted and should include:

a) Sessions where top management demonstrate their commitment to the values and processes of customer excellence and report on tangible measures that were undertaken to achieve this; and
b) Sessions where topics related to the improvement of service delivery, BPPs, customer excellence and customer service are addressed.

- **JOB DESCRIPTIONS**

Job descriptions should be revised to include the new customer service standards and NHI with clear descriptions of corresponding required behaviours.

- **HUMAN RESOURCES RECRUITMENT POLICIES**

Recruitment and hiring policies and procedures should be reformulated in line with reasonable labour relations practice that reflects at least the following:

a) Screening of applicants by the human resources department for specific customer service skills; and

b) A commitment to customer service and service delivery that is signed by the employee as part of the application and employment procedure.

Government has introduced policies to ensure the development of human resources, including the White Paper on Human Resources Management in the Public Service *(*DPSA, 1997), the Human Resources Development Strategy(DPSA, 2002), and theSkills Development Act, 97 of 1998, to name but a few. These policies reinforce the government's commitment to developing its employees in the best way possible.

- **ESTABLISHMENT OF A SERVICE DELIVERY AND BPP COMMITTEE**

A service delivery, BPP and customer service committee should be established to help the provincial hospitals formulate and revise:

a) Service delivery and customer service standards and contracts;
b) Service delivery focus and customer service excellence training programmes to fulfil the BPPs;
c) Generic benchmarks for service delivery excellence and customer excellence in the provincial hospitals, with clinical units tailoring their own;
d) Patient satisfaction surveys; and
e) Training on the Patients' Rights Charter for all staff members.

- **GRIEVANCE PROCEDURES FOR CUSTOMERS AND PATIENTS**

An aggressive customer and patient grievance procedure should be designed in keeping with labour relations, patients' rights and other relevant stakeholders' expectations. Kalisch and Aebersold (2006: 143) propose measures for facilitating patient safety such as clarifying values, encouraging and rewarding the reporting of mistakes, consistently analysing mistakes and near misses, looking for the unexpected, simplifying work, minimizing interruptions, commitment to resilience, encouraging deference to expertise, and promoting team work. Apart from a non-enabling environment, many outpatients felt that the nurses were disrespectful and not very considerate; this results in feelings of dehumanization.

- **REVIEW AND ESTABLISHMENT OF OTHER BODIES**

The effectiveness of the South Africa Nursing Council (SANC), and the Medical and Dental Council should be reviewed to establish whether or not they are playing the expected role in improving the standard of service delivery and customer service. Where necessary, other professional bodies should be established.

- **REWARD AND RECOGNITION PROGRAMMES**

A new reward and recognition programme based on unit performance and continuous evaluation of doctors, nurses, clerks, pharmacists and management by patients, and members of the public should be developed.

- **QUALITY OF CARE ASSURANCE PROGRAMMES**

Quality of hospital care assurance programmes that embody more efficient reporting and working relationships between customer service excellence, service delivery, grievances, quality assurance, and patient care committees and top management should be reformulated.

- **PROVINCIAL HOSPITALS' OUTPATIENT DEPARTMENTS**

Agulair and Stock (1996:4) observe that good customer service means meeting one's patients' needs in a way that has value and meaning to them. The outpatient departments in provincial hospitals should be redecorated to facilitate a friendlier and safer environment by means of:

a) Visibility of doctors and nurses in waiting rooms;
b) Visibility of signs indicating locations; and
c) Signs providing information that is relevant to all hospital services.

8.5 CONCLUSION

Given national and international commitments relating to health, this research study has shown that, from the perspective of patients at selected provincial hospitals in KZN, there are reasons for concern regarding the identified service delivery goals and the intention of the BPPs, among other disquieting issues. Although it is evident that the KZN DoH is giving attention to the development and implementation of NHI and the NHS in post-apartheid South Africa, the findings of this study point to the fact that patients and members of the public, as consumers of hospital services, do not experience the promised improvements in their direct contact with provincial hospitals.

The current service offered by the provincial hospitals is inadequate and has resulted in poor patient care. It seems evident therefore, that one of the main challenges of the new NHI and NHS under the DoH is how to bridge the divide between popular pronouncements with regard to health policy and actual policy implementation; between government intentions and actual manifestation. The results of this study are somewhat disturbing, as to some degree, they reflect the opposite values to those emphasized by the *Batho Pele* legislative framework, which guides healthcare service delivery. Furthermore, the unprofessional conduct demonstrated by some healthcare professionals is not conducive to the creation of an ethical health service delivery environment.

The implementation of each of the six identified BPPs was described in terms of everyday service delivery in wards in the three hospitals. The shortfalls that were identified could be classified in terms of hospital management, unit management and patients' awareness levels.

