COST AND QUALITY OF CARE:

A COMPARATIVE STUDY OF PUBLIC AND PRIVATELY CONTRACTED CHRONIC PSYCHIATRIC INSTITUTIONS

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Dissertation submitted to

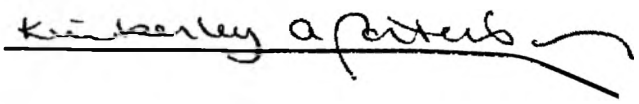
the Faculty of Medicine, University of the Witwatersrand, Johannesburg,

in fulfilment of the requirements for the degree of Masters of Science in Medicine.

Johannesburg, 1998.

Candidate's Declaration

I, Kimberley Ann Porteus, declare that this thesis is my own work. It is being submitted for the degree of Master of Science in Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.



14 Day of November, 1999

Dedicated to the memory of Matron Mdluli

Whose passion for patients
and for the achievement of quality
provided inspiration for this study.

Publications and Presentations

The following presentations have arisen from the work of this thesis:

- Porteus KA, Sibeko M, Lee T. 1998. *Comparing cost and quality in chronic psychiatric hospitals: A comparative study*. Unpublished Conference Paper. 16th Epidemiological Society of Southern Africa Conference: Improving Health: Getting Research into Policy and Practice. Midrand.
- Porteus KA. 1998. *Comparing cost and quality of care in chronic psychiatric hospital services*. Unpublished Seminar Presentation. Centre for Health Policy, Department of Community Health, University of the Witwatersrand. Johannesburg.
- Porteus KA. 1998. *Public vs. Contracted Care: Considering cost and quality of care in chronic psychiatric hospitals*. Unpublished Conference Paper. National Directorate of Mental Health: National Presentation of Research Workshop. Pretoria.
- Porteus KA, Sibeko M, Lee T. 1998. *Cost and quality of care: comparing care in public vs. contracted chronic psychiatric hospitals – findings and way forward*. Unpublished Conference Paper. National Department of Health Annual Health Systems Research Conference: From Research to Policy Development and Programme Implementation. Pretoria.
- Porteus KA and Lee T. 1997. *How does one assess quality of care in chronic mental health institutions? The development of a multifaceted instrument*. Unpublished Conference Paper. 18th African Health Sciences Congress in collaboration with the 15th Epidemiological Society of Southern Africa Conference. Cape Town.

Acknowledgements

There is a large circle of people around this study I would like to thank for their support, insight, and contributions – all of which are woven into the pages which follow.

Many of those who have contributed the most time and insight – the patients and staff at these hospitals – will remain nameless for purposes of confidentiality. I have the deepest appreciation for the time they dedicated, the seriousness with which they considered our questions, the risks they took in addressing the more difficult questions we posed, and the wisdom and insight they put forward.

I would like to thank my supervisors – Dr. Tennyson Lee and Dr. Mary Edginton for their support during the study. I would particularly like to thank my primary supervisor, Dr. Tennyson Lee for his day by day support and encouragement.

I would like to thank my colleagues at the Centre for Health Policy, Helen Schneider, Makhosazana Sibeko, Elizabeth Dartnall, Neil Soderlund, Enoch Peprah, Lucy Gilson, Francesca Clews, and Droby Matsimane for their support and contributions throughout the course of this study. A special thank-you to Makhosazana Sibeko whose insights and approach (as well as sense of humour) are woven into the pages that come. A special thank you to Enoch Peprah for his contribution to the collection of the cost data during the site visits.

I would like to thank students from the University of the Witwatersrand – Mandla Maseko, Evans Mandowa, Lucia Mabasa, Kgaladi Moroni, and Mandlenkosi Hlobo – for their assistance.

I would like to thank Melvyn Freeman, previously of the Centre for Health Policy, for originally encouraging me to take on this study, Professor Paul Fatti, Department of Statistics, University of the Witwatersrand for his patient advice and quality assurance in regard to the statistical analysis, Ruth Zwi, Ray Lazarus, Mental Health Directorate, Gauteng Department of Health, and Allison Beattie for their technical advice and assistance.

I would like to thank Dr. Elliot Wolfe, Dr. Rudolf Moos, Dr. Christine Timko, Dr. Marilyn Winkleby, and Dr. Helena Kramer from Stanford University for their ongoing support and input through the course of this work.

I would like to thank the Stanford University Medical School, the Health Policy Co-ordinating Unit, and the European Union for their financial support for this study.

Finally, I would like to thank Neo Potsane who was my 'solid ground' through the course of this study.

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Nomenclature

The following terms were used purposefully throughout this report. The table below on the following page lists common abbreviations used.

- **'Historically White':** Throughout this report we refer to the one 'historically white' hospital, and the five 'historically black' hospitals. The 'historically white' hospital, in fact, historically took care of both white and black patients, in segregated wards. The 'historically black' wards have since been either destroyed or largely renovated. Most of the previously 'white' hospital wards continue to operate. We term this hospital as 'historically white' as it has historically benefited from its care of white patients, as compared to the remaining hospitals in the study which only cared for black patients.
- Race: The history of mental health care in South Africa has been deeply rooted in a racialised approach to 'psychiatric care.' Not only have psychiatric care institutions been segregated by 'race' since the late 1800's, but the very understanding of mental health, definitions of 'psychiatric care', and the allocation of resources have all been related to the social construct of 'race' (Foster and Swartz, 1997). This study collected and analysed race statistics. *Apartheid* racial classifications were used – black, white, Indian, and coloured. While accepting that 'race' in this sense is a social construct, the collection and evaluation of race-based statistics was motivated in light of the need to evaluate the current move toward equity, as well as the need to evaluate the extent to which the history of race continues to impact institutional care. See Chapter 5.3: Equity and Racial Privilege.
- **'Rehabilitation' and 'Patient Development':** This report uses the terms 'rehabilitation' and 'patient development' interchangeably. The terms are used to refer to interventions to limit disability and support the highest level of independence of individuals and their caregivers. We are well aware that the exact implication of 'development' and 'rehabilitation' must be carefully scrutinised to ensure that the end result is not, in fact, another form of patient control. Foster and Swartz provide a useful definition of 'rehabilitation' to guard against this implication. He defines 'rehabilitation' as promoting, 'active involvement of participants in the production of change, at least partially through their own efforts'. He concludes, and we would agree, that perhaps the most important concept to guide the interpretation of 'rehabilitation' is a 'critical reflexivity; a critical awareness of the power relations along with the capability to challenge and resist...'. Both 'rehabilitation' and 'patient development' throughout this report are used in such a way as to encompass the depth of this debate and its emerging conclusions. A good review of the meaning and goals of 'rehabilitative' and 'developmental' service can be found in Robertson and Zwi (1997).

Overview of Dissertation

The dissertation is divided into six chapters – an introduction, background hospital and sector data, cost findings, quality of care findings, critical explanatory factors (management, nursing staff, racial privilege, and contracts), and a summary discussion of the cost and quality findings.

The introductory chapter provides an overview of the study background, objectives, methods, analysis, and limitations.

The second chapter, 'Background Data: Understanding Hospitals and Sectors,' briefly highlights some of the key differences between the hospitals and sectors by outlining background demographic data across the six hospitals and describing the patient transfer relationships between sectors. These differences provide an important backdrop to the overall study findings -- the ability to compare sectors is limited by these differences.

The third chapter, 'Cost Findings,' outlines cost findings across hospitals.

The fourth chapter outlines quality of care findings across hospitals. This chapter is divided into six sub-chapters. The first sub-chapter explores discharge rates and length of stay statistics. These are traditional markers for quality within chronic psychiatric hospitals. This chapter explains why these simple indicators for quality are not sufficient to explore quality in the South African context. This motivates for a more comprehensive quality assessment framework. The second sub-chapter describes the quality assessment framework adopted in this study. The framework is made up of four levels, each representing an 'objective' of psychiatric care – custodial care, psychiatric treatment, patient rehabilitation and development for discharge, and socially transformative services. The four sub-chapters that follow outline quality outcomes from each of these four levels.

The fifth chapter, 'Critical Explanatory Factors,' is designed to explore the factors which underlie the cost and quality findings. There are four sub-chapters in this chapter, looking at management, nursing staff, the history of racial privilege, and private contracts.

The final chapter (Chapter 6) discusses the cost and quality findings from the study, and considers the lessons emerging with reference to the future function and form of long term psychiatric care services.

- Condemnations of Care

Several studies (WHO, 1977; APA, 1979; RCP, 1990) have condemned quality of care at chronic psychiatric institutions in South Africa in the past, emphasising in particular the quality discrepancies based on racial privilege. In 1979 the American Psychiatric Association undertook an investigation of the then Smith Mitchell institutions. The report concluded that the company was providing sub-standard patient care, particularly for black patients. The study did not, however, undertake a comparative analysis with state hospitals as the team was prevented from inspecting state facilities by the government of the time (RCP, 1990).

1.2. Present

The changes of 1994 culminated a shift in the public sector's social philosophy of care for the chronically mentally ill (Department of Health, 1997.) There was a national policy move away from custodial care toward more community-based care. This was largely based in the social changes of the time, but also reflected changing international conceptions of mental illness[3].

However, while 1994 marked a renewed commitment to this emerging philosophy, the government in practice inherited a mental health system rooted in custodial care and divided along racial lines, financially fragmented and largely unmonitored.

The system included a combination of public and privately contracted hospitals. As of 1996, the government continued to contract out over ten thousand beds at a cost of several hundred million rand per year.[4] The price of private contracts ranged from R14 to R83 per patient day with no understanding of the relationship between cost and custodial quality, let alone whether institutions were moving beyond custodial care.

The context of this time was marked by increased international pressure to increase private contracting in the health sector. While there is little evidence as to the effect of private contracting on health system goals in the context of developing and middle income nations, particularly in terms of formal commercial contracts for hospital clinical care, there is increasing pressure to contract out health services.[5] The World Bank, among others, is exerting increased pressure on developing and middle income nations to increase private provision of health care, despite the limited empirical evidence to justify contracting.[6]

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[3] There has been a growing consensus internationally that mental health services should be decentralised and more community based, moving away from large centralised care. Breakthroughs in psychoactive medications and psychosocial therapies, the recognition of local capacity and ingenuity in mental health care, and the failure of large hospitals to provide a therapeutic milieu all contribute to this shift (Desjarlais, 1995).

[4] As of 1995, Lifecare managed 10,251 long-term psychiatric beds (Broomberg, 1997).

[5] The lack of evidence to support the supposition that contracting out of services is inherently more efficient in the context of developing nations is highlighted by, among others, Broomberg (1994), Bennett et al (1997), Mills (1997). There is particularly little data concerning the pro's and con's of contracting commercial clinical services, as the more common experience in the developing country context has been in non-profit clinical contracts or commercial non-clinical contracts.

[6] Investing in Health: The World Development Report (World Bank 1993).

3. Study Method Overview

3.1. Study Sample: Hospitals

Six hospitals were included in this study out of 27 specialised psychiatric hospitals in South Africa operational in 1995. Three public hospitals and three privately contracted hospitals were selected. One hospital from each sector was chosen from three provinces – Gauteng, Kwa-Zulu Natal, and the Northern Province. The two hospitals in each province were selected on the basis of similar patient profile (existence of chronic patient population) and patient size. The hospitals included in the study sample are outlined in Table 1-1. More detailed background hospital demographic data can be found in Chapter 2.

Table 1-1: Hospital Sample

		Selected Hospitals	
Province	Psychiatric Hospitals in Province	Public Hospital (Number of Chronic Patients)	Privately Contracted Hospital (Number of Chronic Patients)
Northern Province	3	181	343
Natal Province	5	601	1057
Gauteng Province	9	505	1799

3.2. Study Sample: Case Mix

The study population case mix included adult chronic psychiatric and adult mentally handicapped inpatients only. The sample included wards for adult chronic psychiatric patients, adult chronic mentally handicapped patients, and sick-bay wards designed to care for psychiatric inpatients. The study population excluded outpatients and patients seen through community services, as well as other wards for physically ill patients, wards for paediatric, wards for acute psychiatric, wards for forensic observation, wards for state president patients, and closed wards.

3.3 Study Strategy

This study is a cross sectional analytic study. One week was spent at each hospital by a team of five researchers between August, 1996 and March, 1997 to gather cost and quality data, according to set protocols. Costing data was analysed from the fiscal year of 1995-1996. The costing data and quality data were gathered by different researchers. Quality data and costing data were first analysed independently. Once analysed separately, the relationship between the cost and quality outcomes was explored.

The research team included a medical practitioner, an economist, a social worker, and a psychiatric nurse. The background of other team members included the social sciences and psychology.

5.3. Allocation Assumptions

Each cost item was allocated to the final cost centre (chronic adult inpatients) on the basis of one of four allocation assumptions: total patient ratios, inpatient ratios, on-duty nursing staff ratios, or area ratios. These allocation assumptions are summarised in Table 1-3.

Table 1-3: Allocation Assumptions

Allocation Assumption	Description
Total Patient Ratio	Chronic Adult Patient Population / Total Patient Population
Inpatient Ratio	Chronic Adult Inpatient Population / Total Inpatient Population
On Duty Nursing Staff Ratio	On Duty Day Staff for Chronic Adult Wards / On Duty Day Staff Total
Area Ratio	Square Meter Space Allocated to Chronic Adult Patient Population / Square Meter Space Total

5.4. Personnel Costs

The staff complement, salary scales, and benefit scales were collected from the local senior administrative management of each of the public hospitals. Salary and benefit scales for the local Lifecare management were provided by the Lifecare Head Office. Midpoint 1995-1996 salaries were used. There was no on-site verification of staff complement data provided. Salary and benefit scales across the public sector were almost identical. Scales were re-confirmed by the Lifecare Head Office and PUB-HW Statistics Department respectively.

Salary costs were allocated to the final cost centre according to either patient ratios, on-duty nursing staff ratios, or area ratios.

The data was cross sectional. Senior management did not perceive large-scale personnel changes during the period in question except for PRI-2 where there were reports of relatively high fluctuation of staffing during this period. A sensitivity analysis to compare mid 1995/1996 figures with late 1995/1996 figures was conducted. There was a 9% increase in the staff costs from the mid year staff complement to the late year staff complement.

5.5. Pharmaceutical Costs

Pharmaceutical data was abstracted from a sample of target patients' medication cards across wards. A price per patient on medication was calculated using drug prices from the financial year of 1995-1996. Drug price-lists were provided by COMED. A total cost per target population was calculated based on the number of target patients, proportion of patients on medications, and the cost per year per medicated patient.

Pharmaceutical expenditure for this period was provided by Lifecare for PRI-1. Results from our costing method were compared to these data as a check for accuracy. Results represented 98% of drug expenditure during this time period. The remaining two percent is likely to represent error and minimal drug wastage during this period of time.

transport expenditure does not reflect actual local differences in transport use.

5.9. Laundry

Cost data relating to laundry expenditure was not consistently provided across hospitals. Estimated figures for laundry expenditure were calculated based on patient numbers[8], an estimation of laundered items per patient day, and an estimation of the average cost per laundering one item[9].

There are many limitations of this method. Most importantly this method does not reflect actual laundering costs and as such does not reflect differences in actual services efficiency.

6. Quality of Care: Assessment Framework

6.1. Indicators and Institutional Objectives

Quality indicators are chosen to measure the achievement of organisational objectives (WHO, 1984; Bertole, 1993). In an ideal world, a quality assessment would be rooted in clear and relatively stable organisational objectives. A quality assessment tool would then go about measuring indicators that reflect successful achievement of these objectives.

This study, however, did not enjoy the luxury of clear institutional objectives. The study was conducted not only in the absence of specific norms and standards in the field, but more importantly in the context of the emergence of a new paradigm in mental health services, challenging the basis of traditional hospital objectives and design. Even for the traditional 'custodial care' objectives, indicators for quality were not explicit.

In this context we had to identify a framework which would not only measure achievement of 'quality' within a stable set of organisational objectives, but which would *actually acknowledge a changing set of organisational objectives* in the field *and measure the extent to which institutions adopt* emerging objectives and mandates.

We developed a 'hierarchy of objectives' framework to achieve this objective. The framework is outlined in detail in Chapter 4.2: Quality of Care Assessment Framework.

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[8] The number of articles laundered per patient per day were only provided by PUB-HW. On average, PUB-HW launders 7.20 items per patient per day. Significantly fewer items are laundered per patient day at the remaining five hospitals. This was determined by interview and observation within the quality protocol. We assumed that these hospitals laundered 20% less than PUB-HW. Thus, we assumed that these laundry units washed, on average 5.76 items per patient per day.

[9] An analysis done by SDML Consultancy and Training at PRI-1 Laundry shows the weighed average cost per article laundered to be R 0.4991. A comparative figure from the public sector from Ernest Bond Laundry at Baragwanath Hospital is R0.4752 (CSIR, 1996).

The SDML figure includes labour, rent, administration, and transport which are covered in other cost items. The total cost per item excluding labour, rent, administration and transport is R 0.24. This represents 48% of the total laundry costs cited. This percent (48%) allowed us to extrapolate cost per item from data provided by hospitals PRI-1 and PRI-2. The final cost per laundered item used was estimated as the average between the cost estimate for PRI-1 and PRI-2, which resulted in R0.1894 per laundered item.

7. Quality of Care Methodology

7.1. Protocol Principles

A quality assessment tool was developed for this study. Several component tools were based on tools used and validated in other international studies (Timko 1994; Broomberg 1995, WHO 1993 and 1994, Beattie 1995). However, these tools were greatly modified in order to increase the suitability for the South African context. The tools have not been subject to validation studies. The tools were designed to measure chosen indicators, and developed based on the following principles:

- **Triangulation**: Quality assessment literature demonstrates that there is no single uniform perception of quality.[13] Quality is perceived differently by different stake-holders in the system. The literature motivates for the assessment of quality from several perspectives. This study includes the perspectives of patients, staff, management, and research observers.
- **Multi-method**: Several authors argue the strengths and weaknesses of various assessment tools and motivate the use of multiple tools. This protocol included interviews, questionnaires, record abstractions, and observation.
- **Balance of Quantitative and Qualitative Measures**: There is a growing consensus in the literature of the complementary role of quantitative and qualitative measures. Multivariate analysis was performed using quantitative data to consider statistically significant differences. (See description of analysis below.) Qualitative data is used to describe and clarify findings.
- **Patient Involvement**: There is a body of literature which debates the role of patients in quality assessment protocols.[14] Literature concludes that patient input is often as much a reflection of patient expectations for care (often linked to socio-economic background) as quality of a service. However, most authors still conclude that it is important to include patients.[15]

The protocol consisted of four components – institutional profile, management /departmental interviews, a ward based protocol, and patient workshops. These tools are described in more detail below. This protocol was applied systematically and consistently across all hospitals.

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[13] Jenkins (1990) examines attempts to define a single indicator for health outcomes and concludes that the 'approach tends to obscure rather than inform' an understanding of quality as the data cannot be disaggregated for specific evaluation.

[14] For a review of the literature on including patients in quality of care assessments, see Balough et. al. (1995).

[15] The inclusion of patients in quality assessments can be motivated on several levels. First, they are the end users, and by definition have unique understanding of what is required to achieve a desirable outcome. Second, patient perceptions of quality affect usage of facilities, compliance, and patient progress over time. Thirdly, without patient input, there is no 'check' on professional assumptions of what 'quality of care' actually entails. Further and perhaps most importantly, the involvement of patients in these processes can work to empower patients (Balough et. al., 1995; Uys, undated)

- **Patient Record Abstraction:** Patient record data was systematically abstracted from patient files and medication cards in each chronic ward.[16] Data abstracted included patient diagnosis, current medications, background data (date of admissions, date of birth, gender, race), physical screening statistics (blood pressure, weight), and dates of the most recent medical routines.

- **Nursing Staff Questionnaire:** A nursing staff questionnaire was developed to assess nursing staff perceptions of quality of hospital operations. The format of the questionnaire was based on the Community Oriented Programs Environment Scale (COPES) of the Residential Substance Abuse and Psychiatric Programs Inventory (RESPPI) (Timko, 1994). The research team reviewed South African quality of care tools and literature to define sub-scale themes and component questions. The themes and component questions were revised through a process of review among the team and two psychiatrists external to the core research team.

  The questionnaire consisted of 109 true-false questions. Questions were organised into approximately 30 sub-scales reflecting structural[17], process[18], and outcome[19] indicators (as well as indicators from all levels of the hierarchy of objectives (see Chapter 4.2.)) The final page of the questionnaire was designed to facilitate additional written comments. The questionnaire was completed by all day staff working within chronic adult wards.

- **Ward Senior Nurse Interview:** A detailed interview was conducted with the senior ward at each chronic ward of the hospital. The 'Senior Ward Nurse' was the nurse in charge at the ward level. The interview covered issues of ward life, mistreatment / abuse, hospital operations, patient services, and job satisfaction. Interviews took between one and two hours to complete.

- **Patient Interview:** The interview is designed to explore aspects of hospital life as perceived by the patient.[20] The interview covered issues of ward life, treatment, hospital

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[16] Patient files were systematically sampled from shelves with the aim of reaching a 90% confidence level and a 5% margin of error at each of the six sites. (Due to difficulties in the field, at 2 sites the margin of error was 6% and 8% respectively.)

[17] Structural sub-scales included management, human resource systems, nursing staff skills, nursing staff support, nursing staff satisfaction, and patient leadership structures.

[18] Process sub-scales included 'custodial care' processes (staff patient relationships, patient access to nursing staff, personal freedoms, patient daily life order, ward cleanliness, social activities, nursing staff languages), 'psychiatric treatment' processes (medical services, medical services languages / availability of translators, patient record keeping systems), 'patient development' processes (discharge preparation, basic self care development, high level preparation for employment, occupational therapy, discharge planning, discharge support), and 'socially transformative' processes (facilitation of family involvement, community involvement.)

[19] Outcome indicators included 'custodial care' outcomes (patient busyness, interactions, pride), 'psychiatric treatment' outcomes (patient understanding of medications), 'patient development outcomes (patient responsibility, clarity of circumstance, clarity of discharge), and 'socially transformative' outcomes (family involvement, family attitude toward patient discharge.)

[20] There is a great deal of controversy about the importance of involving patients in quality of care assessments (Bjorkman et. al. (1996)). The literature particularly warns against formal interviews and questionnaires due to the power of

Table 1-4: Quality of Care Tools: Study Population, Target, Research Instrument, Sampling Strategy

Study Population	Target Sample	Research Instrument	Sampling Strategy
Patient	90% cnfdnce level	File Abstraction	Systematic random sampling. Sample size determined to allow 90% confidence levels and 5% margin of error at each of the six sites. (Due to difficulties in the field, at 2 sites the margin of error was 6% and 8% respectively).
Patient	1/ward	Interview	Senior Ward Nurse asked to provide ten names of patients who could be interviewed. Senior Ward Nurse asked to provide names of patients who were neither the most positive or negative patients in the ward. Researcher selected a name randomly from this list. Researcher ensured patient willingness to talk, comfort with interview, and received informed consent prior to commencing interview.
Patient	1/hosp	Workshop	Social Worker asked to identify patients to participate in discussion. Asked to identify patients who would be willing to actively engage in a discussion.
Nursing Staff	all on duty	Quest'naire	Distributed to all day shift nursing staff, excluding student nurses.
Snr Ward Nurse	1/ward	Interview	The nurse in charge of each ward at the time of the ward visit.
Facilities, Patients, Nursing Staff	2/ward	Observ'tion	Two observers independently completed the evaluation for each ward. All researchers completed evaluation for the hospital as a whole at the end of each site visit. Consensus forms were completed by a meeting of all site visit researchers upon completion of all site visits. The consensus evaluation was used in analysis.
Superintendent	1/hosp	Interview	Senior administrative manager. Note this position was called the 'Hospital Manager' at privately contracted hospitals.
Matron	1/hosp	Interview	Senior matron of hospital (public hospitals) and Nursing Service Manager (privately contracted hospitals)
Union	1+/hosp	Interview	Constitutional leadership representative from union and 'non-union' organisation.
OT Department	1/hosp	Interview / Observ'tion	Head of the Occupational Therapy Department
Social Worker	1/hosp	Interview	Head of the Social Work Department
Psychiatrist	1/hosp	Interview	Head of Psychiatry Department. One psychiatrist services two of the study sites, and was not available on study site visit days.
Medical Officer	1/hosp	Interview	The senior medical practitioner catering to the physical health needs of patients was identified by the senior administrative management.
Informal		Interview	Patients and staff (nursing, cleaning, maintenance) identified informally by willingness to discuss hospital operations.

Table 1.5: Study Tools by Hospital

Ward Protocol	PRI-1		PRI-2		PRI-3		PUB-1		PUB-2		PUB-3	
	N	%	N	%	N	%	N	%	N	%	N	%
Patient Record Abstraction	351	25%	238	19%	142	30%	79	21%	187	58%	204	30%
Nursing Staff Questionnaire	113	37%	64	32%	34	29%	30	33%	77	24%	47	9%

Interviews	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-3
Senior Ward Nurse	8	7	7	9	9	10
Patient	7	9	7	6	10	10
Superintendent	1	1	1	1	3	1
Matron	4	2	1	1	1	1
Union / Non-Union	2	2	2	1	2	1
OT Department	1	1	1	1	1	1
Social Work Department	1	1	-	-	1	1
Psychiatrist	1	1	0	0	1	1
Medical Officer	1	1	1	0	1	1
Informal	3	7	9	9	5	3

- = none available.

nature of the quality of care tools), and because an overall score would have hidden differences in sub-dimensions of quality.[25]

a. Factor Analysis

A factor analysis was undertaken with data from the nursing staff questionnaire and the observer evaluation. The nursing staff questionnaire contained over one hundred individual questions designed to assess nursing staff perceptions of the quality of care in the institution where they worked. The observer evaluation contained lickert scales to rate items of observable quality in 33 areas of hospital operations.

While analyses of these items on an individual and sub-scale level helped us to address specific quality areas, it was difficult to obtain an overall assessment of quality of care using only a disaggregated analysis. In order to reduce the data within both the nursing staff questionnaire and the observer evaluation to a few manageable and separable aspects of quality, we undertook a factor analysis. We sought to identify a few variables that captured most of the variation in nursing perceptions / observations of quality of care, as revealed by all of the questions asked. The following steps were taken. (See Addendum 1.2 and 1.3.)

- **Sub-Scales:** Individual questions of the Nursing Staff Questionnaire were aggregated into 25 sub-scales. The sub-scales consisted of between two and twelve questions. Sub-scale scores were treated as continuous variables.
- **Assessment of Inter-Variable Correlation:** A high degree of correlation between sub-scales of the nursing questionnaire was evident. This suggests that there was considerable overlap between some of the sub-scales in the dimensions of quality that they represented. The Kaiser-Meyer-Olkin (KMO) test was used to compare the magnitude of the observed correlation coefficients to the partial (adjusted) correlation coefficients. The KMO score for the nursing staff questionnaire was 0.85, and for the observer evaluation was 0.94, confirming the utility of the approach.[26]

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geometric mean to address questions of weighting not addressed in traditional approaches to score aggregation. However, the geometric mean also makes hidden assumptions, weighting low scores significantly stronger than high scores. Further, beyond these technical difficulties, the concept of 'score aggregation' is questionable statistically across disparate areas.

[25] In all likelihood, if we had adopted such an approach, our conclusion would have been that there is little to no quality of care difference between public and privately contracted sector care. 'Historically black' hospitals, whether public or privately contracted, are at most achieving minimal custodial care, and are not reaching beyond custodial care objectives. While this may be a useful conclusion up to a point, it falls short of providing a more discerning picture of the service areas where quality may indeed be different.

[26] Where the difference between these is large (KMO score close to 1) then overlap between variables is considerable, and factor analysis is likely to be useful. As a rule of thumb, a KMO score of greater than 0.75 is considered to indicate that factor analysis will be worthwhile.

Table 1-7: Principle Factors of the Observer Evaluation

Factor	Description	Principle Component Sub-Scales
Factor 1	Physical Infrastructure	Buildings, Outdoor Recreational Facilities, Indoor Recreational Facilities, Variation, Personalisation, Distinctiveness, Overall Facility Rating, Overall Hospital Rating, (Condition of Patient Clothes).
Factor 2	Physical 'Environment'	Grounds, Odour, Lighting, Windows, View, Cleanliness of Toilets
Factor 3	Cleanliness	Cleanliness of Wall, Patient Grooming, Cleanliness of Patient Clothing, Condition of Walls, (Noise)
Factor 4	Patient Functioning	Frequency of Patient Interactions, Frequency of Brief Verbal Exchanges, Quality of Patient Interactions, Patient Activity Levels, Patient Energy
Factor 5	Staff Functioning	Staff – Staff Interactions, Staff – Patient Relationship, Staff Enthusiasm, Staff Quantity, Staff Comfort Levels, Staff 'Organisation'.

- **Regression Analysis Using Factors as Dependent Variables:** A continuous variable score was produced for each factor using the regression method, which produces factor scores with a mean of zero and an effect equal to the correlation between the estimated factor scores and the true factor values. These scores were then used as dependent variables in the four regression model approach described below.

b. Regression Analysis

One of the primary objectives of the study was to identify systematic differences between the public hospitals and the privately contracted hospitals. Certainly, there were difference demonstrated between the data of the public hospitals and the privately contracted hospitals. But given the small sample size, to what extent could we be confident that these differences were significant? Further, there are several competing variables that may better explain the differences. To what extent, for example, were differences so pronounced between individual hospitals that a comparison across sectors was less meaningful? Or to what extent do ward-based variables (such as gender and patient functional levels) or patient based variables (such as a patient's diagnosis) explain the effect? Given all of the possible confounding effects, we approached the analysis of difference conservatively.

In order to take into account the varying variables as much as possible, we selected a multivariate analysis approach. The purpose for the regression analysis was to determine the extent of differences between sectors, not to develop reliable predictive models.

Multivariate analyses were undertaken for data emerging from the nursing staff questionnaire (NSQ), the observer evaluation (OE), and the patient file abstraction. The first two tools (NSQ and OE) reflected data collected at the ward level. We considered four regression models to analyse ward level data. The patient file abstraction reflected data collected at the patient level. We considered two regression models at the patient level. Final public-private differences were interpreted in light of the alternate models. The variables, assumptions, and models for these analyses are summarised below.

The remaining two models used public vs. privately contracted status as an independent variable. These two models were designed to assess the extent of statistically significant difference between public and privately contracted hospitals.

One of the regression models for each set (hospital and public vs. private) included all ward-based independent variables. The second regression of each set included only ward variables that were outside the control of hospital management. The aim of this permutation was to identify whether there were hospital or sector differences if one included only those factors upon which management had no control.

