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Assessment of roles and responsibilities of hospital boards in a public hospital in the Limpopo Province

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CHAPTER 1

INTRODUCTION, LITERATURE REVIEW, AIMS AND OBJECTIVES

1.1 Introduction

1.1.1 Background

With the advent of multiracial democracy in 1994, the government of South Africa adopted a National framework seeking to decentralize hospital management. This was envisaged as a strategy that would bring about the much needed reforms to the hospital management system. It was derived from the 1997 White Paper for transformation of the health system in South Africa, which sought to develop a single integrated National Health System, based on the District Health System approach. It also responded to the need to ensure that the transformation of hospital management was in line with the 1997 White paper on the transformation of the public service.

The National Ministry of Health initiated the Hospital Strategy Project (HSP) in 1996 to set out a framework for the development and restructuring of the public hospital sector. By doing so, it was hoped that this would support the development of Primary Health Care (PHC) and ensure that hospitals were affordable and sustainable. The HSP suggested decentralization of hospital management and accountability. It also recommended the appointment of general management trained chief executive officers (CEOs) and hospital boards. The HSP outlined the expected roles and responsibilities to ensure appropriate governance at the hospital level, where a significant authority was delegated to CEOs. It is evident from the report that there was a need for the public hospitals to reposition themselves so that they could render effective and efficient services. The report also recommended:

- decentralization through a completely revised governance structure characterized by more accountability and responsibility for hospital boards and the chief executive officers;
- that chief executive officers to be accounting officers at the hospital level, replacing hospital secretaries and superintendents in accordance with the terms of the Public Finance Management Act 1/1999;
- the appointment of hospital boards and other management support structures or committees at the institution by the Provincial Member of the Executive Council (MEC) for Health. It is evident from the report that there was need for public hospitals to reposition themselves so that they could render effective and efficient services.

A lack of proper foundation and capacity of governance structures created symptoms for the establishment of non-functional boards. This is supported by research conducted by Hunter and Gerew (1990:12*)* who identified that most boards in public hospitals:

- lack clarity about their role and functions as they are heavily involved in operational issues and at the same time not involved in policy making, development of strategies and performance monitoring, so resulting in them getting bogged down in day to day operations;
- fail to articulate policies that will guide management;
- do not have board and management performance criteria;
- have evaluation processes that fail to ask for or use the right information required for performance analysis.

The noted failures impact on the Limpopo Province's 40 public hospitals found in five municipal districts, where 30 district hospitals, five regional hospitals, three provincial specialized hospitals, and two provincial central hospitals are located. There are also a few private hospitals across the province. Vhembe district, where the research was

conducted, has one regional hospital at Tshilidzini, one specialized hospital, the Hayani Herberg and six district hospitals - Elim, Messina, Siloam, Donald Frazer, Louis Trichardt Memorial and Malamulele. Boards were appointed in all hospitals from 2004 in terms of Northern Province Health Act 5/1998.

1.1.2 History of hospital boards

According Pointer and Ewell (1995:317*)* hospital boards were established several hundred years ago in the United States of America (USA). The USA opened doors for hospital boards in 1756 and since that time governance at hospitals has evolved in response to the changing health care environment. While boards assume ultimate accountability, they do not have the ability to perform the actual work of hospitals - instead they must see to it that work is done by delegating functions and authority to management and medical staff. Management and medical staff are in turn directly accountable to the board for the decisions and actions. In many instances, boards often perform poorly, make only marginal contributions and, as a result, govern ineffectively because they lack clear ideas of things they should be doing. For boards to govern effectively, they must fulfil certain responsibilities and perform certain roles. Responsibilities are the "what" aspects of governance-specific matters to which boards must attend and roles are the "how" aspects of governance-activities boards must undertake to fulfil their responsibilities (Pointer & Ewell 1995:321).

1.1.3 Information on hospital boards in the Limpopo Province

In October 2005, the Limpopo Department of Health and Social Development embarked on a project to train hospital board members in all 40 hospitals. This was after it was realized that there was a need to build capacity of members. The training was outsourced to Regenesys School of Public Management, which is a private company. The course module was comprehensive and it covered: legislation (Acts and White Papers related to hospital functioning) and governance, quality assurance, strategic planning and operational management, financial management, procurement and contract management, general administration, diversity and change management (Regenesys: 2005:17). However, the challenge facing the department now is about whether trained members are able to implement what they have learnt and, whether there are mechanisms to monitor

their performance to ensure improved governance and effective service delivery. It is against this background that this study is conducted. The study also notes that in most hospitals, boards are characterized by role ambiguities, functionality challenges, poor representation of communities being serviced, lack of personal commitment and will and, in other instances, outside interference in the management of the hospitals to the detriment of service delivery.

The challenges faced in Limpopo Province are similar in other provinces of the country. For instance, in Gauteng Province, the then MEC for Health, the Hon. Ramokgopa, urged hospital boards and clinic committees during their annual review meeting in 2003, to play a central role in defending the rights of patients in health facilities. She described them as champions for quality services and argued that boards and committees should step up their efforts in order to provide communities with other avenues that could deal with complaints. This was supported by the Chairperson of the Standing Committee on Health in Gauteng Province, who said that the board could help manage conflict between health providers and patients (Ramokgopa: 2004). Again the MEC for Health in the Free State, the Hon. Belot, challenged the hospital boards in 2004 to develop business and strategic plans based on the hospital strategic plans so that they could put the hospital board on a new level of performance in terms of the mandate given to them. The plans developed should deal with matters such as the marketing of services, revenue collection, quality improvement, fund-raising, health promotion and complaint procedures (www.info.gov.za/speeches-accessed 2007). Furthermore, the Western Cape provincial parliament enacted the Western Cape Health Facilities Boards Act no. 7 of 2001 to enable hospital boards to function effectively and efficiently by fulfilling clearly outlined functions and powers. This, therefore, reflects that hospital boards have an important role to play in public hospitals' governance and oversight and, as such, should be harmonized and coordinated well.

It should be noted that a hospital exists because of the community and must be answerable to the community it serves. Better access to health care can be improved significantly if the hospitals are working together with the community. This implies that hospitals need to be sensitive to what is happening in their respective communities. The structure that makes that happen is the hospital board. As governance structures representing the community, hospital boards must know what is happening in the hospital and inform the management about community needs. Functional hospital boards can use

appropriate communication and operational strategies that can contribute to the effective and efficient management of public hospitals.

1.1.4 Brief background of Tshilidzini Hospital

Tshilidzini Hospital is a regional health facility in the Limpopo Province. It is situated in the Vhembe district, about 5 km from Thohoyandou and it is easily accessed from the main road between Makhado and Thohoyandou. Tshilidzini Hospital was initially opened by the Dutch Reformed Church in 1958 as a missionary hospital. It was later taken over by the former Bantustan of Venda in 1979 and re-integrated into South Africa in 1994.

Tshilidzini Hospital serves a catchment population of 1.3 million people - this includes twenty four (24) clinics, two (2) community health centres and six (6) district hospitals. It refers patients to the Polokwane-Mankweng Hospital Complex for tertiary care and all higher level radiological examinations, such as CT scan and screening. The hospital has access to an air ambulance from Polokwane in the event of serious poly-trauma. It seems, therefore, that access to tertiary care for all citizens in the Vhembe district is possible within the prescribed three-hour limit. The facility also has a gateway clinic and provides primary health care services despite its designation as a regional hospital. This is necessary due to the fact that there is no district hospital nearby.

1.1.5. Information about district hospitals

There are six district hospitals in Vhembe district, namely Elim, Siloam, Malamulele, Donald Fraser, Messina and Louis Trichardt Memorial and all hospitals render level one service. They refer cases to Tshilidzini regional hospital. All hospital boards in the district hospitals have been appointed in terms of the Northern Province Health Act No. 5 of 1998 and provincial gazette extraordinary regulations, 27/12/2000 and details of how the board is supposed to be composed are reflected under section 1.1.6.2 and for “roles and responsibilities” under “literature review”.

1.1.6. Legislative framework governing hospital boards

1.1.6.1 National Health Act 61 of 2003

The National Health Act No.61 of 2003 and other provincial health acts and regulations, provided the legislative framework within which hospital governance and hospital boards operate. According to the National Health Act No.61 of 2003 Hospital board members are appointed for a three year term and must be composed of:

- one representative from a University associated with the hospital;
- one representative from the provincial department;
- not more than three representatives of the communities served;
- special interest groups representing the users;
- not more than three representatives of staff and management of the hospital but such representatives may not vote at meetings;
- not more than five persons with expertise in areas such as accounting, financial management, human resource management, information management and legal matters.

The Act also stipulates that the task of developing the roles, responsibilities and functions of the hospital board is seen as the prerogative of the provincial MEC. However, guidelines for uniformity are not clearly outlined in the Act. This implies that each province is given latitude to develop roles and responsibilities which appointed boards have to perform. Each of the nine provinces in South Africa is therefore faced with the task of drafting its own piece of legislation and regulations which will cover what the boards have to do.

Section 41, (6), stipulates that the relevant Member of Executive Council (MEC) must appoint representative boards for each public hospital or for each group of such public health establishments within the relevant province and also prescribes the functions of such boards and procedures for meetings of each board.

1.1.6.2 Northern Province Health Act No. 5 of 1998 and provincial gazette extraordinary regulations, 27/12/2000

Hospital boards in the Limpopo Province are appointed by the MEC for Health and Social Development in terms of the Northern Province Health Act No. 5 of 1998. According to Section 9 of the gazette the board should consist of:

- a hospital manager or CEO as an ex-officio member;
- one representative of the practitioners employed in the hospital;
- one representative of staff employed, but not a practitioner;
- one representative of each district hospital board in the region served by the regional hospital who is an employee that hospital;
- a representative of municipality nominated by the councillors from the municipality where the regional hospital is situated;
- two additional representatives, who are not employees of the regional or district hospital board served by the regional hospital.

1.2. Literature review

1.2.1 Introduction

This section under Chapter 1 will discuss available literature that examines the roles and responsibilities of hospital boards and, by so doing, will attempt to provide the background and rationale for the current research. The chapter will focus predominately on the literature relating to the main themes such as roles and responsibilities, strategic planning and policy development, advisory and technical support offered to management, financial management issues, physical facility management, human resource planning and training, complaint management, quality management, risk and security management and qualification, and which criteria is necessary for a hospital board.

1.2.2 Strategic management and policy development

Kazemek *et al* (2000:236), highlight that hospital boards must be involved in the strategic planning process where they work with management to craft the mission and vision of the hospital to ensure quality service to patients. This study emphasizes that the hospital management, together with the hospital board, is key to the development of a hospital strategy. According to Regenesys (2005:29-30), the hospital board should be given greater powers by the MEC and should increase capacity in terms of oversight responsibility so that they can assist the hospital management in setting policy and strategy, play advisory and technical support roles, and ensure a meaningful oversight role.

A study which was conducted by Govindarary *et al* (1996:120) in Ghana focuses on two big hospitals, Korle Bu (1600 beds) and KomfoAnokye (750 beds), and identifies important roles and responsibilities for hospital boards. It was discovered that the boards were legally responsible for formulating policies and developing strategies to ensure that the hospital functions effectively and efficiently within the overall health policy of the government. The formulation of a clear hospital strategy and policies will definitely enhance the performance of a hospital and this will serve as a guiding light on how hospitals can achieve their set goals and objectives. It was also observed that many institutions drafted strategic plans and policies each year but the unfortunate part is that they faced challenges on implementation. Kazemek *et al* and Govindarary *et al* thus show that a strategic plan is an important element of organization's roadmap. Board members are supposed to acquaint themselves with what the department of health envisages to achieve at the end of the day.

1.2.3 Financial management

The board must also ensure that funds are utilized in effective, efficient and economic ways at all times. This is in line with Section 38 of Public Finance Management Act 1/1999, where it is emphasized that effective, efficient and transparent systems of financial and risk management and internal control should be maintained at all times by accounting officers of institutions. Section 39 indicates that expenditure should be in accordance with the vote or main division and that effective and appropriate steps

should be taken to prevent unauthorized expenditure and overspending. Section 39 states further that the board must report to the executive authority any impending under collection of revenue and shortfalls in budget. To accomplish this, management shall be compelled to work with the hospital board. . Section 39 indicates that expenditure should be in accordance with the vote or main division and that effective,, appropriate steps should be taken to prevent unauthorized expenditure and overspending. Section 39 states further that the board must report to the executive authority any impending under-collection of revenue and shortfalls in budget. To accomplish this, management shall be compelled to work with the hospital board.

There is evidence to support the section's provisions and intentions. Kazemek *et al* (2000:236) emphasize that the board should be able play a financial oversight role, which will enable it to assess how funds are being utilized for the betterment of the hospital. Needleman *et al* (1996:65), who studied three hospitals in Zimbabwe; central-Parirenyatwa (987 beds), Winkie-district (150 beds) and Avenue's private hospital (148 beds) found out that the hospital board was responsible for managing and controlling funds received from patients and, as such, was involved in revenue generation. According to Middleton (2005:243), the hospital board members need to be competent in financial matters and must be able to understand complex financial statements if they are to fulfil this function adequately. They must also ensure that there are internal audit controls, financial statements for management and the board, risk management covering financial and clinical services, establishment of risk management programmes, determine where risk lie and how risk could be corrected. The important areas of responsibilities which Middleton mentioned are in line with what has been outlined in section 38 of the Public Finance Management Act 1/1999 of South Africa.

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- financial statements for management and the board,
- risk management covering financial and clinical services,
- establishment of risk management programmes to determine where risks are and how risks could be corrected.

