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Health care reform in Iran: Implications for nurses' moral distress, patient rights, satisfaction and turnover intention

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Abstract

Aim: The aim of the present study was to assess the implications of Iran's recent health care reforms on nurses' experience of moral distress, their perceptions of the respect for patient rights and the relationship of these variables to job and income dissatisfaction and turnover intention.

Background: Health systems around the world are reforming themselves to adapt to meeting the future needs of increasing patient care to an ever-growing population.

Methods: This was a cross-sectional correlational study. The participants were 276 nurses at six large private and public hospitals in Tehran, Iran.

Findings: Negative correlations were reported between turnover intention and respecting patient rights ($r = -0.560$, $p < 0.001$), satisfaction with job ($r = -0.710$, $p < 0.001$) and satisfaction with income ($r = -0.226$, $p < 0.001$). The correlation between moral distress intensity ($r = 0.626$, $p < 0.001$) and frequency ($r = 0.701$, $p < 0.001$) was positive with turnover intention.

Conclusions: Moral distress was significantly correlated to poor respect for patient rights, poor job satisfaction and income satisfaction and was a major predictor of turnover intention.

Implications for Nursing Management: Health system reform must take into account the concomitant increasing workload and its negative impact in order to ensure that reform does not lead to unintentional detrimental outcomes of increased moral distress, decreased satisfaction and increased turnover rates among nursing personnel.

KEYWORDS
health system reform, job satisfaction, moral distress, nurses, patient rights, turnover intention

1 | INTRODUCTION AND BACKGROUND

Inequalities in health services in many countries of the world have led to reform programmes in their health systems. These programmes have been conducted in countries such as Australia, Korea, Germany, China, Chile and the USA (Burrows, 2008; Gerlinger, 2010; Jones, 2014; Louviere & Flynn, 2010; Maxwell & Shields, 2014; Wang, Gusmano, & Cao, 2011). Health services reforms are being implemented at a time when the nursing sector is plagued by a number of constraints and tensions, in particular a shortage of staff and general resource limitations.

There are a number of external and internal environmental constraints that are fuelling these shortages. From an external perspective, an ageing population and chronic disease is exacerbating this shortage (Grant, 2016). The population of senior citizens is increasing with an increase of 75% being forecast in the USA between 2010 and 2030 (Knickman & Snell, 2002). According to the National Council on Aging in the USA the majority of senior citizens are

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plagued with at least one chronic illness. In Iran the population of elderly people has also increased significantly over the past 40 years. It is estimated that 10% of the population is over 60 years of age, many of whom have at least one chronic disease. Such an increase in elderly people with chronic disease places a further increasing demand on health care services (Koiek & Gharib, 2013).

In Iran the ratio of nurses to patient is 0.5–0.8 as compared with more developed countries where it is noted that the ratio is 1.8. Nursing shortages are thus a chronic problem in many countries including Iran. Several studies have shown that nursing staff shortages in Iran are caused by multiple factors. In particular, low wages and poor working environments characterized by moral distress have been implicated as causal factors of nursing shortages in Iran (Azimian, Negarandeh, & Fakhr-Movahedi, 2014; Dehaghani, Akhormeh, & Mehrabi, 2012; Ghasemi, Negarandeh, & Janani, 2017; Mosadeghrad, 2013; Tabatabaee, Nekoie-Moghadam, Vafaee-Najar, & Amiresmaili, 2016; Valizadeh et al., 2016; Zarea, Negarandeh, Dehghan-Nayeri, & Rezaei-Adaryani, 2009).

Thus these constraints and tensions are further compounded by health care reforms that expand coverage and thereby further increase patient numbers. This is clearly evident in Iran's health care reform system which was inaugurated in 2014. Aimed at reducing inequalities in the provision of health care to all sectors of the population, the expansion of free services and greater government subsidization of insurance coverage has led to a number of unintended and drastic consequences (Heshmati & Joulaei, 2016). As a result of these measures peoples' recourse to public health services has increased significantly. However, the number of health care personnel has not increased at a commensurate rate.