Table 1-8: Ward Based Variables[29]

Ward Based Variables: Independent of Management Control	Ward Based Variables: Within Management Control
• Gender of Patients in Ward (male, female) • Age of Patients in Ward (paediatric, adult, psychogeriatric) • Functional Level of Patients in Ward[30] (very high, very low, other) • Psychiatric vs. Mentally Handicapped vs. Mixed Wards	• Ward Capacity • Patient : Staff Ratio

Table 1-9: Summary of Ward Level Regression Models: Nursing Staff Questionnaire and Observer Evaluation

Hospital Regression Model 1		Hospital Regression Model 2	
Description This regression model was designed to determine the extent to which either individual hospital differences, or ward based variables outside of hospital control determined effect.	**Independent Variables** • Hospital • Ward Gender • Ward Age • Ward Functional Level • Psychiatric vs., MH • Nursing Rank	**Description** This regression model was designed to determine the extent to which individual hospital differences or any ward based variables determined effect. Note for example, that this included ward-based variables within the control of management. For example, it could be found that a high patient: staff ratio was significant – this variable, however, reflect management decisions, and comments on hospital quality.	**Independent Variables** • Hospital • Ward Capacity • Ward Patient : Staff Ratio • Ward Gender • Ward Age • Ward Functional Level • Psychiatric vs., MH • Nursing Rank
Sector Regression Model 1		**Sector Regression Model 2**	
Description This regression model was designed to determine the extent to which either public vs. private sector differences, or ward based variables outside of hospital/sector control determined effect.	**Independent Variables** • Public vs. Private • Ward Gender • Ward Age • Functional Level • Psychiatric vs., MH • Nursing Rank	Description This regression model was designed to determine the extent to which public vs. private sector differences, or any ward based variables determined effect. Note for example, that this included ward-based variables within the control of management. For example, it could be found that a high patient: staff ratio was significant – this variable, however, reflect a management decisions, and comments on sector quality.	**Independent Variables** • Public vs. Private • Ward Capacity • Patient : Staff Ratio • Ward Gender • Ward Age • Functional Level • Psychiatric vs., MH • Nursing Rank

[29] An additional variable (nursing rank) was included for the analysis of the nursing staff questionnaire. Specifically we looked for difference in perception between senior nurses (sisters) and less senior nurses (nursing assistants and staff nurses.)

[30] The inclusion of functional level became difficult as all hospital used different criteria to grade wards. Ward ratings provided by the hospitals were not meaningful across hospitals. We therefore took a conservative approach and assessed differences only of sick bay wards (wards designed for the care of the physically ill), very low functioning wards (wards with patients who needed complete nursing care (feeding, bathing etc.), incontinent, unable to move on own), and very high functioning wards (with patients who had highly independent daily life schedules, not requiring only basic supervision for daily care routines.) All other wards were not distinguished.

- **Assessing Sector Differences in Light of Alternate Models**

The final step of the regression approach was to assess public vs. privately contracted differences in light of the alternate models proposed. We rated the effect of a variable as 'very strong', 'strong', 'weak', or 'none'. The guidelines used to determine these ratings are outlined in Table 1-11. The results are demonstrated in tables within Addendum 1.1 to 1.3.

We only accepted results that were either strongly or very strongly suggested. We did not accept results that were only suggested weakly. Further, we did not accept results where the test did not demonstrate significant model fit (i.e. p of F<.05; mean chi square (MCS)<.05) This conservative approach was motivated both by the complexity of variables and the assumptions of continuity of sub-scale scores.

Table 1-11: Significance Ratings Guidelines

Effect	Evidence Required within Four Models	Evidence Required within Two Models
Very Strong Effect	At least one model demonstrating significance to p<.001, or a total of four significance stars (*) across the four models (e.g. two models demonstrating significance to p<.01; four models demonstrating significance to p<.05, etc.).	A total of at least three significance stars (*) across the four models (e.g. one model demonstrating significance to p<.001; two models demonstrating significance to p<.05/0<.01 respectfully, etc.)
Strong Effect	More than weak (see below), less than very strong (see above.)	More than weak (see below), less than very strong (see above.)
Weak Effect	One of four models demonstrated p<.05.	One of four models demonstrated p<.05.
No Effect	No suggestion of effect; none of the four models demonstrated a p<.05.	No suggestion of effect; none of the four models demonstrated a p<.05.

*Significance Stars (*): * = p<.05; ** = p<.01; *** = p<.001.*

7.4. Pilot Study

The protocol was piloted at hospital PUB-HW in August 1996. Changes were made to the protocol according to the pilot experience. PUB-HW was revisited with the updated protocol in March 1997.

- **'Historically White':** In the course of the study, the divergence in quality between 'historically white' and 'historically black' hospitals became clear. For this reason, we did not include data from the 'historically white' hospital within the private / public comparative analyses.[31] Rather, we comment on the differences in data between the one 'historically white' hospital and the remaining 'historically black' hospitals in Chapter 5-3: Equity and Racial Privilege. While the generalisability of this data is limited, we believe the exploration of these findings is important in the context of a general condemnation of quality differences between 'historically white' and 'historically black' hospitals (Mental Health and Substance Abuse Committee, 1996), and will highlight questions and policy areas important for mental health service transformation.

- **Excluded Costs:** The cost analysis included the major hospital operation cost items of personnel, pharmaceutical, infrastructure, transport, food and catering, and laundry. Other cost items (such as headquarters costs and basic operating costs) were excluded due to the lack of relevant and reliable data across all hospitals. The exact contribution of excluded costs was difficult to determine, especially given that the centralised cost in the public sector is spread over several departments (health, public works, transport etc.) and distributed over many cost centres. It is unclear whether or not the private company or the public sector has larger centralised administrative costs. This study falls short of considering the public or private sector cost advantage in terms of central administration costs.

  A sensitivity analysis was conducted to consider the impact of excluded costs if they represented up to 8% of the total hospital costs (see Chapter 3: Cost Findings.) An estimate of 8% was used on the basis of international experience, but it was impossible to determine the exact extent of excluded cost contribution, the accuracy of this figure is debatable. The implication of excluded costs in fact contributing more than 8% of the total budget would mean that the overall costs are slightly higher than reported across hospitals. This would also imply that private sector profit margins would be respectively decreased. The actual percent of budget represented by the excluded costs may also vary to some extent between the public and privately contracted hospitals, affecting the cost comparisons in unpredictable ways. The cost findings should be understood within the context of this limitation.

- **Quality Tools:** Beyond the record abstraction analysis, study tools measured perception (from several perspectives) of quality rather than clinical outcomes. While these tools were useful for comparing quality across hospitals, they fell short of providing objective quality measurements. Further, such an approach is limited by the differences in perspectives across hospitals.

[31] All statistical analysis designed to compare public and privately contracted hospitals excluded data from the one 'historically white' hospital.

by management. Several staff were uncomfortable talking to us in the view of management.

This was explained by head office management in terms of the employer – employee relations during the period of the site visits. Wage negotiations had commenced in July 1996; a dispute led to a strike from mid December to early January, 1997. Management indicated that relationships with employees were particularly low during this period.

While we were able to penetrate this fear and establish trust with staff members to some extent, feelings of hesitation were difficult to penetrate, and may have systematically impacted results. It is likely to have the greatest impact on nursing staff questionnaire results, moving them in favour of private sector hospital quality.[32] The results should be interpreted with this in mind.

Box 1-1: 'Talk openly, and you will lose your job...'

When we first entered a new ward we would conduct a short meeting with the nurses to introduce ourselves and the purpose of the study. On our first privately contracted hospital, we walked into the first ward and found a large group of nurses with hard and unfriendly eyes. We were used to the initial scepticism of nursing staff upon our arrival. Ward life is busy, particularly in these large wards, and a research team is understandably viewed with scepticism. Usually we were able to cut through this bad feeling within the first short while of our stay. The scepticism and lack of trust exuding from these nurses felt different on this day. Friendliness and humour was met by silence. By the time we finished with our introduction the nurses seemed no less stern. We asked if anyone had any questions for us. One male nurse raised his hand. 'What is going to happen with all these patients when you shut this hospital down?'

Clearly the question was shared by the other nurses in the room. Over time we came to understand that they had all been told that we were an 'investigative team', coming with the objective of finding reason to close the hospital down. The moral of the story was self evident but also stated, 'talk openly and you will lose your job.'

[Researcher Site Visit Notes]

Box 1-2: 'Talk openly, and you will lose your job...'

- *They have been telling us to prepare everything – to prepare our books, our records, clean the ward. Everything. Yes, we knew you were coming for a long time. We have been waiting for you...' [II, Senior Sister]*
- *We were told to co-operate with you (the research team) or you may close the hospital down. [PRI-1. II1]*
- *Yesterday one of you [researchers] passed by this ward. A mother was here visiting her son. The matron was there as well. The patient said his mother is coming next week because it is his birthday. [Your colleague] asked me, 'what do you do for patient birthday's?' I said, 'No, we don't do anything.' That senior matron stared at me and said, 'What do you mean you don't do anything? Why not? We will start that right away!!' That was not serious. That was for you. There is no way this hospital encourages us to do things like celebrate a birthday. We can't always get sugar for tea – you really think we could get a little something special for a patient's birthday??!! [PRI1, Ward Senior Nurse]*
- I was lost and I wandered into a ward to ask for directions. The nurse involved offered to show me the way. As we began to walk, our pace became slower and slower. ... The nurse paused but quickly proceeded on to say, *'I cannot be seen to be talking to you for too long or else I'll be victimised.' (PRI-1, Researcher Site Visit Notes)*

[32] This was perceived by the research team to be especially true at the PRI-2, where very few staff spoke openly or freely.

- **Outpatient Services**: Only two hospitals (both public) had outpatient services. The extent to which this affected cost[33] and quality is difficult to determine. The presence of outpatient services meant there was more movement of patients through these hospitals in general. This 'movement' may be a positive contributor to quality. However, given that outpatient services were not evaluated in this study, this quality advantage is not highlighted in this report.
- **Adult Chronic Patients (Target Population)**: The ratio of the chronic adult inpatient population over the total hospital patient population ranged from 1 to .38. That is, PRI-1 was dedicated exclusively to adult chronic inpatients, while this group represented less than 40% of the patient load at PUB-HW.

Table 2-1: Overview of Hospitals

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Sector	PRI	PRI	PRI	PUB	PUB	PUB
Province	A	B	C	C	B	A
'Rural', 'Urban', 'Peri Urban'	Urban	Peri-Urban	Rural	Rural	Per-Urban	Urban
Historical Patient Population	HB	HB	HB	HB	HB	HW
Outpatient Services	None	None	None	None	282/day	140/day
Total Hospital Inpatient Population	1799	1284	490	311	668	1177
Chronic Adult Patient Population	1799	1057	343	181	601	505
Chronic Adult / Total Patient Population	1.00	0.82	0.70	0.58	0.89	0.42

3. Operational Areas

The study population case-mix included chronic adult psychiatric and adult mentally handicapped inpatients only.[34] Only one hospital (PRI-1) was a dedicated adult psychiatric hospital. The remaining hospitals had other patients / operational areas, which were excluded from our study (paediatric, closed, observational). While costs were allocated to the adult psychiatric cost centre through allocation assumptions, the differences in operational areas in the different hospitals are still likely to impact upon both cost and quality outcomes.

Graph 2-1 and Table 2-2 summarise data provided by hospital managers about the number of patients in the operational areas excluded from this study across each hospitals. As can be seen from Graph 2-1 three hospitals have significant paediatric (mentally handicapped) patient populations. Two public hospitals have significant acute patient populations. Almost 30% of PUB-1 are physically handicapped patients. Almost 25% of PUB-HW is made up of observation patients, state patients, and closed wards.

[33] Outpatient days were estimated on the basis of a 1:1 ratio given evidence to suggest that psychiatric outpatients require more dedicated care time than psychiatric inpatients.

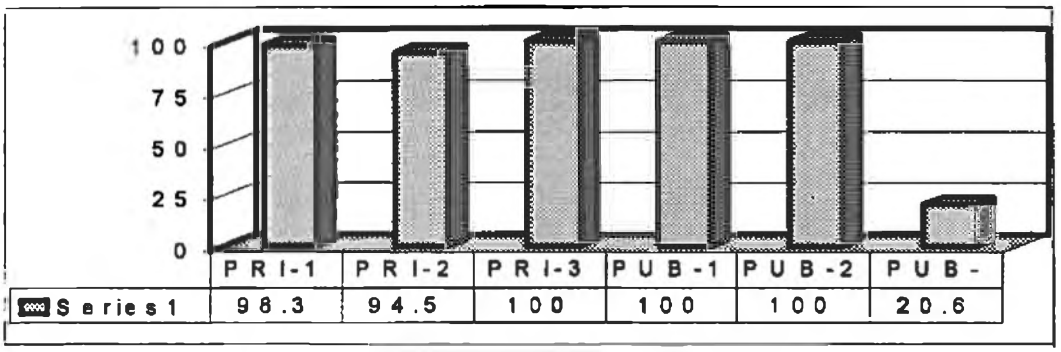
[34] The study population excluded outpatients and patients seen through community services, as well as other physically ill wards, paediatric wards, acute psychiatric wards, observational wards, state president wards, and closed wards.

4. Patient Demographics: Race, Gender, Age, and Diagnosis

4.1. Racial Distribution

The 'historically black' hospitals continue to be almost exclusively black (over 90%). The 'historically white' hospital continues to have a majority of white patients (78%). The proportion of the patient population that is black across hospitals is demonstrated in Graph 2-2. These skewed proportions are a function of both long length of stay of patients (see Chapter 4.1) and enduring traditions which undermine integration. For a more detailed discussion of issues of racial equity across hospitals, see Chapter 5.3: Equity and Racial Privilege.

Graph 2-2: Percent of Patient Population Black



4.2. Gender Distribution

Only 21% of patients across hospitals were female. (One hospital, PRI-1 was exclusively male.) This is consistent with other studies demonstrating a higher number of male patients than female patients in psychiatric institutions in Africa – demographics distinctly different from those in Europe and the US (Rey and Eagle, 1997).

4.3. Age Distribution

The age distribution across hospitals is illustrated in Table 2-3. There was not a significant difference in age distribution between public and privately contracted hospitals. Patients in the rural hospitals were younger, on average, than patients in the remaining hospitals.

Table 2-3: Patient Age Distribution Across Hospitals

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Public^	Private
Median	47	44	34	37	47	49	44.5	44
Mode	56	36	18	22	61	41	-	-
Mean	48.4	45.9	36.0	39.1	46.5	49.4	44.6	45.1
SD	15.1	14.5	16.5	19.1	17.3	15.6	18.1	15.9

^ Public Sector statistics excluded the 'historically white' hospital data to enable comparison.

Table 2-4: Transfer Relationships Between Privately Contracted and Public Sector Hospitals

Patients Transferred to Privately Contracted	Patients Transferred Back to Public Hospitals
'Stable', 'Chronic'	'Aggressive', 'Problematic', 'Relapsed', 'Physically ill'
➢ When the patient has overcome the psychotic period and needs to stay in a chronic institution. (PRI-1SSI7) ➢ When a patient is not fit to be in the community and requires long term institutionalisation. (PRI-1SSI5) ➢ Chronic patients are transferred here, once stabilised. (PRI-3SSI9) ➢ Those who don't receive visitors. (PUB-2SSI3)	➢ In terms of transferring patients, if patients become aggressive they always send them back. They do not tolerate aggressive or problematic patients and send them back. They only like stable patients. (PUB-HWSSI2) ➢ I think that the big difference is that patients in [privately contracted hospitals] are unproblematic. ... If the patients become aggressive or actively psychotic then they are sent back to a state institution. (PUB-HWSSI14) ➢ When a patient relapses or becomes acute rather than chronic. (PUB-2SSI6) ➢ When the patient is very very much uncontrollable...(PRI-1SSI2) ➢ When he is psychotic, uncontrollable, unmanageable. When cooled down, he comes back. (PRI-1SSI7)

6. Conclusions

While the selection strategy of this study was designed to maximise comparison across sectors, the ability to compare cost and quality outcomes across sectors is limited by both the individual differences demonstrated between hospitals and the systematic differences between sectors due to transfer relationships.

One conclusion of this study is that caution must be taken in generalising across hospitals within a sector. While there were common themes running within sectors, and across hospitals as a whole, hospitals often represented unique entities. Given the deeply rooted economic, social, and political histories of these hospitals and their local environments, as well as more subtle differences in patient populations, this conclusion should not come as a surprise. Quality of care differences, in particular, were often not explained by simple sectoral differences.

The comparison of sectors throughout this report must be understood within current transfer relationships between sectors whereby stable patients are transferred to the privately contracted hospitals and less stable patients are transferred to the public sector.

Further analysis sought to estimate the total cost of those excluded cost items. These cost items capture small amounts of total costs and so it was assumed that their costs might represent between 0 and 8 percent of total estimated costs.[36] The results of a sensitivity analysis using 0%, 2%, 4%, and 8% respectively is demonstrated in Table 3-1. As can be seen from this table, using the highest estimate for excluded costs of 8%, privately contracted hospitals on average cost approximately R35 per day. The 'historically black' public hospitals cost on average approximately R84 per day. The 'historically white' public hospital cost approximately R104 per day.

Table 3-1: Cost per Patient: Sensitivity Analysis of Excluded Cost Items (in Rand)

Excluded Cost:	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Pub-HB	Pub-HW
0% of Total Budget	33.03	33.83	35.25	77.24	78.74	96.54	34.04	77.99	96.54
2% of Total Budget	33.69	34.51	35.96	78.78	80.31	98.47	34.72	79.55	98.47
4% of Total Budget	34.35	35.18	36.66	80.33	81.89	100.40	35.40	81.11	100.40
8% of Total Budget	35.67	36.54	38.07	83.42	85.04	104.26	36.76	84.23	104.26

Personnel represent by far the largest cost item (70 to 80 percent of total costs across hospitals) reflecting the labour intensive nature of chronic psychiatric care.[37] The second most important cost item is food and catering, ranging between 9 and 16 percent across hospitals. The third highest cost item is infrastructure, representing between 2 and 7 percent of the budget across hospitals. The remaining cost items -- transport, pharmaceuticals, and laundry represent, on average 3%, 3% and 2% respectively.[38] The cost per item per patient day is demonstrated in Table 3-2. The total costs of each cost item and the percent captured by each cost item are outlined in Table 3-3. These data are summarised across sectors in Graph 3-2 and Table 3-4.

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[36] The exact contribution of excluded costs was difficult to determine, especially given that the centralised cost in the public sector is spread over several departments (health, public works, transport etc.) and over many cost centres. It is unclear whether or not the private company or the public sector have larger centralised administrative costs. While the public sector has a larger breadth of centralised administration, these costs are spread across more units than the private sector. Given the lack of data to inform this area, the sensitivity analysis did not assume a different proportion of costs in the public and private sector. This study falls short of considering the public or private sector cost advantage in terms of central administration costs. Further, if the excluded cost contribute to the overall budget differently across sectors, this effect will not be demonstrated.

An estimate of 8% was used according to international experience. This may be a low estimate of the contribution of these excluded costs. The implication of this would mean that the overall costs are slightly higher than reported across hospitals. This would also imply that the profit margins (discussed below) would be less respectively.

[37] The personnel costs represent between 71 and 80% of costs calculated in this study. Assuming that costs excluded in this study account for approximately 8% of the total budget, these figures represent between 66 and 74% of total costs. Lifecare calculates this figure to be approximately 65% for its hospitals.

[38] Again, these percent figures would be somewhat lower if excluded costs were assumed to be more than negligible. The relative differences between cost items would be similar.

2. Production Cost vs. Contract Cost

The 1995-1996 contract price (Financial Director, Lifecare Head Office) per patient day across the privately contracted hospitals ranged from R35 to R65 per day, averaging R53 across hospitals.

Table 3-5 demonstrates the relationship between contract price and total production costs according to the sensitivity analysis allowing for excluded costs. If excluded costs have a negligible effect on total costs, the contract price exceeded the calculated production costs in the three hospitals by 23%, 4%, and 46% respectively. If excluded costs represent up to 8% of the total costs, the contract prices exceeded calculated production costs in two of the hospitals (by 17 and 41%), while production costs exceeded contract costs in one hospital by approximately 4 percent. The profit margins for these hospitals over this period provided by the company were substantially lower than those calculated in this study.[39] See Table 3-5.

Table 3-5: Cost per Patient Day: Contact Price vs. Production Cost (in Rand)

	Contract Price (Cost/Pt/ Day)	Prod'n Cost	% contract price exceeds prod'n costs	Prod'n Cost	% contract price exceeds prod'n costs	Prod'n Cost	% contract price exceeds prod'n costs	Prod'n Cost	% contract price exceeds prod'n costs	Comp Figures [40]
		0%: Calculated Production Cost		*2%: Calculated Production Cost Plus 2%*		*4%: Calculated Production Cost Plus 4%*		*8%: Calculated Production Cost Plus 8%*		
PRI-1	42.95	33.03	23%	33.69	22%	34.35	20%	35.67	17%	0.43%
PRI-2	35.16	33.83	4%	34.51	2%	35.19	0%	36.54	-4%	7%
PRI-3	64.75	35.25	46%	35.96	44%	36.66	43%	38.07	41%	27% [41]
Avg	47.61	34.04	29%	34.72	27%	35.40	26%	36.76	23%	11.5%

The contract prices over a three-year period were also reviewed and are outlined in Table 3-6. The contract price increases are seen to exceed the Consumer Price Index (CPI) percentage change in all sites. (The largest price increase in 1996/97 at PRI-2 is attributed by Lifecare to the shift in seconded public sector staff during this time period.) For a more detailed discussion of the relationship between production costs and contract price see Chapter 6: Summary Discussion.

Table 3-6: Contract Prices Over Three Years (in Rand)

	July 1994 – March 1995	April 1995 – March 1996*	April 1996 to March 1997	% Price Increase: 95/96	CPI % change 95/96	% Price Increase 96/97	CPI % change 96/97
PRI-1	37.48	42.92	47.43	14.5%	9%	10.5%	8%
PRI-2	31.68	35.16	41.20	11.0%	9%	17.2%	8%
PRI-3	57.55	64.75	71.23	12.5%	9%	10.0%	8%

[39] Reasons for this difference include the possibility that excluded costs represent more than 8% and / or differences in costing methods (especially with reference to capital costs.)

[40] Source: Lifecare Head Office, Managing Director.

[41] Lifecare Head Office reports that higher profit margins in PRI-3 represent at least in part a repayment of capital from the public sector.

Table 3-8: Patient Load / Staff Category, According to the Hierarchy of Objectives Framework

		Patient : Staff Ratios									Sector Ratio	
Objective	Personnel Category	PRI-1	PRI-2[42]	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Pub – HB	Pub-HW	PC / Pub-HB	PC / Pub-HW
Overall	Management	600	628	879	377	202	721	702	290	721	2.42	0.97
	Administration	600	359	440	54	67	30	466	61	30	7.64	15.53
Level 1	Non-Professional Nurse	7.1	7.1	9.1	7.1	3.3	4.8	8	5.2	4.8	1.54	1.67
Custodial	Food and Catering	120	61	29	15	23	12	70	19	12	3.68	5.83
Care	Cleaning Staff	37	27	22	8	46	13	29	27	13	1.07	2.23
	Laundry Staff	43	92	45	14	17	17	60	15.5	17	3.87	3.53
	Maintenance and Grounds	120	176	63	9	47	27	120	28	27	4.29	4.44
	Security	360	468	14	21	69	55	281	45	55	6.24	5.11
Level 2	Professional Nurse	32.7	43.3	32.7	9.5	7.4	6.4	36	8.5	6.4	4.24	5.63
Psychiatric	Medical Practitioner	600	428-714[43]	1372	1810	257	971	895	1033	971	0.87	0.92
Treatment	Psychologist	None	None	None	None	3339	155	None	N/A	155	Na	Na
	Traditional Healer	None	None	None	None	None	None	None	None	None	Na	Na
	Pharmacist	900	2578	8575	None	345	532	4018	345	532	11.65	7.55
	Pharmacist Assistant	900	None	490	None	None	None	952	None	None	Na	Na
Level 3	Occupational Therapist	900	None	None	None	401	126	NA	40	126	Na	Na
Patient Rehab	OTA	600	184	123	50	401	144	302	225.5	144	1.34	2.10
Level 4: Family / Community Services	Social Worker	1799	641	None	None	1398	304	1418	1398	304	1.01	4.66

3.3. Nursing Staff

The public sector hospitals have, on average, 2.2 times more nursing staff per patient than privately contracted hospitals, across all nursing ranks. The public hospitals have proportionately more highly trained nurses than privately contracted hospitals. Professional nurses make up, on average, 39 percent of total nursing staff in public hospitals, while they only make up 18 percent in privately contracted hospitals. The number of patients per professional nurse in the private contracted hospitals exceeds that in the public sector by a factor of 4.3 (See Table 3-9 below).

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[42] As has been mentioned in the previous notes about PRI-2, the staff complement in this hospital underwent some fluctuation during this period. The staff category affected by these fluctuations was nursing staff. A sensitivity analysis using the later year figures was conducted to assess the extent to which these changes impacted on patient : staff ratio outcomes. The patient : non-professional nursing staff ratio was decreased slightly from 7.1 patient per nurse to 6.6 patients per nurse. The patient : professional nursing staff ratio increased from 43 patients per nurse to 63 patients per nurse. The overall change was negligible changing the patient : nurse ratio from 6.1 patients per nurse to 6.0.

[43] Similar to the above note, two sets of data were provided in terms of medical practitioner staff at PRI-2. One set demonstrated the patient load per medical practitioner to be 714. The other set demonstrated the patient load per medical practitioner to be 428.

Table 3-11: Non-Nursing Patient Care Staff: Cost per Patient Day in Rand and Percent of Overall Costs

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Medical	R.81	R.38	R.14	R.00	R 1.44	R 1.04
Occupational Therapy	R.84	R.43	R.59	R 1.84	R.73	R 1.42
Social Workers	R.08	R.23	R.00	R.00	R.14	R.73
Psychologist	R.00	R.00	R.00	R.00	R.09	R 1.27
Physiotherapy	R.92	R.23	R.60	R 1.28	R.08	R.00
Percent of Overall Personnel Costs	11%	5%	5%	5%	4%	7%

3.5. Hospital Support Staff

Hospital support staff (cleaning, food and catering, laundry, grounds, and maintenance) represent, on average, 25 percent of the overall hospital personnel cost. Table 3-12 demonstrates the cost per patient day of personnel from these categories. Table 3-8 above compares the patient load across these staff categories. Staff in the privately contracted hospitals have a dramatically higher patient load than staff in the public hospitals. The one exception to this rule is cleaning staff whereby cleaners in privately contracted hospitals and public 'historically black' hospitals have approximately the same patient load.

Table 3-12: Hospital Support Staff: Cost per Patient Day in Rand and Percent of Overall Personnel Costs

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Cleaning	R 1.4	R 2.6	R 2.3	R 7.6	R 1.3	R 4.6
Food and Catering	R.7	R 1.2	R 2.2	R 4.7	R 3.2	R 6.2
Laundry	R 1.5	R.9	R 1.4	R 4.8	R 4.2	R 5.0
Grounds and Maintenance	R.6	R.4	R.9	R 6.8	R 1.4	R 3.0
Percent of Overall Personnel Costs	17%	20%	27%	40%	16%	23%

3.6. Management and Administration

The personnel costs and the percent of total personnel costs for management and administration on site at each hospital are demonstrated in Table 3-13. The cost per patient for on site administration and management reflects the results demonstrated in the overall costing graphs. For a more detailed discussion of management see Chapter 5-1: Management.

The costing method excluded administrative and management personnel at the head office level for both the privately contracted and the public sector hospitals.

Table 3-13: Hospital Management and Admin Staff: Cost / Patient Day (in Rand) and % of Overall Personnel Costs

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Cost per Patient Day	R .65	R .63	R .44	R 2.18	R 2.10	R 3.31
Percent of Overall Personnel Costs	3%	2%	2%	4%	3%	3%

Table 3-14: Food and Catering Costs (in Rand) and Percent of Overall Costs

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Ratio Private / Public
Cost / Patient on Meds / Day	4.12	5.26	4.45	8.77	7.11	9.55	4.61	8.48	0.54
Percent of Cost	12%	16%	13%	11%	09%	10%	14%	10%	1.37

4.2. Pharmaceutical Costs

Drug costs represented an average of only 3% of total hospital costs. Public hospitals again spent more per patient day than privately contracted hospitals. Drug cost per patient day ranged between less than one rand to more than three rands per patient day. Table 3-15 demonstrates the daily cost per medicated patient and per patient (whether on medications or not) across hospitals.

The source of the difference in expenditure was not explained by quality data. Patients were not systematically more medicated at PUB-2, for example, than other hospitals. This level of drug expenditure is surprising relative to cost findings for acute hospitals where drugs are usually the second largest cost items. This finding confirms the more limited use of pharmaceutical treatment for the care of chronic psychiatric patients than acute care patients.

Table 3-15: Pharmaceutical Costs (in Rand)

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Private / Public
Cost / Patient on Meds / Day	1.44	1.03	2.40	1.57	3.18	1.71	1.62	2.15	0.75
Cost / Patient^ Day	1.07	0.85	1.97	1.07	3.12	1.64	1.30	1.94	0.67

^ Patient whether or not on medication

4.3. Transport

Although a relatively unimportant cost item across hospitals, it is interesting to note that transport costs varied widely between hospitals, costing as low as 38 cents per patient per day, and as high as R 2.30. In general, transport costs were higher in public hospitals than privately contracted hospitals. Graph 3-4 and Table 3-16 demonstrates transport costs per patient across hospitals and sectors.

The privately contracted hospitals congregate together at significantly lower expenditure for transport as compared to the public sector hospitals.

The relatively high transport cost of PUB-1 is surprising given that patient care staff at this hospital perceive there to be no transport available for patient care. Staff from this hospital relate stories of having to transport patients by public transport to the nearest hospital in cases of emergency. This data suggests large inefficiencies in terms of the use of transport resources at this hospital. However, this data must be treated with some caution given the difficulty of getting accurate figures of kilometres traveled across hospitals.

staffing allocation on the basis of the hospital patient load.

Table 3-17: Comparing Patient Load and Average Cost Across Hospitals and Sectors

Variables	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Private / Public
Total Hospital In-Patient Population	1799	1284	490	311	668	1177	1191	719	1.66
Target Patient Population	1799	1057	343	181	601	505	1066	429	2.49
Total Cost / Patient / Day	R 33.04	R 33.83	R 35.26	R 77.25	R 78.73	R 96.54	R34	R84	0.40

6. Factors Underlying Cost Outcomes

Table 3-18 summarises characteristics of hospitals and costs across hospitals and sectors. This data, combined with cost outcomes (see Graph 3.1), suggests that several variables may have a relationship with cost outcomes. We identified four primary factors which may underlie these cost outcomes.