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Studies which focus on the execution of roles and responsibilities in a South African context exist. Kirsten (2006:8-10) found out that the hospital board at Groote Schuur central hospital in the Western Cape Province established an effective finance committee responsible for making finance reports, presenting monthly reports, controlling investment, and ensuring that finances of hospital are audited annually by an independent audit team who prepare financial statements according to the General Accepted Accounting Practice (GAAP). The board's fundraising committee engaged in fundraising efforts or initiatives. In the 2005/6 financial year, the hospital board fundraised more than R18 million, through an annual golf day, correspondence appeal and bequests, and by conducting monthly meetings to buy expensive equipment. This could be one of the success stories of what the hospital boards are supposed to do in comparison with what is happening in other provinces. On the other hand, the Hospital Ordinance 14/1958 (as amended in 1999) emphasizes that the hospital board is to make recommendations to management on improvement plans in all areas, on budget, capital spending, maintenance of assets, measures to increase efficiency, economical functioning and on monitoring hospital performance. Regenesys (2005:36) concurs, as indicated in their statement that the board must ensure that public funds given to hospitals are used wisely and the board must be involved in financial reviews and approval of expenditure of the budget in a given financial year.

1.2.4 Human resource management, planning and training

It is interesting to note that in terms of the Northern Province Health Act no. 5 section 17 of 1998, the hospital board must be involved in the creation of additional posts on

the staff establishment of the health service facility/hospital. Indeed, hospitals are seen as labour-intensive institutions and the issue of reviewing current staff establishments is a serious challenge for the human resource development and planning section of many hospitals. The challenge that remains is about whether members of the hospital board have the skills and powers to execute such an important and complex function of recruiting and improving the structures of hospitals. Nevertheless, the Hospital Ordinance 14/1958 (as amended in 1999) outlines that a board must be involved in the appointment of staff.

Another area of responsibility involves monitoring the implementation of human resource policies and the work ethos of different professionals. Kazemek *et al* (2000:236) highlight that hospital boards must be involved in the selection and appointment of the chief executive officer of the hospital. This requires the board to have a clear understanding of the competencies that are needed for the required chief executive officers. This was evident in the case of Zimbabwe where a hospital board's roles and responsibilities on human resource matters involved them in appointing medical staff, clinical teaching staff and other support staff of a hospital, as discussed by Needleman *et al* (1996:65). The Minister of Health here consulted with the hospital board prior to the appointment of a Medical Superintendent of a hospital and other non-medical staff. This would enable the minister to closely monitor the performance of the hospital board as he or she would have been involved in the appointment process from the beginning.

1.2.5 Roles and responsibilities of hospital boards

Pointer & Ewell (1994:135) note that there is an important difference between the "what" (responsibilities) and the "how" (roles) aspects of governance. They suggest that boards execute three roles in order to fulfil their ultimate responsibilities of policy formulation, decision making and oversight. Policies provide an organization with direction and are the means whereby specific tasks and authority are delegated to management and the medical staff. Policies also guide decisions and actions and provide a framework for the board to carry out its decision-making role. The board makes decisions in each of its areas of responsibility. The board then engages in oversight through monitoring and evaluating outputs, outcomes and actions to ensure that they conform to policy and procedures and produce the desired results. Griffith

(1988:302) also adds that there are five non-delegable duties for any hospital board and as such hospital boards are expected to perform such roles and responsibilities themselves. These are:

- the establishment the hospital's mission;
- the appointment of, and support for the CEO;
- the approval of a long-range plan;
- the recommendation and approval of annual budgets.

In the Northern Province Health Act, Act 5 of 1998, a list of roles and responsibilities which appointed board members are to execute is outlined under section 17 as follows:

- to make recommendations to the HOD, district manager or manager of a health facility on matters affecting health services and on how health services may be improved;
- to consider the suitability and efficiency of officers on the staff of any health services or facility;
- to furnish comments and recommendations to the HOD through the medium of the district manager on all matters, reports, documents or recommendations relating to:
    - the annual estimate of revenue and expenditure,
    - the financial statements and report of auditors,
    - the creation of additional posts,
    - the creation, extension and alterations of buildings,
    - the maintenance of buildings and equipment,
    - the standardization of equipment, buildings and procedures,
    - the entering of contracts,
    - regulations,
    - any complaint by a patient, member of the public, any practitioner or staff,
    - economy and efficiency and the general activities of such health service or facility.

- to inspect the health service or facility at least once in every three months;
- to advise the district manager and local manager on any other matters submitted to it;
- to exercise such other functions and carry out such other duties as the MEC may from time to time determine.

The identified roles and responsibilities for appointed hospital boards would definitely need members who are truly committed, eager to work towards the improved management of the hospital and who have background knowledge about different fields in the health fraternity.

1.2.6 Oversight role: advisory and technical support to management

In his research on "Improving Hospital Board Effectiveness", Kovner (1990:27) confirmed that the hospital board is legally responsible for hospital affairs in totality. To this end he argues that it must ensure that:

- there are quality controls in a hospital;
- they serve as a community steward;
- they assess the performance of the chief executive officer;
- they serve as a strategic decision maker;
- they are risk takers, experts, mentors and evaluators;
- they serve as a rational advisor to management and
- they support management in managing change in a hospital.

In addition to what Kovner (1990) indicates, the Hospital Ordinance 14/1958 (as amended in 1999) also emphasizes is that the hospital board monitors hospital performance, as measured against standards of services and it must inspect the hospital regularly - at least once every three months. In line with the Public Service Transformation White Paper, all institutions are expected to develop service standards in line with Batho-Pele principles and compliance to such standard is compulsory.

In many hospitals, hospital management draft and review service standards and conduct performance reviews including satisfaction surveys as a way to ascertain if they meet the expectations of external customers. This helps to develop improvement

plans to cover the gaps identified. This is an area where appointed hospital boards could play a very meaningful role in improving the services offered to the patient.

1.2.7 Community participation and advocacy

According to Hospital Ordinance 14/1958 (as amended in 1999) the hospital board must:

- represent the community's interests in relation to the hospital;
- build support for the institution in the community it serves;
- decide on how to use any resources received as donations to the institution;
- monitor the extent to which the institution fulfils its commitment to serving all sections of its community;
- ensure that the personnel of the hospital do not practice any form of racism or other kinds of discrimination;
- monitor and support the hospital's contribution to development of primary health care and the building of an effective district health system (Naidoo 2007:11-12 & Mabena 2006:5-7).

Regenesys (2005:28) emphasizes that a hospital board is an important structure which acts as:

- a link between the hospital and community,
- a means to communicate the needs and views of the hospital,
- a structure to build support in the community for health programmes,
- a facilitator of participation in the planning of services which involves the broader communities.

Regenesysis further postulates that a board could promote and market services and also play an oversight role on behalf of the community when it inspects the hospital and monitors the quality of service and other administrative activities while Kazemek *et al* (2000:236) also highlight that a hospital board should ensure enhancement of community/stakeholders relationships and see to it that the needs of communities are addressed.

1.2.8 Physical facility improvements

Revitalization and improvement of hospital structures contribute much to the perceptions on the nature of services to be rendered at a hospital. Section 17 of Act no. 5 of the Northern Province Health of 1998 emphasises the important role which the hospital board can play in the erection, extension and alteration of buildings; the maintenance of buildings and equipments; the standardization of equipment, buildings and procedures, and in entering into contracts and regulations. This would obviously need members of the hospital board to have understanding and knowledge in facility planning and management.

1.2.9 Complaint management: internal and external customers

In terms of service improvement, the board is expected to check the level of patient satisfaction, that clinical quality measures are in place, the costs in service delivery, community involvement, service to the community, provision of service to the indigent, patient safety and infection control issues (Middleton, 2005:243). Section 17 of the Northern Province Health Act no. 5 of 1998 also highlights that the hospital board must address any complaint by a patient, member of the public, any practitioner or member of staff. This requires that the board play a meaningful role in ensuring that there are clear, effective and efficient complaint management systems and procedures for both staff and customers (patients and community at large). If complaint management systems are put in place at satisfactory levels then service delivery should also improve significantly.

1.2.10 Challenges facing hospital boards

Hospital boards sometimes face a number of challenges. Prycor (1994:24) in his investigations found out that boards fail in their operations because of a lack of expertise in the health care fraternity, when member selection is flawed or biased, members are poorly oriented to the organization and they do not understand their role, especially vis-à-vis the CEOs. In addition, boards fail when they do not monitor confidentiality and conflict of interest among their members. Again, the board fails when they do not understand the mission of their organization.

Barry (2005:25) describes his experience as a CEO of a hospital and in the health system for 30 years and focuses on the question of the lack of capacity of board members. He got to know and work with many community leaders who served on hospital boards and thus realized that it is important to create an effective orientation programme which requires continuous education for members of the board. He pointed out that new members of the board must have diverse expertise and experience. He further emphasized that the board must stay focused on its vision and mission and avoid conflict-of-interest at all costs. Finally, he indicated that any new board must be assisted to focus on the right issues so that it will be able to deliberate on effective strategies. To accomplish this, a board will definitely need a hospital management team that is dedicated to the development and improvement of a hospital.

1.2.11 Governance and leadership

The findings from McDonagh and Umbdenstock's (2006:12) study of hospital governing boards at 64 hospitals where hospital board members were evaluated based on six competencies covering contextual issues, educational, inter-personal, analytical, political and strategic matters validated the importance of governing boards in the performance of hospitals. It demonstrated further that there was a strong correlation between more effective boards and positive financial performance in hospitals. It was also established from the study that governing boards provided valuable leadership and were no longer chosen to serve in the board base on the grounds of their social standing or financial capacity but rather for their ability to think creatively and think about what they could contribute. The recommendations from the study emphasized that hospital boards should regularly monitor scoreboard indicators to measure the quality, service and financial progress and the goals of community needs. The study reflected on the fact that the board examined its own effectiveness and how that related to the hospital's overall performance. In "Improving Hospital Board Effectiveness: An update", Kovner (1990:27) confirms too that the hospital board is legally responsible for the hospital's affairs in totality.

There are other studies that focus on the roles and responsibilities of boards. Kane *et al* (2007:245) explore the roles and responsibilities in their study, "Hospital Board Dynamics: The Five Questions". They established that hospital boards are under

increasingly public scrutiny over how they discharge their responsibilities. They noted that hospitals are also scrutinized over the adequacy of public financial disclosure and oversight, excessive executive compensation, hospital policies affecting the provision of care and collection of bad debts, pricing of services to the uninsured and quality of hospital care. In this study they recommend that the board's role should be:

- to strengthen the relationship between the board and the management;
- to increase performance of personnel;
- to harness the decision making process;
- to provide information management;
- to promote a good relationship with the CEO of the hospital so that accurate and up to date reports are received for accountability's sake. These roles will strengthen the governance matters of hospitals.

The study by Govindaraj *et al* (1996) established that the two hospitals in Ghana found it important to ensure that enabling conditions existed for the board to function effectively and this entailed clear and unambiguous guidelines on the role, functions, and powers of the board. The study argues further that the responsibilities of the boards must also be clearly specified to enhance good governance and that hospital board members should be held publicly accountable for their decisions and actions - with a clear definition of the sanctions to be imposed for contravention of their duties. The other important finding, especially relevant to the South African situation, is that the boards must be allowed to function independently, without the Ministry of Health's interference, subject to the overall policy direction of the government. The researchers felt that in the absence of such arrangements, the Board will, very likely, end up either as just another organ of the government or a body incapable of making effective decisions.

Another interesting finding from the study is that in many ways, the situation in Ghana proved that the powers of the hospital boards were so heavily circumscribed that they were autonomous only on paper. Moreover, the majority of the appointees to the boards were either from the government itself or owed their appointments to the government, which raised questions about their ability to function as an autonomous body. The political nature of the appointments to the hospital boards meant that the boards did not enjoy the complete confidence and full support of the staff at the two

hospitals. Under these circumstances, it was not surprising that the presence of the boards has not brought about many significant improvements at the two hospitals, either in their day-to-day functioning or in the overall performance (Govindaraj *et al* 1996:125). The situation in South Africa is similar as the appointment of most of hospital boards is politicized even though the guidelines on nominations from the Act are very clear. In most of the hospital boards one is appointed by virtue of one's political affiliation and not for the skills and knowledge of health matters and or the eagerness to work for the community. This observation is supported by investigations on several hospitals' governance matters as discussed by Humans (2006:6) and Lobelo (2006:8).

Finally, as Middleton (2005:243) pointed out, governing a hospital or healthcare system is a difficult and demanding job. If done properly, the organization can operate well. If the board is inept or incompetent, the organization will suffer. He also highlights some of the important aspects for a hospital board to be effective. These include emphasis on the advocacy, risk management, information technology, compliance to norms and standards, and service provision improvements.

1.2.12 Qualifications and skills of hospital board members

The issue of qualification criteria is very important in the evaluation of some of the roles and responsibilities of hospital boards. Earlie & Schlosser (2005) note that an increasing number of healthcare boards are embracing the same governance practices as private boards, by adopting best practices and critically evaluating current and potential board members to ensure that they comprise the right mix of skills and independence necessary for responsible governance. They argue that:

> "To recruit board members with business skills that will best complement the strategic direction of the board, those involved in community issues and those with corporate experience, those with passion and time to be committed to the organization's mission, those with past experience working with both corporate and not for profit boards (2005:14)."

Furthermore, Alexander *et al* (2006:291) studied how governing boards' configuration has influenced organizational changes in the US hospitals and they found out that hospitals governed by boards which closely resembled a corporate governance model were more likely to experience positive changes such as diversification and mergers and less likely to undergo negative changes such as closure.