Hospital Management

- Insufficient planning and budgeting for capital expenditure such as equipment and ineffective utilization of equipment deter the implementation of a service delivery strategy and of the BPPs' imperative of "increasing access". The fact that BPPs, the Patients' Rights Charter and complaints boxes were not conspicuously displayed in wards in the three hospitals impeded the setting of service standards, the provision of more and better information, and remedying mistakes and failures.

Unit Management

- Ineffective planning, organization and control by the unit management led to ineffective implementation of the service delivery plan and the *Batho Pele* imperative of "increasing access"; this is hampering the delivery of quality services to patients at the three provincial hospitals in KZN;

Patients' awareness levels

- A lack of awareness and understanding of the BPPs and the Patients' Rights Charter by patients and the general public hindered the implementation of the service delivery plan and the BPPs' requirement of "remedying mistakes and failures/redress". The service quality standards and BPPs were not all implemented in the three hospitals' wards where the study data were collected. However, with increased awareness and effective monitoring, based on relevant in-service education programmes, most of the problems identifiedcould be addressed successfully.

Finally, the negative experience of service quality delivered to patients in outpatient departments also reflects negatively on the image of the healthcare services on the one hand, and on the other, could negatively affect the health of patients. Thus, thoughtful consideration is needed of the interventions required to manage the negative experiences of outpatients in terms of the quality of service delivery. An ethical healthcare environment needs to be cultivated in the outpatient department. This will promote quality service delivery and make the patients' experience more meaningful.

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18 April 2012

Mr Simphiwe Emmanuel Ndlovu (205524776)
Graduate School of Business and Leadership

Dear Mr Ndlovu

PROTOCOL REFERENCE NUMBER: HSS/1189/011D
PROJECT TITLE: Evaluating Public Sector Service Delivery at Provincial Hospitals. A case study of the Durban Metropolitan and Ilembe Regions

EXPEDITED APPROVAL

This letter serves to notify you that your application in connection with the above has now been granted full approval following your response to queries raised by the Humanities and Social Sciences Research Ethics Committee.

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

Best wishes for the successful completion of your research protocol.

Yours faithfully

.....

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

cc Supervisor Dr Abdul Kader
cc Mrs Wendy Clarke

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
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Reference : HRKM160/11
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

12 January 2012

Dear Mr S Ndlovu

Subject: Approval of a Research Proposal

1. The research proposal titled **'Evaluating public sector service delivery in provincial hospitals: A case for Durban metropolitan and iLembe Regions'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Stanger, Addington and King Edward VIII Hospitals.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

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

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 12/01/2012

62 Ferguson Road
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Tel: 072 442 7896
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28 October 2012

This is to confirm that I have edited the thesis, "Evaluating Public Sector Service Delivery at KwaZulu-Natal Provincial Hospitals: A Case Study of the Durban Metropolitan and Ilembe Region," by Simphiwe Emmanuel Ndlovu, student number 205524775.

Yours sincerely,

(Ms) Deanne Collins (MA)

THE QUESTIONNAIRE

Background

My name is Simphiwe Ndlovu. I am presently completing my Doctoral Thesis **on Evaluating Public Service Delivery in Provincial hospitals**, A Case for Durban Metropolitan and iLembe Regions, at the University of KwaZulu Natal (UKZN), Graduate School of Business.

I would greatly appreciate your time taken in answering this questionnaire.

The supervisor of the study is Dr Abdul Kader.

The contents of the questionnaires are confidential and at no time will your identity be revealed.

Thank you

Simphiwe Ndlovu (Researcher)

Contact number- 079 388 5102

Email uzzie@webmail.co.za

Dr Abdul Kader (Supervisor)

Contact number- 082 901 0255

PERSONAL DEMOGRAPHICS INFORMATIONS

Please mark a (X) in the appropriate block.	
1.1 Age in years	
18-30	
31-40	
41-55	
56-65+	
1.2 Gender	
Female	
Male	
1.3 Your Marital status	
Single [Never married]	
Married	
Widowed	
Divorced/ separated	
1.4 Occupation	
Unemployed	
Student	
Administrative	
Domestic worker	
Professional	
Technical & other	
Home executive/Retired	
Managerial	
Self employed at home	
1.5 Highest educational qualification	
Between Grade 1-7	
Between Grade 8-12	
Passed Matric	
Certificate	
Diploma	
Degree	
Post-graduate	
Uneducated	
1.6 Principal language spoken at home	
Zulu	
Xhosa	
English	
Afrikaans	
Other [specify]	