Expanded health coverage to the public has thus led to an increase in the workload of nursing personnel working within Iran's public health sector. Furthermore, nurses' wages in Iran have not increased proportionally with increasing workloads. These issues have impacted negatively on nurses' psychological well-being and job satisfaction and have escalated their turnover intention within the profession. In an environment characterized by work overload and shortages of personnel the nursing shortage crisis in Iran has thus been aggravated. Further problems within Iran are poor specialist/physician and nurse to patient ratios, particularly in rural areas. This has led to an influx of patients from rural areas to urban centres exacerbating the patient load in such centres. Many hospitals in Iran are also constrained by a lack of resources. Shortages of equipment and/or poorly working, ageing equipment also hamper the system's ability to meet the need of increased patient loads. As a consequence, this massification of patients into the public sector; that is, all government hospitals, has led to an overall decline in care.

Moreover, the private sector is not exempt from the effects experienced in the public sector. Physicians and specialists seeking better working conditions and higher fees have led to a haemorrhaging of such personnel from public to private hospitals (Bahadori, Ravangard, Alimohammadzadeh, & Hosseini, 2014). This further reduces the ratios of physician/specialist to patient and nurse to patient, placing greater pressure on public sector nurses. In turn, a decline in care in the public sector care leads to a greater flow of patients to the private sector.

2 | LITERATURE REVIEW

As outlined above, the research literature has implicated a number of negative factors as unintended consequences resulting from health care reform both internationally and within Iran (Bahadori et al., 2014; Mahdavi, Parsaeian, Jaafaripooyan, & Ghaffari, 2018; Sadati et al., 2017). These pertain to an increase in workload, poor personnel to patient ratios, an increase in moral distress, poor respect for patient rights and an increase in job dissatisfaction and turnover intention; all leading to nursing shortages.

Studies have shown that when implementing such reform plans, patient rights tend to suffer and thus more attention should be paid to a means of how to mitigate negative impact upon patient rights (Gerlinger, 2010; Jones, 2010; Parekh & Barton, 2010). Such reforms put more pressure on health workers, especially nurses. When the workload increases, nurses are more likely to face moral tensions and to experience moral distress (Corley, Elswick, Gorman, & Clor, 2001). Also, in such a situation, the likelihood of an intention to leave the profession will increase (Atabay, Çangarli, & Penbek, 2015).

According to Stone et al. (2006) nursing shortages are ubiquitous and have severe implications for patient care and respect for patient rights. Patient rights refer to a set of rights that an individual has in the health care setting that ensure that they receive ethical treatment and quality care (Ibrahim, Hassan, Hamouda, & Abd Allah, 2017). However, while there is a general consensus as to what the broad term of patient rights implies, the practice of such rights remains vague and ambiguous (Joolaee & Hajibabaee, 2012). In an environment plagued by staff shortages such rights may often be compromised and become a critical form of collateral damage. As nurses struggle to balance their workloads in an environment pervaded by a shortage of personnel, they may find that their moral decision-making and thereby their ability to provide the best care for their patients becomes compromised. Their conscious awareness of any failure to fully meet patient needs and rights can impact negatively upon their well-being, creating a level of moral distress for them that may increase their desire to leave their employment, if not the profession.

As mentioned, in recent years in Iran, simultaneously with the health system reform programme of 2014, a significant increase in nursing shortages has been reported (Ashghaly Farahani, Oskouie, & Ghaffari, 2016; Yadegary, Aghajanloo, & Negarandeh, 2017). Specific factors that compromise staff shortages and, in turn, patient rights are inexorably intertwined in an inter-causal chain of organisational work ethical climate, moral distress, job dissatisfaction, turnover intention and actual turnover (Dyo, Kalowes, & Devries, 2016).