The need for better qualified board members and corporate strategies also extends to rural hospital facilities. The study by Saleh *et al* (2002:321*)* of 140 rural hospitals found that there was a need to revisit the board composition before actively pursuing a strategic action and after examining the compatibility of the type of strategic activity with the background of board members and the interest of populations they represent they suggest governing boards use their best resources in determining which new strategic activities to undertake. In addition, as alluded by Hageman *et al* (1990:29), the responsibility of governance is conferred to governing boards on behalf of the community it serves. According to Hageman *et al* to govern is to exercise continuous authority, to guide and direct, hence a hospital's authority and direction should serve the needs of its patients and area. The board must perform tasks with the valued expertise and assistance of its primary delegates: the management and the medical staff. Hageman *et al* thus purport that appointed hospital board members should at least have background knowledge and experience in the different fields of a hospital set-up. This observation is supported by stipulations in the National Health Act of 2003, where it is indicated that those with expertise in finance, accounting, human resources, legal and information management should avail themselves to serve on the hospital board.

1.3 Aims and objectives of this study

1.3.1 Main aim of the study

The aim of the study is to assess the capacity of hospital board members in relation to the roles and responsibilities at public hospital boards in the Limpopo Province.

1.3.2 Objectives of the Study

- To determine the roles and responsibilities of hospital boards in the Limpopo Province since 2004.
- To establish the main challenges faced by public hospital board members in fulfilling their roles and responsibilities.
- To determine the qualification criteria for those appointed onto hospital boards.

1.4 Rationale and problem statement

1.4.1 Justification for the study

The researcher's interest lay in assessing the roles and responsibilities being played by appointed hospital board members in line with available health legislative framework in South Africa. This is to ensure that public hospitals are managed effectively and efficiently and that quality service is provided to both internal and external customers. In the Limpopo Province, Hospital board members are appointed by the Member of Executive Council (MEC) for Health and Social Development in accordance with the Northern Province Health Act 5/1998 and its regulations (Gazette 27 December, 2000). The question of uniformity in appointing hospital boards still remains as currently it is left to the discretion of provincial departments to appoint the boards, using a different legislative framework. This obviously impacts on the boards' activities. The new National Health Act 61/2003, which came into effect in 2004, gives guidance on how to set up the boards but some provinces have failed to adhere to the Act's stipulations, bringing into question the issue of uniformity regarding the establishment of hospital boards.

1.4.2 Statement of the problem

Hospital managers' view appointed hospital board members as failing to effectively and efficiently execute their roles and responsibilities in line with the legislative

framework and available guidelines which seek to ensure improved service delivery in public hospitals. Instead they are characterized by role ambiguity or role confusion, apathy and with having no link with the communities they represent. In addition, there seems to be no mechanism in place that can monitor and review the members of boards in order to enforce accountability to the Provincial Members of Council who appointed them. Mashishi (2007) indicates that board members at Dilokong Hospital in Limpopo Province were unable to effectively execute such tasks due to a lack of understanding and experience over the complex nature of hospitals and health care, finances, budgeting or quality assurance. Another complicating aspect hindering progress was that various board members had hidden agendas other than the interests of the community. These manifested in the way members failed to attend meetings, did not give the needed support to management and, ignored the monitoring that was required. They also failed to provide feedback to communities regarding health issues, failed to submit performance reports to the MEC as stipulated in the Provincial Health Act and finally, did not safeguard the hospital image due to their own interests or agendas (Mashishi 2007:9-10).

1.5 Limitations of the study

The researcher faced serious apathy as some board members' participation in the study was low. The timing was also not conducive due to the fact that the term of office of some had expired and most hospitals were busy with the process of establishing new hospital boards. In terms of the Act, the current board members are expected to serve until a new board has been reappointed. The other challenge which the researcher experienced was that most members were not easily available as they are engaged in other activities; most work in other government departments, municipalities and non-governmental organizations. Furthermore, the fact that all CEOs are ex-officio officers of hospital boards created some challenges as they had their own strong feelings about the roles performed by board members who exposed poor relationships between the management and the hospital boards. Another limitation was that of telephonic interviews in that the researcher could not observe non-verbal aspects related to answers given by the respondents.

The researcher noted recall bias, though it was minimized to a certain level by giving clear- cut roles and responsibilities which the board members were supposed to perform, but respondents from outside the hospital failed to recall some of the roles and responsibilities they were involved in since 2004 to the date of the research. They also had no chance to go through the questionnaire prior to the interview to remind themselves of such important roles performed in an orderly fashion. Finally, respondent and selection bias was also noted as another limitation where members who used to attend hospital board meetings at the regional level might not have reflected the true picture of what is happening in the hospital they represent.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 Study Design

This is a qualitative study. The researcher gathered views of current board members who were appointed by the MEC for the Department of Health and Social Development in the Limpopo Province since 2004. The rationale behind focusing on these board members is that they would be able to share their experiences of what happened during their terms of office.

2.2 Study population

The study focused on all appointed hospital board members who form part of the regional hospital board at Tshilidzini hospital. It is the only regional hospital in the Vhembe District Municipality and serves four sub district municipalities, namely Musina, where there is one district hospital (Messina), Thulamela sub-district municipality, which has two hospitals (Donald Frazer and Malamulele), Makhado sub-district, with three hospitals, (Elim , Louis Trichardt Memorial and Siloam) and Mutale sub-district, which has no hospital. The above mentioned district hospitals have their own hospital boards which were appointed by the MEC for Health and Social Development.

The key respondents in the study were selected from the regional hospital board. The boards in all district hospitals are composed of the hospital manager, who is the CEO, one full time hospital employee (practitioner), one full time employee (non-practitioner), one municipality representatives and five community representatives. The arrangement is the same in all six district hospitals in the district and also in other district hospitals in the province as stipulated by the Northern Province Health Act of 1998. As a result three members of such boards are supposed to be members of the

regional hospital board. This implies that the members who are part of the regional hospital board should be eighteen as there are six district hospitals. The board of a regional hospital is comprised of the hospital manager, who is the chief executive officer, one full time hospital employee (practitioner), one full time employee (non-practitioner),one representative from each district hospital in the region, each of who should be is an employee of each hospital, one local municipality representatives and two representatives designated by each district hospital board, not employed by its health services, meaning that they should be coming from outside structures. Thus the members who should come from Tshilidzini hospital are supposed to be five. The total numbers of members who participated in the study were twenty three (23).

2.3 Study sample

The purpose of the study is to get the views of those members who formed part of the regional hospital board. The sample is a purposive one made up of 18 members from Malamulele, Messina, and Louis Trichardt Memorial, Donald Frazer, Siloam and Elim district hospitals and 5 members from Tshilidzini regional hospital, all found in Vhembe district. The selection criterion is in line with Northern Province Health Act of 1998, which stipulates clearly how a regional hospital board is supposed to be constituted. All district hospitals in Vhembe were considered in the study. A list of who form part of the regional hospital board was obtained from the secretariat of the regional hospital board and then all the respondents were contacted after seeking permission from the responsible CEO of that particular hospital. In instances where board members from a particular institution were replaced, an alternative name was obtained.

The researcher was able to interview respondents using the face-to-face format and through telephone interviews. A tape record was used, after getting permission from participants using on both open ended and closed ended questionnaires. This approach provided participants, to record their responses with an opportunity to express their own views about the research topic. The respondents' were interviewed at the identified hospitals, their working stations or homes using tape-recorder as per prior arrangement with them. Recorded telephonic interviews were used for those who

were not available due to work or other commitments. Open-ended questions were used in the study as they are very powerful in understanding and describing people's opinion, experiences, feelings and insights. Open-ended questions allowed the respondents flexibility in reflecting their thoughts and perceptions. They also provided a number of alternative answers from which a choice has to be made. Respondents were asked on whether they were involved in performing tasks as required by the act or never performed such roles and responsibilities. For the respondents profile see annexure F.

2.4 Study area

The study was conducted at Vhembe District where participants who are members of the regional hospital board at Tshilidzini were interviewed at their place of convenience or place of abode or workstations.

2.5 Pilot study

A pilot study was not conducted for this study taking into consideration the nature of the study and kind of respondents involved in the whole study.

2.6 Data collection, management and analysis

The data for the study was collected during the month of September 2008. The demographic particulars of the participants were also ascertained. These covered the gender, age, the year when the board member was appointed and employment status. The rationale of including such background information was for the researcher to have clear information on who comprised the board and also align it with the research objective of establishing the time when the board members were appointed.

Close-ended questions, based on the actual roles and responsibilities the board members were expected to perform as outlined in the Northern Province Health Act, Act 5 of 1998, and other related training material from Regensysis school of Public

Management, were formed. Board members were asked to reflect on their experiences as hospital board members from the time they were elected into office in 2004. They were free to agree or disagree if they performed or not performed the roles and responsibilities during their term of office. The close-ended questionnaire focused on specific areas of the board responsibilities in line with the Act and covered the following areas, (see annexure A):

- strategic planning matters;
- advisory and technical support to management and oversight;
- financial management and supply chain management;
- physical facility management;
- human resource management, planning and training;
- community participation and communication;
- information management and technology;
- complaint management;
- advocacy and fund raising;
- quality assurance and quality of service;
- risk and security management.

The researcher allowed those who were interviewed personally to complete the questionnaire themselves to enable respondents to finish without other influences. For the others, the researcher read out the questionnaire to them with a brief background about the research and the consent issues. An in-depth interview based on open-ended questions was conducted with selected hospital boards from district hospitals and the regional hospital. The focus was on the following:

- the hospital management's appreciation of what they were doing;
- possible challenges or problems faced by the hospital board members;
- what was needed to ensure effectiveness and efficiency of board functionality;
- who they thought should be members of the hospital board and why they thought it was important to include such a member;
- recommendations to enhance the hospital's overall performance through the hospital board and management.

The researcher used the Microsoft Excel Software and Electronic Health Information System (EHIS*)* package, to analyze the data. The questions were put into categories in line with the roles and responsibilities stipulated in the Act and other related guiding documents for hospital boards. As the study was a descriptive, the collected data was analyzed, taking into consideration the views and inputs as presented by different participants in the study. A tape-recorder was used to enable the researcher to recall the participants' contributions. This enabled the researcher to capture the views of the respondents as they were expressed and it also assisted when it came to transcribing the inputs. The participants were assured of confidentiality (see attached annexure C for informed consent and annexure D for consent form on tape recording).

Qualitative data analysis is primarily an inductive process of organizing the data into categories and identifying patterns (relationships) among the categories. As a result the researcher developed some themes or topics in accordance with the main focus areas of study and what had been learnt from the literature reviews on the roles and responsibilities of hospital boards in the country and internationally. The views of the respondents were then summarized accordingly.

2.7 Ethical considerations

A number of procedures were considered and followed to ensure proper ethical consideration. A formal letter was forwarded to the Head of Department (HOD) of the Department of Health and Social Development through the research unit in Limpopo province to seek permission to conduct the research. The permission was granted (See annexure G). Permission to conduct the research was also granted in September 2008 by the Ethics Committee from the University of Witwatersrand in Johannesburg. An application form was also forwarded for their approval.

An information sheet was developed outlining the main focus of the study to enable participants to have clear background information on why the study was being conducted. Those who were interviewed telephonically were briefed about the research and on information sheet was faxed to them (See annexure B).

In order to ensure proper informed consent, all respondents were briefed about the nature and purpose of the study prior to its commencement and permission was sought to record the interview. All participants in the study were informed that their involvement was purely voluntary and they were reassured that their contribution was confidential and would not lead to any victimization for playing a part in the study or choosing not to. All respondents were assured that the data collected would be kept confidential and would not be shared with anyone, apart from my research supervisor. The participants completed the questionnaire to gather demographic information before the commencement of the interview. This demographic information included age, gender, time of appointment and employment status.

CHAPTER 3
FINDINGS

3.1 Introduction

The aim of this chapter is to present the findings. The aim of the study was to assess the roles and responsibilities of hospital boards in the public hospitals in the Limpopo Province.

3.2 Social demographic characteristics of participants

3.2.1 Age of respondents

It is interesting to note that from the findings that 70% (16) of the respondents were between the ages of 41and 50 years. This implies that they are likely to engage in rational thinking processes as they are in the middle adulthood in contrast to the 17% (4) in the young adulthood age. The table below reflects the statistics with regard to ages of respondents.

Table 1: Age of respondents

Age of respondents	n=23	%
20-30yrs	0	0
31-40yrs	4	17
41-50yrs	16	70
51-60yrs	2	9
60yrs	1	4

3.2.2 Gender

A majority of the board members were males representing 65% (15) of the participants while only 35% (8) were females. The results as reflected in the diagram below show that more males than females were interested in engaging themselves in the community affairs.

Table 2: Gender of respondents

Gender of respondents	n=23	%
Males	15	65
Females	8	35

3.2.3 Employment status of board members

The majority of the board members, 80% (20) are government employees, mainly the Department of Education and local municipalities in Vhembe district while only 4% (1) are self employed and 9% (2) are unemployed.

The table below depicts statistics of the employment status of the respondents.

Table 3: Employment status of respondents

Employment status of respondents	n=23	%
Government employees	20	80
Self employed	1	4
Unemployed	2	9

3.2.4 Year of appointment

As the study focused much on members who were appointed since 2004, it was noted from the study that 65% (15) of board members were appointed in 2004 when new board structures were put in place. Furthermore, in order to replace those who had vacated their positions new appointments were made: 17% (4) in 2005, 13% (3) in 2006 and only 4% (1) were appointed in 2007. This is reflected in the table below

Table 4: Year of appointment of respondents

Year appointment of respondents	n=23	%
2004	15	65

2005	4	17
2006	3	13
2007	1	4

3.3 Strategic planning matters

3.3.1 Strategic planning and monitoring implementation of plans

It was confirmed by 17% (4) of the respondents that board members were involved in strategic planning when invited by the management while 83% (19) disagreed. In terms of monitoring developed plans, some 65 % (15) indicated that they were involved and 35% (8) disagreed.