Table 3-18: Hospital Variables in Relation to Total Costs

Variables	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Private / Public
Sector	PRI	PRI	PRI	PUB	PUB	PUB	-	-	-
Province	A	B	C	C	B	A	-	-	-
Historical Patient Population	HB	HB	HB	HB	HB	HW	-	-	-
Total Hospital In-Patient Population	1799	1284	490	311	668	1177	1191	719	1.66
Target Patient Population	1799	1057	343	181	601	505	1066	429	2.49
Total Cost / Patient / Day	R 33.04	R 33.83	R 35.26	R 77.25	R 78.73	R 96.54	34	84	0.40

Firstly, the cost distribution between sectors suggests that the sector impacts cost outcomes. At least three differences between sectors are suggested to underlie this cost difference -- personnel, staff mix, and the ability to allocate personnel on the basis of patient load. Higher average personnel costs in public hospitals are primarily a reflection of greater staff availability across all cadres in these hospitals, as well as proportionately more highly trained staff in the overall staff mix. The lower costs in privately contracted hospitals not only reflect lower numbers of staff and proportionately fewer highly trained staff, but also reflect that staff in the privately contracted hospitals are more rationally allocated on the basis of patient load across hospitals.

A second key factor underlying cost outcomes seems to be historical racial privilege. The 'historically white' hospital had higher costs than the remaining 'historically black' hospitals. The cost per patient is at least 20% higher than average costs at any 'historically black' hospital suggesting that historical racial privilege may have some influence over cost findings. For a more detailed discussion of cost and quality findings between 'historically black' and the 'historically white' hospital, see Chapter 5-3: Equity and Racial Privilege.

Chapter 4: Quality of Care Findings

Chapter 4.1: Discharge Rates and Length of Stay

1. Introduction

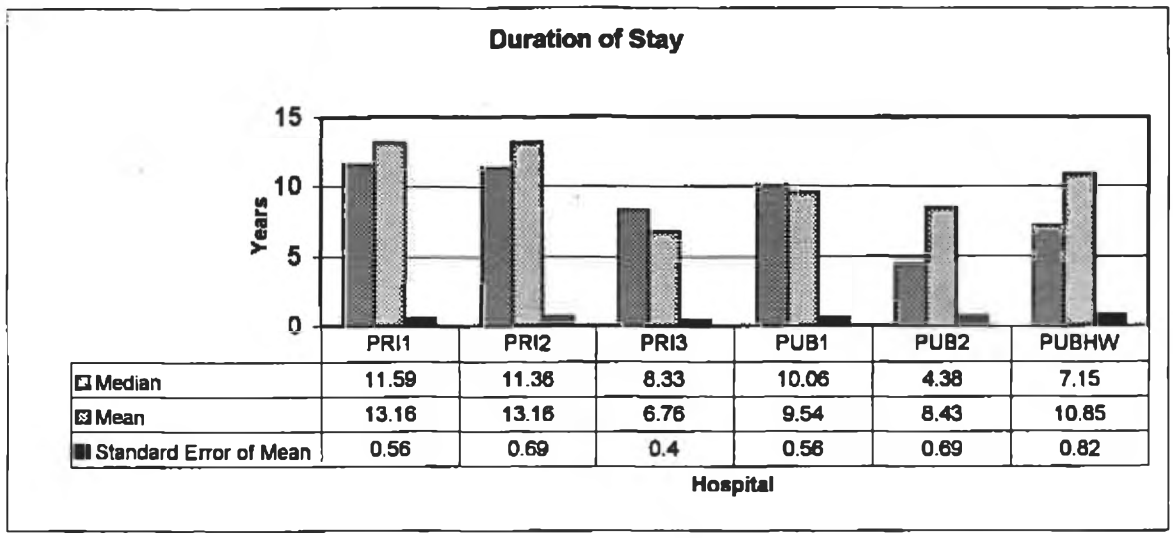
- *In this ward I have never known anybody who was discharged. I only know of people who have died. (PRI-1; Patient)*
- *I am thinking of home, but I would be lying if I said I have seen people leaving or being discharged. (PRI-1; Patient)*
- *No, [patients are not discharged] except those who escape. (PRI-2; Patient)*
- *He smiled but his eyes registered tired resignation, 'Discharge here is by death.' (PUB-1; Researcher Site Visit Notes, Nursing Assistant)*
- *The only patients I've seen going out of this place are those who have died. Four have died since I've been here. Most patients think this is home and like them I do not want to be discharged. (PUB-1; Patient)*
- *Patients get LOA's. They are not discharged. We don't discharge. Discharge is very rare. The only time we discharge is when the patient has run away. We give them 24 hours and if they are not back then we discharge them. (PUB-3; Senior Ward Nurse)*

Before moving into a more detailed description of the framework we used to evaluate quality and the more detailed quality findings, we report on the two most common quality outcome measure used for long term psychiatric institutions, short of clinical evaluation – namely, patient discharge rates and length of stay statistics. We look at these two indicators up-front, as they not only motivated for our more complex quality assessment framework, but also provide a good backdrop for the quality findings to come.

2. Discharge Rates

The annual discharge rates of the 1995/1996 period ranged between 0 and 10 percent. This is inclusive of patients who were discharged due to absconding from the hospital, as well as patients who were temporarily discharged and subsequently readmitted. Thus, the rate of sustainable discharges (whereby patients were not readmitted) is lower than this. Graph 4.1-1 demonstrates the discharge rates during this period, across institutions.

Graph 4.1-2: Duration of Stay by Institution



	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Median	11.59	11.36	8.33	10.06	4.38	7.15
Mean	13.16	13.16	6.76	9.54	8.43	10.85
Standard Error of Mean	0.56	0.69	0.4	0.56	0.69	0.82

Hospital

4. Implications and Way Forward

Discharge rates and length of patient stay are common indices for hospital quality and efficiency (Jenkins, 1990; Broomberg, 1997). If we used discharge rates and length of patient stay as central indicators for hospital quality, we could stop here and conclude that hospitals are not providing quality care. It is a useful point to pause. If the role of these institutions is to actively facilitate patients' discharge, they are currently failing to achieve their mandate.

However, to stop here would neither be true to the complexity of the sector nor illuminate a way forward. First, discharge per se is not an indicator of quality on its own. Discharge without psychiatric treatment, skills to cope outside of the institutional environment, and supportive relationships in the community can be more damaging than beneficial to both the individual and society. Further, discharge into a community lacking basic support services is of questionable benefit to severely ill psychiatric patients. The backlog of affordable housing and housing for the unemployed contribute to the complexity of a 'quality discharge' in our context.

Moreover, the simple lack of discharge does not explain the *reasons* underlying hospital failure. Are hospitals failing in their objective to treat the psychiatric symptoms of patients? Are patients treated with reference to psychiatric symptoms but otherwise not developed and prepared for discharge? Are hospitals failing to discharge patients who are currently ready to be discharged? Are hospitals failing to achieve the pre-requisites of successful discharge? Are the barriers to discharge primarily social, for example, family and community alienation and the lack of community services? And if so, to what extent are hospitals involved in transforming these social barriers?

Thus, in our context, simple discharge / length of stay statistics are not an adequate measure of quality. This motivates for a more detailed framework for the evaluation of hospital service quality. This motivation provides the backdrop for the 'hierarchy of objectives' framework outlined in the next chapter.

These outcomes were ultimately consistent with the analysis of interviews of management, staff, and patients from this study. Two conclusions of this analysis stood out. First, there are several subgroups of patients in these hospitals, with *different* care requirements. Second, while most staff believed that hospital objectives should move beyond custodial care, staff were not articulating a clear and consistent set of hospital objectives to address needs beyond custodial care.

These conclusions and the data from the Gauteng Mental Health Directorate study, in the context of transforming hospital objectives (and the lack of norms and standards), underpin the hierarchy of objectives that provides the framework for this study.

2. Quality of Care Assessment Framework: Hierarchy of Objectives

The diagram below illustrates the four levels of the 'hierarchy of objectives', which provide a framework for this study -- custodial care (long term care), psychiatric treatment, patient rehabilitation for discharge, and social transformation services. Each level of this model is motivated by *the needs of a certain subgroup of patients*. This patient population implies specific care requirements, which suggest corresponding quality indicators. There is arguably overlap between these levels which is why the model is organised according to a hierarchy rather than as isolated levels.

Each level describes the subgroup of patients motivating the model, and the quality indicators (organised according to structure, process, outcome, and satisfaction) flowing from the patient requirements of this level[45]. (Note that patient discharge is a common outcome indicator for all levels except custodial care.)

Indicators used in this study were chosen from each of these four levels.

[45] This is not meant to be a comprehensive listing of all indicators at each level. It is meant only as an initial framework to be built upon in future efforts to build quality assurance tools.

Model Level 3: Patient Rehabilitation and Development for Discharge

The following is a basic system model for an institution servicing patients who are institutionalised due to a combination of mental illness and 'low social functioning'. That is, discharge is not only dependent upon psychiatric treatment, but requires the improvement of patient skills and social functioning (social skills, care skills, family relationship etc.) and active planning and preparation to ensure discharge. Hospital services continue to focus on the patient, but reach beyond psychiatric services to patient rehabilitation and development for discharge.

Table 4.2-3: Model Level 3: Patient Rehabilitation and Development for Discharge

Patient Population	→	Structure	→	Process / Programme	→	Outcome	→	Satisfaction**
Discharge Development Needs		• Management (development oriented) • Infrastructure (developmental) • Supplies (developmental) • Staff (development oriented)		• Patient Rehabilitation Services • Patient Discharge Orientation		• Improved functional level of patients • Independent Functioning • Patient discharge		• Patient • Family • Community • Nurse (Care Taker)

***NB: Quality outcome (discharge) may not imply high satisfaction of patient and families if the hospital is not able to transform attitudes in the process.*

Model Level 4: Social Transformation: Family and Community Services

The aetiology and course of mental illness is a complex combination of factors relating to an individual and his/her social environment. Management, staff, and patients alike perceive the primary barriers to successful patient discharge to be family and community factors. That is, even if patients, as individuals, are ready for discharge, successful discharge is undermined by non-supportive or non-existent relationships to support discharge.

The following is a basic system model for an organisation servicing patients who are severely displaced from family and community. That is, even if mental and social functioning were improved, discharge would be unsuccessful unless community, family, or support services were transformed.

Table 4.2-4: Model Level 4: Social Transformation: Family and Community Services

Patient Population	→	Structure	→	Process / Programme	→	Outcome	→	Satisfaction**
Severe Social Displacement		• Management (oriented toward social transformation) • Staff (social / community worker skills) • Infrastructure (community oriented) • Supplies (community oriented)		• Facilitation of Family Involvement and Change • Facilitation of Community Involvement and Change • Facilitation of Community Service Development		• Improved family relationships • Improved community relationships • Improved community services • Patient Discharge		• Patient • Family • Community • Nurse (Care Taker)

*** Quality outcome implies high satisfaction.*

Chapter 4.3: Objective Level 1
'Custodial Care' / Long Term Residential Care

1. Introduction

- *Although there is no rehabilitation, but for just keeping patients this place is OK. [PRI-3; Ward Senior Nurse]*
- *We offer refuge to the homeless. We mother patients with no families. We have adopted our black community. You see the appreciation on the patients' face. [PRI-1; Ward Senior Nurse]*
- *If someone comes and says, 'I have no place to stay,' we accommodate them. [PUB-HW; Ward Senior Nurse]*
- *[What are good things about this hospital?] A bed – you have one all to yourself. Food – you are provided with food. You are bathed. [PRI-1; Patient]*

The hospitals in this study were born of an era of 'custodial care' where hospitals were organised to keep patients, with no focus on patient rights, let alone discharge or developmental objectives. The hospitals have thus operated for many years on the basis of historical 'custodial care' objectives.

While there is a policy move attempting to minimise 'custodial care' facilities, particularly with reference to its historical connotation and application, there will arguably remain a need for long term residential care / maintenance facilities. Our first question then, is whether or not these hospitals are achieving quality care with reference to simple long-term maintenance.

To assess quality of care at this level, we evaluated structural indicators, process indicators, and briefly looked at outcome indicators. These indicators are outlined in Table 4.3-1. The evaluation of management and nursing staff can be found in Chapters 5.1: Management, and 5.2: Nursing Staff.

Table 4.3-1: Custodial Care Indicators

Structural Indicators	Process Indicators	Outcome Indicators
1. Budget Orientation	1. Patient Daily Care Routines	1. Patient Functioning Rating
2. Management	2. Staff Patient Relationship	2. Patient Interactions
3. Staff	3. Personal Freedoms	3. Patient Busyness
4. Infrastructure	4. Cleanliness and Hygiene	4. Patient Pride in Hospital
5. Supplies	5. Absence of Patient 'Physical Abuse'	5. Patient Cleanliness

part, 'historically black' hospital wards have no indoor space, beyond bedrooms, in which to spend time during daytime hours. Physically disabled patients who are unable to go outside during the day sit in areas of the ward temporarily cleared of beds. (See Box 4.3-2: 'They Must Stay Inside'.)

During daytime hours patients for the most part are outside the wards on concrete slabs, either sitting in folding chairs, concrete benches, or lying on the ground. Outdoor facilities are either non-existent, not maintained, or not used. None of the 'historically black' hospitals had protected outdoor facilities. Patients who sit outside are exposed to extremes of sun and rain. Thus, on rainy days, patients are largely confined indoors.

Table 4.3-2: Ward Buildings and Facility Design

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
'Hostel' Model Organisation	Yes	Yes	Yes	Yes	Yes	No
Diversification / Personalisation of Bedrooms	None	None	None	None	None	Extensive
Indoor Recreational / Relaxation Area	Limited to None	None	None	None	None	Extensive
Outdoor Recreational / Relaxation Area	Concrete Patios	Concrete Patios	Grassy Area	Concrete Patios	Concrete Patios	Extensive
Protected Outdoor Sitting Area	No	No	No	No	No	Yes

Box 4.3-1: An Image of Institutionalisation

This hospital's questionable claim to fame is it's kilometre long hallway cutting through the psychiatric section. 'It is the longest hallway in any hospital, or so we have been told...' The hallway is covered by a maze of piping and plumbing, and leads on either side to wards, evenly lined up, separated by concrete patio areas.

Wards are brick buildings. The space inside is divided by shoulder height partitions into sleeping areas of beds lined up in formation. There is no sign of personalisation, whether by picture, possession, or bed making style. The ends of the wards are the ablution facilities. This is apparent from the moment you walk into the ward, as the stench is almost unbearable. The toilets are old, and too many unheard efforts to get the plumbing fixed have translated into a strategy of pouring buckets of water to coax the toilets to flush. These efforts, often unsuccessful, are abandoned out of frustration. Most of the indoor showers no longer work, and so patients bathe in the showers outside.

Each ward has a concrete patio where patients spend daytime hours. A concrete 'bench' runs across one length, covered by an awning that may protect patients from some of the worst sun, but is too thin to protect patients from the rain. Along the outside of the ward runs a drain. The drainage system is long since blocked up, creating pools of stagnant water mixed with garbage collecting over time.

Standing at one end of that hallway makes it feel as if the hallway carries on forever.

[PUB-2, Researcher Site Visit Notes]

Box 4.3-2: They Must Stay Inside...

It was our first day at this hospital. And, as usual, the hospital management was nervous, going out of their way to show us around, watching where our eyes fell, rushing into quick explanations if they registered concern in our gaze. On this day one Matron in particular was watching my moves, and often joining me as I looked around.

We had walked by the children's ward where the nurse had explained that the children remain inside, in their cots, for the majority of the day.

As we walked out, the Matron rushed to explain. 'There is no protection for the patients from the sun. There is a nice grassy area, but nothing set up to provide protection from the sun – only the small pieces of shade under the trees. This is why most children are not allowed out of the ward. In 1991 children were let out, but then one day they got sunstroke. Patients wander. This is their right. But if they wander behind the building and lay in the sun and we can't see them, then it is dangerous.' One time a patient walked behind that building. He slept in the hot sun and we could not see him, and he died of sunstroke. So you can see, we cannot just let these children out like that.

[PRI-3, Researcher Site Visit Notes]

space beyond space for beds and ablution facilities.

2.3. Patient Supplies

> ➢ *Patient supplies are non-existent. Clothes are of poor quality and lacking in terms of volume. Food seems to be bare minimum – pap and porridge are main staples. No blood pressure machines. No basic safety supplies – not even one fire extinguisher per ward. There are so few wheelchairs that many patients who are unable to move on their own simply get left in their beds for months on end. Basic supplies like cleaning agents are lacking. [PUB-2; Researcher Site Visit Notes]*

Quality custodial care includes the provision of basic patient amenities. We defined 'basic patient amenities' for the purpose of this study as food, clothes, bedding, and ward amenities like heating.

The 'historically white' hospital is providing relatively high quality basic patient amenities, and provides amenities beyond our definition of 'basic amenities. The 'historically black' hospitals teeter on the line between minimal provision and lack of provision of these amenities.[56] These findings are summarised in Table 4.3-3.

Table 4.3-3: Summary of Patient Supplies Indicators

Hospital	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Food: Quantity	Enough	Enough	Enough	Enough	Enough	Enough
Food: Quality	Poor	Poor	Poor	Poor	Poor	High
Quality of Clothes	Poor Institutional	Poor Institutional	Poor Institutional	Poor Institutional	Poor Institutional	Personalised
Patient Wearing Shoes[57]	Few	Few	Few	Few	Few	Majority
Linen Quality	Low	Low	Moderate	Low	Low	High
Mattress Quality	Low	Low	Low	High	Low	High
Sufficient Heating for Winter	No	No	No	No	No	Yes

a. Patient Food

> ➢ *'The food is poorly prepared and minimal. It seems every meal is organised to save money. In the morning there is porridge and four slice of bread. The bread is dry. No butter or anything like that ever. Often there is no sugar for the porridge. Lunch is always the same – prepared the same – pap, meat (like boerewors) – always the same. And there is no sensitivity about preparation.' [PRI-1; Ward Senior Nurse]*

This study did not undertake a caloric or nutritional food analysis, but rather rated food quality on the basis of meal observation and interviews with patients and staff.

All hospitals provided detailed and diversified menu schemes, which theoretically guided the provision of patient food. In practice, the 'historically white' hospital seemed to follow this menu scheme, while 'historically black' hospitals did not.

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[56] As was said in the introductory sections, the research team perceived that the privately contracted hospitals actively prepared for the site visits by improving hospital operations, if only temporarily. There was suggestion from staff at these hospitals that the supply and quality of amenities that we observed during our site visit were superior than day to day operational supplies. This limitation underlies the results in this section. See Introduction, Box 1-4.

- We are usually short of linen. If things were like this everyday we would work very well. (PRI-3, II9)
- When you moved from one ward to another linen would come and the cleaning staff were supposed to quickly change the beds. (PRI-1, II, Cleaning Staff)

[57] This was measured by observation. Observers rated patient shoes on a 1 (few: most patients without shoes) to 3 (majority: most patients with high quality shoes) scale.

d. Ward Amenities

- *The heating is totally ineffective. It is very cold in winter. Patients are not given more clothing or more blankets. The wards are cold. Clothing is thin. [PRI-1; Nursing Assistant]*
- *In the winter patients have one blanket each and you can sometimes see them shivering from the cold and damp clothing. [PRI-2; Nursing Assistant]*

Only 50% (N=42) of ward senior nursing staff across hospitals indicated that there was a fully reliable supply of clean potable water. Only 40% of ward senior nursing staff across hospitals indicated that warm water is consistently available. Only 70% of ward senior nursing staff across hospitals indicated that there was a fully reliable electricity supply. None of the 'historically black' hospitals had adequate heating systems, leaving patients and staff cold during winter months.[60]

3. Patient Daily Care Routines

Nursing staff achieve the very basic daily care requirements of bathing[61], clothing, feeding, and preparing patients for sleep. Patients bathe and change their clothes[62] at least once per day. Patients feed and get medications three times during the day. Bed linen is changed at least once per week, and more commonly on a daily basis.[63]

Nursing staff go beyond what they consider their duty to ensure that these minimum tasks are achieved, often taking on a hospital system which is not co-ordinated to meet these daily needs. Nurses seem to expend a great deal of energy confronting organisational inefficiencies, whether it means negotiating for patient clothes at the laundry or picking up undelivered food at the kitchen. There was no evidence during our site visits that needs beyond these daily basic care requirements (such as exercise or individualised attention) are consistently met.

Staff are achieving some extent of individual care at hospitals where the wards are smaller than 50 patients. Staff are less likely to be providing any individualised care, or even know all patients names, in wards larger than 50 patients. In these large wards, primarily found in privately contracted hospitals, care is conducted via mass routines, with patients being bathed, dressed, fed, and otherwise catered to *en masse*.

Time between basic care routines in the privately contracted hospitals is spent in 'groups' where patients largely sit or sleep. While very self-motivated patients in the public hospitals may be

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hospital had old collapsed mattresses. Mattresses were missing for some patients altogether. The remaining two public hospitals provided higher quality mattresses.

[60] 86% (N=23) of patients interviewed in privately contracted hospitals, and 27%(N=16) patients interviewed in public hospitals indicated that there was adequate bedroom heating. Nurses across hospitals complained of lack of winter heating.

[61] 100% (N=39) of patients and over 95% (N=42) of nursing staff indicate that patients bathe at least twice per week.

[62] 90% (N=39) of patients and 95% (N=42) of nursing staff across hospitals indicated that patients change clothes at least two times per week. Some hospitals indicated that the lack of patient clothing at times prevented clothing change once per day. But there was no indication that patients were not changed if there were available clothes. Further nursing staff went out of their way to ensure, if at all possible, clothing and linen were available. See Patient Supplies.

[63] 90% of patients and over 95% of nursing staff indicate that bedding is changed at least once a week. Nurses from some hospitals indicated that the lack of linen (often due to unreliable laundry services) prevented linen being changed as much as necessary.

3.2. Very High Functioning Patients

There appears to be a large difference in patient daily life routines for a small group of the very highest functioning patients as compared to the remainder of the patient population. In three of the six hospitals, this small group of high functioning patients were involved in OT-based activities for at least part of the daytime hours. Patients not falling into this very high functioning category are largely inactive.

Approximately 80% of nursing staff (N=365) across hospitals indicate that patients are not busy most of the day. The only independent variable suggested as significant in reference to patient activity levels was very high functioning patients ($p<.001$), confirming the difference in busyness and activity among this small group of patients (see Addendum 1.2.)

3.3. Very Low Functioning Patients

Patients in 'profoundly mentally retarded wards' often remain inside the whole day, either lying or sitting in an area of the ward. They appear to have no source of stimulation. Nurses appear to have resigned themselves to the basic struggle of feeding and cleaning (see above), without any remaining energy for further stimulation. Patients whom are disabled or have difficulties in moving, for the most part remain immobile, either in beds, or propped on the floor.[65]

The achievements are probably best summarised by an extreme ward, full of very low functioning and disabled young patients who remain in their beds for the entire day. These patients were free from bedsores -- reflecting the dedication of the nursing staff to basic patient hygiene. On the other hand, these patients were rarely taken out of bed, with the nursing staff perceiving this work to be beyond their mandate and ability. (See Box 2-3: Achieving Custodial Care?)

Box 4.3-3: Achieving Custodial Care?

There was one young patient who I befriended during this site visit. He was in an adult ward, although appeared to be in his adolescence. Like all kids with hydrocephalus his head was enlarged, and he suffered further from physical handicaps preventing him from moving on his own. Although he was in a profound mentally retarded ward he was less than profoundly mentally retarded. He liked repeating things. He asked for me to take him outside. I had time the following day and so went and got the only wheelchair in the hospital. I propped up his heavy head, got him settled and we were off. His expression was nothing less than the essence of human joy. I am not sure I have seen such joy very many times before. We went up and down the hospital. We said that we were seeing the world. He was thrilled. He greeted all the voices he recognised.

When he was more than exhausted I brought him back to the ward and we went around to the other children in the cots. He knew them all by voice. But had never seen any of them before. Their eyes caught each other's and filled with tears.

The senior sister approached me and said, 'we have learned something today'. I did not understand. He said, ' this boy has not been out of his bed in nine years...'

[Researcher Site Visit Notes, PUB]

[65] The physiotherapy departments were not evaluated in detail. All of the 'historically black' hospitals had a small physiotherapy department. This department, for the most part, focused on the physiotherapy needs of children patients.

sentiment. And second, the answers, particularly in the 'historically black' hospitals, imply low expectations around human relationships – basic care and the lack of abuse are considered good. That is, patient levels of satisfaction with staff are related, either directly or indirectly, to learned expectations. Given that mentally ill patients often come from difficult and at times abusive living situations, the generally low level of expectations underlying patient answers provides an important context for understanding these results.[68] . See Table 4.3-5: Patient Perspectives: Positive Staff Relationships.

In this context, the more negative responses should be considered carefully, even if smaller in number. Less than 20% (N=9/49) of patients described the relationship with staff in negative terms. The patients expressing negative relationships in 'historically white' hospitals all expressed their answers in race terms (white patients frustrated with black staff). Patients expressing negative relationships in 'historically black' hospitals described relationships as more actively abusive. See Table 4.3-6: Patient Perspectives: Negative Staff Relationships. The issue of patient abuse is explored in more detail in the section on mistreatment and abuse below.

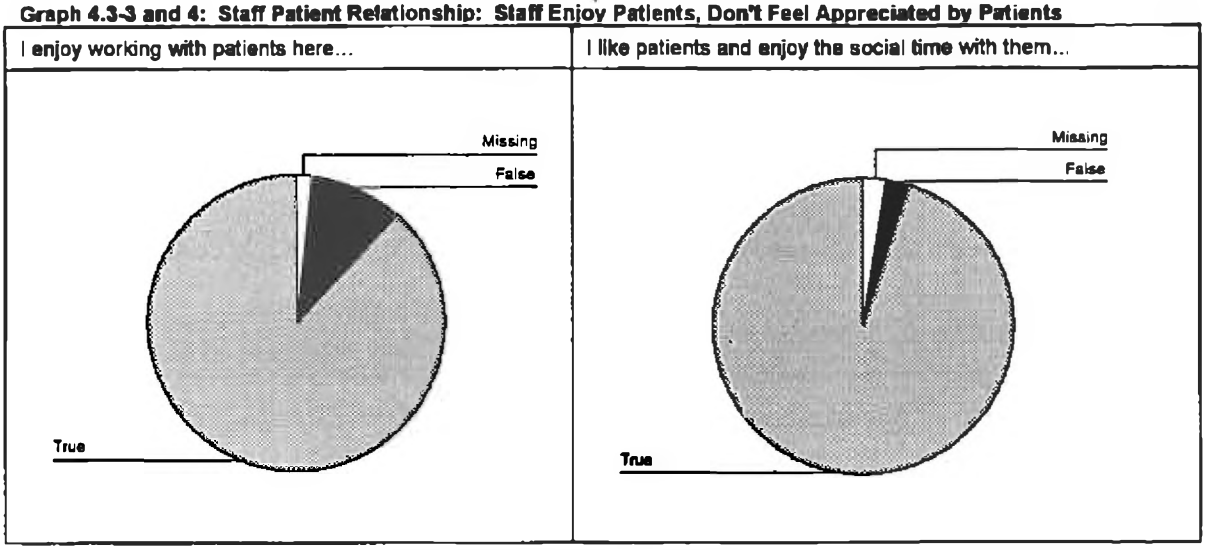
Table 4.3-5: Patient Perspectives: Positive Staff Relationships

1.	Generally positive	➢ *I would be lying if I said they did not take good care of us. [PRI-2; Patient]* ➢ *I get on well with the nurses. I think they work hard. I can't judge if they are good or bad but generally they are good. [PRI-2; Patient]*
2.	Positive in the absence of very negative incidents	➢ *'I have not seen anything bad happening here. The staff work well.' [PUB-2; Patient]* ➢ *The relationship with the staff is good. I have never had problems. [PUB-1; Patient]* ➢ *The nurses treat us well. They don't just fight with any patients. [PRI-3; Patient]* ➢ *The nurses treat us well. I have seldom seen a nurse beating a patient except at one incident where one nurse was seen beating a patient but it was not serious. [PUB-2; Patient]*
3.	Expression of appreciation for basic care provided	➢ *They treat me well. They encourage me to take pills. They take good care of us. [PRI-2; Patient]* ➢ *I work well with the nurses here. They supply us with clothes, food, and medication. I even asked one to talk to my wife and give her my message. [PRI-1; Patient]* ➢ *They do help me to get up from the chair, which I cannot do without assistance. I tell them when I feel palpitations and then they give me medication. [PRI-1; Patient]* ➢ *I get on fine with the nurses. They take good care of us. They give us pills. [PUB-HW; Patient]*
4.	Contradictory	➢ *They are good. The staff don't allow us to share jokes with them. They shout at us, telling us that we are patients. But they perform their work quite good. [PRI-2; Patient]* ➢ *They are friendly. Some take our food to give to other patients. They take our curry and give it to the white patients or all the patients. But they understand me very well. I am taken care of here – but in other sections there is no care. [PRI-2; Patient]*
5.	Very Positive	➢ *They take good care of us and once you get out of line they talk to you politely – whether you are young or old. They treat us like family. If you have a problem, you go to the nurse and when she doesn't have time, she'll inform you. But will come back to you. Most of us are older than them, yet we give them the respect. [PRI-1; Patient]* ➢ *They are excellent. Oh, I get on well with them. They are very very good. I really can't see anything bad about them. [PUB-HW; Patient]* ➢ *We talk to the nurses the whole time! [PUB-HW; Patient]*

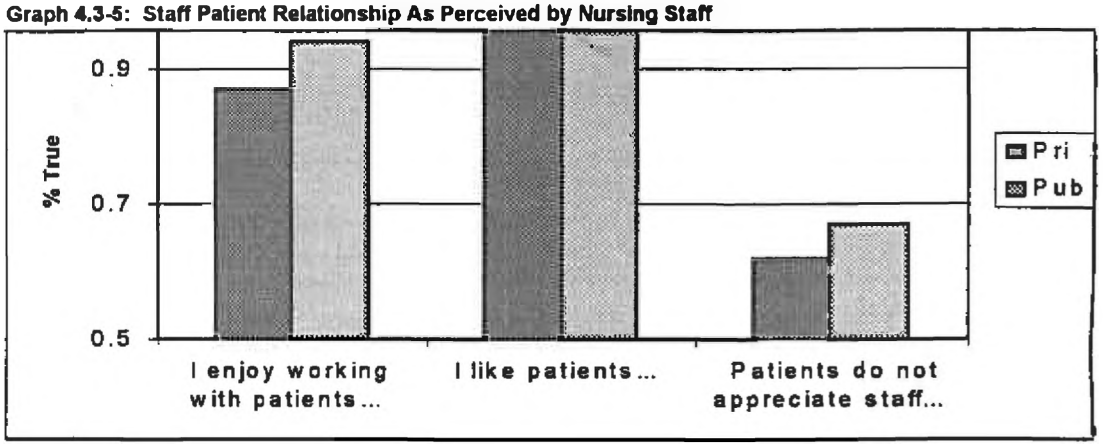
[68] This conclusion is consistent with the literature which questions whether the high rate of patient satisfaction is related more to expectations for care, and/or limited knowledge as opposed to service quality. (Shaw, 1977: 277)

feel insufficiently appreciated by patients, with approximately 40% of staff across hospitals indicating that patients *'complain too much and do not appreciate all the staff does for them.'* And thirdly, while the differences are relatively small, more public hospital nurses perceive the staff patient relationship in positive terms than do nurses in privately contracted hospitals ($p<.001$).[69] The outcomes of these questions are illustrated in Graph 4.3-3 and 4.3-4.[70]

Graph 4.3-3 and 4: Staff Patient Relationship: Staff Enjoy Patients, Don't Feel Appreciated by Patients



Graph 4.3-5: Staff Patient Relationship As Perceived by Nursing Staff



[69] One of the most significant factors emerging from the factor analysis of the nursing staff questionnaire was the staff-patient relationship, thus demonstrating the importance of the staff-patient relationship. (See factor analysis results in Addendum 1.2: Nursing Staff Questionnaire: Overview of Methods and Results.)