2. HOUSEHOLD DEMOGRAPHIC INFORMATION

Please mark a (X) in the appropriate block.	
2.1 Geographical residential region	
Durban North	
Durban East	
Durban South	
Durban West	
Ilembe Region;	
Stanger	
Ndwedwe	
Mandini	
Maphumulo	
2.3 How many kilometres do you travel to reach this hospital?	
0-10km	
11-50km	
51-70km	
71-90km	
91-99km	
More than 100km	
Which Hospital are you visiting today?	
Stanger	
King Edward	
Prince Mshiye	
Time of your of arrival at this hospital	
Between 06h00 and 07h00	
Between 07h00 and 08h00	
Between 08h00 and 09h00	
Between 09h00 and 10h00	
Between 10h00 and 11h00	
Between 11h00 and 12h00	
Between 12h00 and 13h00	
Between 13h00 and 14h00	
Between 14h00 and 15h00	
Between 15h00 and 16h00	
Between 17h00 and 18h00	
Between 18h00 and 19h00	
Between 19h00 and 20h00	
Between 20h00 and 21h00	
Between 21h00 and 22h00	
Between 22h00 and 00h00	
After 00h00 and 05h00	

3. Please tell us your opinion about the access to the hospital? [Place an [X] in the appropriate boxes.	**Yes**	**No**
1. Was there visible security personnel in the hospital gates & inside?		
2. Were signs to the OPD clear?		
3. Were signs to the WARDs clear?		
4. Was it easy to find the disable parking bay/wheel chair ramp?		
5. Signage to indicate where the toilets are clear?		
6. Signage to different areas of the hospital is clear?		

4. Please indicate the level of communication received [Place an [X] in the appropriate boxes.			
Did the following staff attended you wear the badge:	**Yes**	**No**	**Unsure**
1. Security personnel			
2. Clerk			
3. Nurse			
4. Doctor			
5. Pharmacy personnel			
6. Other			
7. Were you able to communicate with staff on your language?			
8. Where necessary were interpreter service arranged?			
9. During your treatment were the procedures explained to you			
10. The questions and queries you made, were they dealt with satisfactory?			
5. Please indicate the level of courtesy.			
Were you treated politely by the following staff members? [Place an [X] in the appropriate boxes.	**Yes**	**No**	**Unsure**
1. Security personnel			
2. Clerk			
3. Nurse			
4. Doctor			
5. Pharmacy personnel			
6. Other			
7. The nurse explained the findings before seeing the doctor			
8. The doctor asked for permission before examination			
9. Doctor explained my condition to me			
10. Were you treated in a respectful manner			
11. Advice was given on how to improve my health status			

6.Please indicate the cleanliness of physical environment	**Yes**	**No**	**Unsure**
1. The outpatient department was clean?			
2. The Pharmacy department was clean?			
3. The toilets were clean?			
4. There was a toilet paper in the toilet?			
5. There was soap to wash hands in the toilet?			
6. There was paper towels/air dryer to dry hands in the toilet?***(Place an [X] to indicate your answer)*** ⟹	**Yes** [ ]	**No** [ ]	**Unsure** [ ]
7. Did the staff wash/spray their hands before & after examining you?			
8. Were you happy with overall cleanliness of the hospital?			
7. Were the following areas in hospital clean? [Place an [X] in the appropriate boxes.	**Yes**	**No**	**Unsure**
1. Grounds			
2. Corridors			
3. Building			
4. Ablution facilities			
5. Was the bed linen clean			
6. Was the ward free of pests			
7. If no please specify.....			
8. Other section you attended.....			
8. On respect of Patient's Right [Place an [X] in the appropriate boxes.	**Yes**	**No**	**Unsure**
1. Did the hospital staff draw your attention to patient's rights & responsibility?			
2. Did your consultation by the nurse or doctor take place in a private manner?			
3. Was there a bench/chair provided for you to sit on while you waited?			
4. Did you have a complaint?			
5. If you had a complaint, did you report it?			
6. If you had a complaint were you satisfied with the way it was handled?			
Security at the hospital	**Yes**	**No**	**Unsure**
7. At night was the nurse available when you called?			
8. Did you feel safe in the hospital?			
9. If no give reasons.....			
9. On medication given to you	**Yes**	**No**	**Unsure**
1. You were issued with the medication that the doctor prescribed for you?			

2. Instructions regarding medication /follow up were provided?			
3. Was the instruction communicated in the language you understand?			