Some 22% (5) agreed they were involved in developing the institutional policy framework while 78% (18) disagreed and in terms of monitoring implementation only 13% (3) confirmed participation and 87% (20) disagreed. The table presented below reflects the views of the respondents.

Table 5: Strategic Planning matters

n=23	Strategic planning	%	Policy development	%	Monitoring implementation	%	Participation	%
Agree	4	17	5	22	3	13	15	65
Disagree	19	83		78	20	87	8	35

3.4 Advisory, technical support and oversight role

A hospital board is expected to play an advisory role and also to give technical support to the management of a health facility. The table below reflects the views of the respondents on issues of participation in performance reviews, conducting inspections, playing an oversight role, attendance of meetings and also the issue of giving expert advice.

Table 6: Advisory and Technical Support

N=23	Expert advice	%	Meetings	%	Oversight	%	Inspection	%	Performance reviews	%
Agree	9	39	13	57	9	39	11	48	5	22
Disagree	14	61	10	43	14	61	12	52	18	78

One of the key findings of this study is that 61% (14) of the respondents felt that board members did not provide expert advice toward the hospital's handling of finance, human resource management, information management and legal issues, while 39% (9) agreed that they did perform such a role.

Findings on attending hospital board meetings are that 57% (13) of the respondents confirmed that board members attended meetings when invited as per schedule, while 43% (10) indicated that they did not attend.

As far as performing an oversight role on performance of staff and management through monthly, quarterly and annual reports, the findings are that 39% (9) agreed that members of the board performed the oversight, while 61% (14) disagreed. This is however in total contrast with the views of 78% (18) of the respondents, who indicated that they did not attend the monthly, quarterly and annual performance reviews and the 22% (5) who pointed out that board members were able to attend.

Hospital board members are expected to conduct inspections regularly at the hospital. However, it was found out in the study that 48% (11) were able to conduct institutional or hospital inspection visits while 52% (12) indicated that they did not perform such an important task.

3.5 Financial management

The table below reflects the research findings on financial management and it covers the views of the respondents on important aspects about what the appointed hospital board members are expected to do in terms of the Northern Province Health Act of 1998.

Table 7: Financial Management

n=23	Budget planning	%	Budget approval	%	Recomme-ndations	%	Financial reports	%
Agree	6	26	2	9	2	9	5	22
Disagree	17	74	21	91	21	91	18	88

Table 8: Financial Management (continue)

n=23	Report to MEC	%	Fundraising	%	Revenue strategy	%
Agree	5	22	3	13	2	9
Disagree	18	88	20	87	21	91

It is shocking to establish from the findings that 74% (17) of the respondents disagreed with the view that board members were involved in the budget planning process. In terms of the effective and efficient utilization of the budget of any given hospital only 26% (6) of the respondents indicated they were involved in the whole process. This leaves much to be desired. Some 91% (21) of the respondents pointed out that board members never approved of or made recommendations on the budget for the hospital to the MEC.

The review, compilation, presentation of financial expenditure reports on a monthly, quarterly and annual basis to the office of the MEC/HOD as required by the Act, was not done as indicated by 78%(18) of the respondents. It is also disappointing to learn that the 87% (20) of the respondents were not involved in fundraising efforts to supplement the budget of the hospital.

The performance of such a role assists management of the hospital to realise an improvement of the services delivered to the community. It is, therefore, not surprising to note that 91% (21) of the participants felt that board members play no role in the development of a hospital's revenue strategy.

3.6 Supply chain management

The table below reflects how respondents were involved in the supply chain management process.

Table 9: Supply chain management

n=23	Supply chain management	%	Bid-tender committee	%	Tuck-shop management	%	Equipment management	%
Agree	2	9	3	13	2	9	1	4
Disagree	21	91	20	87	21	91	22	96

The findings show that only 9% (2) of the respondents indicated that they were involved in the procurement process of the hospital where members served as part of the hospital bid committee adjudicating and awarding tenders to service providers. There were 91% (21) who also disagreed with that and the figure reflects that board members know very little of what will be happening and as such, it will be very difficult to play their oversight role effectively. This is again evident in the fact that 91% (21) of the respondents suggested that board members played no role in the monitoring and inspecting of tuck shops at the hospital.

Furthermore, 96% (22) of the respondents indicated that board members were not involved in the process of purchasing equipment, while only 4% (1) claim that board members were part of the procurement process.

3.7 Physical facility management

On the question of whether the hospital board members were involved in the process of making recommendations regarding the building of the hospital and maintenance to the province, some 74% (17) disagreed while only 26% (6) agreed that they were involved in the process. Only 13% (3) agreed that boards had submitted architectural plans to the province and 87% (20) disagreed. Some 83% (19) indicated that the members were not involved in the establishment of recreational facilities, while only 17% (4) agreed with that. All 100% (23) of the respondents disagreed with the fact that board members helped in opening a crèche for the children of members of staff. These statistics are depicted in the tables below.

Table 10: Physical facility management

n=23	Building recomm-endation	%	Approved hospital plan	%	Recreation for staff	%	Crèche opening	%
Agree	6	26	3	13	4	17	0	0
Disagree	17	74	20	87	19	83	23	100

Table 11: Physical facility management (continued)

n=23	Ground use	%	Monument	%	Name change	%	Governing body	%
Agree	3	13	2	9	1	4	1	4
Disagree	20	87	21	91	22	96	22	96

As the submission of architectural plans to the province is another important responsibility of any hospital board, it is interesting to note from the findings that 74% (17) of the respondents disagreed that hospital board members were involved in the process of making recommendations to the province regarding building of the hospital and maintenance, whereas only 26% (6) agreed that they were involved in the process The findings show that 87% (20) disputed the fact that board members are involved.

The findings also reflect that 87% (20) of the respondents disagreed with the point that the hospital board was engaged in approving of the use of the grounds and buildings of the hospital for community activities and projects. Only 13% (3) agreed that the boards were doing such tasks. Also, on the question of hospital name changes, only 4% (1) indicated that they were involved whereas 96% (22) disagreed and this was also the case with matters relating to engaging themselves in governing matters of the hospital.

3.8 Human resource management, planning and training

On the question of whether the board ever made any recommendations to the MEC on the recruitment and appointments of managers and clinicians, some 87% (20) disagreed, while 13% (3) agreed. On the question of whether members are part of developing staffing practice, 83% (19) disagreed while only 17% (4) agreed. All,

100% (23) disagreed with the fact that board members are involved in the PMS evaluation and no one indicated if ever boards are engaged in the activity. On the question of whether they should be involved in workplace discipline matters, some 70% (16) of the respondents disagreed while 30% (7) of the respondents agreed. On involvement with career development matters of staff some 87 % (20) disagreed that board members were engaged in this issue and only 13% (3) agreed. The question of their involvement in the short listing and interviewing process as observers led to some 48% (11) of the respondents to agree with the fact that board members were involved and 52% (12) disagreed. On staff recreational matters some 87% (20) disagreed that board members were engaged in recreational matters of staff and only 13% (3) agreed. All, 100% (23) disagreed that the board was responsible for recommending good performers and no respondent agreed to that.

The study revealed that 70% (16) of respondents did not engage themselves in staff discipline matters while only 30% (7) agreed that they had been part of the process.

It is interesting to note that 48% (11) of the respondents played a role as observers during the short listing and interviews process whereas 52% (12) denied having played any part in that. The tables below depict the views of the respondents.

Table 12: Human resource management, planning and training

n=23	Appointments recommendation	%	Staffing practice	%	PMS Evaluation of staff	%	Workplace Discipline	%
Agree	3	13	4	17	0	0	7	30
Disagree	20	87	19	83	23	100	16	70

Table 13: Human resource management, planning and training (continued)

n=23	Career development of staff	%	Observers in interviews	%	Staff recreational facility	%	Good performers awards	%
Agree	3	13	11	48	3	13	0	0
Disagree	20	87	12	52	20	87	23	100

3.9 Community participation and communication

On the question of the hospital board being able to communicate the community's needs and views to the hospital through proper channels such as board meetings, village committees and surveys, as well as giving regular feedback to the community some 74% (17) disagreed with the point. Only 26% (6) agreed that the board was able to do that. Only 43% (10) agreed that board members were able to give feedback, while 57% (13) disagreed.

There are also findings based on the responses to the question on whether the hospital board members were able to officiate during the official hospital's activities on behalf of the MEC when requested and 48% (11) of the respondents indicated that they were able to officiate while 52% (12) failed to acknowledge that such roles and tasks were performed by the board.

On the question of whether board members at various institutions were able to communicate the community's needs and views to the hospital through proper channels such as board meetings, village committees and surveys so that regular feedback could be given to the community represented, some 74% (17) of the respondents disagreed. Only 26% (6) of the respondents agreed that the board met this expectation. It is interesting to note that members were able to attend the Health and Social Development Summit as confirmed by 83% (19), while only 17% (4) disagreed with that. It was noted that on the question of whether the hospital board members were able to officiate on behalf of the MEC when requested, some 48% (11) of the respondents indicated that they were able to do this while 52% (12) failed to acknowledge that such a role and task were performed by the board.

The table below summarises the views of the respondents.

Table 14: Community participation

n=23	Communicate needs	%	Give feedback	%	Officiate functions	%	Attend summit	%
Agree	6	26	10	43	11	48	19	83
Disagree	17	74	13	57	12	52	4	17

3.10 Information management and complaint management

The results from the study reveal that 57% (13) of the respondents indicated that the appointed boards failed to provide a forum to hear the community's complaints, and to listen to the grievances between staff and the public at large. For the 43% (10) of the respondents who indicated that they were able to perform such tasks, it will be interesting to know how they were doing it, the issues they discussed in such meetings and which methodology they would have used in disseminating information to the communities. Some 61% (14) respondents indicated that the appointed boards failed to provide a forum to hear community complaints, grievances between staff and the public at large or to monitor the investigation and complaints resolution progress. Furthermore only 39% (9) agreed to the fact that the board is involved in the process.

The issue of complaint resolution shows that 48% (11) of the respondents agreed that board members were part of the process while 52% (12) disagreed. The views of the respondents are reflected in the table below.

Table 15: Information management

n=23	Information dissemination	%
Agree	13	57
Disagree	10	43

3.11 Advocacy and fundraising

In all instances, 39% (9) of the respondents agreed that they were able to execute such tasks while 61% (14) pointed out that they never engaged themselves in it. The majority 87% (20) of respondents indicated that they were never involved in fundraising and the making of fundraising plans for the hospital. It is not surprising, therefore, to learn that the board members failed to raise or receive some donations and bequests or to even open and administer a trust account for the hospital, as was confirmed by 91% (21) of respondents.

The tables below reflect the results of an evaluation of the advocacy role, fostering of partnership with stakeholders and the promotion and this is reflected in a similar pattern in the marketing of hospital services to communities.

Table 16: Advocacy and Fundraising

n=23	Advoc-acy role	%	Foster partnership	%	Promote & Market services	%	Fundraising	%
Agree	9	39	9	39	9	39	3	13
Disagree	14	61	14	61	14	61	20	87

Table 17: Advocacy and Fundraising (cont.)

Develop Fundraising Plan	%	Donations & Bequest	%	Open Trust Account	%
4	17	2	19	2	9
19	83	21	91	21	91

3.12 Quality assurance and monitoring

Only 9% (2) of the respondents indicated that they are involved in patient safety monitoring and 9% (2) check and monitor the level of patients' satisfaction, while 91% (21) disagreed. 13% (3) agreed that they were part of patient surveys with 87% (20) disagreeing. Furthermore only 4 % (1) indicated that they monitored the norms and standards while 96 % (22) disagreed. It is also shocking to learn that 91% (21) of the respondents disputed the view that the elected hospital board members were engaged in checking patient safety and monitor the level of satisfaction while only 9% (2) of respondents indicated that they are involved.

With regard to engaging themselves in patient surveys and developing and monitoring develop norms and standards, 87% (20) and 96% (22) of the respondents disagreed that the appointed hospital board ever performed such a task and only 9% (2) pointed out that they monitored patient satisfaction and compliance to norms and standards.

Table 18: Quality assurance and monitoring

n=23	Ensure patient safety	%	Conduct quality assurance survey	%	Monitor patient satisfaction	%	Ensure compliance to norms and standards	%
Agree	2	9	3	13	2	9	1	4
Disagree	21	91	20	87	21	91	22	96

3.12.1 Development of ethos and attending to patients' interests

Having an active interest in the well-being and welfare of patients warrants one to be truly committed. It is, however, amazing to learn from the study that 65% (15) of the respondents were not eager to be involved in programmes which address the interests of patients. In addition 65% (15) of the respondents were unable to develop ethos for caring over the patients at all levels of the hospital. It is only 35% (8) and 39% (9) of the respondents who agreed that they were able to engage themselves in such tasks. The table below depicts the inputs from the respondents.

Table 19: Quality assurance and patient's interests (continued)

n=23	Catering ethos	%	Patient interest	%
Agree	9	39	8	35
Disagree	14	61	15	65

3.13 Risk and security management

It is interesting to note that 91% (21) of the respondents disagreed with the point that hospital boards are involved in the implementation of risk and security management programmes that cover both clinical and financial services, while only 9% (2) agreed that hospital board members were involved in risk management matters.

3.14 Appreciation of roles and responsibilities by the hospital management

A majority of 57% (13) of the appointed hospital board indicated that their efforts were not appreciated by the hospital management. This is because management claim that there was a hidden political agenda by the board to impress the MEC who appointed them rather than improving health care service delivery. Other respondents claim that they were not acknowledged because they did not seem to understand what they were doing and did not perform the expected roles and responsibilities. 1 respondent mentioned that:

> "It is like board members are there to police management on what they are supposed to do and only demand reports when they visit the hospital" and further alluded to the fact he once attended a meeting where it was clear that the board members were not sure of their expectations, except for demanding a report from the management."