A linear regression using the staff patient relationship as the dependent variable suggested a very strong difference between the public and privately contracted sector, with privately contracted sector hospitals scoring significantly lower ($p<.001$). Similar results were demonstrated from a regression analysis using the staff-patient relationship sub-scale directly as a dependent variable ($p<.01$).

There were other independent variables, beyond public-private which related to staff-patient relationship scores inconsistently (e.g. ward size, mentally handicapped wards, patient functional level.) Perhaps unexpected there was a consistent suggestion that staff perceive their relationship in less positive terms in very high functioning wards ($p<.01$), and in more positive terms in mentally handicapped wards ($p<.05$). There was also a strong suggestion that senior sisters perceive their relationship with patients in less positive terms than nurses from lower nursing categories ($p<.001$).

[70] Note that the nursing staff questionnaire measured nursing staff's perceptions of their own relationship. It did not validate responses through observation. For example, while nurses indicate that they enjoy social time with patients, this was not confirmed by measuring the extent to which nurses spent social time with patients.

The daily lives of patients in private hospitals are structured by group routines (whether bathing, feeding, or sitting in groups). Patient 'groups', in practice, seemed to serve primarily the purpose of patient control through limiting patient movement. Patients in the public sector, on the other hand, are largely left to choose what to do during times between basic care – they are equally 'free' to sit or wander.

The most significant variable predicting freedom of movement results was the gender of the ward.[73] Female wards scored significantly lower than other wards ($p<.01$). It appears to be a common practice to keep female patients confined close to or in ward compounds in the name of their own safety. In at least two of the hospitals, female patients are kept locked within ward courtyards during daytime hours.

Another variable suggesting less freedom of movement were wards for very low functioning patients, demonstrating that patients who are unable to move on their own are largely confined to ward premises.

5.2. Right to Basic Dignity and Expression[74]

- *They are lined up naked to bath. We bathe grown men who are children. They stand there with vulnerability and you see their appreciation. [PRI-1; Ward Senior Nurse]*

Patients in privately contracted hospitals are bathed, clothed, fed, and grouped in large group routines. While there is little individually based care across both public and private hospitals, there is particularly little individually based care in the context of these large group routines, leading to little expression of individuality among patients.

Four questions probing patient freedom of expression were included in the nursing staff questionnaire. The high degree of variance between individual hospitals makes a public versus privately contracted comparison difficult.

Nursing staff in both public and privately contracted hospitals report that patients are free to wear jewellery and makeup, choose their own hairstyle, change their clothes, and listen to their own music. In practice, patients in 'historically black' hospitals do not have access to makeup, jewellery, personalised clothes, or radios. Changing of clothes is largely limited by clothing supplies; hairstyles are for the most part uniform. So while these freedoms may exist in theory, they do not translate into individual expression practically.

These freedoms were more demonstrable in 'historically white' hospitals where the majority of patients wore personalised clothes, many wore make-up and adornments, and hairstyles were observably distinct. The roots of this difference require further investigation. To what extent does this difference represent the different economic situations of the patients, with more white patients

[73] See Addendum 1.2: Nursing Staff Questionnaire – Overview of Methods and Results.

5.4. Cleanliness and Sanitation

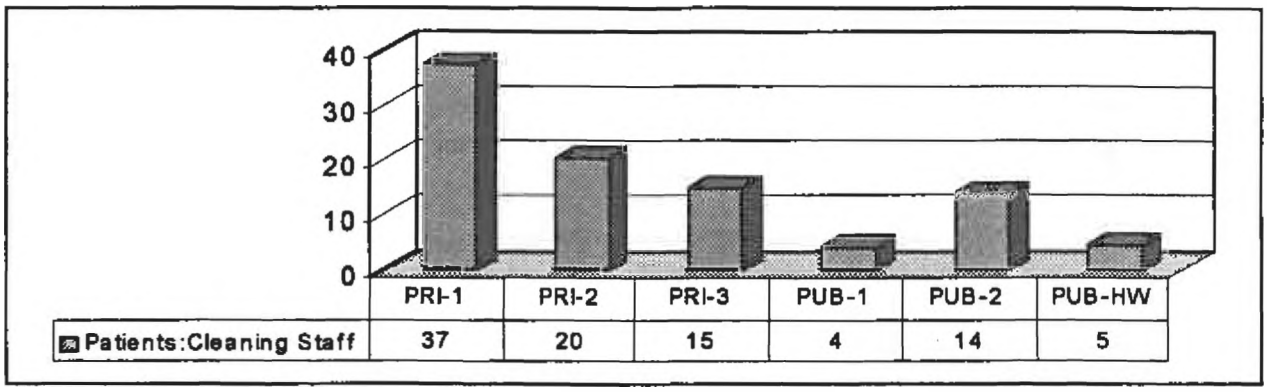
- *We came to the wards early that morning, to observe the early morning routine. We were not expected, and so hoped to see a more true picture of daily functioning. We arrived just after bath time. Patients were bathed en masse, standing in line, naked, waiting their turn to be scrubbed by the nursing staff operating in formation. By the time we arrived there was a layer of faeces smeared across the floor, interrupted only by patients' footprints. [Site Visit Researcher Notes, PRI-2]*
- *Oral hygiene is appalling. We lose lots of teeth. There is poor personal hygiene generally – lots of otitis media, maggots in patient's ears... [Medical Officer, PRI-3]*

Cleanliness and sanitation were evaluated by observation. While three hospitals (Pri-3, Pub-1, Pub-HW) achieved a basic level of facility cleanliness, three hospitals (Pri-1, Pri-2,Pub-2) were unacceptable, and contravened the human right to a relatively sanitary environment. Over 70% (N=318) of nursing staff indicated that some patients are untidy or messy.[77] Approximately 40% (N=318) of nursing staff indicated that the common area is often untidy. At least two of the five medical officers interviewed were seriously concerned about environmental hygiene, which they saw as an underlying cause of high rates of infection. (See Chapter 4-3.)

Statistical data on perceptions of cleanliness included nursing staff perceptions of patient cleanliness, nursing staff perception of ward cleanliness, and observer evaluation perception of hospital environment cleanliness. None of the three analyses demonstrated a significant difference between public and privately contracted hospitals. Large ward size ($p<.001$)[78] and low numbers of staff per patients ($p<.01$)[79] suggested lower ward cleanliness outcomes.

The cleaning staff : patient ratios across hospitals are demonstrated in Graph 4.3-7. The number of patients for each cleaning staff related to some extent to observed hospital cleanliness. The two hospitals with the least cleaning staff per patient were observed to be the least clean hospitals.

Graph 4.3-7: Patients : Cleaning Staff Ratios, Across Hospitals



[77] Nursing staff in female wards ($p<.001$) and very high functioning ($p<.05$) wards rated patients cleanliness in significantly more positive terms.

[78] Large wards strongly suggested low cleanliness outcomes for the regression on observer evaluation perceptions of hospital environment ($p<.001$).

c. Introduction

We evaluate five areas related to patient abuse:[82] First, we evaluate institutional mistreatment. While this theme runs throughout this report, it arguably represents the most pervasive form of 'mistreatment' and thus we touch upon it specifically here. Next, we evaluate the sense of patient security with regard to personal possessions. We then evaluate physical assault and try to explore the extent to which patient physical assault is common in these institutions. We then explore the current use of seclusion and restraints. And finally we explore the extent to which patients have channels of recourse when confronted with situations considered abusive.

6.2. Institutional Mistreatment

By far the most pervasive form of patient mistreatment and abuse, and the one with the most negative patient impact, is in the form of institutional design, resources, and the lack of services--with particular reference to 'historically black' hospitals. Other chapters of this report attempt to highlight some areas where basic hospital functioning has the effect of patient abuse, whether in the form of confining patients to overcrowded wards, gross lack of hygiene and poor resources -- let alone the lack of development and discharge services.

6.3. Basic Security of Possessions

- *[Privately Contracted] There is a gross lack of patient security. Very few patient lockers. Most patient carry their possessions around their neck in a bag. Patients who have shoes sleep with their shoes for fear of losing them. Patients were not relaxed in the sense of basic security. [PRI-1; Site Visit Researcher Notes]*
- *[Privately Contracted] ... there are feet problems – lots of them. Corns and cracks. I think that is from the slippers. The slippers get wet and then dry and the patients keep them on. Even if the slippers are very wet the patients will wear them to bed because the patient does not want them stolen. There is not a sense of security at all for patients. [PRI-2, Primary Health Care workers describing the most common physical ailments they encounter at the hospital]*

Patients in the two larger privately contracted hospitals (wards larger than 60) carried their possessions with them at all times. Patients in public hospitals and the one smaller privately contracted hospital, were either provided with lockers, or felt secure leaving possessions like shoes in their wards.

6.4. Reported Incidents of Assault

Only one out of five psychiatrists interviewed perceived abuse as a problem. The remaining four psychiatrists felt that abuse was often directed *from* patients *to* staff. The psychiatrist who felt that abuse was a problem said that non-assault abuse (for example, withholding of food and theft) rather than physical assault was of most concern.

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[81] While staff in one public hospital shared this same hesitation, staff in the remaining two public hospitals were strikingly open in discussing these issues.

[82] This is not a comprehensive evaluation of these issues. For example we did not evaluate verbal or emotional abuse. While this area is extremely important, it remained outside the scope of this study.

Table 4.3-7 Assault Categories Definitions

Category	Quote Illustrating Category
Assault – Ongoing Physical	➢ *I can't sleep. They beat us up to go and sit with others. They just hit us. Give us a shock. You can die. They use fists. I don't report it to anyone. Once I nearly fainted. I just tell my family member to come and get me. They don't say why they beat us. (PRI-3, Patient Interview 1)* ➢ *A staff member made patients lie on the floor and was hitting them with the cord from a kettle. It was painful, they even cried. A patient was biting himself and then many staff were hitting him. There was blood. Staff was kicking a patient today before lunch. (PRI-1, Patient Interview 4)*
Assault – Few Isolated Incidences	➢ *Some other patients are beaten by staff members as punishment, but not badly. Though the law doesn't allow them to beat us. The staff nurse will be given a notice by the management. This (beating) happens after a long time -- this year I don't remember any incidents. (PRI-2, Patient Interview 1)*
Assault – Ongoing Low Level	➢ *Sometimes nursing staff will carry a small stick and they threaten / hit to get a patient to do something, especially in morning when getting patients to bathe. Some patients are running away from the water, jumping through windows. [PRI-1, Nurse Senior Nurse]*

Box 4.3-6: A Call for an Investigation...

The extent of reported physical abuse of patients was markedly high at one public hospital, PUB-2. The repeating theme of patient abuse motivates for a more intensive investigation of abuse in this hospital, which falls outside the scope of this study.

- *A patient was beat to a point where their teeth came out. One patient was locked in a room and banged the head against the door until he died. You think I am being funny but I will get into court myself because you now know. (PUB-2, Ward Senior Nurse)*
- *Now we have a patient repeatedly raped by a professional nurse, and this is common knowledge. This person is untouchable, and not charged. This incident has been suppressed by management because the culprit is related to one of the untouchables [grouping of nurses undisciplined by management due to family ties with management]. (PUB-2, Ward Senior Nurse)*

6.5. Seclusion and Restraints

The hospitals without state patients[85] did not have extensive seclusion facilities. Two of these hospitals had no seclusion facilities at all, while the remaining two had one to two small seclusion rooms for the entire hospital For the most part this is a function of stabilised patient populations. However, staff in these institutions indicate that the lack of seclusion facilities prevents good handling of emergency situations and difficult patients.[86] Staff are at times forced to use other facilities as 'seclusion rooms'.[87] Standing orders of Clothiapine (Etomine)[88] are utilised with 'difficult' patients. Etomine is theoretically ordered only under doctor's orders, although it appears that in some hospitals it is used at the discretion of nursing staff.

- *Patients will steal from other patients and the others will take something and hit them. Staff try to calm them and get a male nurse to hold them down and give them a sedative. [PRI-1; Ward Senior Nurse 5]*

[85] This included all three privately contracted hospitals, and one public hospital. Note that privately contracted hospitals transfer 'aggressive' or 'acute' patients back to public hospitals, See chapter 2.2.

[86] The lack of seclusion facilities and easy access to a medical practitioner (to approve usage of sedatives) was cited frequently at one hospital to have led to an incident of assault between patients and staff leading to a patient's death.

[87] For example, during one early morning visit, we visited a ward where patients were waking up, bathing, and making their beds. There was one nursing assistant responsible for over 20 patients. She was clearly overwhelmed by the patients, who were dependent and some hyperactive. One patient was locked into the toilet stalls. The Nursing Assistant later explained that she put patients in the toilets when they were overly active and she had to focus on other patients.

[88] Standing orders of Clothiapine (Etomine) ranged from 40 to 80 mg/ml IMI.

- **Patient Cleanliness**: Over 70% (N=318) of nursing staff indicated that some patients are untidy or messy.[89] There was no significant difference between public and privately contracted hospitals in patient cleanliness (whether rated by nursing staff or observer). (See Addendum 1.2 and 1.3.)

- **Patient Busyness**: This was a measurement of the extent to which nursing staff perceived patients to be busy during daytime hours. There was no difference suggested between public and privately contracted hospitals. The only ward based variable demonstrating a strong effect was wards for very high functioning patients. As expected, significantly more nurses in wards with very high functioning patients perceive patient to be busy as compared to nurses in other wards. (See Addendum 1.2.)

- **'Patient Interactions'** This was a sub-scale of three questions from the nursing staff questionnaire reflecting the dynamism of patient interactions and relationships. Again, there was no significant difference demonstrated between public and privately contracted hospitals. Three ward-based variables demonstrated a very strong effect on this sub-scale. First, low staff : patient ratios suggested low patient interaction outcomes. Secondly, interactions were perceived in significantly more positive terms by nurses in wards for very high functioning patients. And finally, nurses in wards for mentally handicapped patients perceive patient relationships in more positive terms than nurses in other wards. (See Addendum 1.2: Nursing Staff Questionnaire: Overview of Methods and Results.)

- **Patient Pride in Hospitals**: This was a measure of the extent that nursing staff perceived patients' pride in the hospital. No difference was suggested between public and privately contracted hospitals. Several ward based variables demonstrated a significant effect on this indicator. Nursing staff from female wards, and from wards for very high functioning patients perceive patient pride in significantly more positive terms than nursing in other wards. Interestingly, nurses in wards for mentally handicapped patients also responded more positively on this item. Nurses from wards with low staff : patient ratios responded in more negative terms than other wards. (See Addendum 1.2.)

Table 4.3.B: Custodial Care Outcome Indicators: Summary of Effect

	Patient Functioning	Patient Cleanliness	Patient Busyness	Patient Interactions	Patient Pride
Difference between sectors?	No	No	No	No	No
Ward based variables demonstrating very strong effect	Very High Functioning: + Very Low Functioning: -	Female Ward: + Very High Functioning: +	Very High Functioning: +	Very High Functioning: + Female: + Low Staff : Patient Ratio: - M Handicap: +	Female: + M Handicap: + V High Func: + Capacity: + Low Stf : Pt: - Sickbay Ward: -

The second row lists the ward variables which were significant. For example, nurses in very high functioning wards perceived patient cleanliness in significantly more positive (+) terms than other nurses, while wards in very low functioning wards perceived patient cleanliness in significantly less (-) positive terms.

[89] Nursing staff in female wards ($p<.001$) and very high functioning ($p<.05$) wards rated patients cleanliness in significantly more positive terms.

4.4-1 below.

In the first section we will explore the psychiatric profiles of patients in these hospitals. We will then evaluate patient mortality rates. From there we will examine the indicators from the four areas of care illustrated in Table 4.4-1.

Table 4.4-1: Psychiatric Treatment Indicators

	Structure	Process	Outcome
1. Counselling Services	• Psychologist : Patient Ratios • Psychiatric Nurse : Patient Ratios • Traditional Healer : Patient Ratio	• Counselling Services	• Patient Understanding of Medications
2. Psychiatrist Services: Medication / Diagnosis Management	• Medical Practitioner : Patient Ratios	• Patient Contact • Medication Dosages • Record Keeping System	• Medication – Diagnosis Analysis
3. Medical Services	• Medical Practitioner : Patient Ratios	• Preventative Screening • Infection Control • STD Control	• Mortality Rates
4. Pharmacy Services	• Pharmacist : Patient Ratios	• Pharmacy Services	• None

2. Patient Diagnosis Profile

Patients with psychiatric conditions and mental handicap are mixed in these institutions, and within wards. The three most predominant diagnoses are schizophrenia (36%), mental handicap (28%), and epilepsy (14%). The distribution of predominant diagnoses across hospitals is demonstrated in Graph 4.4-1 and Table 4.4-2 below.

The following conclusions can be drawn concerning the distribution of diagnoses across hospitals:

- **Public vs. Private**: The distribution of diagnoses across hospitals is relatively similar, with approximately 7% more diagnoses of mentally handicap at privately contracted hospitals.
- **'Historically white' vs. 'Historically black'**: There are fewer diagnoses of mental handicap at the 'historically white' hospital as compared to the remaining 'historically black' hospitals.
- **Province**: There are significantly more diagnoses of mental handicap in the Northern Province hospitals.

3.2. Patients Not On Medications

Table 4.4-4 demonstrates the percent of patients at each institution who were not on any medications at the time of the site visit. As has been said previously one of the main components of psychiatric care is the management of medication. The higher the number of patients who are not on medication, the less relevant the traditional 'psychiatric care' model is to successful rehabilitation.

Over 15% of patients across hospitals were not on any medication at the time of the site visit. There were significantly more ($p<.001$) patients not on medications at privately contracted hospitals than public hospitals. However, large variance between hospitals limits the generalisability of the sector differences.[90] Further, this finding is consistent with the fact that more stabilised patients are transferred to privately contracted hospitals.[91]

Table 4.4-4: Patients On No Medications

	PRI-1		PRI-2		PRI-3		PUB-1		PUB-2		PUB-HW		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
On no meds	90	25.6	44	18.5	25	17.6	25	31.6	4	2.1	8	3.9	196	16.3

3.3. Medications Profile

The following table demonstrates the top four medications used for the three most prevalent diagnoses across hospitals (schizophrenia, mental handicap, and epilepsy).

Table 4.4-5: Common Medications for Prevalent Diagnoses

Schizophrenia	Mental Handicap	Epilepsy
1. Chlopromazine (Largactil)	1. Carbamazepine (Tegretol)	1. Carbamazepine (Tegretol)
2. Thioridazine (Melleril)	2. Phenytoin (Epanutin)	2. Thioridazine (Melleril)
3. Haloperidol (Serenace)	3. Thioridazine (Melleril)	3. Chlopromazine (Largactil)
4. Trifuoperazine (Stelazine)	4. Phenobarb	4. Phenytoin (Epanutin)

[90] There were significantly more mentally handicapped patients ($p<.001$), black patients ($p<.001$), and psychogeriatric patients ($p<.01$) not on medication as compared to other patients. There were significantly fewer schizophrenic patients ($p<.01$) and epileptic ($p<.001$) patients not on medication as compared to other patients. See Addendum 1.1, Section 3.1: Patients Not on Medications.

[91] See Chapter 2.1: Background Data: Understanding Hospitals and Sectors

However, on observation, there was *no evidence* of systematic therapeutic individual or group counselling – in either public or privately contracted hospitals.

Many nurses were observed to have individualised relationships with patients and were observed to provide support and dialogue on patient request. These informal discussions fell short of systematic counselling sessions. Appointments were not regular or routinised. All patients were not covered. There was not a methodical approach to ensure that a broad range of issues (beyond daily crises and needs) were covered. There were not facilities for confidential individualised therapy.

On observation, there was also no evidence of group counselling. Private sector hospitals organised patients into groups between basic care times. The objective of the groups included 'group-counselling' services. However, there was no evidence during our site visits of group counselling (or any form of participative group discussions) occurring in these groups. The groups practically seemed to serve a 'control' rather than 'counselling' purpose. There was no form of group counselling at public sector hospitals.

The only outcome measure of counselling services we evaluated was patients' understanding of their medication, with the assumption that a minimal outcome of counselling would be a basic understanding of medication on the part of the patient.

There was not a significant difference between public and privately contracted hospitals. Seventy percent (N=49) of patients interviewed at 'historically black' hospitals did not have even a basic understanding of their medications. That is, they did not understand the reasons for taking medication, nor had they received any education as to their medication regimen. Approximately 50% (N=318) of nursing staff indicate that patients know what medications they are taking. Less than 60% of these nurses indicate that patients understand why they are taking medications, and 90% indicated that patients do not understand issues like side effects of medications.[93]

Table 4.4-6: Staff : Patient Ratios: Across Counselling Categories

Ratio	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public
Professional Nurse per patient	0.03	0.02	0.03	0.11	0.14	0.16	0.03	0.13
Non-Professional Nurse per patient	0.14	0.14	0.11	0.14	0.30	0.21	0.13	0.20
Psychologist per patient	0	0	0	0	0.0003	0.0065	0	0.0023
Traditional Healer per Patient	0	0	0	0	0	0	0	0

[93] The lack of patient education in this regard may have direct consequences in terms of successful patient discharge, as a common basis for readmission is lack of compliance with medication protocol.

this effect is limited by particularly poor performance from one public hospital (PUB1).[95] Disturbingly, black patients appear to have had less frequent contact with medical practitioners ($p<.001$) across sectors (Addenda 1.1.)

Psychiatrists have to carry heavy patient loads, and thus cannot, and do not, spend much time with patients. Psychiatrists in the 'historically black' hospitals were involved solely in medications and diagnosis management. They did not play a strong role in a multidisciplinary team. They did not speak in depth about issues of patient discharge, with the exception of the one psychiatrist (PUB2) who manages a community services department See Table 4.4-7:.

- *First of all the doctor (physician) does not examine the patients when they are presented to her. She only asks the nurses and issues orders for that patient. (PRI2, Nursing Staff)*
- *Ever since I have arrived at this hospital this [current patient interview] is the longest discussion I have had with any staff like a psychiatrist or social worker. When these people see me there is no real discussion. There is just writing of notes told primarily by the sisters. He just writes if you are helpful – what the sister tells him... There are no long conversations. (PRI-3; Patient)*
- *I do not know how patients are treated here because the doctor come here every time and write. (PUB-2; Patient)*

The nursing sisters serve as translators. A common practice was described as nurses updating the psychiatrist on patients' 'behaviour' and the psychiatrist completing notes and prescribing/repeating medication accordingly. Patients complain that psychiatrists do not spend meaningful time with them. Patients indicate that they do not discuss issues directly with the psychiatrists. The main focus of patient contacts seemed to be the updating of patient files.

Only two out of the five psychiatrists interviewed[96] were able to speak to most patients in the language of their choice. Over 95% (N=318) of nursing staff across hospitals indicated that nurses serve as translators for psychiatrists (Addendum 1.2). Over 25% (N=382) of nursing staff indicated that cleaning staff often serve as translators for psychiatrists. There were no professionally trained translators in any of the hospitals.

While these findings could have been expected, there is a disturbing lack of sensitivity to this issue, as captured in the sentiment of one psychiatrist interviewed who explained why he had no problems in communicating with his patients, *'I ask a simple question, for example, 'What is your name?' If the Sister has to repeatedly explain, and the patient gives very long answers, I will know the patient is incoherent.'* The results underscore the urgency of language proficiency with reference to future training and selection of candidates for medical training.

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[95] This effect is also limited by the suggestion that privately contracted hospitals systematically updated files in preparation for our visit. At one hospital for example, nursing staff were told to update files according to the record abstraction protocol after the first day of our visit.

[96] Two psychiatrists were interviewed at one site. No psychiatrist was interviewed at two sites. See Addendum.

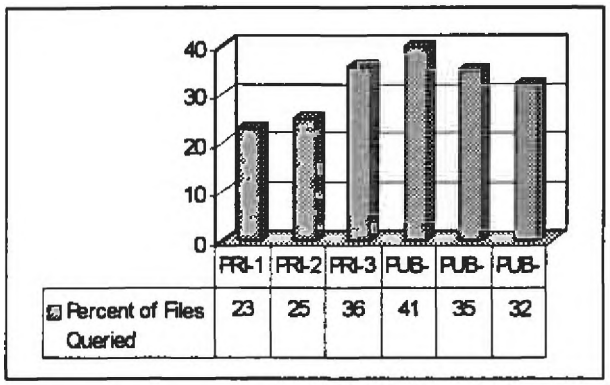
concern; e) multiple or mismatched diagnoses.[98] Queries do not necessarily indicate incorrect practice - but rather indicate a need to review the patient and his/her treatment.

Graph 4.4-3 demonstrates the total percent of queries across institutions and across sectors.[99] Table 4.4-8 provides a more detailed breakdown according to category of query. (See Addendum 1.1.)

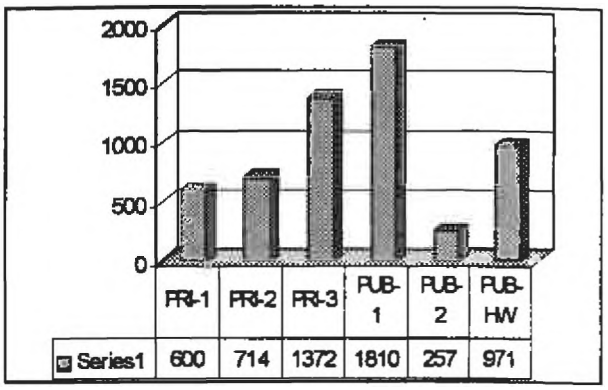
Comparing Graph 4.4-3 with Graph 4.4-4 demonstrates that the number of queries did not relate linearly to the patient : medical practitioner ratios.

Privately contracted hospitals had significantly fewer queries than public sector hospitals ($p<.05$), including the 'historically white' hospital ($p<.05$) (Addendum 1.1). A reason for this may be the nature of transfer relationships between these hospitals whereby privately contracted hospitals transfer less stable (relapse, aggressive etc.) back to public sector hospitals. (See Chapter 2.)

Graph 4.4-3: Percent of Files Queried Across Hospitals



Graph 4.4-4: Patient per Medical Practitioner



Graph 4.4-5 and Table 4.4-8 below demonstrates the type of queries and their frequencies across hospitals. Graph 4.4-5 demonstrates the percent of total queries across the five most prevalent query categories. Table 4.4-8 demonstrates the number (N) and percent of queries in each category across hospitals.

The most frequent basis for profile query was a concern for the *match* between diagnosis and

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[98] Examples of reasons for queries under the different categories are given below

a) Medications not appropriate for diagnosis: *'Mental Retardation as a diagnosis does not justify Clopixol and Camcolit', 'Diagnosis of epilepsy on no medications'; 'Diagnosis of schizophrenia - why only on anticonvulsant?' 'Diagnosis of epilepsy - why only on Clopixol?'*

b) Medication dosage too high: *'Too high dose of Melleril (400 mg po BD).*

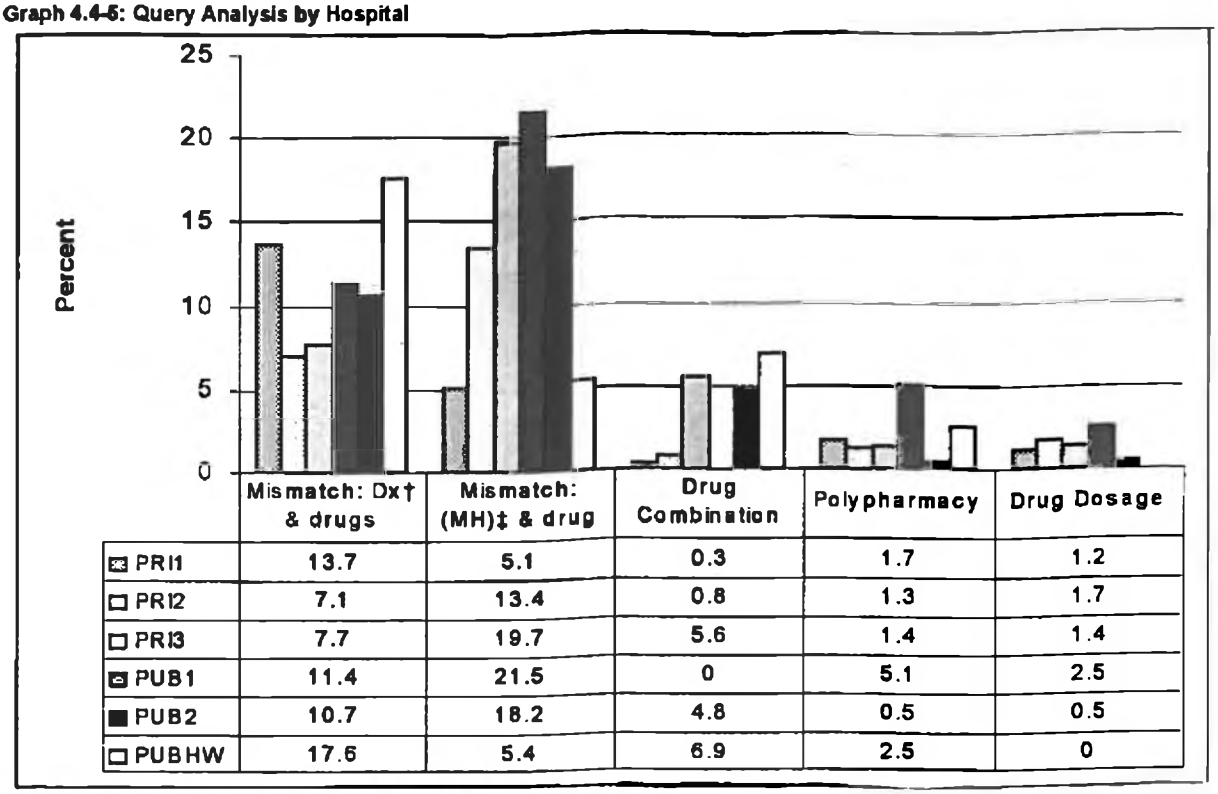
c) Polypharmacy: *'Too many oral medicines - haloperidol, lorazepam, biperidan as well as depot use.'; 'On too many anticonvulsants - 3 different types'*

d) Drug combination of concern: *'Should not be on 2 oral antipsychotics especially if one of them is Leponex."*

e) Multiple or mismatched diagnoses: *'Too many diagnoses, none of which match the treatment.'*

[99] The high number of queries at the 'historically white' hospital is notable, given the academic status of this institution. (PUB-HW has the highest frequency of queries based on drug combination and diagnosis – medication mismatch concerns.) Further, variance between northern hospitals is not expected given that the same psychiatrist services these institutions, suggesting an additional factor influencing results.