9.2 Inpatient survey

9.2 Inpatient items. Use a [X] to indicate your choice	**Yes definitely = [100]**	**Yes to some extent = [50]**	**No = [0]**
1. Access to care (single item): If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?			
2. Patient engagement in care (single item): Were you involved as much as you wanted to be in decisions about your care and treatment?			
3. Patients education regarding care:	**Yes always**	**Yes sometimes**	**No**
a) When you had important questions to ask a doctor, did you get answers that you could understand			
b) When you had important questions to ask a nurse, did you get answers that you could understand?			
c) Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? **(place a [X] to your answer**	**Yes completely [ ]**	**Yes to some extent [ ]**	**No [ ]**
d) Did a member of staff tell you about any medication side effects to watch for when you went home?			
e) Did a member of staff tell you about any danger signals you should watch for after you went home?			
f) Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?	**Yes definitely [ ]**	**Yes to some extent [ ]**	**No [ ]**
4. Coordination of care (single item): sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	**Yes Often = 0 [ ]**	**Yes sometimes = 50 [ ]**	**No = 100 [ ]**
5. Emotional support (single item): Did you find someone on the hospital staff to talk to about	**Yes definitely**	**Yes to some**	**No**

your worries and fears?	[ ]	extent [ ]	[ ]

10. Please place a [X] that best indicate how strongly you agree	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1. The food was good & the way it was presented to you?	1	2	3	4	5
2. The eating utensils e.g spoons were provided with your meals?	1	2	3	4	5
3. Do you agree that the visiting hours are convenient to the community?	1	2	3	4	5
4. On you stay at the hospital you were offered pyjamas/nighties daily	1	2	3	4	5
5. You and your family were advised about changes in your condition?	1	2	3	4	5
6. The hospital staff assisted you in making arrangements for you when you were discharged?	1	2	3	4	5
7. At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?	1	2	3	4	5
8. Would you return to this hospital for treatment?	1	2	3	4	5
9. Were you treated in a polite, courteous & friendly manner by all health professionals?	1	2	3	4	5

11. Waiting times during your stay at the hospital (rate from scale of 1-5)	0 -15 minutes	15-30 minutes	30-45 minutes	45mins -1hr	1hr and more
1. How long did you wait for your outpatient card?	1	2	3	4	5
2. How long did you wait to be treated by a nurse?	1	2	3	4	5
3. How long did you wait to be treated a doctor?	1	2	3	4	5
4. How long did you wait for medication in the department pharmacy?	1	2	3	4	5
5. How long was the waiting time to get a folder?	1	2	3	4	5
6. How long was the waiting time in the outpatient department?	1	2	3	4	5

7. How long did you wait for a doctor to discharge you on the last day at hospital?	1	2	3	4	5

12. Service expectation questions

No. Expectation items. Please place a [X] to indicate the importance of services received at the hospital	Very important	Important	Not important
1. Not have to wait too long to receive doctor assistance			
2. Not have to wait too long to receive a nurse assistance			
3. Not to wait too long to for my surgery procedure			
4. Not to wait too long for my medication			
5. Not have to wait too long here during my visit			
6. Adequate information about my anaesthesia and surgery			
7. Adequate friendliness and courtesy			
8. A comfortable hospital to be in			

13. Patients' perception

No. Perception Items, Please place a [X] to indicate your opinion about the hospital service rendered	Excellent	Very good	Good	Fair	Poor
1. Convenient of appointment time in hospital					
2. Convenient of hospital location					
3. Appearance of hospital waiting area					
4. Hours when hospital is open					
5. Friendliness and courtesy shown to you by nurse					
6. Friendliness and courtesy shown to you by nurses					
7. Friendliness and courtesy shown to you by nurse					
8. Friendliness and courtesy shown to you by other staff					
9. The thoroughness of care you received from your doctor					
10. Explanation about your anaesthesia and surgery					
11. The amount of time spent with your doctor					
12. How well were your questions answered by					

your doctor?					
13. How well were your questions answered by your nurse?					
14. How long did you wait to see the doctor after arriving at the hospital?					
15. The overall service and care you received					

14. Doctors and Nurses questions (staff questions ONLY) Employee turnover intention

10. To what extent to you agree on the following items. Please place a [X] to indicate your choice.	**Strongly Disagree**	**Disagree**	**Uncertain**	**Agree**	**Strongly Agree**
1. To what extent do you agree with the following? I often think about leaving my current employer.					
2. I will probably look for a new job in the next year.					
3. As soon as I can find another job, I will leave my current employer.					
4. I am involved in deciding on the changes introduced that affect my work area/team/department.					
5. I am consulted about the changes that affect my work area/team/department.					
6. Managers/supervisor asks for my opinion before making decisions that affect my work.					
7. Manager here try to involve staff in important decisions.					
8. Managers encourage staff to suggest new ideas for improving services.					
9. Communication between managers & staff is effective					
10. On the whole, the different parts of the organisation communicate effectively with each other.					