Only 23% (8) of the respondents highlighted that hospitals' management appreciated what they were doing.

3.15 Possible challenges or problems faced by hospital boards

3.15.1 Lack of commitment and multi-tasking board members

Some 35% (8) of respondents indicated that the main challenge was a lack of commitment on the part of appointed board members. They did not have enough time to perform the expected roles and responsibilities. It was further highlighted that a majority of the board members are involved in other activities or appointed in a number of committees - either in community structures or municipalities. This then, prevents them from being fully active in the affairs of a hospital. Respondents argued that the board members seem

to be preoccupied with their own affairs and pay little or no attention to hospital activities.

3.15.2 Knowledge, experience and expertise in health matters and lack of capacity

Some 30% (7) of the respondents confirmed that as board members they do not have to have adequate knowledge about health-related issues and other challenges that rendered the board members to be ineffective in executing their roles and responsibilities. One respondent said:

> "How do you expect a teacher or an educator to contribute towards good governance issues of a hospital if the member is just a teacher with no background in health matters?"

Other members indicated that most hospital board members do not know how the hospital functions. As a result, one cannot expect any meaningful contribution toward the development of the hospital from such members. They also noted that people with no interest in health matters are appointed and agreed with an observation stating that appointed hospital board members were not accounting quarterly to any structure at the district and province. Another respondent indicated that members show no sign of commitment in meetings when discussing strategic matters in line with what they are expected to do in terms of the Act. Instead, a lot of time is spent discussing issues of personal interest and squabbles with management. One respondent further mentioned that:

> "If you want to confirm this, check all our minutes since we started in 2004. There are not many strategic issues that we discussed except for the stipend allowances for board members, late-coming to meetings, postponement of meetings, differences with management on who had to be appointed or not to be appointed in cases where board members had personal interests on appointments. Board

> members also demanded reports from management in a negative way. What I know is that it was the management team that used to prepare reports for the board but nothing much was coming from the board members themselves on what they were supposed to do in line with the Act. Some board members would only opt to attend functions when the MEC or high profile politicians are attending.*"*

The fact that a majority of the hospital board members did not have expert knowledge in health matters obviously impacted negatively on what they did at a hospital set-up. The views expressed by those representing staff or management indicated that most of the board members had no adequate knowledge about health related issues or challenges and that rendered the board members ineffective in executing their roles and responsibilities.

3.15.3 The relationship between the management and the hospital board

About 21 % (5) of the respondents noted that there was a poor relationship between the appointed hospital board members and management. One respondent indicated that:

> *"*As a hospital board we are not even told of developments in the hospital especially when it comes to appointments and the purchase of equipment. Management will just continue without informing us and as such we cannot serve as rubber stamps."

Another one indicated that:

> "There is suspicion from both sides: management thinks the board is there to sabotage it and the board thinks it is not respected and given latitude to excise its powers."

It is evident that relations between the management and the board seem to be strained and the manifesting mistrust, in turn, hampers service delivery. A majority of the respondents alluded to the fact that the relationship between management and the board is not conducive for good governance and harmony as the two occupy two different worlds. An indication has been made that there is often a struggle for power and authority. Those representing the hospital in the board argued that the board wanted to operate as if it is above the management and wanted to give directives to management. Some members are even seen as having hidden agendas seeking to advance their personal and political interest thus hindering the progress of the hospital.

Nevertheless, board members from outside the hospital argued that they are sidelined by management in many instances. As a result, they were always left in the dark on activities happening in the hospital and this made them unable to make proper and well-considered interventions in the case of challenges. One respondent even went to the extent of saying that:

> "We just see things happening in the hospital and we are not even asked for any opinion and in terms of meetings, 'the secretary' from the hospital just issues the letter without consulting with the chairperson on issues to be discussed. We are not even linked with the province on issues discussed so that we can get proper feedback from the MEC. The MEC, on the other hand, used to call us for *Imbizos* and a number of resolutions are taken following which we are not even updated on progress made. We are worried about that and we feel that should be addressed."

3.15.4 Role confusion: misinterpretation of powers

Another finding was that some board members felt that they are above the management of the hospital. Board members had a different understanding about their roles and responsibilities despite the fact that they were trained for

a week in October 2005 by Regenyses. Board members felt that they had more powers than the management. They felt that they could interfere with the appointment of staff and even told the management what to do. One member of the board, representing the management, alluded that the board was not worried about progress made in the hospital but instead only interested in their stipend allowance. They also stated that the board insisted that the management should be reporting to them. The Act is not explicit on the roles and responsibilities of the board. The act developed by the province seem to be contributing to the confusion as it is not clear about what the board is supposed to do in contrast with the role of hospital management.

Management representatives on the hospital board indicated that most of the hospital boards are seen as ceremonial board members who seemed not sure of what they are supposed to do. One manager explicitly indicated that:

> "It is like board members are there to police management on what they are supposed to do and only demand a report when they visit the hospital. I once attended a meeting where it was clear that the board members were not sure of their responsibilities, except for demanding a report from the management."

It is clear that if these misconceptions and perceptions about systematic modalities and policy framework are not cleared up there would be no need to have such hospital boards. A programme of action should be developed with aim of bringing about synergy on what the management and the appointed hospital board members will be doing to avoid conflict.

3.15.5 Inadequate incentives for board members attending meetings

A number of respondents complained about a lack of incentives or stipend when they attend meetings. They claimed that non-payment of allowances discouraged them from attending meetings. One respondent raised the question that:

> "How do you expect us to be effective without being compensated adequately? The department must review the allowances they are giving us when we attend functions. Some of us stay very far away from the hospital. For example, if I travel all the way from Masisi village which is more than 100km from the hospital where public transport such as buses is so scarce, then the department must look into giving us seating allowances which are reasonable like in private companies and that might serve as a motivation to attend the meetings."

The fact that hospital board members are only receiving a travelling allowance is also impacting on their eagerness to serve on the board. In some instances, some board members have not been paid their meagre subsistence and travelling allowances since their election into the board in 2004. One secretary of a board even supported the notion that hospital board members are supposed to be paid adequately as a way of motivating them to attend the meetings. However, sometimes the reason of non-payment related to the members of the boards failure to submit their payment advice forms despite being given reminders.

One wonders whether the incentives in the form of a sitting allowance, will motivate the board members into being effective members or not. Some argued that people cannot be motivated by money to do voluntary work; it should rather come from within a person to perform to the best of their ability. Hageman *et al* (1990) consider the voluntarism spirit and state that paying board members will not increase their accountability or their effectiveness. This were supported by Delbecq *et al* (1988:28) who argued that a typical health care board member apparently functions from a lay-trustee mindset, i.e. board members should be volunteers with little or no health care experience. Furthermore, Anonymous, (2007:8-14) found out that once board members are compensated, the social contract between a board member and the organization change. From the study it was felt that it is only when board members are purely volunteers that their hearts are in the right place. Others, however, felt that compensation helps to recruit better board members and

strengthen accountabilities. Other hospitals only pay board members a nominal amount per meeting and also cover travel expenses for those residing outside the area of operation.

3.16 Recommendations on how hospital boards can be more effective and efficient

3.16.1 Training and development

Some 35% (8) of the respondents emphasized that hospital board members should receive training before they embark on any task. This will build capacity and enhance performance and as such, workshops should be organized to capacitate the board. In addition, they indicated that a clear policy with clear guidelines on the roles and responsibilities should be developed.

3.16.2 Incentives

About 21 %(5) indicated that there is a need to revisit the Act on the question of allowances. Board members are supposed to have six meetings unless other urgent matters arise. The impression deduced is that the allowance given is not enough. One respondent alluded to the fact that institutions are supposed to have a clear budget for the board members to finance activities such as meetings, workshops, benchmarking exercises and strategic retreat sessions. From the remarks given by interviewed members it would seem that the appointed board members want to be adequately compensated for the time spent attending meetings. A seating allowance would be appropriate.

3.16.3 Monitoring and evaluation of activities

Respondents indicated that there should be a section or a directorate at the provincial office which is responsible for monitoring and evaluating the work performed by appointed hospital boards. One respondent asserts that

appointed chief community liaison officers at hospitals can also assist by ensuring that the appointed hospital board is sending monthly and quarterly reports to the district and province. Another respondent indicated that it is of value for the hospital board to develop a clear programme of action based on the strategic plan they might have developed with the management team and such program must be adhered to at all times.

3.17 Criteria for the selection of board members

3.17.1 Local community members with interest in health matters

The majority of the respondents indicated that members with interest in health-care matters, and those with skills, knowledge and a vast experience in health-care matters should be considered when selecting those who can be part of hospital boards. One respondent even indicated that:

> "When you appoint members do not forget to include the traditional healers in rural community as they are the ones who know the health-care challenges being experienced by people."

The issue of checking the skills of board members is also pointed out as valuable by Earlie and Schlosser (2005:14) who highlight that an increasing number of health-care boards are embracing the same governance practices as public boards, by adopting best practices and in evaluating current and potential board members to ensure they comprise the right mix of skills and independence necessary for responsible governance. One member interviewed pointed out that:

> "When hospital board members are recruited it is important to check those with business skills that will best complement the strategic direction of the board, those that are involved in community issues, those with passion and time to be committed to the organization's mission and those with past experience working with both corporate and not-for-profit boards."

Furthermore, Carolyn and Connors (1998:297**)** argue that it is better for community-based leaders to serve voluntarily as trustees or board members of health-care delivery organizations as they are the most appropriate, best positioned and the most influential persons to lead the changes needed in health-care delivery in the best interests of their community.

3.17.2 Skill and Experience

Some 57% (13) of the respondents felt that a hospital is a complex organization and as such needs a governing board with a multi-faceted background in finances, human resource management, clinical matters and quality assurance so that they can enhance good governance. One respondent remarked that:

> "It is vital to appoint board members with the necessary, required knowledge, skills and competences so as to bring value to the hospital management structure of the hospital. This can also curb unnecessary struggles and wrangling for power between the appointed hospital and the chief executive officers because both parties will know clearly what is expected of them at all times."

Respondents further noted that community members with a clear background, understanding and experience of health matters are the ones to be considered. The majority of managers representing the hospital management indicated that to be appointed board members should at least have some understanding and experience on how health institutions function. They suggested that board members should be aware of how services are rendered and some of the challenges to be faced. One respondent said that:

> "It would be better to consider those who have retired from health to serve in boards so that they can bring their own expertise in the hospital governance."

Another important point that was raised was that members should be appointed in line with the new National Health Act of 2003 which emphasizes

that member should be representing the community and a related expertise area. The act gives allowance for the following to be appointed: two community representatives, one community counsellor, people with expertise in human resources, finance, accounting, information and records, and the legal field. Respondents indicated that it is crucial for members to be recruited from such fields so that they can bring value to the management of the hospital rather than come as observers only.

In addition to what is stipulated in the Act, other respondents indicated that we should have people with experience in other areas. There is a need for members experienced in quality assurance matters in order to improve on the service delivery for patients. Another area of responsibility is to check usage of physical structure and approval of plans to the province. It was also indicated that appointed board members should have experience in infrastructure and preventative maintenance. Other respondents felt strongly that the board should include the whole spectrum of community leaders with interest in health matters. Yet others also alluded to the fact that if the department is serious about appointing hospital boards that contribute to the good governance of the hospital then the interested members should apply for the position. The view is that applications will indicate that they have an interest in serving the hospital. Others argued that the method that is presently used has serious loopholes as members often lobby and convince fellow community members to support their nominations to be in the hospital board for their own good which defeats the main purpose of being in the board.

3.18 Hospital board members' recommendations on how to enhance overall hospital performance

3.18.1 Review of the subsistence and travelling allowance

A minority, 26% (6) of the respondents, emphasized that the National Ministry of Health should review the allowances given to those attending the meetings. One respondent even went to the extent of pointing out that the appointed

hospital board is not attending meetings in a satisfactory manner because they are not compensated adequately.

3.18.2 Review of the Act and policy guidelines governing hospital boards' operations.

Respondents indicated that the department should develop policies with guidelines which clearly indicate the roles and responsibilities for both the appointed hospital boards and management of the hospital. This they argued will enhance the working relationship between management of the hospital and the hospital board. One respondent raised the point that there is need to review the National Health Act of 2003 so that it can explicitly indicate the roles and responsibilities and provide clear guidance to provinces on how and what the hospital boards are supposed to operate.

3.18.3 Monitoring and Evaluation

Some 21% (5) of the respondents supported the notion that appointed hospital board members are supposed to account, on a monthly or quarterly basis, to the member of an executive authority (MEC) on what they would have been doing and also give the local CEO a report. One respondent stated that they should attend institutional monthly, quarterly and annual reviews conducted and also develop a plan of what they are supposed to do for the whole year.

3.18.4 Training and Development

A majority of the respondents indicated that there is need to build capacity on appointed hospital boards. They suggested that training should be offered during the very first month after appointment by the MEC so that they would become acquainted with what is expected of them. One respondent commented that:

"How do you expect us to be effective as a governance structure when training sessions are organized after two years of appointment and no one from the office of the MEC even bothers to make a follow up as to whether we are doing the correct things?"

CHAPTER 4

DISCUSSION OF FINDINGS

4.1 Introduction

The aim of this chapter is to present a discussion of the findings. It should be noted that the aim of the study was to assess the roles and responsibilities of hospital boards in the public hospitals in the Limpopo Province.