Graph 4.4-5: Query Analysis by Hospital



	Mismatch: Dx† & drugs	Mismatch: (MH)‡ & drug	Drug Combination	Polypharmacy	Drug Dosage
PRI1	13.7	5.1	0.3	1.7	1.2
PRI2	7.1	13.4	0.8	1.3	1.7
PRI3	7.7	19.7	5.6	1.4	1.4
PUB1	11.4	21.5	0	5.1	2.5
PUB2	10.7	18.2	4.8	0.5	0.5
PUBHW	17.6	5.4	6.9	2.5	0

Table 4.4-8: Basis of Queried Patient Profiles, by Institution

	PRI-1		PRI-2		PRI-3		PUB-1		PUB-2		PUB-HW		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Queries	80	22.8	59	24.8	51	35.9	32	40.5	66	35.3	66	32.4	354	29.5
No Query	271	77.2	179	75.2	91	64.1	47	59.5	121	64.7	138	67.6	847	70.5
Mismatch: Dx† & drugs	48	13.7	17	7.1	11	7.7	9	11.4	20	10.7	36	17.6	141	11.7
Mismatch: (MH)‡ & drug	18	5.1	32	13.4	28	19.7	17	21.5	34	18.2	11	5.4	140	11.7
Drug Dosage	4	1.2	4	1.7	2	1.4	2	2.5	1	0.5	0	0	13	1.1
Drug Combination	1	0.3	2	0.8	8	5.6	0	0	9	4.8	14	6.9	34	2.8
Polypharmacy	6	1.7	3	1.3	2	1.4	4	5.1	1	0.5	5	2.5	21	1.7
Diagnosis^	3	0.9	1	0.4	0	0	0	0	1	0.5	0	0	5	0.4
Total	351		238		142		79		187		204		1201	

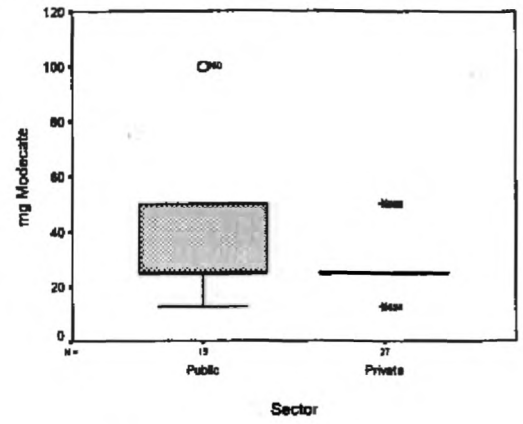
† All diagnoses other than Mental Handicap; ‡ Diagnosis is mental handicap
^ Multiple or mismatched diagnoses.

5.3. Medication Dosage Analysis

An indicator of low quality care of psychiatric institutions is the overmedication of patients, which may reflect a strategy of sedating patients as a mechanism to decrease patient care requirements. One of the primary objectives of the medications analysis was to determine whether or not patients are being overly medicated.

We evaluated potential patient over-medication in two ways. First, similar to above, we evaluated over-dosage queries. Second, we performed a more detailed analysis on the drug dosages of the top five medications used across hospitals.

Graph 4.4-10: Modecate Dosage Distribution



Private N= 27; Public N=19.

'historically white' hospital not included.

6. Medical Services

This section explores the physical health services provided to patients at these hospitals. Given the higher level of co-morbidity in psychiatric patients compared to the general population, medical services were viewed as an essential aspect of quality of care in this study. We begin by exploring the one outcome measure in this section, mortality rates. We then look at preventative screening procedures, infection control systems, and STD management.

6.1. Patient Mortality Rates

Mortality rates ranged between 2 and 10 percent per annum across hospitals. A significant proportion of deaths was under the age of 35 – up to 60% in one hospital (see Table 4.4-8.) Over 60% of the deaths across the 'historically black' hospitals were patients under the age of 55. There were no reported suicides during this time period. Patient mortality rates are demonstrated in Table 4.4-9. Table 4.4-10 illustrates the cause of death per institution.

The most frequently reported cause of death is infectious. The highest mortality rate (demonstrated in PRI2) resulted from a Shigella outbreak discussed below.

Table 4.4-9: Patient Mortality Rates per Institution

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB- HW
Deaths	96	122	31	7	29	93
Death Rate	0.05	0.10	0.06	0.02	0.02	0.07
% Deaths < Age 35	7% (7/96)	35% (43/122)	61% (19/31)	not available	41% (12/29)	9% (6/68)*
% Deaths < Age 55	39% (37/96)	70% (85/122)	81% (25/31)	not available	62% (18/29)	35% (24/68)*
Age Distribution	Md=.47 Mode=56 Mn=48.4 SE=15.1	44 36 45.9 14.5	34 18 36.0 16.5	37 22 39.1 19.1	47 61 46.5 17.3	49 41 49.4 15.6

Data source: Institutional questionnaire, One-year period: 1995-1996. PUB-1: Patient mortality records are not kept at PUB-1. They are kept at the local hospital, and thus unavailable and difficult to access. Only ages of 68 patients recorded.

transmission statistics, and protocol for both the identification and management of infectious outbreaks.

The high Shigella case fatality rate points to the need for more responsive medical treatment services in general, as well as infectious disease control mechanisms in particular.

6.4. STD Management

- *[Responding to question: Do you encourage condom use?] It is encouraged but I don't think we have much success here. We have a few HIV positive patients, but I don't think [condom distribution] has been successful. I don't think a patient has asked for a condom here.' [Medical Officer, PRI2]*
- *[Responding to question: Do you encourage condom use?] No. (This hospital is) not an environment where willing to admit sexual activity occurring [Medical Officer, PUB3]*

All hospitals performed poorly regarding STD control. The failure to comply with national policy of a syndromic approach to STD management[106], the non-treatment of partners, and the poor availability of Ciprofloxacin all underline this poor performance.

Condoms are available in three of the six hospitals. However, even in these three hospitals the impact of condom distribution is limited by poor distribution. Only two factors predicted condom distribution. It appears that condoms, when they are distributed, are primarily distributed in female wards. Secondly, condom distribution is negatively correlated with wards for very high functioning patients – where condom distribution systems presumably could have the most effect. (See Addendum 1.2.)

Table 4.4-11: STD Control Systems Across Hospitals

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Use of syndromic approach to STD treatment	No	No	No	D/K	No	No
Treat partners†	No	Yes	No	D/K	No	No
Ciprofloxacin available†	No	No	No	D/K	No	No
Up to date statistics on STDs†	No	No	No	No	No	Yes
STD Tracking Programme	No	No	No	No	No	Yes
Patients given condoms	No	Female	No	No	Female	Yes[107]
AIDS Counselling‡	No	No	No	No	No	No

† Data source: MO interview
‡ Data source: Senior Sister interview

[106] Only one medical officer interviewed had heard of the term 'syndromatic approach').

[107] High functioning wards only.

Chapter 4.5: Objective Level 3
Patient Rehabilitation, Development, and Discharge

1. Introduction

As discussed in Chapter 4.1, the annual discharge rates of the 1995/1996 period ranged between 0 and 6 percent, inclusive of patients absconding. The mean duration of patient stay ranged between 6.8 and 13.2 years.

The previous chapter examined quality of care with specific reference to psychiatric treatment, with the underlying assumption that if the psychiatric symptoms can be resolved, the patient can be discharged back into the community.

However, psychiatric treatment of patients in these hospitals may not be enough to ensure patient discharge. For example, over 15% of patients in these hospitals are currently not on medications. They are stabilised without medication (Addendum 1.1). Psychiatric services, with their current focus on provision of medications, are clearly not enough to ensure patient discharge in these cases.

The Gauteng Mental Health Directorate study exploring Lifecare facilities provided further support for this suggestion. Of the 39% of patients who were not considered 'dischargeable', in only 15% was this because they were actively psychotic. The remaining patients were not considered ready for discharge for a combination of non-psychiatric treatment requirements. They were either deemed too low functioning to live in the community without active supervision, or had no family contact to support discharge.

The strong relationship between medical, psychiatric, social, and behavioural factors in the aetiology and outcomes of mental health patients is not peculiar to South African institutions. The interrelationships between these variables is a primary theme throughout Desjarlais's 1995 review of mental health challenges in low income countries. He motivates that successful mental health services must reach beyond medical psychiatric care to consider individual and social factors which contribute to mental health outcomes.

We move then to hospital services that extend beyond psychiatric care. The hierarchy of objectives framework divides these services into two parts. In this chapter, we will look at patient services at the hospitals that reach beyond psychiatric care to develop patients and facilitate patient discharge. The premise underlying this chapter is that the patient, as an individual, should be actively developed and prepared for discharge.

The number of OT staff and their total patient load across hospitals is demonstrated in Table 4.5-2. The average patient load per occupational therapy staff member is demonstrated in the final row. On average, OT staff have 30 times the patient load as nursing staff. Thus, while undoubtedly patient rehabilitation can benefit from the specialised skills of OT personnel, given these ratios, the implementation of the programme cannot be left to the responsibility of OT personnel alone.

Table 4.6-2: Occupational Therapy Staff Across Hospitals and Patient : OT Staff Ratios

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Private / Public
Occupational Therapist	2	0[111]	0	0	2	4	1	2	0.36
OT Assistant	12	6	3	4	2	4	7	3	2.39
Total	14	6	3	4	4	4	8	4	1.92
Patients : Total OT Staff	129	176	114	45	150	126	140	107	1.30

2.2. Patient Rehabilitation Programming: Looking at a 'System of Rehabilitation'

Rehabilitation implies change and movement -- a lack of patient stagnation. A service facilitating patient rehabilitation would be characterised by *internal* movement. In the context of these institutions, a patient rehabilitation system would arguably include the following four points.

a. **Patient and Ward Grouping:** Wards graded into functional levels; patients assessed and placed by a multidisciplinary team according to functional level.

b. **Services and Activities:** Co-ordinated hospital rehabilitation services designed to facilitate and complement ward- and patient-based rehabilitation goals. Activities and incentives designed to develop patients to move from one functional level to a higher level. Activities and incentives designed with particular emphasis on developing skills required for patient discharge, at all functional levels.

c. **Co-ordinated Staff:** Good working relationships in a multidisciplinary team, with specific emphasis on working relationships between nursing and occupational therapy staff.

d. **Reassessment and Movement:** Frequent reassessment of patients to review placement and programmes when increased functional level is achieved.[112]

The following sections will explore each of these areas in more detail. As will be seen, these components are not woven into the hospitals' approach to patient rehabilitation.

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personnel (p. 2).

[111] The personnel full time equivalents relate to the 1995-1996 financial year. There were no trained occupational therapists during this period, although there was one part time OT at the time of the site visit.

[112] The upgrading of a patient functional level could serve as a quality marker for staff self-assessment. The downgrading of patient functioning would be a marker to focus on both patient status and staff operations.

Table 4.5-3: Ward Groupings Across Hospitals

Private	Basis for Ward Groupings	Public	Ward Groupings
PRI-1	3% of highest functioning patients placed in a 'Rehabilitation Ward'. Remaining patients not in wards based on rehabilitation objectives. Physically handicapped patients are placed in one ward, regardless of level of impairment.	PUB-1	Divided into 'high', 'medium', and 'low' functioning wards. Distinction between grades unclear. Ratings made by nursing staff alone.
PRI-2	4% of 'high functioning' patients are placed in a recently built 'High Functioning Ward.' In practice, white and Indian patients are placed in this ward, regardless of functional level.	PUB-2	Divided by length of stay in hospital, age, and gender.
PRI-3	Wards and functional groupings not consistent. Physically handicapped patients grouped together regardless of level of impairment. Female patients grouped into two wards – 'high' and 'low'. Male patients are grouped according to age and length of stay in hospital.	PUB-HB	Wards divided by functional level, with some movement of patients based on functional improvement.

2.4. Services and Activities

- *It [the ward programme] is more of a routine than a programme. (PRI-3; Ward Senior Nurse8)*
- *The ward programmes are just a picture on the wall. (PUB-1; Ward Senior Nurse6)*
- *We don't know what is going on at OT. Patients don't do anything. We have no activities and OT is doing nothing. (PRI-3; I18)*

2.4.1. Patient Rehabilitation Objectives

Patient rehabilitation services refer broadly to any service designed to increase patient abilities, functioning, and knowledge relevant to discharge.[116] Importantly, this includes all levels of impairment – from the very severely to the less severely impaired. Functional improvement for a severely impaired patient may imply increased ability to manage basic daily care routines (e.g. to dress). Functional improvements for the higher functioning patients would include skills useful for future employment.[117]

Graph 4.5-1 demonstrates nursing staff perceptions of patient rehabilitation achievement across sectors.[118] There was not a significant difference between public and privately contracted hospitals in terms of nursing staff perception of the achievement of patient rehabilitation.[119]

While nursing staff, across hospitals, perceive that patients daily life skills (such as bathing, dressing, and eating) are being developed (90% N=318), nurses, for the most part, do not indicate a great degree of rehabilitation beyond these basic life skills. Approximately 60% (N=318) of nursing staff across hospitals indicate that patients are being developed for discharge. Less than

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[116] See definition of 'rehabilitation' and 'development' outlined in the introduction.

[117] The Gauteng Mental Health Directorate Study (1997) revealed that 65% (N=209) of patients interviewed were employed prior to hospitalisation. Approximately 50% of these patients were employed in unskilled labour and 30% in semi-skilled labour. While the objective of development toward patient employment is difficult in the context of high unemployment rates, this data serves a reminder that patient employment is an appropriate objective, particularly for less institutionalised patients.

[118] There was no suggestion of statistically significant differences between public and privately contracted hospitals in this area.

[119] The fifth significant factor in the factor analysis was high level patient preparation of discharge including preparation for employment and patient clarity of discharge status. The factor analysis demonstrated the importance of this level of development of patient as a powerful predictor of nursing staff perceptions of quality. There was no significant difference

tice were formations where patients largely
se groups explain that given the large
e. They explain that the groups provide a

Box 4.5-1: Watching Patient Activity

nstrate a significant difference between the
d programmes'. Approximately 80% of both
ewed described limited to non-existent ward

d an occupational therapy rather than ward
al or overwhelmed occupational therapy
Graph 5.5-1 above, high level preparation,
achieved.

velop basic skills like bathing and dressing
unoccupied between basic care times. While
g volley ball game (for the few patients who
ball with low functioning patients.

to sit in the back and watch the patient groups. I sat with the pressure of patients. I spoke to them and other nursing 'the world go by...

space for sitting groups in the back of the wards. The groups level, there are no outward differences. While supposedly g given nursing staff attempts to start something up, knowing

vity groups. He pauses, for some time. And says, 'You can see o do anything, but try to keep some control.' He pauses again. senior sister calls us to another duty, like they have called me We just have to leave our groups, and the patients are left on

ost sit slouched over on their designated seat, others lay on the ants are wandering aimlessly to the dismay of the nurses who try uddles with their bare feet. Two men try to drink out of a dirty e formed around the leaking taps.

ice. There are too few staff, and the attempt to even put on an e theoretically fewer, in reality there seems to be approximately each group. Nurses spend their energy trying to keep patients rities as nurses were struggling for basic control – a concept this hospital.

Another nursing assistant catches my unbelieving eye. He agrees with his eyes and says softly, 'The groups are not really groups. We do not do anything. We just try to organise patients like that. But there are too many patients to actually do anything. They are seating arrangements -- for the control of patients.' He continues, 'Hey, we are all just trying to keep the peace, really. What can you do?' (PRI-2; Nursing Assistant)

Box 4.5-2: A Corner of Inspiration

Patients are knocking at the door while we have our interview. He answers each patient's questions with patience and compassion. I watch with a sense of awe. His patience and compassion seem to come from a well that has no bottom I ask him, how do you keep such a good attitude day after day. He smiles and says, *'I have been given this job by God, if I'm not mistaken.'*

His history was as a welder in the hospital workshop. He smiled shyly when he explained that he did not know what OT was when he applied for the training. He was selected for OTA training, and has been managing this programme ever since.

'I wish there was someone here with more training. But we do what we can do. Most nurses do not support this programme. But there are group of nursing assistants who do try. We work together and get some small things done.'

'We try to do things that may help them live back in the community. Mainly they make sisal crafts. My hope is that they could continue to do this if they were ever discharged. We have a garden. Once a week patients cook and we have a sit down meal.'

He points to the old man working to our side. He has no arms, and wanted to do woodwork. He rigged up a mechanism whereby the old man could sand down work using his feet.

'We do not believe that there is anybody who can't do anything.'

2.4.4. Patients and Work

> ➢ *The company does not employ staff, they utilise patients. There is exploitation of patients in terms of work. Patients clean, wash, do gardening, run errands for nurses. If they refuse they are beaten. For example they are told to collect bones for nurse' dogs. (PRI-3; Staff Nurse)*

Many patients have menial hospital jobs. Patients in both privately contracted and public hospitals engage in menial labour. Patient work for the most part includes cleaning, sweeping, and other miscellaneous menial labour hospital jobs.

There is a heated and unresolved debate about the appropriateness of patient work – in particular what type of work represents 'rehabilitative' activity and what type of work represents inappropriate / exploitative labour. The debate around appropriate patient jobs is currently a source of tension and confusion at the ward level. On the one hand, staff perceive patients to be used inappropriately as they perceive the patient 'jobs' to be motivated by staff shortages rather than patient rehabilitation. On the other extreme, patient activities like gardening and bed-making are being cancelled in the name of preventing 'patient slave labour.'

There are clear policy guidelines in this area in the privately contracted hospitals.[123] While the guidelines seem sound on a policy level (and should be reviewed for incorporation into norms and standards in this sector), they are not monitored, and thus appear to not be upheld. While patient work, according to this policy, should be on a voluntary basis, based on patient rehabilitation assessments, supervised, and not designed to cover for staff shortages, in practice these principles are seemingly contravened. The perception of misuse of patient labour was more frequently suggested among nursing staff at privately contracted hospitals than public hospitals. The misuse of patient labour has been reported within previous studies of chronic psychiatric hospitals in South Africa (APA, 1979; RCP, 1990).

[123] Lifecare Special Health Services Therapeutic Classification System for Psychiatric Facilities, Policy No. M18/96

2.6. Patient Reassessment and Developmental Progression

Patients are not functionally re-assessed, nor have a sense of developmental progression through activities nor wards. Thus, there is no sense of improvement among patients, or professional achievement among staff (Box 4.5-3).

In public hospitals there is not a patient assessment programme beyond the psychiatric reassessment of medications and diagnoses.[126] The policy document for the privately contracted hospitals indicates that patients should be functionally assessed on admission, and annually thereafter.[127] However, again, this was not being achieved.

Box 4.5-3: The Rehabilitation Ward

At this hospital we have what is now called the 'Rehabilitation Ward'. I hate this ward. While others in this hospital demonstrate our success by pointing to that ward, to me, it is proof of our failures.

If this one ward is a 'Rehabilitation Ward' then what are other wards? By implication then, other wards are not rehabilitative, which unfortunately is the case.

This ward is for high functioning patients who are perceived to be capable of discharge. There is no graded system supporting it. And so either you are in this ward, with all of the hope that it connotes, or you are not. Either there is hope for you, or there is not. There is not a sense of improvement and hope for all patients.

One patient in the rehabilitative ward is named Thabo. He is co-operative, engaged in activities, and holds down hospital jobs. His family is supportive and would like him at home. But he has a fixed delusion. He is from the East Rand, and he believes that the 'comrades are waiting to kill him'. All of our attempts at facilitating discharge have led to anxiety attacks. His brother moved to Soweto hoping that this would alleviate his delusion. On his leave of absence, he would not get out of the taxi. He cowered under the taxi seat and screamed for the whole weekend before they finally brought him back.

So, in the immediate run, he is not going to be discharged. A complicated community support service would need to be in place. Because he is not to be discharged, he will be moved OUT of this rehabilitation ward. Back to a ward without any rehabilitation orientation or activities. He will be expected to sit in non-active groups. It as if he has been thrown out of hope.

(Report of opinion of staff member, PRI-1, Researcher Site Visit Notes)

[126] Even this is not achieved regularly. See Chapter 4.4: Psychiatric Treatment.

[127] The patient reassessment was not explicitly linked to stepped developmental progression through a rehabilitation programme.

had somewhat more social workers, with the patient population per social worker at 304.

Social workers do not have regularly scheduled contact with patients, but rather consult newly admitted patients and respond to specific problems of longer staying patients. They are involved with facilitating social problems which can be solved within the hospital -- applying for disability grants, processing admission papers etc. There are no social workers who make home visits[131], citing either language or resource constraints.

The two social worker programmes which have a good reputation among staff are perceived in sympathetic rather than performance terms. [132] Even so, approximately 70% (N=52) of senior ward nurse across hospitals rate the social work programme as weak.

Two hospitals have social workers who do not speak the majority of patients' languages, limiting access to patients and families alike.[133]

Table 4.5-4: Number of Social Workers, Patient Population per Social Worker by Hospital

	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW
Number	1.00	1.65**	0.00	0.00	0.43	1.66
Patient Load	1799	641	NA	NA	1398	304

**Neither speaks the language of the majority of the patient population.

3.2. Discharge Preparation

> ➢ *No, this hospital does not prepare patients to leave. It is a weak point of this hospital -- rehabilitation. There is no facilities or staff for this. (PRI-3; Ward Senior Nurse5)*

Discharge preparation, in terms of developing skills, practices, and knowledge relevant for discharge has been largely covered in the section covering patient rehabilitation services above. In summary, patients, across hospitals, are not systematically developed for discharge.

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covered in the following chapter.

[131] PUB-2 has a community services department. Community service workers at this one hospital do make some home visits. See Chapter 4.6: Socially Transformative Services.

[132] *The social workers do try, although they are not so successful. Most of the patients end up here, because really the primary problem is with their families.* (PUB-HW; Ward Senior Nurse2)

[133] *Our social workers do not speak black languages and do not want to go into black communities. You could find more families if our social workers were willing to go into the community. (PRI-2; Ward Senior Nurse1)*

nurses indicate that once a patient is discharged they do not have contact with the patient unless the patient is readmitted. There is neither family nor patient contact after discharge. Eighty percent (N=318) of nursing staff indicate that hospitals do not retain contact with patients for the first six months after discharge.

Only one hospital (Pub-2) had a community services department. Community services workers within this department do have some contact with patients post discharge at this hospital.

4. Patient Rehabilitation Outcome Indicators

Patient developmental assessments were beyond the scope of this study. The following indicators were examined as outcome indicators for this area. These outcome indicators are summarised in Table 4.5-5.

- **Discharge Rates**: The annual discharge rates of the 1995/1996 period ranged between 0 and 10 percent. This is inclusive of patients who were discharged due to absconding from the hospital, and patients who are temporarily discharged and subsequently readmitted. There was no significant difference between sectors.
- **Length of Stay**: The mean duration of stay across privately contracted hospitals was 11.9 years (SD 10, median = 10.6). The mean duration of stay in public hospitals was 9 years (SD 8.3, median = 7.2
- **Patient Clarity of Their Circumstances**: Nursing staff in public hospitals perceived patient clarity to be higher than nursing staff in privately contracted hospitals ($p<.01$).
- **Patient Clarity of Discharge Status**: Only 11% of nursing staff believe that most patients know when they will be considered ready to leave the hospital. Only 21% of nursing staff believe that patients understand what is required to them in order to be discharged. Patients indicated frustration with their lack of knowledge of whether they were being considered for discharge. There was no significant difference between public and privately contracted hospitals in this area.
- **Patient Responsibility**: This was a sub-scale of four questions from the nursing staff questionnaire reflecting nurses perception of patients' sense of responsibility. (See Addendum 1.2: Nursing Staff Questionnaire: Overview of Methods and Results.) Again, more nurses in public hospitals perceived patient responsibility to be high than did nurses in privately contracted hospitals ($p<.05$).

Chapter 4.6: Objective Level 4
Socially Transformative Services: Family and Community Services

1. Introduction

1.1. Background

In the previous chapter we focused on services which developed and prepared the patient, as an individual, for discharge. We now look at hospital services that reach beyond the patient per se, to affect family and community relationships.

Again, the recent Gauteng Mental Health Directorate study provides useful background information to this chapter. Sixty six percent (N=218) of patients interviewed were single prior to admission. Over 80% (N=187) were living with their families as dependants. Eighty percent of patients indicate that they would like to go back to living with their family if they should be discharged.

The importance of this final level of our hierarchy of objectives is rooted in two points highlighted in Desjarlais' recent review of mental health challenges in low-income countries. (Desjarlais, 1995).

First, the aetiology as well as course of mental illness is a complex combination of factors related to the individual and his/her social environment. Desjarlais suggests that the roots of mental illness are based in overlapping clusters of problems including health problems, social problems (substance abuse, family / community violence, nature of support relationships), and exacerbating conditions (poverty, unemployment, discrimination). He summarises current research as providing 'strong evidence that all mental disorders are bio-social and the quality of a person's social environment is closely related to risk for mental illness and likelihood that an illness will be chronic.'

The second point motivating the family and community services of hospitals, is simply that the family and community are ultimately the key to a sustainable discharge. Desjarlais concludes that across low-income nations, families are at the centre of managing the care for mental illnesses (Desjarlais, 1995, 53). Moreover *'research indicates the benefits of psychoeducational work with families – both in managing the burden families experience and in increasing the effectiveness of their role as care providers'* (Phillips, 1994).

Interviews from this study support these two conclusions. A common barrier to patient discharge, as perceived both by staff and patients, is a lack of supportive family and community relationships. Staff and patients alike perceive many families to be either unwilling or unable to support the

1.3. Summary of Findings

Hospitals in this study for the most part are closed systems with little to no external contact, and little to no patient discharge beyond patients who abscond.[137]

Further, they are not transformative systems. Only one hospital (PUB-2) of six had a community services department supporting the development of community based services. The mandate of the remaining 5 hospitals extends to the hospital's walls. External social factors undermining discharge are not perceived to be within their mandate. While the absence of community and family services reflects factors not entirely within the control of hospital management, support in the community needs attention if patients are to be discharged to community care.

2. Social Barriers to Patient Discharge

As previously described, the social barriers to patient discharge in the South African context are enormous. They cut to the core of socio-economic issues, culture, value systems, and philosophies of life itself. The factors consistently identified by patients, staff, and management of these hospitals as barriers to patient discharge are outlined in Table 4.6-1. Staff feel largely paralysed by these barriers.

Again, these barriers strongly suggest that the scope of hospital concern, by necessity, must reach beyond the individual patient to the societal context.

This implies a dramatic re-conception of these institutions, from introspective institutions overwhelmed by external social forces, to outward looking institutions with the self-concept of being managers of social change. Far from being just rhetorical language, this re-conception guides us in conceiving hospital design and performance indicators, from the role of the social worker in a multidisciplinary team to the family contact and community service promotion.

Table 4.6-1: External Barriers to Discharge

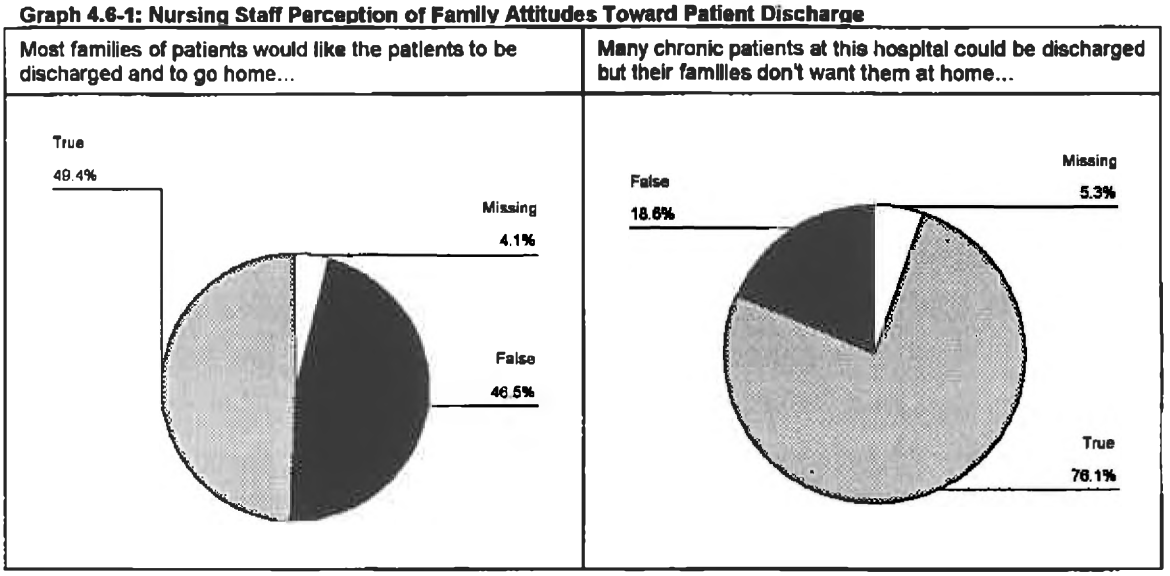
Family	➢ *The social workers do try, although they are not so successful. Most of the patients end up here, because really the primary problem is with their families. (PUB-HW, Ward Senior Nurse 2)* ➢ *When we send a patient for LOA for say 2 months, she returns to the hospital ill, maybe they didn't give her food, maybe she has relapsed. Often they bring her back before the end of 2 months. Sometimes families return and say the patient is here for good. I think that is the mind of the people outside. Families rarely visit, they hardly even stay half a day. I see there is rejection from the families. For example, they say 'she's troublesome at home' or 'she was aggressive to others at home.'* (PUB-1, Ward Snr Nurse 6)
Community	➢ *The patient makes it for a few days at home. The family can't watch him the whole time. Then he goes to the shebeen. And there are some people who encourage him to get drunk. The next thing you know he has reverted back again. Patients can't survive out there. (PUB-1, Ward Senior Nurse)*
Context	➢ *We are trying our best really. Yes, we try to prepare patients for discharge. We give LOA but they come back – they suffer from hospital neurosis. Here there is a schedule – breakfast, tea – at home you get a slice of bread a day. We are blamed when they come back on their own. (PRI-1, Ward Senior Nurse 6)*
Lack of Services	➢ *We are trying our best really… Where do you discharge patients to? (PRI-1, Ward Senior Nurse 6)*

[137] One hospital out of six (PUB-2) had a developed community services department. This service did open up the system at this hospital to some extent. However, evidence indicated that these services were particularly effective at stimulating an open system for the more acute patients. Patients who had been hospitalised for more than a year had little if any contact with community services.