The presentation of the discussion is based on the responses from twenty three (23) participants who answered some structured and open-ended questions. The results are presented according to the themes identified as the main focus area of the research and where applicable, sub-themes that are developed and identified. Participants are given pseudo names, identified according to the hospital they come from and have their spoken words quoted verbatim where applicable.

The discussion is based on the themes developed and other verbal descriptions. The presentation of the discussion on findings is the main focus of the chapter. The overall execution of roles and responsibilities will be reviewed as per the experiences of the appointed hospital board members. Thus each open-ended research question will be discussed in detail.

4.2 Strategic planning matters

It is interesting to learn that a majority of the respondents were not involved in strategic planning matters of the hospital, yet planning is considered to be the most important area of responsibility for any hospital board. The finding is in total contrast with what Kazemek *et al* (2000:236) highlight in their research: that hospital boards must be involved in the strategic planning process, where they craft together with management the mission and vision of the hospital to ensure quality of services to patients. Furthermore, most of the hospitals in the Limpopo province embark on strategic review processes each year where they examine their Annual Performance Plans (APPs) in line with the Medium Term Expenditure Framework (MTEF) for the coming financial year. It is in these retreat sessions that hospital board members are

supposed to be seen playing their roles. The fact that 83% of the respondents indicated that they never engaged in strategic planning processes poses a challenge to the department and the hospitals in that the board members will never have a clear knowledge and background on the hospital's plans. As a result it would be very difficult for them to even monitor the implementation of the yearly plans and even participate in policy development because they require skills.

From this study it is apparent that a majority of board members knew little in as far as the development of policies was concerned. The research findings on policy formulation by board members reflect sharp contradictions with what has been discovered by Govindaraj *et al* (1996:120) in their research, where they note that the hospital boards are legally responsible for formulating policies and developing strategies to ensure that the hospital functions effectively and efficiently within the overall health policy of government. Strategic planning and policy formulation obviously need hospital board members who are capacitated enough so they can interrogate such plans and determine if they are bringing any improvement in the quality of life of the ordinary citizens who are the clientele of the hospital. One wonders whether the training conducted by Regeneysis in 2005 for the appointed hospital board had any positive impact on the capabilities and competency of board members to engage meaningfully in strategic planning matters. One would have expected to find a picture indicating that the board members, who were trained by Regeneysis, brought some meaningful changes in strategic planning matters considering that this research was conducted three years after the training. Instead, the finding highlighted a different picture where members were not part of the planning and policy formulation process.

4.3. Advisory and technical support

A hospital board is expected to play an advisory role and also to give technical support to the management of a health facility. The table below reflects the views of the respondents on participation into performance reviews, conducting inspections, playing an oversight role, attendance of meetings and also the issue of giving expert advice.

One of the key findings of this study is that 61% (14) of the respondents felt that board members did not provide expert advice toward the hospital's handling of finance, human resource management, information management and legal issues, while 39% (9) agreed that they did perform such a role. In line with the presentation by Regenesys (2005:29-30), the hospital board should be given more power by the MEC to increase capacity in oversight responsibility so that they can assist hospital management in setting policy and strategy, engage in advisory and technical support roles and function meaningfully in oversight roles. The findings compel one to ask serious questions on how appointed hospital boards can give expert advice or provide technical support to management if they themselves are not well capacitated in different fields that are pertinent to the operations of a hospital. It might also be interesting to establish further how the 39% of respondents managed to provide such expert advice and whether they used a standardized tool or developed clear guidelines to perform oversight roles or not.

Findings on attending hospital board meetings are that 57% (13) of the respondents confirmed that board members attended meetings when invited as per schedule, while 43% (10) indicated that they did not attend. A question which arises is what issues were covered during the deliberations of such meeting. An analysis of the minutes of meetings held from 2004 to 2007 shows a serious gap on the strategic issues that were expected to be covered. The Northern Province Health Act 5 of 1998 stipulates that the board must convene six (6) meetings per annum and minutes of such meetings must be kept and forwarded to the MEC. This did not take place during the period under study. A finding in this study suggests that in most cases board members never availed themselves for such meetings. Most members apologized for attending to other engagements at their places of work or other areas, leading to many meetings being postponed.

Surprisingly, even measures to determine the functionality and effectiveness of the boards were not followed. Therefore, an important indicator of the existence of hospital boards under governance and strengthening hospital management, put in place by the national Ministry of Health, was undermined by apathy or lethargy in attending hospital board meetings. When institutions present their monthly, quarterly and annual service delivery reports they indicate that hospital boards are in place and yet the indicator does not address the issue of how effective the board is and what

value, if any, they add. This is an area that needs to be looked at in future when focusing on the issue of the appointment of hospital boards. The office of the MEC does not even have a way of tracking the performance and effectiveness of the hospital boards.

As far as performing an oversight role on performance of staff and management through monthly, quarterly and annual reports, the findings are that 39% (9) agreed that members of the board performed the oversight, while 61% (14) disagreed. This is, however, in total contrast with the views of 78% (18) of the respondents, who indicated that they did not attend the monthly, quarterly and annual performance reviews and by 22% (5) respondents who pointed out that board members were able to attend. Nevertheless, the department of Health and Social Development in the Limpopo Province, under the Chief Directorate of District Hospitals, compels each hospital to conduct monthly performance reviews, where sectional supervisors present progress reports in line with the developed business plans to determine if they are meeting the targets which they would have set for themselves. It is during such review sessions, that hospital board members should be seen to play a meaningful oversight role by checking if hospital management and staff are realizing the set goals and objectives. By attending such performance reviews sessions the hospital board might be able to understand the different programmes run by being at such a hospital. Together with management of the hospital, a programme of action that would enable the hospital board to enhance performance and also to encourage and motivate those who are doing well in their sections, could be developed.

Hospital board members are expected to conduct inspection regularly at the hospital. However, it was found out in the study that 48% (11) were able to conduct institutional or hospital inspection visits while 52% (12) indicated that they did not perform such an important task. Any manager needs to make rounds and check closely all operational aspects and strategic areas in order for them to understand well what is going on in a hospital set-up. Furthermore, the Northern Province Health Act of 1998 states that a hospital board must conduct inspection at any time of the day to identify service delivery challenges and good practices by hospital staff. This implies that the hospital board members must develop a clear plan and set aside time to perform such an important responsibility and thereby assist management in coming up with an improvement plan to address any identified gaps.

4.4 Financial management

It is shocking to establish from the findings that 74% (17) of the respondents disagreed with the view that board members were involved in the budget planning process. The budget planning process is a critical stage in any organization and it warrants that all stakeholders are involved from an early stage for the sake of accountability and transparency. This was articulated clearly by the training consultants from Regenesysis when they trained the hospital boards in Limpopo in 2005. The consultants indicated that the board must ensure that public funds given to hospitals are used wisely and, in addition, the board must be involved in the financial reviews, approval and expenditure of the budgets in a given financial year. It leaves much to be desired that only 26% (6), of the respondents indicated that they were involved in the whole process - particularly considering the effective and efficient utilization of the budget of any given hospital.

If board members are not sure of the budget for the specific hospital they would have been appointed to assist, then it might be very difficult for them to monitor such a hospital's financial performance at any given time. In terms of Section 17 (2) (a) of Northern Province Health Act 5 of 1998, a board must submit annual estimate of revenue and expenditure, the expenditure of capital funds, financial statements and reports to the provincial auditor. The board must also ensure that funds are utilized in effective, efficient and economic ways at all times. Therefore, if any board is not performing these tasks then it means mechanisms must be put in place to fulfil these expectations. Section 38 of the Public Finance Management Act 1/1999 (as amended) emphasizes that effective, efficient and transparent systems of financial and risk management and internal control should be maintained at all times by accounting officers of institutions. In addition, Section 39, which indicates that the expenditure should be in accordance with the vote or the main division and that effective and appropriate steps should be taken to prevent unauthorized expenditure and overspending as well as to report to the executing authority any impending under-collection of revenue and shortfalls in budget. Hence, management is compelled to work with hospital boards in order to then accomplish the expected budgetary targets. In fact, Kirsten (2006:8-10) explores how a hospital board can bring meaningful

contribution in financial management and fundraising in South Africa. She outlines how the hospital board at Groote Schuur central hospital in the Western Cape Province managed to establish a finance committee that was responsible for making financial reports, presenting monthly reports and controlling investment. The committee also ensured that the finances of the hospital are audited annually by an independent audit team that also prepared financial statements. However, from the findings of this study, is evident that board members in other provinces failed to execute their required roles and responsibilities in as far as financial management oversight is concerned. This is confirmed by 91% (21) of the respondents who pointed out that board members never approved and made recommendations on the budget for the hospital to MEC.

The review, compilation, presentation of financial expenditure reports on a monthly, quarterly and annual basis to the office of the MEC/HOD as required by the Act, was not done as indicated by 78%(18) of the respondents. It is also disappointing to learn that the 87% (20) of the respondents were not involved in fundraising efforts to supplement the budget of the hospital. The findings are in total contrast to Kirsten's (2007) findings that the hospital board members at Groote Schuur were involved in fundraising efforts and the committee was able to fundraise more than R1million to purchase critical equipment for the hospital. The performance of such a role assists management of the hospital to realise an improvement of the services delivered to the community. It is, therefore, not surprising to note that 91% (21) of the participants felt that board members play no role in the development of a hospital's revenue strategy. Again Kirsten (2007) notes that the 2005/6 financial year saw the above-mentioned Western Cape hospital board successfully fundraise more than R18 million to buy expensive equipment through an annual golf day, correspondence appeal and bequests and by conducting monthly meetings. This, indeed, could be one of the success stories of what hospital boards are capable of doing in comparison to what is happening in other provinces.

4.5. Supply chain management

In line with the Northern Province Health Act, Act 5 of 1998, board members are supposed to be part of the supply chain management process. It is important that the process should be transparent.

The findings show that only 9% (2) of the respondents indicated that they were involved in the procurement process of the hospital where members served as part of hospital bid committee adjudicating and awarding tenders to service providers. Some 91% (21) also disagreed with that and the figure reflects that board members know very little of what will be happening and as such it becomes very difficult to play their oversight role effectively. This is again evident in the fact that 91% (21) of the respondents suggested that board members played no role in the monitoring and inspecting of tuck shops at the hospital. All hospitals in the area of Vhembe have tuck shops that assist both workers and patients. However, the fact that board members are not any way involved in their running leaves much to be desired - unless if they are not aware tuck shops are a significant part of revenue generation for the hospital.

Furthermore, 96% (22) of the respondents indicated that board members were not involved in the process of purchasing equipment, while only 4% (1) claim that board members were part of the procurement process. The procurement of both medical and non-medical equipment in public hospitals can be a cumbersome exercise if they are not addressed strategically. Thus the development of procurement plans is paramount. The findings reflect a serious gap of hospital board involvement in the whole process which would warrant serious attention from the powers that be at the hospital if the board is truly expected to play any meaningful role. National reports from both print and electronic media and from the Auditor General reflect that the membership of public hospital boards, especially those serving in tender committees, are involved in corrupt procurement tendencies. This implies that whenever a member of the hospital board intends to be part of the tender committee in a hospital there should be thorough training in line with the Preferential Procurement Policy Framework Act, Act 5 of 2000 and the treasury regulations.

4.6 Physical facility management

The revitalization and improvement of hospital structures contribute much to the perceptions on the nature of services to be rendered at a hospital. It is interesting to

note, from the findings that 74% (17) of the respondents disagreed that hospital board members were involved in the process of making recommendations to the province regarding building of the hospital and maintenance whereas only 26% (6) agreed that they were involved in the process. This is in total contradiction to the stipulations of Section 17 of Northern Province Health Act no. 5 of 1998, where emphasis is put on the important role that the hospital board should play in the erection, extension and alteration of buildings; the maintenance of buildings and equipment; the standardization of equipment, buildings and procedures, and entering into contracts and regulations. This obviously needs members of the hospital board to have an understanding and knowledge of physical facility management, especially on the hospital's infrastructures' improvements and maintenance.

The submission of architectural plans to the province is another important responsibility of any hospital board. The findings show that 87% (20) disputed the fact that board members are involved. In terms of the provincial Act, hospital boards are expected to promote and establish recreational activities for staff, facilitate the opening of a crèche or a day-care centre for children of staff and levying of day-care fees and management thereof. The findings also reflect that 87% (20) of the respondents disagreed with the point that the hospital board was engaged in approving of the use of the grounds and buildings of the hospital for community activities and projects. Only 13% (3) agree that the boards were doing such tasks. Also on the question of hospital name changes, only 4% (1) indicated that they were involved whereas 96% (22) disagreed. Similarly, the same goes for matters relating to engaging themselves in governing matters of the hospital. The process of name change is a cumbersome exercise, which could involve a number of stakeholders, and the results reflect that the appointed hospital board showed no interest.

4.7 Human resource management, planning and training

Section 17 of the Northern Province Health Act no. 5 of 1998 makes provision that the hospital board should be involved in the process of reviewing the staff establishment of a health service facility. However, it is amazing to note that 87% (20) of the board members disagreed with the fact that they ever made any recommendations to the MEC on the recruitment and appointment of managers and

clinicians, while only 13% (3) agreed. The challenge then, is on whether the hospital board members have capacity and powers to execute such an important function of recruiting and improving the staff establishment of hospitals. This can be an interesting topic in future research.

It is also surprising to learn that all (100%) of the respondents indicated that the board members never involved themselves in the PMS's evaluation of employees and supply of recommendations on good performers to the MEC so that they can be considered for annual cash bonuses. This shocking scenario raises the question whether all board members who took part in the study were not aware of this responsibility as required by the Northern Province Health Act of 1998. Even Part VIII of the Public Service regulations of 2001 outlines clearly that the Department shall manage performance in a consultative, supportive and non-discriminatory manner in order to enhance organizational efficiency and effectiveness, accountability over the use of resources and for the achievement of best results. The regulations further emphasize that performance management processes shall be linked to the broad and consistent plan on staff development and be aligned with the department's strategic goals. In terms of performance management guidelines, public hospitals have to establish a moderating committee each year to evaluate the performance of employees to check whether they are working toward achieving their set goals in the Annual Performance Plan (APP). The challenge, then, is about whether the hospital board members are aware of the responsibilities that they are expected to perform when it comes to employees annual evaluation or whether they are capacitated enough to participate effectively in the moderating committee.

Workplace discipline is an important management function in any organization and as a result labour-peace-managers should be seen to be doing their job in a more effective and efficient way. The study revealed that 70% (16) of respondents did not engage themselves in staff discipline matters while only 30% (7) agreed that they had been part of the process. Act 65 of the Labour Relations Act 65 of 1995 and other disciplinary codes and procedures of the public service, including Public Service Bargaining Council (PSBC), provide frameworks and guidelines on how discipline should be enforced at all times in the working environment. Hospital board members should therefore be acquainted with such legal prescripts to ensure consistency and play their oversight role correctly.

The question of the career development of staff is important. The majority 87% (20) of the respondents highlighted that they were not part of ensuring that there are career development programmes for the hospital personnel. The findings contrast with what is stipulated in Part IX of the Public Service Regulations of 2001 Part IX on training and education. This also contrasts with Act 97 of the Skills Development Act, of 1998, which indicates that employers are compelled to ensure that employees have ongoing and equitable access to training that is geared towards achieving an efficient, non-partisan and representative public service and which states that training should support work performance and career development. Employees are also expected to develop themselves and the government has an obligation to capacitate its employees after gaps have been identified.

It is interesting to note that 48% (11) of the respondents played a role as observers during the short listing and interviews process, whereas 52% (12) denied having played part in that. Hospital board members are expected to be part of the process to ensure that there is transparency and to guard against corrupt tendencies such as nepotism when the panel finally makes recommendations to the executive authority. The question which arises from the whole arrangement is about whether the appointed board members consider themselves as just mere observers or consider themselves as people who have got a major say who is to be appointed or not. If the role is not clarified well, then the board members might think that they are there to appoint whomsoever they like in a particular hospital. The department should thus develop clear guidelines on what the hospital board members are supposed to do when they perform their roles as observers. Indications are that the department might have circulars that clearly inform officers in government on what they are supposed to do during the short-listing and interviewing process and yet this is not the same with the hospital boards.

4.8 Community participation and communication

Regenesys (2005:28) emphasizes that the hospital board is an important structure which acts as a link between the hospital and the community, communicates the needs and views of the hospital, builds support in the community for health programmes and participates in the planning of services that involves the broader communities. The

findings, however, showed a different version. The majority 74% (17) of the respondents disagreed with the view that the board members at various institutions were able to communicate the community's needs and views to the hospital through proper channels such as board meetings, village committees and surveys so that regular feedback could be given to the community represented. Only 26% (6) of the respondents agreed that the board met this expectation. The results run contrary to the expectation postulated in the Hospital Ordinance 14/1958 (as amended in 1999). Regenesys further postulates that the board can promote and market services and play an oversight role on behalf of the community when it inspects the hospital and monitors the quality of service and other administrative activities, Kazemek *et al* (2000:236) also highlight that the hospital board should ensure the enhancement of community/stakeholders relationships and see to it that the needs of the communities are addressed.

It was noted, on the question of whether the hospital board members were able to officiate on behalf of the MEC when requested, that 48% (11) of the respondents indicated that they were able to do so while 52% (12) failed to acknowledge that such a role and task were performed by the board. This clearly reflects that the initial view that most of the board members only avail themselves when political heads are visiting an institution is true to some extent. It is interesting to note that members were able to attend the Health and Social development Summit as confirmed by 83% (19), while only 17% (4) disagreed with that. Summits in the Vhembe district are organized each year in May, and here all hospitals present their reports to the communities and stakeholders. Hospital boards are one important stakeholder in these sessions as they are seen to be representing the communities in the catchment areas. Some of the hospital board members, who are also councillors, are requested to officiate or present a speech on behalf of the MEC, if he or she is committed in one way or another, at such summits.

4.9 Information management and complaint management

Board members are expected to disseminate information to the community through proper channels and to hear their complaints in order for the communities to know what is going on in the hospitals.

The results from the study reveal that 57% (13) of the respondents indicated that the appointed boards failed to provide a forum to hear the community's complaints, or to listen to the grievances between staff and the public at large. The Northern Province Health Act of 1998 makes provision for hospital boards to have the responsibility of conducting community meetings and discussing issues pertaining to the services rendered by the hospital so that the communities could also air their views. Zablock (2006) strongly emphasizes that, indeed, the hospital board is the main connection between the hospital and the community it represents. This would mean that appointed hospital board members must come up with a clear programme of action on how and when they will conduct such meetings. For the 43% (10) of the respondents who indicated that they were able to perform such tasks, it will be interesting to know how they were doing it, the issues they discussed in such meetings and which methodology they would have used in disseminating information to the communities.

Besides the responsibility of disseminating information to the communities, appointed hospital board members are also expected to manage complaints presented by external stakeholders.

Nevertheless, in terms of service improvement, the board is expected to check the levels of patient satisfaction and whether clinical quality measures are in place, reduce costs in service delivery, engage in community involvement and service to the community, provide service to the indigents and ensure patient safety and infection control issues are upheld (Middleton, 2005:243). Section 17 of the Northern Province Health Act no. 5 of 1998 also highlights that the hospital board must address any complaint by a patient, member of the public, any practitioner or staff member. This implies that the board should play a meaning full role in ensuring that there are clear effective and efficient complaint management systems and procedures for both staff and customers (patients and community at large). If complaint management systems are put in place then satisfaction over service delivery also improves drastically.

The issue of complaint resolution shows that 48% (11) of the respondents agreed that board members were part of the process while 52% (12) disagreed. Patients and other external customers are expected to forward their complaints in written form in line with the policy developed by the Transformation and Transversal Services in the Department of Health and Social Development in Limpopo. It is only when such complaints are received that hospital board members can be called by the Quality

Assurance Officer and the complaints checked closely for purposes of formulating an appropriate response. The national Ministry of Health guideline on resolving complaints indicates that complaints should be resolved within twenty-five working days. This implies that the board can play a very important role in resolving such complaints and it is impressive to learn that eleven respondents have confirmed that they are involved in the process

4.10 Advocacy and fundraising

In all instances, 39% (9) of the respondents agreed that they were able to execute such tasks while 61% (14) pointed out that they never engaged themselves in it. This poses serious questions over the hospital boards' ability to function optimally and with no difficulties. The results reflect a serious challenge on the part of appointed board members as one would have expected that this would be an area where the respondents could have indicated their success as they are considered to be the mouth-piece of communities. However, the results show a different picture.

On the question of fundraising, the results reflect a dismal performance by the appointed hospital board members. The majority 87% (20) of respondents indicated that they were never involved in fundraising and the making of fundraising plans for the hospital. It is not surprising, therefore, to learn that the board members failed to raise or receive some donations and bequests or to even open and administer a trust account for the hospital - as is confirmed by 91% (21) of respondents. The appointed hospital board could play a prominent role in fundraising for the hospital as it is a known fact that the equitable share budget that is given each financial year is inadequate. In many instances the equitable budget hardly covers all planned activities and it is through the fundraising efforts by the hospital boards that supplementary funds can be realised. Most hospitals conduct their institutional excellence awards functions at the end of the year to acknowledge the good performers. It is during such sessions that hospital boards can be seen playing a meaningful role by going all out to secure donations and funding from the local business community to ensure that such functions become a reality.

4.11 Quality assurance and monitoring

If indeed this is considered to be one of the most important responsibilities of the board, one wonders if the hospital board members were informed of this when they were trained by Regenesysis in 2005. Grabbin (2007:34) even highlights that the case of quality and patient safety is a moral and ethical leadership issue and as such it must be the board's priority, simply because it is the right thing to do.

With regard to engaging themselves in patient surveys and developing and monitoring developed norms and standards, 87% (20) and 96% (22) of the respondents disagreed that the appointed hospital board ever performed such a task and only 9% (2) pointed out that they monitored patient satisfaction and compliance to norms and standards. Each hospital's Quality Assurance Officers are responsible for ensuring that surveys are conducted and that norms and standards are reviewed quarterly. Moreover, hospital board members are expected to be involved in the process as a way of improving service delivery to the community.

The research results reflect a different picture for Tshilidzini hospital; the board members' involvement in the process leaves much to be desired. It may be difficult for the board to be engaged in monitoring aspects if they were not part of the process from the beginning. The results reflect a serious gap between what the hospital is doing with regard to surveys and norms, and the standards reviewed by the quality assurance officer and the board. The quality assurance officer is being guided in his work by the District Hospital Package and other relevant transformation documents which unpack clearly how a hospital is supposed to be managed.

4.11.1 Development of Ethos and Attending to Patients' Interests

Having active interest in the well-being and welfare of patients warrants one to be truly committed. It is, however, amazing to learn from the study that 65% (15) of the respondents were not eager to be involved in programmes which address the interests of patients. In addition 65% (15) of the respondents were unable to develop an ethos for caring over the patients at all levels of the hospital. It is only 35% (8) and 39% (9) of the respondents who agreed that they were able to engage themselves in such tasks.

The fact that there are no clear guidelines on how to develop that may, in the long run, pose a serious challenge on how the appointed hospital boards are supposed to act and ensure uniformity in all hospitals. For those who indicated that they were able to perform such activities it is still questionable how they did that as there is no policy framework that was developed at national level to guide them.

4.12 Risk management

It is interesting to note that 91% (21) of the respondents disagreed with the point that hospital boards are involved in the implementation of risk and security management programmes that cover both clinical and financial services, while only 9% (2) agreed that hospital board members were involved in risk management matters. This implies that there is a lot of work to be done in ensuring that health related risks are addressed effectively by people with skills and expertise with a view to minimising litigation against hospitals.

Karen (1990:43) emphasizes that the hospital board has a significant role to play when it comes to the safety of patients and staff working with patients every day. She indicated that in case of any disaster the people who are working there must know what to do. From this background it is clear that hospitals must develop plans that address health related risks and appointed hospital boards should also be trained in such areas so that they can be well capacitated to give a meaningful advice to management.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The main aim of this research project was to assess the capacity of hospital board members in relation to the roles and responsibilities of public hospitals in the Limpopo province. It is evident from the findings that hospital boards in public hospitals are not adequately performing the expected roles and responsibilities due to a number of reasons - as given by participants during the study. A number of recommendations are proposed in the quest to ensure good governance in public hospitals and to ensure that hospital boards perform their roles and responsibilities effectively and efficiently. This will, hopefully, improve governance and service delivery in public hospitals in the Limpopo Province and the country at large. The following are some of the recommendations in line with the objectives of the study:

5.1 Roles and responsibilities (Objective 1)

Review of the National Health Act 61 of 2003 and Northern Province Health Act 5/1998 and its Regulations

- Objective number one of the study was to assess the roles and responsibilities of hospital boards in public hospitals and from the findings it is evident that there are problems in the implementation of the Act as it does not reflect clearly the main roles and responsibilities. Therefore, a recommendation is made that there should be a systematic review of the National Health Act 61 of 2003 so that the roles and responsibilities of the hospital boards are clear and provide unambiguous guidance to provinces on how the hospital boards are supposed to function.
- Another specific recommendation for the Department of Health and Social Development in the Limpopo province is to review the Northern Province Health Act of 1998 and its Regulations in line with the National Health Act, Act 61of 2003.

5.2. Challenges experienced by board members (Objective 2)

Training: capacity building of appointed board members on roles and responsibilities

- In order to address identified challenges experienced by board, the department must organize and conduct building capacity on all appointed hospital boards, before they assume their duties, with a view to avoiding role confusion between the board and the management. It is evident from the inputs from respondents that hospital board members need intensive training on roles and responsibilities and they also need a constant follow-up on how best they can execute such responsibilities.

Budgets for board activities: review of incentives

- A budget must be set aside to address hospital board activities and a business plan must be developed.
- A policy guideline that addresses challenges relating to the incentives given to hospital board members from outside the hospital needs to be developed.

Signing of Performance Management Agreement (PMA) and develop a clear programme of action

- A performance monitoring tool and reporting guide should be developed by the Executing Authority or Head of Department so that boards can account their activities on a monthly basis or quarterly basis.
- The hospital board should be involved in the strategic planning process of the institution so that they understand the strategic thrust and focus of the department.
- The hospital board must develop a clear programme of action based on a strategic and hospital business plan that would have been developed with the management team and such a programme must be monitored at all times.

- A full time coordinator, both at provincial and at district level, should be appointed to coordinate activities of the hospital board as a governance structure.

Strengthen relationship between the appointed hospitals board and management

- The department should develop clear guidelines on the roles and responsibilities in order to synergize the relationship between board members and management and to avoid frustrations and squabbles which could in the long run affect service delivery at the hospital.

5.3 Criteria for selection (Objective 3)

- Community members selected to be hospital board members should have an interest in representing their communities and have the zeal to improve health service delivery.
- The appointed hospital board members should have background in financial management, financial accounting, strategic management, community development, human resource management, clinical matters, legal environment, quality assurance and risk management so that they can enhance good governance in a public hospital.