3.3. Perceptions of Barriers to Family Involvement

There is a strong perception among staff that families, for the most part, no longer want patients at home.[138] As can be seen from Graph 4.6-1 below, only about 50% (N=318) of nursing staff believe that most families would like patients to be at home, and over 75% (N=318) of nursing staff believe that there are chronic patients at the hospitals who are ready for discharge, but are not discharged because their families do not want them at home.

Graph 4.6-1: Nursing Staff Perception of Family Attitudes Toward Patient Discharge



The following reasons were cited as underpinning low family involvement / lack of positive attitudes toward discharge. Note that very few nurses point to hospital services – the lack of family involvement is perceived as dependent on factors outside of hospital control.

3.3.1 Complete Loss of Family Connection

- *The majority of the families have been contacted, but given the recent violent history most letters are returned un-opened because people were displaced by the carnage. (PRI-2, Ward Senior Nurse 3)*
- *They don't know where their kids are!! They have been separated by the stresses of apartheid. For example if a rural family is removed and the patient is lost and don't know where they have been replaced. (PRI-1, Ward Senior Nurse 6)*

The most commonly cited explanation for lack of family involvement is total lack of family contact, with particular emphasis on how recent history served to separate these patients from their families. Black patients were put into custodial care in urban areas with no family contact. Rural families were relocated. See Box 4.6-1: Lost in the System.... The violence and dislocation in Natal was also cited as a factor underlying loss of contact for patients in Natal.

[138] Only approximately 50% of nursing staff perceive that most families want the patient to be discharged home.

3.3.4. Families are Afraid

- *There is one man in a ward I used to work. He was living with his brother and sister in law. He stayed at home while they worked, and he looked after the children. The sister in law asked him one morning to cut up the meat for dinner, so that when she arrived home she could cook dinner. He had a psychotic episode, and cut up the children instead. That was years ago. He is fine now. But the family won't take him back. I'm not sure you can blame them for that. Even if a patient is now stable, there are some things you cannot forget.* (PUB-HW, Ward Senior Nurse)

Some nurses cited family fear and alienation reflecting patients' past behaviour. They believed that it is important to not underestimate the impact patients have had on family life in the past.

3.3.5. Poor Hospital Services

- *'[They] need to be told from admission that the hospital is not a home...' (PUB-HW, Ward Senior Nurse 10)*
- *'We do not have a social worker who could make contact with families, but when a patient passes away [then someone] writes to the family or even visits.' (PUB-1, Ward Senior Nurse 1)*

Few staff cited hospital services as responsible for the lack of family involvement. Nurses' analysis for the most part was that family involvement was outside of hospital service responsibility. The few who did cite hospital services as a factor focused on admission policies and poor social worker services.

3.4. Hospital Facilitation of Family Contact

While 60% (N=318) of nursing staff indicate that hospitals keep families informed of patient progress, and over 75% (N=318) of nursing staff indicate that the hospital actively involves families in discharge planning, there was no evidence in any of the hospitals of services or programmes designed to facilitate family contact. While family contact is described within the mandate of the social worker services, these services are severely understaffed, and focus on addressing hospital based patient problems rather than family outreach. Those who are involved in family outreach describe this as a process of writing letters 'but the family does not respond.'

The community services workers at PUB-2 are currently making home visits (see section 3.6 below.) Beyond this, there are no social workers who are currently making home visits. The reasons cited for lack of family visits are both language and resource constraints. There are reportedly patients who have been technically released but remain at the hospital due to an inability of the hospital to facilitate families coming to pick up the patients.[139]

While all nurses interviewed emphasise the importance of family involvement to facilitate discharge, there is neither effort nor a sense of responsibility to facilitate this contact by ward based nurses. The problem is seen to rest with the families themselves (or be blamed on the social worker), with little sense of power or responsibility to impact on family behaviour on the part of nurses. There is no proactive contact or communication with families, or active facilitation of

[139] *There is one patient who was discharged -- actually quite a few -- who HAVE been discharged but they are still here. There is no social worker. The company in this guy's case know where the family are -- the sister just says 'they will come'.*

health services through a school based programme, and support to fixed and mobile clinics throughout the catchment area.

This service provides direct back-up to patient discharge by home and employment based visits to over 100 patients.

The head of the programme describes the service as follows. *'[The objective of our programme] is to treat our psychiatric patients as outpatients rather than inpatients. .. [We are] the frontline contact of the hospital. This unit decides whether a patient is admitted or can be treated as an outpatient.'* In terms of chronic psychiatric patients, he explained, *'[our role] is after [discharge] care and follow up. [We] ensure that patients get medications and [we] attend to physical condition that might trigger illness...'*

Table 4.6-3: 'Cultural' Differences in Attitudes Toward Mentally Ill Patients

'Black Culture' is Less Tolerant	➢ *Another problem is cultural. For example, one gentleman the parents passed away. His sister is the only one alive. She married. According to our culture if the brother in law is not interested in the mentally disturbed it is difficult to get permission for the sister to visit. (PRI-3, Ward Senior Nurse 2)* ➢ *Most black patients were picked up on the streets with no relatives where with other races there is more family contact. I think in the black community once they become mentally ill they are rejected and isolated. Other races do take care of their patients, they really do. (PRI-2, Ward Senior Nurse 1)* ➢ *Families are scared of catching the disease. Some believe the patients are bewitched and are scared they will catch it. Some people who have people who are mentally retarded, they lock their child away in a room, away from others. They may also experience difficulties with finding people to assist them with looking after their child. (PUB-1, Ward Senior Nurse 5)*
'White Culture' is Less Tolerant	➢ *It's a cultural thing. White families do not accept mental illness, and do not provide support to the patients. (PUB-HW, Ward Senior Nurse 9)* ➢ *We blacks have a community style of living, so there is someone to look after you if you are sick. We can take stress and pain better than white people due to our way of living; sharing every little bit we have. (PUB-HW, Ward Senior Nurse 1)* ➢ *In our culture [black] the family believes that if you don't look after your offspring you might not get luck from the ancestors. One mother said after a visit that things go well for her but if she misses a few months things go badly. (PRI-1, Ward Senior Nurse 5)* ➢ *The reason the majority of patients here are white is primarily a cultural issue. Blacks accept their people back no matter how – an uncle, aunt, brother, sister, someone. It is different with whites. Once a patient is here they close the door and don't want to hear about you. (PUB-HW, Ward Senior Nurse 11)* ➢ *It is a cultural thing. Just like the old aged. Blacks tend to care for their elderly. It is taboo to send our people off. With the whites they say they don't have enough space at home. It is also affected by blacks belief in ancestors and traditional medicine. They take their people home. Most blacks are used to living with the their problems; they absorb them. Whites have always had these systems. Blacks did their best at home. When you were sick you were sick. Depression did not exist, it is only now we have identified depression. (PUB-HW, Ward Senior Nurse 4)* ➢ *Whites [patients] are staying here permanently because whites don't tolerate stress, or mental illness. (PUB-HW, Ward Senior Nurse 8)* ➢ *White parents will take a child in very early even if there is the tiniest of problems. There is less of a tolerance for difference and so this means that whites are treated from an earlier age. Blacks are stronger and don't go in as early. And mental problems are not only dealt with by coming to a hospital. Also in white culture it seems they only want the patient to be released if they are worth something. If they have money they want the person released. If they don't have money then they don't want them to be released. Some patients are long term. The problem is they don't have relatives / social contacts. I think it is a problem if you have patients who comply with the treatment and are apsychotic and are still here. There is a cultural problem with whites. There are relatives but there is a sense that if you're not useful, not benefiting them, then people are thrown away. That puts me in a difficult situation. The patients see me as the one with the key, locking them up, when it is really people like their families who have the key. (PUB-HW, Ward Senior Nurse 14)* ➢ *White patients become dependent on the institution. Black patients become less dependent on the institution, either being accepted back into their families, or building a shack of their own. (PUB-HW, Ward Senior Nurse 10)*

Chapter 5.1: Management

1. Introduction

- *The management of this hospital is failing to run this hospital. The ship of this hospital is sinking. (PUB1; Staff Nurse 20)*
- *Management clearly has no sense of how to deal with human beings. Most of us do not even bother to attend patient care meetings. These are like a car with its engine on but not moving.*
- *They are weak and staff does not respond to them.*

Management, to a large extent, determines organisational performance.[140] While staff skills are important, it is management that largely determines whether staff skills and motivation are built or undermined over time. While the budget and resources available to a hospital are important, it is largely management that determines whether resources are used effectively to produce quality outcomes.

Management in the context of this sector is particularly challenging. It requires an ability to understand the details of ward life to facilitate working systems at the ward level. It requires the ability to motivate and co-ordinate multidisciplinary care. It requires the successful management of staff who are confronted with extremely challenging working conditions. It requires the ability to manage relationships beyond the hospital boundaries to families and communities. And it requires the ability to lead change in a sector where values and objectives are in transition.

Several sets of data from this study suggest that management is one of the key factors underlying quality outcomes. Management was mentioned as the most pressing hospital weakness in open-ended answers made by nursing personnel on the questionnaires. The factor analysis of nursing staff questionnaire results points to management factors as the most important for describing variance in nursing perceptions of quality outcomes (Addendum 1.2).

In this chapter we will first describe our findings with reference to management skills and performance at these hospitals. Unless otherwise stated, we refer to senior administrative management when we discuss management below. We will again concentrate on 'historically black' hospitals, and include in our analysis the management from Natal and Northern Province

[140] This contention is supported by a wide range of public and private sector management literature. Esman summarises: the capacities of the hospitals to achieve system goals, utilise resources, capitalise on opportunities and adjust to changes, depends largely on management skills (Esman, 1991: 20). Data from this study confirmed this contention. .A factor analysis of the outcomes of the sub-scales of the nursing staff questionnaire demonstrated that the most significant factor explaining variance in outcome was a combination of management sub-scales and those measuring staff satisfaction.

Nursing staff do not perceive any channels for meaningful participation in current management practices. This leads to uninformed decisions[143], staff alienation[144], and ultimately, conflict[145].

3. Management Style

Management style is perceived by staff to be retributive, reactive, and unresponsive. Management's interaction with staff is seemingly restricted to recognising bad behaviour, failing to recognise or acknowledge performance and contribution. Decisions are made in response to emergencies rather than planned to increase quality. While there are allegedly few to no formal avenues for staff input, those staff who have the initiative to make suggestions perceive their suggestions to be either not heard or disregarded. These common themes, illustrated in Table 5.1-1, run through nursing staff's descriptions of management.

Table 5.1-1: Nursing Staff Descriptions of Management

Retributive	Reactive	Unresponsive
➢ *Management want to be feared by all staff.* ➢ *The management only looks for the mistakes from the nursing staff. There are no incentives considered in spite of work overload which is done here. (PUB-2; Nursing Staff 67)* ➢ *Good work is not recognised by supervisors, they only see the bad things... (PRI-3; Nursing Staff 34)* ➢ *Management want to be feared by all staff. They instil fear through the matrons. The matrons are also scared. They are not comfortable. You can see it.*	➢ *I'm very frustrated with management. Management only approve what they call 'urgent' or 'emergency' orders. When a handle on a door breaks, then there is money. If you want to paint so that you prevent further damage, then there is no money. The plumbing system is a real problem. We spend most of our time unblocking the thing. A few weeks back it blocked everyday. Every week there are big problems and it takes all of my team to fix it.*	➢ *Senior management don't have any interest in patients. Proposals from staff are not implemented. Even small things that don't require a budget are not implemented. For example, you see these broken chairs in this courtyard. They are dangerous for patients. I have proposed that they are moved. And still they sit here. The management don't think it is important.*

4. Management Skills

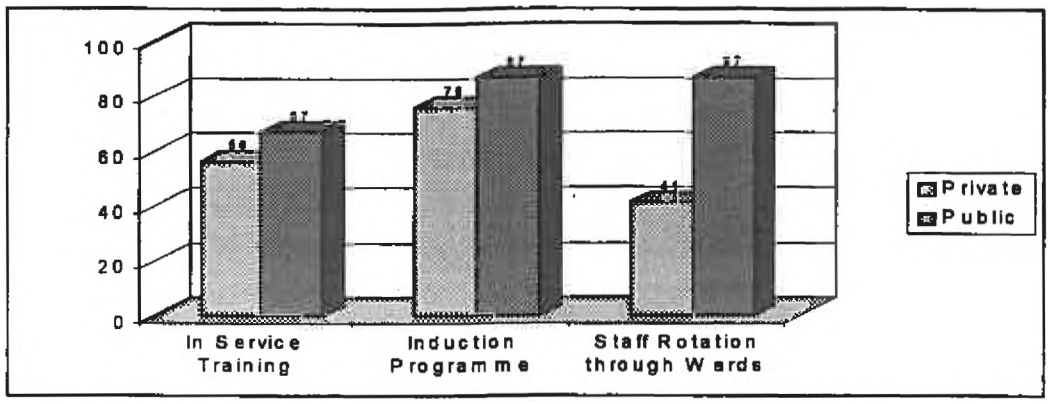
We evaluated management skills according to the following competency areas: knowledge of the field of mental health, financial management, human resources management, and performance management (with special reference to monitoring and evaluation).

[143] There is a sense among staff, particularly strong at the privately contracted hospitals, that the lack of staff participation in management decisions which impact on patient care leads to short sighted or wrong decisions. One nurse articulated this as follows, *'I believe if they involve staff the hospital would operate better. For example, the staff would simply not have allowed them to hire a second Asian social worker who does not know Black languages. It is a bad decision for the patients.'*

[144] Several staff link resignations to the lack of channels for staff input, *'there has been a staff exodus. If your voice is not taken into account, even if the ideas are sound, then you must leave...'* See Chapter 5-2: Nursing Staff for a more detailed discussion of staff satisfaction and perceptions of management.

[145] There was a great deal of animosity expressed by hospital staff toward management across all hospitals. One nursing staff expressed this common theme as, *'There is little that management does to support my work. They only promise that they will respond to our concerns. You always have to fight. Here the status quo prevails and people protect each other...'*

Graph 5.1-1: Human Resources Development Systems: By Sector



Nursing staff ratings of HR management programmes. Columns represent percent of nursing staff who rated the programme in positive terms. Source: Nursing Staff Questionnaire (N=318). See Addendum 1.2.

4.4. Performance Management

- *It is like there is a vacuum there... The problems that exist are never attended to. Even when there are meetings at head office, we do not get any feedback. Sisters have started having their own monthly meetings having started last month. [Senior Ward Nurse]*
- *I do not think they are doing their job properly. They just sit in their office and they should walk around the hospital as a whole and see what can be improved. [Senior Ward Nurse]*

By performance management we include management's understanding of organisational objectives and ability to manage to ensure achievement of these objectives.

We asked managers what they considered as the primary objectives of the hospitals. One could not answer the question. One answered in terms consistent with custodial care. The remaining two acknowledged the aim to discharge patients, but indicated that factors preventing discharge were largely outside of hospital control. See Table 5.1-2.

Table 5.1-2: Management Understanding of Hospital Objectives

Management Understanding of Hospital Objectives	
➢	*I cannot really say.*[146]
➢	*To have quality care for them. To treat them as normal. They must have a normal life.*
➢	*Quality patient care. These people should be treated as an individual, a human being with dignity and respect. This should include clothing, hygiene, nutrition, and vocational skills where possible. Where possible the objective should be rehabilitative and getting patients back into the community. Most of these things don't depend on us. For maintenance, for example, we have to go through public works, for transport we have to go through the transport department.*
➢	*Those patients who we take for a long time there are reasons for this – they are state president patients, or have no family. We want to keep as few as possible. We want to reach out to the community. We don't like to keep people indefinitely. That's why we have community services and satellite clinics.*

[146] The question was re-worded several times to demonstrate our meaning. The question was met with a sense of confusion. He finally said that he thought it was a good question but he was not quite sure.

5.2. Subjective Power

- *I feel partly supported. Sometimes they come sometimes they don't. Maybe they do not know what to do and are afraid. [Senior Ward Nurse]*

Subjective power is an intrinsic sense of sense of self-efficacy and power to lead. We evaluate three aspects of management related to subjective power -- an internal sense of self efficacy, vision (the ability of a manager to see beyond the day), and change management (the ability and confidence of a manager to lead change).

5.2.1. Internal Efficacy

Three of the four hospital superintendents demonstrated a profound sense of lack of self efficacy, and a resignation to the lack of power to bring about positive change. When describing hospital challenges, superintendents described problems which they perceived they had little to no power to change.[147] They described the problem of low budgets, but did not perceive themselves as having the power to negotiate budgetary terms. They described low staff morale and performance, but did not perceive themselves as having influence over this area. They described family and community barriers to successful discharge, and were resigned to these barriers, perceiving them to be outside of their power.

A further indicator of the low sense of self efficacy is demonstrated by managers' sense of satisfaction with current hospital performance, in face of the low quality outcomes. When asked whether they were satisfied with the current levels of service, superintendents demonstrated a resigned sense of satisfaction -- at best a resigned sense of 'all you can do is try.' Two superintendents responded:

- *[Long pause]. Yes. [Sigh]. Because that's what can be given at the present time. The people who are here are doing their best. I must be happy with what I have even if I need to go further.*
- *No, but the way staff are working there is nothing we can do. The way workers are -- they are just reluctant. The higher authorities must change this. They know patient care is not up to standard...*

5.2.2. Vision

Interviewer ratings of vision, creativity, and problem solving ranged between 'poor' and 'very poor'.[148] When asked to envision and describe a future model mental health system, two of the four superintendents could not see beyond custodial care objectives.

- *Have an institution like this one but decrease it – have fewer people staying in each room.*
- *Guarantee security and protection – patient must feel secure, they must feel at home. Provide suitable accommodation and food. Take into account any problems [of the patients] – take each and every one without undermining any.*

---

[147] This was closely related with a sense of lack of managerial autonomy described below.

[148] See Addendum 1.6: Management Interviews: Methods and Results

managers' of the privately contracted hospitals perceived their skill base to lie in 'business'. Privately contracted hospitals appointed superintendents with a business orientation.

- *I consider myself a business man. A Company man . [The major challenges facing this hospital are] ...health competitive management, and public relations.*

Thus, instead of blaming individual managers for not having the required skills, perhaps it is more accurately a reflection of values demonstrated in appointment requirements.

5.3.2. Organisational Context

- *I don't have power. Authority is with the regional office. I cannot finalise anything, for example, appointments, staff transfers, charging staff for misconduct, upgrading staff to non-prescribed posts. These should be done locally but I cannot do them. [Public Hospital Superintendent]*
- *Authority is centralised in Lifecare. The hospital management is accountable to the regional management, which in turn is accountable to the national management. Because of the bureaucracy and hierarchy, time is wasted and things then blow out of proportion. [Privately Contracted Superintendent]*

Managers from both public and privately contracted hospitals expressed a frustration with the lack of autonomy they were given to manage effectively. Managers of public sector hospitals (operating within a large state bureaucracy) and the privately contracted hospitals (operating within a large centralised national corporation) have restrictions dictated by the larger bureaucracies in which they operate.

a) **Budgetary Allocations:**

- *During the past two financial years the salary budget alone is more than the budget given to us. Our agreement is that when it comes to salaries it should not be our problem – it is a government problem. The budget is allocated according to our previous year's spending. [Public Hospital Superintendent]*
- *It was explained why it [budget allocation/determining financial priorities]] is done up there -- the reason is because the money to run the hospitals is given to the HO and so they have to make the decisions. I accept that. [Privately Contracted Hospital Superintendent]*

One of the most profound sources of external organisational restriction lies in budgetary allocations. Power to influence budgetary allocation decisions, for the most part, remain outside of local management's sphere of influence. Superintendents across the 'historically black' hospitals did not have power in budgetary allocation decisions. While they are able to provide 'recommendations' or 'suggested budgets' they feel that for the most part final budget allocation does not depend on them. Budget allocations are for the most part related to previous expenditure (basic operating costs.)

Thus, budgets are almost exclusively oriented toward meeting fixed costs including personnel, infrastructure, and pharmaceutical costs. As stated earlier in this report, there is minimal to no budget allocated for new initiatives in care beyond custodial requirements. On average, only 8 percent of total personnel cost is captured by staff other than nursing personnel and hospital operations personnel. Thus, even if a manager did have a vision for organisational transformation toward patient rehabilitation or social transformation, they would be largely restricted by budgetary allocation procedures to achieve this shift.

6. Summary

This study demonstrates a strong link between poor quality outcomes, and poor management. All hospitals are characterised by hierarchical structures of authority, where top managers yield power by virtue of position, leaving staff and middle management out of the management processes. Management do not have the basic skill competencies required to run the hospitals. They do not have a sense of internal power, nor assertively grasp the 'core value' of the hospitals, to provide them with the confidence needed to get things done. They feel restricted and unsupported institutionally, taking away their objective power to manage effectively.

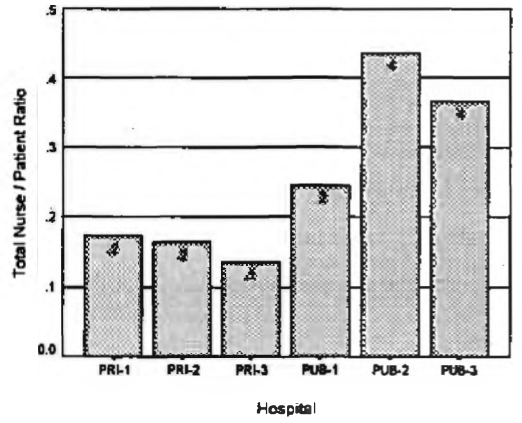
The lack of dynamic management is one important factor underlying the quality outcomes outlined above. While managers are focused on retributive management of basic custodial care routines, managers are not able to proactively manage dynamic change beyond minimal institutional goals. The strengthening of management should be considered a priority area to develop this sector in the future.

2.1. Total Nursing Staff : Patient Ratios

Public hospitals have consistently higher nursing staff : patient ratios than the privately contracted hospitals. The average patient : nursing staff ratio in the public sector hospitals was 2.9, while the average ratio in the privately contracted hospitals was 6.3. Thus, nurses in privately contracted hospitals have approximately double the patient load as nurses in public sector hospitals. Total nursing staff : patient ratios are summarised in Table 5.2-1 and demonstrated in Graphs 5.2-1 – 5.2-2 below.

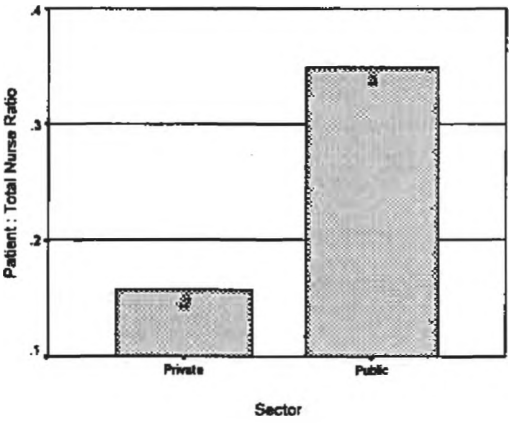
When converting this into the number of patients per nurse in any one day shift, nurses at the public sector hospitals are responsible for on average 9 patients, while nurses in the privately contracted hospitals are responsible for 20. Similarly on average, night shift nurses are responsible for 24 patients in the public sector hospitals, and 53 patients in the privately contracted hospitals.

Graph 5.2-1: Total Nurse : Patient Ratios Across Hospitals



NB: Inclusive of Residential Health Worker

Graph 5.2-2: Total Nurse : Patient Ratios Across Sectors



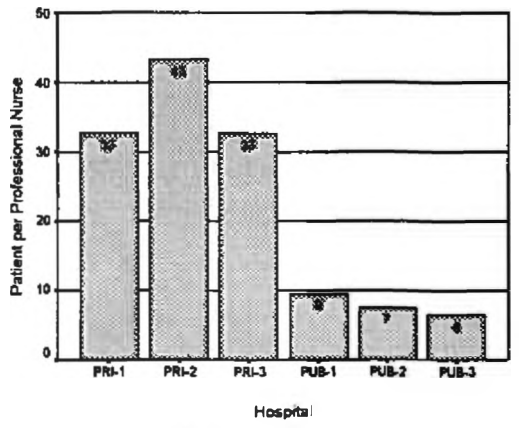
NB: Inclusive of Residential Health Workers

Table 5.2-1: Nursing Staff : Patient Ratios Summary

Ratio	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Pri/Pub
Total Nursing Staff : Patient	0.17	0.16	0.14	0.25	0.44	0.37	0.16	0.35	2.19
(Patient : Nurse)	5.88	6.25	7.14	4.00	2.27	2.70	6.25	2.86	0.46
Practical Day Shift Patient Load[151]	18.53	19.69	22.50	12.60	7.16	8.52	19.69	9.00	0.46
Practical Night Shift Patient Load	50.11	53.24	60.85	34.07	19.36	23.02	53.24	24.34	0.46

[151] These figures calculated as follows: an average of 73% of nursing staff across hospitals work on day shift duty; 2.1 shifts of nursing staff on day shift per week, if calculating an average of a 40 hour working week.

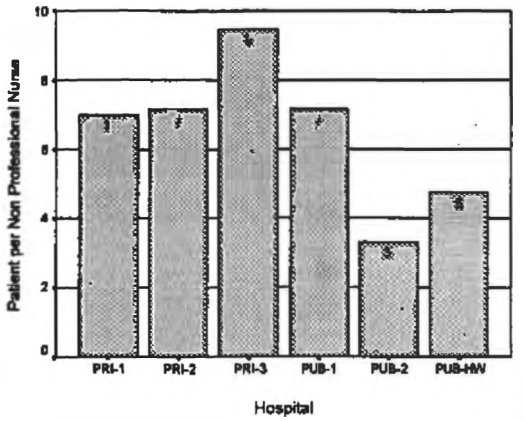
Graph 5.2-3: Patient per Professional Nurse



Pr

ofessional include matrons, sisters, and staff nurses.

Graph 5.2-4: Patient per Non-Professional Nurse



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on Professional nursing staff include senior assistant nurses, Assistant Nurses, and Residential Health Workers.

Table 5.2-2: Patient : Nurse Ratio by Nursing Staff Rank

Ratio	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Pri/Pub
Patient per Professional Nurse	32.7	43.3	32.7	9.5	7.4	6.4	36.2	7.8	4.64
Patient per Non-Prof Nurse	7.1	7.1	9.1	7.1	3.3	4.8	7.7.	5.1	1.51
Patient per Matron	599.7	314.0	294.0	379.1	188.2	72.1	402.6	213.1	1.89
Patient per Sister	50.0	69.8	46.4	18.1	9.1	7.6	55.4	11.6	4.78
Patient per Staff Nurse	112.4	179.4	176.4	21.1	53.8	90.2	156.1	55.0	2.84
Patient per Assistant Nurse	7.5	7.7	12.3	7.2	3.3	4.8	9.1	5.1	1.78
Patient per RHW	100.0	100.0	50.0	NA	NA	NA	100.0	NA	NA

Table 5.2-3: Practical Day Shift / Night Shift Patient Loads: Professional vs. Non-Professional

Ratio	PRI-1	PRI-2	PRI-3	PUB-1	PUB-2	PUB-HW	Private	Public	Pri/Pub
Practical Day Shift Load: Patient per Prof Nurse	103.03	136.42	103.03	29.93	23.32	20.16	114.05	24.58	4.64
Practical Day Shift Load: Patient per Non-Prof Nurse	22.37	22.37	28.67	22.37	10.40	15.12	24.26	16.07	1.51
Practical Night Shift Load: Patient per Prof Nurse	278.56	368.85	278.56	80.93	63.04	54.52	308.37	66.44	4.64
Practical Night Shift Load: Patient per Non-Prof Nurse	60.48	60.48	77.52	60.48	28.11	40.89	65.59	43.44	1.51

Beyond having a greater nursing staff : patient ratio in all nursing staff ranks, public sector hospitals also have a greater proportion of professional nurses in their total nursing staff complement. These results are summarised in Table 5.2-4. Results are illustrated by hospital in Graph 5.2-5 – 5.2-6. Professional nurses make up, on average, 39% of total nursing staff in public hospitals, while they only make up 18% in privately contracted hospitals. Thus, public hospitals have a higher proportion of professional nursing staff by more than a factor of two.

more individualised routines. The nature of the relationship between staff and patients is mostly consistent with friendly (if at times passive and paternalistic) custodial care. While the relationship between staff and patients is more positive in public hospitals than privately contracted hospitals, it is generally positive across hospitals. There was very little demonstration of individualised care between basic care time across hospitals. For the most part nursing staff use this as social time, rest time, or passively interacting with patients. There was a more 'group' approach to care between basic care routines at privately contracted hospitals. There was a particular lack of individualised patient care at two of the three privately contracted hospitals – where low staff patient ratios combined with large wards. Nursing staff in these wards relate to patients via impersonal large group routines. Professional nursing staff often do not know the names of patients in their wards. See Chapter 4.3: Custodial Care.

In terms of psychiatric treatment, medications are administered to patients four times a day by nursing staff. Observation of medication routines across hospitals suggested that this was routinely achieved by ward nursing staff.[152] Nursing staff are the link between patients and the psychiatrists. Psychiatrist visits often take the form of nurses updating the psychiatrist on patient behaviour, and making recommendations as to required medication regimen adjustments, with the psychiatrist making medication decisions based on this nursing staff analysis. Nursing staff are not involved in therapeutic counselling. See Chapter 4-4: Psychiatric Treatment.

For the most part, nursing staff do not perceive their responsibilities to include patient rehabilitation. For the most part, this is seen as the responsibility of occupational therapy staff. Time between patient daily care routines is not used developmentally. Non-professional nurses at privately contracted hospitals are responsible for overseeing 'groups' whereby patients sit or sleep. While patients had more freedom of movement and choice in public hospitals (reflected in higher patient responsibility ratings), for the most part, there were not organised developmental programmes at the ward level. Staff patient relationships, while positive, fall short of mentoring, individualised developmental relationships. See Chapter 4.5: Patient Rehabilitation.

In terms of socially transformative services, nurses do not work with families or communities, to either facilitate contact, involvement, or social change. This is considered outside of nursing duties. The exception to this rule was PUB-2 which had a developed community services department. While this department was not evaluated in detail, the interaction between nurses in the chronic wards and the community services seemed to be minimal (whereas the relationship was particularly dynamic with nurses in the outpatient department and acute wards.) See Chapter 4.6: Socially Transformative Services.

[152] The quality of the administration of medications differed across hospitals. While all nurses said that they observed patients taking the medications, our observation demonstrated that this was inconsistently practised.

sub-standard conditions, with little recognition or support. As such, addressing low staff satisfaction should be an operational objective of these hospitals, beyond patient care.

We evaluated staff satisfaction through a nursing staff questionnaire, interviews, and observation.

4.2. Levels of Staff Satisfaction

Staff interviews, whether formal or informal, revealed an enormous amount of frustration, if not desperation among the nursing staff at all institutions. Table 5.2-5 illustrates terms used to describe staff by researchers after extensive ward observation. While there are ever present signs of deep humanity, for the most part staff appear burdened, overwhelmed, or burned out. Observer ratings of 'staff enthusiasm' were significantly higher for public hospitals nurses than privately contracted nurses.