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ANNEXURES

ANNEXURE A: QUESTIONNAIRE

HOSPITAL BOARD: ROLES AND RESPONSIBILITIES GUIDING QUESTIONNAIRE AND QUESTIONS

SECTION 1: RESPONDENT'S INFORMATION: MARK WITH A CROSS

GENDER

Male	
Female	

AGE

Between 20-30 years of age	
Between 31-40 years of age	
Between 41-50 years of age	
Between 51-60 years of age	

YEAR OF APPOINTMENT AS A HOSPITAL BOARD MEMBER

2004	
2005	
2006	
2007	

EMPLOYMENT STATUS

Government employee	
Private sector employee	
Self employed	
Unemployed	

SECTION 2: ROLES AND RESPONSIBILITIES OF A HOSPITAL BOARD IN PUBLIC HOSPITALS

SECTION 2.1: CLOSED ENDED QUESTIONS

- From your experiences as a hospital board member, what are the actual roles and responsibilities have you performed since 2004? Indicate by means of a tick if you agree or disagree that you never performed any of the roles and responsibilities listed.

Focus Area	Roles and responsibilities	Agree	Disagree
1. Strategic planning	1.1 Involved in developing hospital strategic and business plan document in line with provincial and national policies.		
	1.2 Monitor implementation of developed strategic and business plan		
	1.3 Assisted in formulation and drawing of hospital internal policy framework and guidelines		
	1.4 Monitor implementation of formulated policy guidelines and frameworks		

Focus Area	Roles & responsibilities	Agree	Disagree
2. Advisory and technical support to management	2.1 Provided expert advice and input to hospital management as required by law on Finance, Human resource management, Information management and legal issues		
	2.2 Attended meetings regularly as required by the act		
3. Oversight role	3.1 Performed oversight role on performance of staff and management through perusal of monthly, quarterly, and annual reports		
	3.2 Conducted regular institutional inspections visits to hospital		
	2.4 Attend regularly hospital performance reviews conducted monthly, quarterly and annually		

Focus Areas	Roles & responsibilities	Agree	Disagree
4. Financial management	4.1 Involved in the budget planning process		
	Approve the hospital budget prepared by management		
	4.2 Make recommendation to the MEC on financial matters		
	4.3 Review and present financial expenditure reports on monthly, quarterly, and annually		
	4.4 Compiled and present expenditure report to the office of MEC/HOD quarterly as required by the act		
	4.5 Involved in fundraising efforts to improve service delivery of the institution		

	4.6 Developed revenue collection strategy for the hospital		
Supply Chain Management: Procurement	4.7 Played a role in contract and supply chain management of the hospital		
	4.8 Serving as a member of evaluation committee for local service tenders		
	4.9 Monitor and inspects affairs of tuck-shop of the hospital		
Equipment procurement and management	4.10 Approving purchasing of expensive equipment for submission to provincial tender committee		

Focus Area	Roles & Responsibilities	Agree	Disagree
5. Physical facility management	5.1 Make recommendations to province regarding hospital building and maintenance programmes		
	5.2 Approve architectural plans for submission to the province		
	5.3 Promote and establish recreational activities for staff		
	5.4 Facilitate opening of a crèche or day care centre for children of staff and levying day care fees		
	5.5 Established a governing body to manage the crèche or day care facility		
	5.6 Facilitate approval of the use of the grounds and building of the hospital for community activities and projects		
	5.7 Motivate to the national monuments council for buildings or parts of buildings to be declared national monuments		
	5.8 Involved in the process of name change of a facility		

Focus Area	Roles & Responsibilities	Agree	Disagree
6. Human resource management, planning and training	6.1 Make recommendations to the MEC on recruitment and appointments of managers and clinicians		
	6.2 Review hospital staffing practices to ensure fairness		
	6.3 Serving as members in the process of determining cash performance bonuses of good performers in the hospital		
	6.4 Assist hospital management in conducting disciplinary proceedings and resolving		

	disputes		
	6.5 Assisting hospital management in creating career development pathways for staff members		
	6.6 Serving as observers during short listing and interviewing process		
	6.7 Improve working conditions at hospital through sponsorship of recreation facilities		
	6.8 Recommend outstanding staff members for a particular commendation by the MEC		

Focus Area	Roles & Responsibilities	Agree	Disagree
7. Community participation and communication	7.1 Communicate community needs and views to the hospital in a structured through proper channels: e.g. Board meetings, village committees, and surveys		
	7.2 Regular feedback or report back meetings with community represented		
	7.3 Officiate at official hospital functions on behalf of MEC, when requested		
	7.4 Attend organized departmental Summit on Health and Social development annually		
Information management & technology	7.5 Disseminate information to community when appropriate through proper channels		
Complaint management	7.6 Provide a forum to hear community complaints, grievances between staff and the public at large		
	7.7 Monitor the investigation and complaints resolutions progress		

Focus Area	Roles & Responsibilities	Agree	Disagree
8. Advocacy and Fund-Raising	8.1 Act as an advocate of hospital interest to the province and public at large		
	8.2 Build support for the hospital by fostering partnerships in the wider community		
	8.3 Promote and market the services of the hospital as centre of excellence in proving quality health services		
	8.3 Raise additional funds for the hospital		
	8.4 Assist management of the hospital in developing business plan for fund raising		
	8.5 Accepted donations and bequest for the benefit of the hospital		
	8.6 Able to open and administer a trust account for the hospital		

Focus Area	Roles & Responsibilities	Agree	Disagree
9. Quality of Service	9.1 Take an active interest in the welfare/wellbeing of patients		
	9.2 Involved in the development of ethos of caring at all levels of the hospital		
Quality assurance	9.3 Ensure Patient safety and infection control issue		
	9.4 Conduct quality assurance surveys of the s services, facilities and ground		
	9.5 Check and monitor the level of patient satisfaction		
	9.6 Compliance to norms and standards and service provision improvements		
10. Risk and security management	10.1 Ensure that there are risk and security management programmes covering both clinical and financial services		

SECTION 2.2: OPEN ENDED QUESTIONS

- Do you feel your roles/responsibilities are being appreciated by the hospital management? Explain.
- From your own experiences as a hospital board member, what could be the possible challenges or problems facing a hospital board?
- In your opinion, what should be done to make hospital boards more effective and efficient?
- What are your views on who should be part of the hospital board, and why?
- What are your recommendations in enhancing hospital overall performance by hospital board and management?

Thank you very much for your time and cooperation.

ANNEXURE B: INFORMATION SHEET

INFORMATION SHEET

Good day
I am Tshimauswu A.G a student at University of Witwatersrand, School of Public Health. As part of fulfilment of the requirement towards the Master of Public Health degree in Hospital Management, I am undertaking a study on the roles and responsibilities of hospital boards in our public hospitals in Limpopo Province. Therefore you are kindly invited to participate in the study.

WHY AM I STUDYING THIS TOPIC?
The main focus of the study is to assess the main roles and responsibilities of hospital boards in public hospitals as structures representing the interest of community. The hospital board constitutes a fundamental base of governance structure in a public hospital and as such is obliged to be effective and efficient.

The National Ministry of Health initiated the Hospital Strategy Project (HSP) in 1996 to set out a framework for the development and restructuring of the public hospital sector that would support the development of Primary Health Care (PHC). The HSP suggested decentralization of hospital accountability and responsibility and also recommended appointment of Chief Executive Officers, (CEO) and hospital board. A strategic document provided the range of roles and responsibilities that should ensure appropriate governance at the hospital level. From the report it was evidence that there was a need for the public hospitals to reposition themselves with a view of rendering effective and efficient services and that included: decentralization through a completely revised governance structure, characterized by more accountability and responsibility for hospital board and the Chief Executive Officer(CEO), CEO to be accounting officers at hospital level, replacing hospital secretary and superintendents in terms of the Public Finance Management Act of no. 1/1999 and appointment of hospital board by the Provincial Member of Executive Council(MEC) and other management support structures or committees in the institution.

WHAT IS EXPECTED FROM PARTICIPANTS?
As a participant in the study, you will be expected to freely complete the questionnaire to be provided and answer few questions to be asked by me during interview sessions arranged with yourself at the best convenient place and time. The questions framed will serve as a guide to the interviewer and you will be requested to express your objective views around the roles and responsibilities of hospital board. The process of completing the questionnaire and answering the questions will take between twenty (20) to thirty (30) minutes of your time. The questionnaire shall be completed by yourself if available or by the researcher through any other means such a telephone if it would not be possible to avail yourself for session, (please note that for the telephonic interview, there will be a tape recorded consent after the information sheet is read out or faxed/e-mailed to you as a participant) and that is applicable to open ended questions. A tape recorder will also be used in recording our discussion and as a requirement of research the tapes will be stored for two years if there is going to be a publication or six years if there is no publication. As a participant in the research your permission to use a tape recorder is significant and as such a consent form will be provided to you before any recording take place.

BENEFITS TO THE PARTICIPANTS
It is hoped that the results of the study shall contribute enormously in ensuring that good quality health care services are given to communities and hospitals are better managed. Be informed that you will also have access to the results after study.

CONFIDENTIALITY
In this study confidentiality will be maintained at a higher level where your views will be summarized by the researcher on anonymity for the purpose of compiling a research report. As you will realize that hospital board members are not a large group of people, you are therefore reassured that by participating in the research project you would be victimized by giving your honest opinion on the roles and responsibilities of hospital boards in public hospitals.

Hesitate not to liaise with the researcher on any uncertainty about the study and I can be contacted at this mobile number: **082 466 8443**

Kindly be informed that necessary permission has been sought from the Provincial Department of Health and Social Development and approval by the University of Witwatersrand ethics committee. In case you would like to get more information about the research or to register any concerns regarding your rights as a research participant feel free to contact the chairman of Human Research Ethics Committee (HREC) at University of Witwatersrand at **011 717 1234(tel.) or 011 717 1265(fax). Attach herewith please find approval letter.**

Thank you for your understanding in advance

……..

Tshimauswu A.G

ANNEXURE C: INFORMED CONSENT

INFORMED CONSENT:

- **I** hereby confirm that I have been informed about the study; the nature, conduct, benefits and risks of study.
- I have also received, read and understood the above written information (Participant Information Leaflet) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and inputs will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed by the researcher
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name **Signature / Mark or Thumbprint** **Date and Time**

I, Tshimauswu A.G herewith confirms that the above participant has been fully informed about the nature, conduct and risks of the above study.

Researcher:

TSHIMAUSWU AG

Printed Name **Signature** **Date and Time**

ANNEXURE D: INFORMED CONSENT: (Tape Recording)

INFORMED CONSENT:

- I hereby confirm that I have been informed about the study; the nature, conduct, benefits and risks of study.
- I have also received, read and understood the above written information (Participant Information Leaflet) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and inputs will be anonymously processed into a study report.
- In view of the requirements of research, I agree that a tape recorder can be used for the purpose of data collection during this study can be processed by the researcher and in addition the tape will be stored for two years if there is publication or six years if there is no publication.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare

myself prepared to participate in the study.

PARTICIPANT:

Printed Name **Signature / Mark or Thumbprint** **Date and Time**

I, **Tshimauswu A.G** herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Researcher:

TSHIMAUSWU AG

Printed Name **Signature…….. Date: …… Time……**

ANNEXURE E: RESPONDENTS' PROFILE

No.	Respondents	Institution	Date interviewed	Remarks on portfolio of board member
1	Respondent	Hospital A-District	2008-08-26	Community member
2	Respondent	Hospital A	2008-09-23	Community member
3	Respondent	Hospital A	2008-09-15	Hospital rep-Doctor
4	Respondent	Hospital B-District	2008-09-15	Community rep
5	Respondent	Hospital B	2008-09-15	Community member
6	Respondent	Hospital B	2008-09-15	Staff representative
7	Respondent	Hospital C-District	2008-09-13	Staff rep-CEO
8	Respondent	Hospital C	2008-09-13	Community member
9	Respondent	Hospital C	2008-09-19	Community member
10	Respondent	Hospital D-Regional	2008-09-19	Community liaison officer
11	Respondent	Hospital D	2008-09-13	Secretary of regional board
12	Respondent	Hospital D	2008-09-13	Community member
13	Respondent	Hospital D	2008-09-09	Community member: chairperson
14	Respondent	Hospital D	2008-09-14	Staff rep
15	Respondent	Hospital E-District	2008-09-14	Community member
16	Respondent	Hospital E	2008-09-15	Community member
17	Respondent	Hospital E	2008-09-13	Staff rep-Doctor
18	Respondent	Hospital F-District	2008-09-13	Community member
19	Respondent	Hospital F	2008-09-13	Community member
20	Respondent	Hospital F	2008-09-13	Staff rep-CEO

21	Respondent	Hospital G-District	2008-09-09	Community member
22	Respondent	Hospital G	2008-09-12	Community member
23	Respondent	Hospital G	2008-09-09	Staff rep-Doctor

ANNEXURE F: ETHICS CLEARANCE LETTER FROM WITS UNIVERSITY

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Tshimauswu

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M080740**
PROJECT	Assessment of Roles and Responsibilities of Hospital Boards in Public Hospital in the Limpopo Province
INVESTIGATORS	Mr GA Tshimauswu
DEPARTMENT	School of Public Health
DATE CONSIDERED	08.07.25
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 08.09.10 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof S Pillay

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE G: APPROVAL LETTER FROM THE HOD- DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT LIMPOPO PROVINCE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquiries: Malomane EL

Ref: 4/2/2

30 September, 2008
Mr G Tshimauswu
P O BOX 2970
Thohoyandou
0950

Dear Mr G Tshimauswu

Assessment of roles and responsibility of the hospital boards in public hospitals in Limpopo Province

- Permission is hereby granted to Mr G Tshimauswu to conduct a study as mentioned above in public hospitals in Limpopo Province
- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study
- The Researcher/s should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institutions management where the study is being conducted should be made aware of this,
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

16/10/08

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

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