Table 5.2-6: Words Used to Describe Nursing Staff

Indications of...	
Low Satisfaction	*subdued, reluctant, stern, low morale, sceptical, not happy, hesitant, resigned, poor trust, overworked, under-utilised, frustrated, resigned to mass care, no sense of co-operation, low spirit, serious, don't interact, disgruntled, distant,, irritable, professionally compromised, afraid, just getting by, overwhelmed, burned out, giving up, distant, high frustration, encumbered, unsupported, hierarchical, drunk, harsh*
High Satisfaction	*friendliness, friendly, committed and engaged, heart felt, camaraderie, keen, skilled, strength of character*

Words used to describe ward based nursing staff in researcher site visit notes.

These outsider impressions, however, contrast with nurses' own perceptions. Nursing staff questionnaires revealed that approximately 60% (N=365) of nursing staff say they are satisfied with their job on the whole. Almost 90% say that they look forward to work when they get up in the morning. Further, only approximately 37% (N=42) of nurses who were interviewed in depth described their level of satisfaction in very negative terms. There was not a significant difference demonstrated between nurses in the public and privately contracted sector.

4.3. Roots of High and Low Satisfaction

These results call on us to look a bit deeper into the source of both job satisfaction and job dissatisfaction among nursing staff. The basis underlying both low and high job satisfaction was common across hospitals. The roots of positive feelings toward work are based in intrinsic factors – the love for patients, psychiatry, and nursing. The roots of negative feelings toward work are rooted in extrinsic factors – management, lack of training and development, and poor working conditions in general.

The roots of high and low job satisfaction can be summarised by the results of two questions in the nursing staff questionnaire. See Graph 5.2-8: Roots of Staff Satisfaction. Approximately 60% of nurses across hospitals agreed that they would take another job in another mental health institution because they were not happy with the working conditions at their hospital. However only approximately 8% of nurses across hospitals indicated that they would take a job in another field of work due to not liking to work with mentally ill patients. That is, while they would consider a job in another psychiatric hospital due to their frustration with the working conditions, they are not

Table 5.2-6: The most positive aspect of my job is...

Patients	*...seeing a patient recover and improve. I like the patients. (PRI-3; Senior Ward Nurse 8)* *It is nice to work with these patients. They mix well with us. We laugh. (PUB-2; Senior Ward Nurse 1)* *I am dealing with people who are solely dependent on me. When I'm giving help I know I'm really giving help. (PUB-2; Senior Ward Nurse 3)* *... This is a good place to work. We are laughing all day. Most jobs are not like that. I prefer to work here because I like the aged. They are people who need love. It is very rare that they give problems. I love them. (PUB-HW; Senior Ward Nurse 6)* *It is nice to help a person that a family or community has rejected. It is a blessing to me. No one chooses to be mentally sick ... and although it is rare the small times of seeing progress in patients and family's response. (PUB-HW; Senior Ward Nurse 10)* *To see patients become apsychotic. Like to restore self-respect and dignity to what it was before. (PUB-HW; Senior Ward Nurse 13)* *It is good that we should have different people with different problems. I feel I am specially gifted with working with these people. That my heart and soul are also here. (PUB-HW; Senior Ward Nurse 14)* *I give myself to the disabled. And I feel good about it. Giving strength, heart. Loving them. When we come on duty we find them waiting for us at the gate. (PRI-1Senior Ward Nurse 8)* *The humanity of the job, respect and caring. (PRI-2; Senior Ward Nurse 5)*
Mental Health Work / Psychiatry	*I like listening to other people's problems, interviewing them, to see why they are like this... (PUB-HW; Senior Ward Nurse 4)* *I have love for the discipline. It broadens my knowledge. I like seeing patients improve and becoming apsychotic. (PUB-HW; Senior Ward Nurse 5)* *Taking care of patients - of their basic needs. Learn to understand other people as well as yourself. (PUB-HW; Senior Ward Nurse 3)* *I enjoy seeing how people see differently. I see a pen she sees a snake. Interesting listening to their stories. I listen to their problems. Many of the problems they have could have been solved -- with other people they are solved. It is interesting to consider why they led to this in these patients. (PUB-HW; Senior Ward Nurse 9)* *This job has taught me a lot. It has built me up. I am able to solve my own problems now, even personal problems. (PRI-1Senior Ward Nurse 2)* *I like working with psychiatrically ill patients. Just to have the technique, how to help them; to approach - its good. (PUB-1; Senior Ward Nurse 6)* *I like this work [psychiatry] very much. When I come here I know I will be laughing. I will be doing something. I wont regret at the end of the day. I go home and I know I have done something for the patients. (PUB-1; Senior Ward Nurse 7)* *Personally, I like to work with psychiatric patients. I have been working with psychiatric patients for most of my life. I only broke with psychiatric patients for two years. I like to communicate with them. They are very much interesting. (PRI-2; Senior Ward Nurse 1)* *I like to work with mentally ill patients because I like them, I sympathise with them, I feel sorry for them. I feel I am doing good work, otherwise I would have left ages ago. (PRI-2, Senior Ward Nurse 6*
Nursing	*I know that nursing field. I am so much interested in the nursing field. I know this field. I know I can excel. (PRI-3; Senior Ward Nurse 2)* *I like to see somebody being very ill, then apply the treatment myself, and see somebody improve. (PRI-1Senior Ward Nurse 6)* *I believe that nursing care is for the well being of others. I feel I reach that goal here and it makes me proud. (PUB-1; Senior Ward Nurse 3)* *I enjoy the opportunity to learn more about people and nursing offers this. I feel fulfilled when people can get well because I have nursed them. (PUB-1; Senior Ward Nurse 4)*

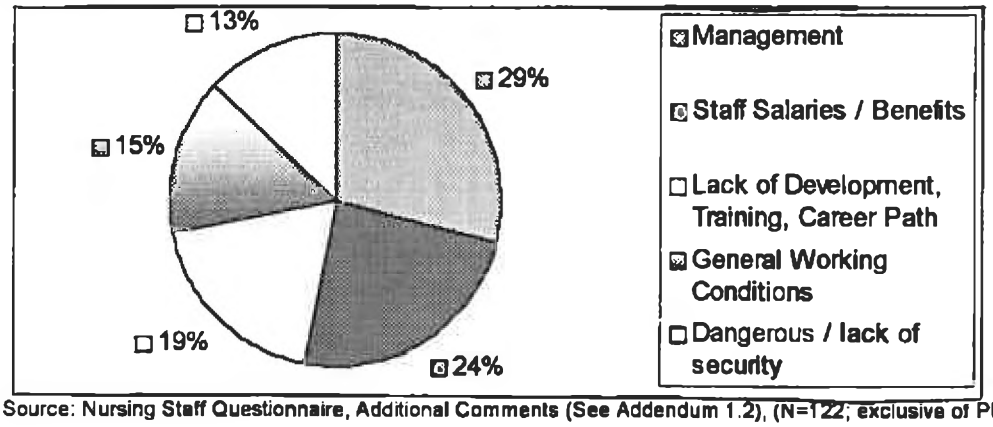
staff questionnaire (35%, N=122). The three most pronounced frustrations were their punitive approach to managing ward based staff, lack of support, and lack of participatory channels for staff to input into management decisions. See Chapter 5-2: Nursing Staff.

b. Development Opportunities

- *The majority of nursing are very de-motivated. They feel they are being abused... There is no career path... (PRI-3; Senior Ward Nurse 8)*
- *One big issue in this hospital is that it is very difficult to get upgrading. There is a lot of talk about upgrading courses and experience but it is not happening in practice. Access to this is controlled by the HO of Lifecare – and the HO is inaccessible to us. It seems that the only opportunity for upgrading is for a sister to get the psychiatric bar – but no upgrading / opportunities for [other] nurses. (PRI-3; Senior Ward Nurse 2)*

As was discussed above, approximately 60% (N=122) of comments on nursing staff questionnaires expressed a low level of job satisfaction. Beyond the frustration with management and low salaries and benefits relative to the value of work provided, the most common source of low satisfaction in these responses was the lack of development opportunities and career path. See Graph 5.2-11 below.

Graph 5.2-11: Nursing Staff: Source of Low Satisfaction



Source: Nursing Staff Questionnaire, Additional Comments (See Addendum 1.2), (N=122; exclusive of PUB-HW)

5. Staff Support

One of the most pronounced cross cutting themes was nurses' perceptions of a lack of support from senior management. Nursing staff across hospitals perceive management to be oriented toward the identification of mistakes rather than the acknowledgement of successes. A common theme in nursing staff interviews was a perception of being abandoned when difficult situations arise at the ward level.

Only 50% (N=318) of nursing staff across hospitals say they feel supported in their work. The lack of support was particularly perceived in terms of senior administrative management. Relatively more staff perceive support from their direct ward supervisor (64%, N=318). The greatest number of nurses perceived support from ward based colleagues. Graph 5.2-12 demonstrates indirect measures of staff perceptions of support from these groupings. While the measures are only indirect, they support the conclusion that staff feel support from colleagues, and to some extent

6.1. Competence

Competence is defined as the combination of skills, knowledge, and attitudes required to successfully carry out a function. The first question we ask is what is the 'basic competence' for a ward based nurse in these hospitals? Traditionally, it has been a loose combination of technical nursing skills and an ability to relate with compassion to mentally ill patients.

We did not assess nursing staff competence directly. However, our data did not suggest that nursing competency was grossly problematic. Staff perceive themselves as having the required skills for the job[155], and demonstrate an attitude and value system committed to patient care, psychiatry, and the nursing field.[156] Our data does not suggest that poor quality in these institutions can be explained in simple traditional nursing 'competence' terms. That is, investing resources into training of nurses in the traditional competencies alone, in all likelihood, will not result in increased nursing performance.

However, throughout this report we have argued that the focus of ward based 'nurse' competencies in the future should shift away from medical nursing skills and toward developmental and social transformative skills. We will discuss this in more detail in relationship to nursing staff performance below.

6.2. Subjective Power

- *There is no progress, as if we are just marking time. If [a patient is] discharged, [they are quickly] readmitted, ... I am not going anywhere professionally. I am nursing the same patients who do not want to do anything or go anywhere. Not seeing any progress. Sometimes I think we are just being paid for nothing.* (PUB-HW; Senior Ward Nurse 10)
- *Given the time we have spent at the hospital, for me over ten years of my life, in retrospect, we have wasted our lives here. (PRI-2, Ward Nurse II9)*
- *I have been working here for 13 years. I consider leaving – I love the patients – but sometimes I think it is a question of integrity. For example, the diet for diabetic patients. Supper is around 4 or 5, they get four slices of dry bread. And then nothing until the morning breakfast. Diabetic patients need more in between. And yet they can get nothing. I have seen diabetic patients faint between meals. Here, you are trained to understand diabetes, and then not given the basic support to do what you know is right. (PRI-1, Ward Nurse II5)*

Subjective power, closely related to the common conception of 'motivation', is a combination of an intrinsic sense of self-efficacy, combined with experiences of success and achievement. Cook emphasises that experiences of success can build a sense of self-efficacy, while continual experience of failure can destroy such a self concept. (As performance builds capacity, under-performance can lead to a loss of capacity.)

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[155] 89% (N=318) of nurses across hospitals indicated that they feel that they have the skills required to do their jobs well. The only variables which came out significant in this analysis were very low functioning wards and psychogeriatric wards. More nurses in very low functioning wards did not feel properly skilled for their job ($p<.01$). While more nurses in psychogeriatric wards felt adequately skilled ($p<.05$). (See Addendum 1.2.) This suggests the need for additional training to support nurses in very low functioning wards.

[156] The nursing profession was one of few professions open to black women under the system of apartheid. There is a concern in our context that people entered the nursing field not because they were interested in nursing, but rather because there were limited professional options open. However, the proposition that this led to nursing staff without the required values of nursing in this sector were not confirmed in this study.

model is illustrated in Graph 5.2-13 below. This model suggests the areas of change which may make the most difference in terms of increasing staff performance over time.

The bold horizontal line marks the level of 'minimal standard of care that current nursing staff are achieving in these hospitals. This marks the line below which the nursing staff themselves feel that their individual integrity is grossly compromised. It is retained largely on the basis of a value set held by nursing staff in this sector. At present this line is equated with minimal custodial care requirements of bathing, feeding, and providing medications to patients.

Nursing staff enter these institutions with a competence level above this line, and differing levels of subjective power. Several nurses explained that when they first came to the hospital from training they were excited about 'making a difference' in the patients' lives, and were eager to apply techniques and knowledge they had gained through schooling.

Currently, hospitals do not provide organisational power (objective power). The lack of power to make day to day decisions in their work life is most pronounced for staff entering the system, who largely enter at the bottom of the nursing staff hierarchy. As such, incoming competencies and subjective power are not increased by organisational facilitation of success.

Instead, the lack of success and achievement, largely determined by organisational constraint, erodes subjective power over time. Over time, nursing staff lose their subjective power (their 'motivation') and sink to what is considered informally as the 'minimal standard of care.' Staff do not fall under this standard as it would conflict with a strong value system and training rooted in patient care. This value system and training is one of the biggest assets in the system.

The implications of this model is that staff 'competence' and 'motivation', per se, are not the limiting factor of the system. Performance, according to this model, can be facilitated in three ways.

First, the line defining the 'minimal standard of care' can be shifted up. This line is an informal line, accepted by nursing staff as the minimal standard of care, below which would compromise an internal sense of integrity. This line is defined by a complex combination of factors. Some lie in the organisational objectives and design of the hospitals themselves. A re-definition and re-organisation of these hospitals away from custodial care objectives toward developmental and socially transformative objectives will contribute toward integrating developmental and discharge facilitation work into the 'minimal standard of care'.

Second, incoming subjective power can be built upon rather than undermined by weaving in opportunities for graded successes. Presently, incoming subjective power is undermined by the combination of lack of support and the lack of experiences of success. The reversal of this is both an organisational design challenge and a management challenge. In terms of organisational design, the hospitals must be organised to achieve patient goals (developmental, discharge). This

Chapter 5.3: Equity and Racial Privilege

1. Introduction

The history of mental health care in South Africa is deeply rooted in a racialised approach to 'psychiatric care.' By the 1860's, patients were classified by race; by the 1890's, 'black' and 'white' 'lunatics' were segregated. Understanding of mental health, definitions of 'psychiatric care', and the allocation of resources were all related to the social construct of 'race'[158] (Foster and Swartz, 1997). In the context of this history, perhaps the most important indicator of quality is equity[159].[160] Said another way, in the context of this history, inequity is perhaps the most important pointer to poor quality.

In their 1995 report to Parliament, the Mental Health and Substance Abuse Committee stated, 'The policy of racial segregation and its inherent inequality logically implied the unequal allocation of resources. Historically white institutions remained better off compared to their historically black counterparts in terms of resources. There have not been any significant changes in this regard. Therefore, while the official policy is one of racial integration, in practice, the status quo remains.'

Two years later, at the time of writing this report, our conclusions are not different. Despite the adoption of a constitution based on the end of race-based privilege, service inequity based on historical racial privilege, continues with momentum contributed by both formal and informal forces. This section is designed to explore the extent of race inequity demonstrated in this study.

This section is limited by our study design. Five of the hospitals in the study historically only cared for black patients ('historically black' hospitals). Only one hospital in the study cared for both white and black patients, albeit in segregated wards. Post 1990 this hospital became integrated. Its 'historically black' wards were either demolished or dramatically upgraded. We refer to this hospital as 'historically white'.

This chapter is largely based on the findings of the one 'historically white' hospital as compared to the remaining 'historically black' hospitals. While the generalisability is limited, we believe the exploration of these findings is important in the context of a common condemnation of quality

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[158] The cost per patient day given to Lifecare for white patients was approximately three times that for black patients. (Foster and Swartz, 1997)

[159] Several studies have commented on the dramatic difference of care based on *apartheid* racial classifications (WHO (1977), APA (1979), RCP (1990))

[160] Equity is one of the most common components of 'quality of care' models. (Donabedian 1988, Whittaker, 1997). The

2.3. Quality of Care Comparison

> ➢ *[On assessing a 'historically white' hospital.] ...It is difficult to be objective, having only just returned from PUB-1. The disparity in care levels, patient functioning, services, skills, facilities, are extreme... (Researcher Site Visit Notes, HW)*

As was said previously the immediate visual differences between the one 'historically white' hospital and the remaining 'historically black' hospitals are extreme. It is like walking between two worlds. One world with rows of institutional beds in 'worker hostel' wards; the other world with diverse ward buildings divided into personalised bedrooms and living areas. One world where ward grounds meant concrete 'slabs'; the other world where grounds included large well maintained grassy areas for patients to walk and spend time. One world with mass 'mess halls'; the other world with ward based dining rooms. One world where patients wore institutional clothes and lived in institutionalised routines; the other world where patients were individually dressed and individually expressive.

Without going into the details of the quality indicators the difference in quality of care between these two worlds is unquestionable. The following sections, however, summarise quality of care differences in terms of structure, process, and outcome indicators in relation to the hierarchy of objectives framework.

The differences in terms of structural indicators is most dramatic. The 'historically white' hospital has dramatically higher quality inputs, whether in the form of staff, management, infrastructure, or supplies. Structural advantages translate into process and outcome advantages in terms of custodial and psychiatric rehabilitation indicators. Structural advantages do not translate directly into marked process and outcome advantages for developmental or social transformative indicators. The potential for positive relationships, particularly between staff and patients, are still undermined by the pressures of racist beliefs of many long term white patients.

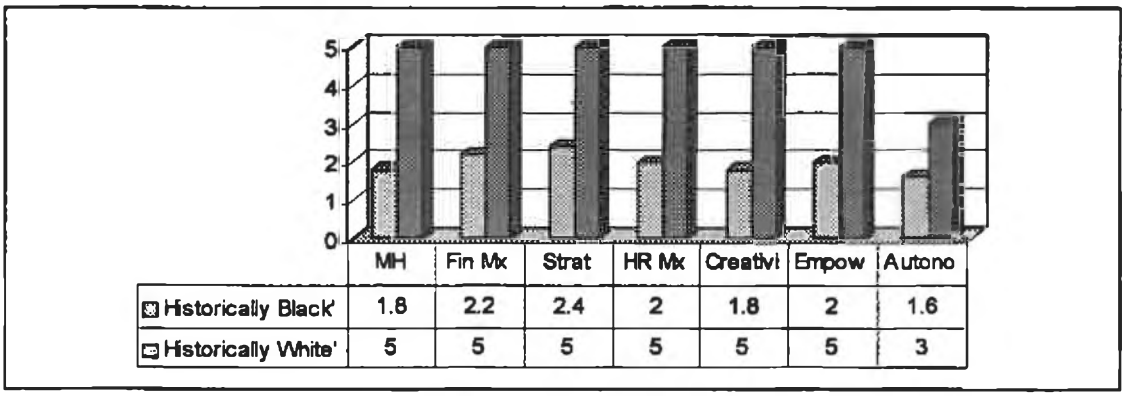
2.3.1. Structural Aspects of Care

All structural aspects of care evaluated, namely management, staff, infrastructure[161], and supplies were of dramatically higher quality in the 'historically white' hospital. These results are summarised in the table on the following page.

[161] Facility design and specifications were in fact dictated by the apartheid legislation of the time they were built.

management skills. Graph 5.3-3 demonstrates nursing staff perceptions of human resources systems. These differences were both statistically significant ($p<0.5$ and $p<.01$ respectively.)

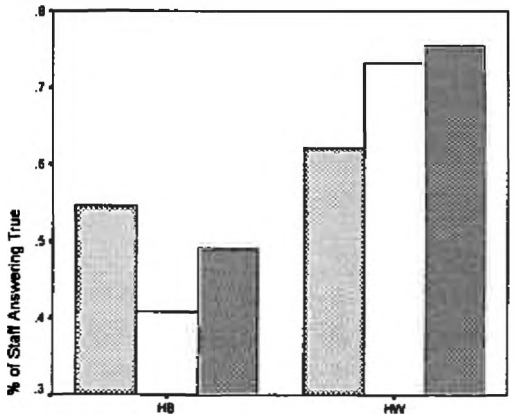
Graph 5.3-1: Management Skill Ratings Comparison



	MH	Fin Mx	Strat	HR Mx	Creativi	Empow	Autono
Historically Black'	1.8	2.2	2.4	2	1.8	2	1.6
Historically White'	5	5	5	5	5	5	3

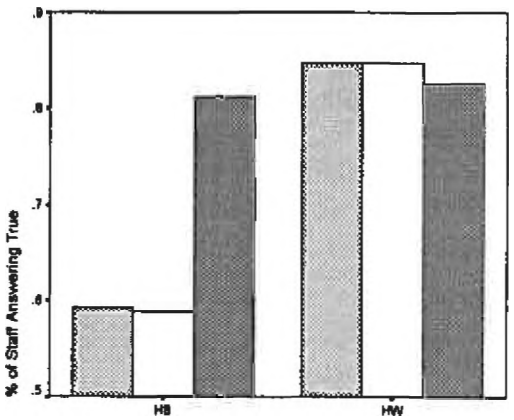
MH: Knowledge and understanding of mental health issues; Fin Mx: Ability to discuss financial management issues; Strat: Ability to talk strategically about hospital operations including strengths and weaknesses; Creati: Demonstration of sense of creativity in problem solving; Empow: Demonstration of sense of self efficacy and power in relationship to job; Autono: Degree of autonomy perceived by management.

Graph 5.3-2: Nursing Staff Perception of Management



- (Grey) The superintendent of this institution is not involved with the staff.
- (White) I think the superintendent[163] of this institution does a good job at keeping the hospital organised and well run.
- (Dark Grey) I think the senior matrons[164] of this institution do a good job at keeping the hospital organised and well run.

Graph 5.3-3: Perceptions of HR Systems



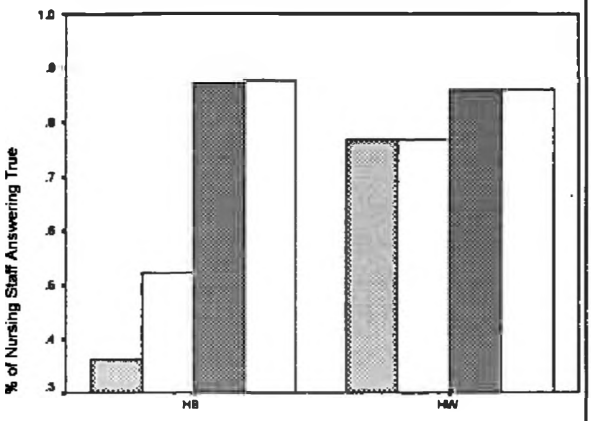
- (Grey) There is a good programme of in-service training to support and develop staff.
- (White) Staff are rotated through different areas to prevent 'burn-out'.
- (Dark Grey) When I began the job there was an organised programme to orient me to my new job.

management was the senior matron's knowledge of mental health field.

[163] The 'Superintendent' at the Lifecare hospitals is known as the 'Hospital Manager'. The questionnaire in Lifecare hospitals substituted 'Hospital Manger' for 'Superintendent' in this question.

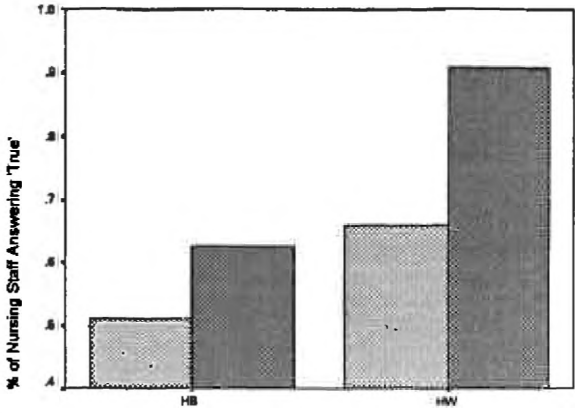
[164] The 'Senior Matron' at the Lifecare hospitals is known as the 'Nursing Services Manager'. The questionnaire in Lifecare hospitals substituted 'Nursing Services Manager' for 'Senior Matron' in this question.

Graph 6.3-4: Nursing Staff Perception of Satisfaction



- (Light Grey) Staff Satisfaction in Relation to Working Environment[165]
- (Light Grey Crossed) On the whole, I feel satisfied with my job.
- (Dark Grey) In general, I look forward to work when I get up in the morning.
- (Dark Grey Crossed) Satisfaction in Relating to Working with Mentally Ill Patients[166]

Graph 6.3-5: Perceptions of Support



- (Grey) I feel supported in my work here.
- (Dark Grey) My supervisor is skilled and knowledgeable, and is able to provide valuable input into my job.

c. Infrastructure

The differences between the 'historically white' hospital and the remaining 'historically black' hospitals are most visibly pronounced in terms of infrastructure.[167]

The 'historically white' hospital was designed for long term living comfort. Bedrooms are personalised, diversified and have an average of nine patients per bedroom. Bedrooms are separated by complete walls providing visual and audio privacy. Relaxation space is extensive including rest rooms, sitting rooms, television viewing rooms, and other discussion rooms. Wards have patios connected to well kept grounds. Inactive patients sit outside in patio chairs or well kept grass, or inside in furnished lounge areas.

The 'historically black' hospitals[168] reflect a different philosophy toward patient care. They are designed along the model of institutional hostels, with space dedicated to institutionalised rows of beds and minimal ablution facilities. Wards are open-plan spaces, filled with beds lined in rows. If

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[165] If I was offered a job (same responsibilities, salary, etc.) at a different mental health institution, I would take the job because I am not totally happy with the working environment here.

[166] If I was offered a job at the same salary in another field of work I would take it because I do not like the working with patients with mental illness.

[167] Facility design for black institutions were previously dictated by apartheid legislation. The differences in infrastructure reflect this legacy.

[168] Infrastructure indicators (buildings, grounds, outdoor recreational facilities, indoor recreational facilities, condition of walls, condition of ablution facilities, personalisation, distinctiveness) did not demonstrate a statistically significant difference between public vs. privately contracted 'historically black' hospitals. One privately contracted hospital scored markedly high, while the remaining two privately contracted hospitals scored markedly low. See Addenda: Observer Evaluation: Methods and Results..

'Historically white' hospitals provided dramatically better quality and magnitude of patient supplies. Clothes were plentiful and high quality, as was linen. Meals were well balanced with a variety of meats, vegetables, and starches. Supplements reached far beyond sugar and butter to peanut butter, deserts, biscuits, in between meal snacks. Provisions beyond clothes and food included items such as toothpaste, deodorant, etc. The differences in supplies are demonstrated in Table 5.3-4.

Table 5.3-4: Comparing Supplies

	'Historically Black'	'Historically White'
In-house Nutritionist	No	Yes
Meat	Boerewors, Liver, Stewing Meat	Beef, Chicken, Fish
Vegetables	Cabbage	Diversified
Starch	Maize, (Bread)	Bread, Rolls, Pap, Rice
Dairy	Powdered Milk	Fresh Milk, Cheese
Condiments	None	Sugar, Butter, Peanut Butter
Treats	None	Weekly Desserts

2.3.2. Process Indicators

The higher quality and quantity of structural indicators in 'historically white' hospitals translate interestingly to process and outcome indicators. While the 'historically white' hospital scored consistently higher on the majority of indicators measured in this study, we chose conservative assumptions in terms of determining the statistical significance of these results.

The 'historically white' hospital is achieving dramatically higher quality custodial / long term care. It scored significantly higher on quality of care indicators in this area. The only exception to this role was in the area of relationship indicators, which is discussed below.

While the hospital had more and higher trained medical personnel, there was not a statistically significant difference in psychiatric treatment scores between the 'historically white' and 'historically black' hospitals.

Similarly, while there were proportionately more staff dedicated to these areas, there was not a statistically significant difference in indicators relating to patient rehabilitation and social transformation services. While more developed in its acceptance of non-custodial care goals, the hospital is still designed to meet custodial care and psychiatric treatment objectives within its chronic wards.

Table 5.3-6: Relationships

Patient Perceptions	Nursing Staff Perceptions
➢ *I do not talk to the nurse. I hate them because they ill-treat the patients. The nurses are lazy, they just sit and drink tea the whole day ...There is nothing good about this hospital. It used to be good when whites were in this hospital...)(PUB-HW, PI3)* ➢ *They don't like me very much. It's a black-white relationship. I don't mind them. They do things to upset me. They say I haven't bathed and I'm dirty – that sort of thing. They make you feel small. (PUB-HW, PI6)*	➢ *There is still an attitude by white patients, 'I can't be nursed by a kaffir'. White patients will not give full information to black nurses -- only superficial information. When the white doctor comes they tell the whole story -- they trust whites and will tell them the truth. And this makes it look as if the nurses are not doing their job. (PUB-HW, Ward Senior Nurse 2)* ➢ *[In the still white wards...] They are like suburban whites who think that if blacks move next door the property value will come down. They protest that black patient go there because they say it will lower their standards. (PUB-HW, Ward Senior Nurse 3)* ➢ *Another problem is both patients and families look down on black staff -- meaning that we are not in a position to be therapeutic as they do not have respect for our input. (PUB-HW, Ward Senior Nurse 6)*

3. Equity Within Institutions

- ➢ *We recently began to admit white patients. They didn't like the place. They say the conditions are appalling. And the relatives complain about the quality of care. The white patients who are here are those whose relatives are not involved in their lives at all. [The others have been transferred back to 'historically white' hospitals.] (PRI-1, Ward Senior Nurse 3)*
- ➢ *The white patients are separate; they get a different diet and eat off proper plates. (PRI-2, Ward Senior Nurse 4)*
- ➢ *The race dynamics are still alive. Large large majority of hospital still black. Fairly recent integration of Indian and white patients. These patients complain about conditions more readily -- or at least their complaints seem to be heard more by management. They have mostly been put into section 4 -- a much smaller and higher quality ward than the others. This is said to be a 'high functioning ward' but on investigating the patient functionality ratings this does not hold true. White and Indian patients, regardless of functional level, for the large part are in this ward. (PRI-2, OE9-HW)*

Two 'historically black' hospitals have recently begun to admit non-black patients. A repeating theme in 'historically black' hospitals was that the few white patients admitted are provided with higher quality care. These quality differences are justified in the name of 'culture', but often represent quality increases for white patients that would be desired by all patients, regardless of 'cultural' background. The four common areas where differences were identified are outlined in Table 5.3-7: Different Standards of Care.

Table 5.3-7: Different Standards of Care

Placement in Higher Quality Wards	➢ *The race dynamics are still alive. There has been a recent integration of a few white and Indian patients. A new ward was recently opened, where most of the white and Indian patients have been placed. This ward is much smaller and higher quality than the remaining large mess wards. They call this the 'high functioning ward.' However, when I investigated the patient functional levels, this does not hold true. White and Indian patients, regardless of functional level, are placed in this ward. (Researcher Site Visit Notes)*
Different Diet	➢ *Patient care seems to differ. White patients who are admitted call other patients kaffir. They expect better care. Like buttered bread -- and they get it when other patients never get buttered bread. Our patients eat dry bread. There is one white patient who is eating butter, jam, peanut butter, 'wheatbix'. (PRI1, Senior Sister)*
Increased Amenities	➢ *The whites are given the highest quality of care, they say it is because of their culture, the nurses are not happy with this, they are given a different diet, they eat lunch and breakfast in a different place. The management give roll-on deodorant and perfumes to the whites only. (PRI-2, Ward Senior Nurse 6)*

is due to family pressure. See Table To Transfer or Not to Transfer....

Table 5.3-8: Perceived Barriers to Black Patient Access to HW Hospital Care

'Racial Sympathy' Among White Medical Practitioners	➢ *There is a pitying by the doctors of the white patients. Even if they are stabilised they will be kept because the families does not want them. At least 90% could go but families don't want them. Chronic patients are admitted d by long relationship with doctors in acute wards for years and years. (PUB-HW, Ward Senior Nurse 2)*
White Families 'Know the System'	➢ *Black patients are not admitted for chronic care. There are many reasons for this. Black families and patients do not know the game. White families know the bureaucracy. They come with the correct papers and documents and use the correct words. They know what symptoms to display and what to say to be admitted – for example, if a patient says they are suicidal they know they will be admitted. Black patients and families are not oriented to the bureaucracy. They are not oriented as to the procedure to admit. They come from far – from KwaNdebele, using all of their money for transport. When they arrive the doctors will ask them for forms from the police etc. etc. They will have no idea how to get them done. And so the doctors will send them home. (PUB-HW, Ward Senior Nurse 3)*
Communication Barriers	➢ *Black patients DO come for care, but are never admitted. They are treated as outpatients only. The race problem is still here. Maybe the admitting problems would change if we had a black psychiatrist / doctor come to do the work up. Currently, black patients cannot communicate with doctors and psychiatrists and therefore are not understood. (PUB-HW, Ward Senior Nurse 6)*

5. Summary

The 'historically white' hospital is providing higher quality of care than the 'historically black' hospitals (albeit within the confines of custodial and psychiatric rehabilitative care) in this study. While some of this quality difference is a reflection of the legacy of apartheid (for example, facility design was dictated by past policies), the continuation of differences in quality is a cause for concern.

While the formal policy is one of equal access to any institution, 'historically black' hospitals are still almost exclusively black, while the 'historically white' hospital remains with a majority of white patients. The underlying reasons for this include the momentum of informal forces such as the role of family expectations and clinical bias.

There is an emerging tendency in recently integrated hospitals to justify higher quality care provided to white patients in the name of 'culture.'

While this study only skimmed the surface of these issues, they should be examined in greater depth to ensure movement toward service equity on an institutional and national level.

2. Approach and Length of Contract Bidding

2.1. Approach to Contract Bidding

All contracts were negotiated on the basis of direct negotiation with a pre-selected contractor. In principle, the advantages of the process are initial ease, lower up-front bidding costs, and the development of a trusting relationship with the provider over time. Such a relationship, in an ideal setting, can be important in reducing the costs associated with monitoring the contract, and has particular value where the purchaser and provider have similar goals and motivations.

None of these advantages seem to have particular relevance to these contracts. Initial ease and up-front bidding costs are insignificant when compared to the long term financial costs of these contracts. The advantages of a 'trusting relationship' with regards to the current contracts also appear limited. While it appears that the relationship with the past government was 'comfortable' and that there was little expenditure on evaluating implementation (see below) this did not imply high quality service provision existed. The relationship with new government structures, which are expending more energy in assuring quality care provision, has become, in many instances, less comfortable, perhaps reflecting the different goals of the two agents.

There are also two important disadvantages of direct non-competitive bidding. Firstly, if the provider has more negotiating skills than the purchaser (in this case government), the contract can locate contract risks disproportionately on the side of the purchaser. The disproportionate risk burden of the public sector that is demonstrated in these contracts (see Section 6 below) suggests that such an imbalance existed at the time of contract negotiations. Second, non-competitive bidding does not encourage the emergence of additional suppliers and so leads to dependence on a private monopoly contractor. This accurately describes the sector today. However, while the government may have perceived a lack of alternative suppliers at the time of initial contract negotiations, the growth in the private and non-governmental sector means that there is presently more possibility of awarding contracts through a more competitive bidding process.

2.2. Length of Contracts

The duration of the contract has similar disadvantages for government. All contracts were long term. Contract A did not specify in the text the duration of the contract. It was signed in 1979 and is still binding. Contract B and C set the duration at 20 years.

The advantages of a long-term contract (reduction of ongoing frequent contracting transaction costs, and the establishment of a trusting relationship) appear to have been outweighed by the particular disadvantage of preventing government from periodically re-negotiating the contract to better meet its needs. Combined with government's lack of monitoring and evaluation, this led to the burden of risk being borne primarily by the public sector.

that the company shall provide 'suitable' transport. It specifies, but does not quantify, the provision of 'social workers', 'pharmacists', and medications. The specifications around medications allowed the company to reject some drugs prescribed on the basis of expense.

There are two provisions within Contract A whereby important quality of care inputs are to be determined jointly with the government – staff : patient ratios, and dietary guidelines. These ratios and guidelines have reportedly remained unspecified for the almost 20 year of the contract life.

The guidelines which are specified and Contract A and B, even if in vague terms, address custodial care objectives. At least 4 of 10 (contract A) and 3 or 5 (contract B) quality specifications are directed only at custodial care. The failure to achieve other objectives is consistent with the lack of specifications concerning developmental, family, and community services.

Table 5.4-2: Contract Specifications for Quality

Hierarchy Level	Contract A	Contract B	Contract C
Custodial Care Quality	• Infrastructure to meet 'satisfaction' of government (4a) • Meals according to 'agreed' dietary scales (4d) • Arrangement for burial of patients ('pauper funerals') (4f) • 'Proper attention' to recreational facilities (4k)	• Provision of food (9) • Provision of Nursing Services (9) • Hospital to be kept in clean, sanitary condition (17)	None specified
Psychiatric Treatment	• Provision of medications (with ability to dictate extent to which expensive medication prescribed) (4g/j) • Provision of pharmacists (quantity unidentified) (1f)	• Provision of Drugs (9)	There is an overarching but unclear clause relating to supervision of 'medical and nursing issues'. It implies that the state rather than the company per se is responsible for quality. While this clause may have been intended to provide the public sector with power for intervention, it in fact implies that the state, rather than the company, hold responsibility for quality in this area. [175] Patient labour and compensation will be 'in accordance with DoH' and monies kept in a trust for patients
Patient Rehabilitation	• 'Proper attention' to occupational therapy (4k) • Provision of 'teachers' (quantity not specified) (1f)	• 'The Department of Health shall be entitled to decide on the admission and discharge of patients at the hospital and the period and nature of the treatment of patients while in the hospital. (22)	None specified
Family and Community Services	• 'Suitable' transport (4h) • Provision of social workers (quantity not specified) (1f)	None specified	None specified

[175] The clause reads as follows: [Translation from Afrikaans] *'Where medical and nursing issues are concerned, the hospital will be under the supervision of the Department of Health, which will exercise control for the admission of patients to the hospital, the type of patient, the period and spectrum of treatment, as well as provide the necessary psychiatric and general medical coverage.'* (12)

offered an opportunity for monitoring and evaluation. In reality the annual fee adjustment usually took the form of the company submitting an annual audited letter requesting a fee increase, and the government signing. This was not a process of negotiating on the basis of performance.

5.4. **Joint Control Areas / Government Approval Required:** As stated above, Contract A specified areas (staff : patient ratios, dietary requirements) which were supposed to be determined jointly with the government. Contracts also identified areas where government approval was required[178]; these areas were focused on facility upgrades and improvements.

6. Distribution of Burden / Risk

One of the most important criteria on which to evaluate contract design is the extent to which burden or risk is distributed between the public sector and the service provider. Risk can be broken down into financial risk in relationship to price per patient day, and risk related to other contract specifications.

6.1. Financial Risk : Cost per Patient Day

The financial risk to the private sector in terms of the cost per patient day were minimal given the ability of the privately contracted hospitals to transfer high care patients back to the public sector, combined with the lack of quality specifications.

The cost per patient day ranged between R35 and R65 across hospitals. That is, the highest price almost doubled the lowest price across hospitals. Given the lack of documentation to the contrary, it may be assumed that the public sector negotiators did not have an understanding as to how much a reasonable 'cost per patient day' should cost. The differences in price may also suggest that there was little collaboration between public sector negotiators between provinces.

The lack of a rational basis for contract negotiation across provinces left the public sector vulnerable to large price differences. This, combined with the lack of quality specifications meant that contract price and quality outcomes were not rationally linked.

The relationship between quality, production costs, and price per patient day is discussed in more detail in Chapter 6: Discussion and Summary: Cost and Quality of Care. Risk and burden in relation to contract specifications is discussed here.

6.2. Contract Specification Burden and Risk

Table 5.5-3 summarises the distribution of burden / risk specified in these contracts.

The contracts are designed with burden / risk distributed between the public sector and the patient population, with little to minimal burden / risk residing with the service provider.

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[178] Areas where contract specifically specified need for government approval were: Contract A: New accommodation, major alterations, and extensions to existing buildings (4b); Major items of equipment or subsequent major additions (4c).

7.1 Private Sector Opportunities

There are several reported advantages of providing service through the private sector, financed by public resources. The following summarises the extent to which some of the most common advantages associated with private sector contracting were observed in this study. (Doherty, 1997).

1. **Specialised Expertise:** One assumed strength of the private sector is its 'specialised expertise, especially in areas that are not a core competency of government, or which government does not think are its highest priorities (Doherty, 1997).

   This strength is not demonstrated in the context of hospitals in this study. The privately contracted sector does not have a dramatically better skill set than the public sector hospitals.

   Further, mental health services continue to be a priority area for public health services (National Department of Health, 1996) and, according to current government policy do not fall outside the scope of core competencies.

2. **Decentralised Management and Improved Managerial Efficiency:** A second assumed strength of the private sector is a more decentralised management structure with greater *expertise* and *flexibility* leading to a more productive use of resources. The assumption is that private sector management structures will be less bureaucratic and more responsive than public sector bureaucracies.

   However, the private sector company in this study is a large bureaucracy with centralised managerial power. Management in both the public and privately contracted hospitals in this study were found to share a bureaucratic, hierarchical, non-responsive structure. (See Chapter 5.2: Management.)

3. **Flexibility:** Closely linked with the potential for managerial efficiency, is the argument that private sector companies are more flexible, for example in adjusting staffing allocations. As was explored in Chapter 3: Cost Findings, staff allocations seem to be better adjusted to patient load within the privately contracted hospitals. This is suggested by PRI-3, which as a much smaller patient load, and a correspondingly smaller budget and staff allocation. Thus, the patient : nurse ratio of between 6 and 7 is maintained across the privately contracted hospitals despite differences in patient load. However, the quality of care data suggest that the staffing allocations are not necessarily allocated in terms of patient care requirements.

4. **Responsiveness and Access to Technology:** Again, linked with the potential for managerial efficiency, is the argument that private sector companies are more responsive and adjust more quickly to changes in price, technology, and demand than the public sector. The private sector is also presumed to have better access to new technology and innovations. There was no evidence of more efficient incorporation or quicker access to new

7.2. Private Sector 'Dangers'

There are several arguments against the shift of public services into the private sector. Commonly cited dangers are discussed, and the extent to which these dangers have been demonstrated in this study are summarised.

1. **Labour Relations:** Organised labour has argued strongly against the shift of public sector services to the private sector. Included in their argument is that union rights and job security may be depends at least partially on their relationship to management, this area becomes important in this context.

   1.1 **Union:** There was a strong perception among union representatives at privately contracted hospitals that there was a concerted national company strategy to destroy the union. Union demands were allegedly met largely with hostility. There was perceived favouritism to non-union staff. The company facilitated the establishment of a counter union, 'non-union body' allegedly designed to split worker allegiances. Union members were hesitant to discuss union operations openly, allegedly for fear of victimisation by management.

   While union representatives from the public sector had concerns about public sector management and operations, they were confident of their right to exist and of channels for functioning. Public sector union members spoke of their membership and union activities openly.

   1.2. **Job Security**: There was a stronger sense of job insecurity at the privately contracted hospitals, manifesting strongly in staff's unwillingness to speak openly about hospital functioning.

2. **Staff Development and Support / Reduced Investment in People:** There is an argument that private sector management will lead to less investment in human resources and training, particularly when not directly linked to profit gains (CSEA, 1995). Nursing staff at public hospitals perceive opportunities for in-service training and development, as well as day to day job support in more positive terms than staff at privately contracted hospitals. See Chapter 5-2: Nursing Staff.

3. **Risk Selection / 'Cream Skimming':** Risk selection refers to the private sector tendency to select less expensive patient populations, leaving risk and expense to the public sector services. This study found evidence of such practices.

   Nursing staff were asked to describe when patients are transferred between the public and privately contracted sectors. All respondents provided a common understanding of the transfer relationship between these institutions. Patients who are stable and apsychotic are transferred to privately contracted hospitals for long term care. Patients are transferred from privately contracted hospitals back to public hospitals when they become

8. Summary

The contracts were not designed to promote quality or efficiency. The quality specifications which did exist were vague and related only to custodial care objectives. There were no penalties for non-performance. Monitoring mechanisms were non-existent, specified in vague terms, or ineffective in practice. The contract price increased annually despite little or no evaluation of performance. The design of the contracts places risk disproportionately on the public sector and the patient population, with little to minimal risk residing with the service provider. The low quality outcomes – minimal achievement of custodial care objectives – flows logically from this design. A more detailed discussion of the relationship between these cost, quality, and contract findings is explored in the following chapter.

In terms of cost to the public sector, 'historically black' public hospitals cost between 1.6 and 1.8 times[187] the contract cost of the privately contracted hospitals. The 'historically white' hospital costs approximately double[188] the contract cost of the privately contracted hospitals.

1.2. Understanding of Cost Findings

These cost differences are explained almost entirely by personnel expenditure. The personnel cost per patient at 'historically black' public hospitals is more than double the privately contracted hospitals while the personnel cost per patient at the 'historically white' public hospital is more than triple the cost at the privately contracted hospitals. The dramatic personnel expenditure differential reflects differences in the number of staff per patient, rather than salary scale differences. Table 6-1 demonstrates this relationship between staff, and staff : patient ratios specifically, with overall cost outcomes. For a more detailed outline of personnel and overall cost findings see Chapter 3: Cost Findings and Chapter 5-2: Nursing Staff.

Table 6-1: Comparing Sectors: Personnel Costs vs. Overall Costs

	Cost / Patient / Day	% of Budget	Personnel Cost / Patient / Day	Patient / Nursing Staff	Ave annual Nursing Staff Salaries
Privately Contracted (PC)	R34	74	R25.2	6.4	R56970
Public HB (Pub-HB)	R78	78	R61.1	3.1	R62204
Public HW (Pub-HW)	R97	78	R75.3	2.7	R62359
PC / Pub-HB	*0.44*	.95	*0.41*	2.06	.95
Pub-HB / Pub-HW	*0.80*	1	*0.81*	1.15	1.00
PC / Pub-HW	*0.35*	.95	*0.33*	2.37	.95

Note: This table is calculated using the costs calculated for each hospital assuming that excluded costs are negligible.

1.3. Summary: Factors Underlying Cost Outcomes

Table 6-2 summarises characteristics of hospitals and costs across hospitals and sectors. This data, suggests four primary factors which may underlie these cost outcomes.

[187] The 'historically black' public hospitals cost 1.6 times the contract price of the privately contracted hospitals assuming the excluded costs contribute a negligible amount to overall costs. The 'historically black' public hospitals cost 1.8 times the contract price of the privately contracted hospitals assuming the excluded cost account for up to 8% of total costs.

[188] The 'historically white' hospital cost 2.0 to 2.2 times the contract price of the privately contracted hospitals if excluded costs are negligible or represent up to 8% respectively.

1.4. Production Cost vs. Contract Prices

Three key points emerge in reference to the relationship between production costs and contract prices in this study.

The first key point is the extent to which profit margins calculated in this study (approximately 23%) deviate from profit margins reported by the company. There are alternative explanations for this discrepancy. First, the excluded costs may account for more than 8% of the total budget which would result in lower profit margins. Alternatively the method used to calculate costs (especially capital costs) in this study could be different from that used by the company.

The second key point is in reference to profit margins. The average difference between production costs and contract costs was calculated to be within the range of 23 and 29 percent (assuming excluded costs represent up to 8% of the total budget). (We consider the average across the three hospitals since the hospitals are not operated as individual profit centres but rather are part of a centralised corporate management structure.) In the context of an inflation rate of around 8 percent this implies real profits of 15 to 21 percent, which are probably quite high for what is a low risk activity.

The last key point is in reference to the relationship between the contract prices and the production costs across hospitals. The contract prices across the three hospitals ranged widely between R35 and R65 per patient day. The production costs across hospitals, on the other hand, clustered within one rand of R34 per patient day. Thus, there was no evidence that an increase in the contract price translates into more investment of resources into a hospital.

2. Summary: Quality of Care Differences Between Sectors

2.1. Overview

The previous chapters examined quality of care outcomes in detail, according to a hierarchy of objectives framework. Differences between public and privately contracted sectors were highlighted and discussed. This section is designed to summarise these differences.

Before moving forward, we need to again point out that we did not aggregate quality outcomes into one final quality score. The following summary therefore, is meant not to declare a 'quality winner' but to identify the areas demonstrating quality of care differences between sectors.

The 'historically white' public hospital demonstrated significantly higher levels of quality, with specific reference to custodial care and psychiatric treatment objectives. See Chapter 5.3: Equity and Racial Privilege.

The differences between 'historically black' public and privately contracted hospitals are summarised below. The differences between the two sectors were very limited. The differences were demonstrated more clearly in the qualitative data results. The quantitative results revealed fewer significant differences.

2.3. Structural Indicators

The largest differences between sectors reflected structural indicators. A summary of these differences is illustrated in Table 6-4. The largest difference demonstrated between sectors was in reference to staff complement. Privately contracted hospitals had dramatically fewer staff per patient than public hospitals. (See Chapter 5.2: Nursing Staff.) Differences were also demonstrated in the area of infrastructure, with privately contracted hospitals having higher patient density statistics per ward unit. (See Chapter 4.3: Custodial Care.) Few clear differences were identified with reference to management and staff quality (including skill, support, and satisfaction).

Table 6-4: Comparing Public and Privately Contracted Sectors: Structural Indicators Summary

	Public Sector	Privately Contracted
Management	Centralised, Bureaucratic, Non-Responsive	
Staff Complement	8 Patients : 1 Professional Nurse 5 Patients : 1 Non-Professional Nurse	36 Patients : 1 Professional Nurse 8 Patients : 1 Non-Professional Nurse
Staff Performance	Basic Custodial Care Requirements Achieved	
Staff Satisfaction	Low	
Infrastructure Design	Hostel Design	
Infrastructure Density	Average 44.5 Patients Per Ward	Average 209 Patients Per Ward
Supplies	Lacking / Minimal Custodial Care Requirements	

2.4. Process Indicators

The majority of process indicators did not demonstrate significant quantitative differences between public and privately contracted hospitals. However there were qualitative and style differences demonstrated in the areas of basic care routines, time between basic care routines, the staff – patient relationship, and the ward based patient administration system. While these differences were largely qualitative, and issues of 'style', they are important when considering long term care for the mentally ill. These differences are summarised in Table 6-5, and discussed briefly below.

- **Basic Care Routines:** Basic care routines are achieved in both public and privately contracted hospitals. They occur in more depersonalised routines in privately contracted hospitals.
- **Time Between Basic Care Routines:** Time between basic care routines is not used to develop patients in either public or privately contracted hospitals. But whereas the majority of patients are largely left to lie, sit, or wander in public sector hospitals, patients are organised into large groups in private sector hospitals, where patients largely sleep or sit unoccupied.
- **Staff – Patient Relationship.** The relationship between staff and patients is perceived in positive terms by patients across hospitals. However, while both public and privately contracted nurses perceived their relationship with patients in positive terms, public hospitals

public hospitals. Wards, on average, were larger. Care was organised into large group routines. As compared to this 'group routine' approach to care, public hospitals' approach to care was somewhat more individualised.

All hospitals in this study share a place in space and time – suspended between their awareness that they no longer should be an emblem of custodial care and yet having little to no orientation toward patient rehabilitation or discharge. The place is a painful one. It is characterised by good one-line answers, answered in careful monotones as if rooted to a terminology used but not understood, later transforming to heartfelt confessions of inadequacy – articulated with animation, compassion, guilt, and hope. These hospitals, with a history rooted deeply in custodial care, continue to fail – in theory and practice – in their patient rehabilitation role.

The hospitals are currently not transformative systems. For the most part they see families and communities as undermining of patient discharge, but as outside of their hospital mandate. The outcome, for the most part, are enclosed and socially detached systems; worlds unto themselves; protected from change; protected from possibility.

If there is one critical finding emerging from this study it is that patients are currently enduring low levels of care in these hospitals. In the spirit of an emerging commitment to human rights, these hospitals need to be put on the centre stage for health sector improvement.

3. Contracts and Quality Outcomes

The lack of quality performance is consistent with the contract designs. The contracts were not designed to promote quality or efficiency. The quality specifications which did exist were vague and related only to custodial care objectives. There were no penalties for non-performance. Monitoring mechanisms were non-existent, specified in vague terms, or ineffective in practice. The contract price increased annually despite little or no evaluation of performance. The design of the contracts places risk disproportionately on the public sector and the patient population, with little to minimal risk residing with the service provider.

The low quality outcomes – minimal achievement of custodial care objectives – flows logically from this design.

4. Comparing Cost Items: Cost vs. Quality

The relationship between personnel cost / quantity with personnel performance is complicated. The low levels of staffing at privately contracted hospitals appear to compromise important aspects of quality. The low staff : patient ratios, for example, seemingly leave staff unable to achieve basic daily care routines except in depersonalised group routines. Further, staff : patient ratios were a common significant factor in predicting nursing staff perceptions of hospital quality. The regression analysis of the nursing staff questionnaire identified the nursing staff : patient ratio as a strong predictor of lower quality in terms of specific sub-scale outcomes. Nurses in wards with a lower

5. Conclusions: Hospital Cost and Quality

The findings and discussion in the previous chapters lead us to the following conclusions:

- The privately contracted hospitals cost the least per patient day. However the relatively low costs are associated with low quality outcomes across these hospitals.
- The 'historically black' public hospitals appear to be the least efficient tier. While it costs approximately 1.6 times the contract cost of the privately contracted hospitals per patient day, its quality of care gains are less pronounced. [191]
- The 'historically white' public hospital cost the most per patient day. This hospital cost double the privately contracted hospitals, and 1.2 times the 'historically black' public hospitals. It is the only hospital in the study, however, whereby inputs translate into some measurable quality of care. The quality of care at this hospital, with reference to custodial care and psychiatric treatment, is far superior to the remaining hospitals. In this way it may be argued that the increased costs are explained, and therefore justified, by the higher quality of care outcomes. Further, this hospital is an academic hospital; the greater costs must be considered in the light of its dual patient care and teaching objectives.

  Before recommending this hospital as a model for hospital improvements, we must consider several questions emerging from our findings. First, this study motivates that chronic psychiatric care be transformed to a more rehabilitative and social welfare model. This argues against locating large numbers of chronic psychiatric patients in hospital facilities. If hospital facilities are used, how can they be transformed to achieve objectives of rehabilitation and social transformation? Second, even if it were desirable, could the national health system, in the context of current restrictive national economic policy, afford to equalise services on the basis of the costs of this hospital? If not, should we maintain quality at the 'historically white'? Can we (and should we) move toward equity in resource allocation without undermining the one centre of relative excellence in the process? And thirdly, this study suggests that not all quality advantages demonstrated in this hospital were rooted in higher costs. How can we better isolate these non-budgetary advantages and better develop them in the remaining hospitals?

[191] Again, this is a difficult judgement to make. The quality of care advantages of the public sector include greater individual patient attention, a higher staff-patient ratio, and the more positive view of staff-patient relationship. Given that the differences in these areas were at times subtle, with particular reference to outcome measures, we judge these differences conservatively. Therefore the quality advantages are judged to be less pronounced than the cost differential.

quality care, the question then becomes, how can the public sector either transform itself, or the contracting partner to produce higher quality outcomes?

If contracting is continued, the nature of the censures and incentives, both in terms of the contract and relationship, must be transformed with the explicit objective of changing these institutions. Greater initial investment to establish balanced contracts and develop the monitoring and evaluation capacity of the public sector are prerequisites to the continuation of contracting with a commitment to quality.

In terms of relationships, contracts must be negotiated with a provider who can ultimately be cultivated as a service 'partner' sharing public sector values for transformation of services toward equity and quality provision of care. While the interests of the contracting partner cannot be assumed to be in line with public sector interest, censures and incentives must be oriented toward the providers' adoption of public sector objectives. This is particularly important in the context of other recommendations emerging from this study. This study motivates for the transformation of hospitals from simple medical models to a socially transformative model, where principal operations shift from psychiatric to rehabilitative and social welfare service. This implies intersectoral collaboration with primarily public sector services. This will be achieved largely on the basis of a shared 'core value' between local management and other public sector services. The complexity of establishing this type of relationship with a private partner needs to be appreciated in considering the viability of, and options for, private sector contracting .

Another aspect of the 'relationship' which requires change is the development of a strong monitoring capacity of the public sector. Contracts must be negotiated only if the government has a strong monitoring and evaluation capacity. Contracting in the absence of a strong monitoring capacity of government runs a high risk of patients receiving sub-standard levels of care.

In terms of the contract itself, contracts must be negotiated so that penalties and incentives are oriented toward the institutional changes desired. This includes negotiating contracts on the basis of explicit quality performance indicators and including incentives for performance and penalties for non-performance. This type of contract negotiation implies a greater degree of symmetry between the government and the provider in the negotiating process.

The alternate option available to the public sector is to transform its own services to more efficiently produce quality psychiatric care. The internal transformation challenges are somewhat distinct, but also overlap the challenges related to private contracting. Quality improvement in the public sector would equally depend upon clearly specified performance objectives (either in the form of 'public contracts' and / or explicit norms and standards) and the ability of the public sector to monitor quality outcomes. Quality improvement within the public sector would also require the public sector to be directly involved in local management development and the development of integrated quality improvement systems at the hospital level.

avoid the 'shows' that can be easily achieved in the context of very short-term visits. The Observer Evaluation (Addendum 1.3) provides a useful starting point with reference to a tool to guide direct observation at the ward level.

3. Future assessment processes must be rooted in explicit (as well as debated and changeable) 'standards of care' understood by hospital stake -holders. Service standards should either be easily measurable or define part of a minimal safety net for patients, providing important principles for purposes of recall. They should be designed to identify achievement as much as service failures. Tools such as those used in this study should ultimately be rooted in these service standards.

4. Ultimately ongoing service quality will not depend upon a strategy of monitoring quality, but on the growth of a 'culture of quality' reaching from management, to staff, to service users. This includes a management culture of proactive rather than retributive performance management. This includes building a staff culture of confidence, self-criticism, and creative initiative. This includes a service user culture of rights, protection, and recall.

5. Quality assessment, without guiding service improvement, should not be a priority. The development of a quality assurance system (which contributes toward the growth of quality) is an urgent priority. Such a system can utilise the model, tools, and lessons from this study, but must be rooted in management, staff, and patient objectives and expectations for hospital improvements, and designed to inculcate a spirit of reflection among hospital stake holders.

9. Way Forward: Long Term Care Function and Form: Where Should We Go?

One of the most critical conclusions of this study is that patients are currently enduring low levels of care in these hospitals. In the spirit of an emerging commitment to human rights, improvement of these hospitals – whether public or contracted – needs to be put on the centre stage for health sector improvement. Without clear vision and strong public management for change, there is no evidence that these hospitals will being to transform themselves.

Hospitals are not currently structured (in terms of both function and form) to meet objectives beyond minimal custodial care and medications oriented psychiatric treatment. As has been said, and confirmed by the Gauteng Mental Health Directorate (1997), patients are characterised as much for social displacement and social / behavioural impairment as their psychiatric diagnosis or symptoms. The hierarchy of objectives framework developed for this study helped us recognise that hospitals are currently not reaching levels of patient rehabilitation nor family and community services. The organisational design does not cater to patient needs, and thus outcomes (most importantly patient discharge) are not achieved. The experience of the study, then, supports the call for a strategic redesign of these institutions.

The 1997 White Paper on Health (National Department of Health, 1997) provides principles to guide the transformation of mental health services. The core principles include a move away from

welfare. Our experience suggests that a great many of them are. The proposition that hospitals are primarily serving a 'control' rather than a 'developmental' purpose, is meant, rather, to challenge policy makers to recognise the historical momentum behind 'controlling' policy in order to steer away from this rutted track.

While the Constitution, and more specifically the 1997 White Paper for Health Transformation, provide a policy scaffolding which theoretically breaks away from 'controlling care', it will remain a challenge to policy makers to ensure that the tradition does not persist due to the power of its momentum alone. This challenge should provide a backdrop for policy formulation and change initiatives in the future.

The second proposed shift relating to both the function and form of long term psychiatric care is a move away from a strictly medical model and toward a more 'developmental' model.

Hospitals within this study are organised according to a bio-medical model of care. Care is organised into 'hospital' spaces, on the basis of 'hospital wards', and staffed primarily by medically trained personnel.[192]

Diagrammatically, these hospitals are organised according to a simple medical model – a linear model whereby one is seemingly able to isolate the input and output stages. The 'process' is often drawn as a black box, implying that the process itself is responsible, in relative isolation, for a favourable or unfavourable result. In this case, the 'process' is psychiatric care – in the hands of professional psychiatric nurses and psychiatrists.

The fact that there is no output from this system in the form of high rates of sustainable discharge suggests that there is a problem with the *process* or with the *model* generally. Both need to be reviewed.

Again, it is useful to return to the Gauteng Mental Health Directorate study. Out of 60% of patients who were considered not to be ready for discharge, only 15% were not dischargeable because they were actively psychotic. The remaining 85% of patients were considered not dischargeable for a combination of non-psychiatric treatment requirements. They were either deemed to be too low functioning to live in the community without active supervision, or had no family contact to support discharge.

Long term patients, then, have impairment (social, behavioural etc.) which reaches beyond psychiatric symptomatology. If this impairment is *not* addressed through *rehabilitation and social*

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[192] Foster and Swartz point out that the medicalised control over the mental health sphere was not always the norm internationally, 'There was a long political struggle to wrest control over the fate of those identified as 'lunatics' from the jurisdiction of magistrates, on the one hands, and churchmen on the other. Medicine won; and in Europe and the US, a medical hegemony has been in place roughly over the past one and a half centuries. South Africa inherited the consequences of this process...' (Foster and Swartz, 1997).

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