Moral distress refers to a situation in which the individual is aware of the morally correct, ethically appropriate or responsible action that is required, but is inhibited from fulfilling this action

by organisational constraints (Mealer & Moss, 2016). Mealer and Moss (2016) note that nurses may often be disempowered in morally complex decision making with the power balance being typically shifted in favour of physicians, management or the overall hierarchically structured edifice of institutional power. Ongoing exposure to such disempowerment compounds moral distress and in the longer term may manifest in 'psychological disequilibrium', that is, emotional withdrawal, exhaustion and depersonalization, impaired respect for patient rights and care, increased job dissatisfaction and ultimately possible resignation from work (Ando & Kawano, 2016; Ando & Kawano, 2018; Mealer & Moss, 2016). Low staffing further compounds upon the climate in which there may be acquiescence to violations of patient rights, both of which serve to exacerbate moral distress. This may create a downward spiral in which there is overall deterioration of nurses' psychological well-being and experience of working conditions (Ando & Kawano, 2016; Ando & Kawano, 2018).

As with the rest of the world, the health care system within Iran and the Iranian nursing professionals are subjected to the above described negative factors (Borhani, Abbaszadeh, Mohamadi, Ghasemi, & Hoseinabad-Farahani, 2017). It is thus likely that Iran's 2014 health care reform with its concomitant patient overload and nursing shortages will have negative consequences for nurses, manifesting in a decline in respect for patient rights and an increase in moral distress, dissatisfaction and turnover intention.

Consequently, given the crucial ethical requirement to respect patient rights while at the same time maintaining nurses' psychological well-being and staff retention, the present study sought to examine the relationships between respect for patient rights, moral distress, job dissatisfaction, dissatisfaction with income, and turnover intention, in both the public and private sector. This study was conducted in the third year of the Iran's health care reform programme to assess nurse's perceptions of the extent to which they perceived that patient rights were respected in the wards within which they work, the intensity of the moral distress that they were exposed to, their satisfaction with their job and income and the relationships of these variables to their turnover intentions.

It was hypothesized (1) that there would be inverse relationships between moral distress, compliance with patient rights, job satisfaction and income satisfaction and a positive relationship between moral distress and turnover intention. That is high levels of moral distress would be associated with low levels of job satisfaction, lower levels of compliance with patient rights and a greater turnover intention one's job. (2) Further, it was predicted that moral distress, low compliance with patient rights and low satisfaction (job and income) would all predict turnover intention. (3) Demographic variables were also examined to determine if there were significant differences between groupings on age, gender, marital status, educational level, job experience, hospital type, ward type and shift type for all the aforementioned variables.

3 | DESIGN

This was a descriptive study utilizing a cross-sectional correlational design. The research data were collected in the third year of the implementation of health reform programme carried out in Iran.

3.1 | Sample/participants

The participants were 276 nurses at three large public hospitals and three private hospitals in Tehran, Iran. An equal number of responses (138) were received from public and private hospitals, respectively. Females constituted 80.8% of the sample. The convenience sampling method was used. The minimum sample size was determined using the equation for correlation estimation:

$$n=\frac{(Z_{\alpha}+Z_{1-\beta})^2}{\frac{1}{4}\left[\mathrm{Log}_e\left(\frac{1+r}{1-r}\right)\right]}+3\Rightarrow n=\frac{(1.96+1.64)^2}{\frac{1}{4}\left[\mathrm{Log}_e\left(\frac{1+0.22}{1-0.22}\right)\right]}+3\Rightarrow n=\frac{12.96}{0.05}+3=263,$$

and parameters as follows: an alpha of 0.05, a power of 0.8, and a correlation coefficient 0.17.

3.2 | Data collection

The data were collected utilizing three questionnaires namely: a demographic/work characteristics questionnaire, the Moral Distress Scale and Turnover Intention Scale. The items included in the demographic/work characteristics questionnaire were age, sex, marital status, level of education, hospital type, ward type, job experience and shift type.

Job satisfaction (which is defined as satisfaction with general working conditions and policies and procedures) was assessed with a single item question followed by a single question pertaining to satisfaction with income. In addition, another single question specifically aimed at determining respect for patient rights was included.

To assess job satisfaction and income satisfaction the questions were: 'How satisfied are you with your job?' and 'How satisfied are you with your income?'. Both these questions were scored on a 5-point Likert scale ranging from 1 (completely dissatisfied) to 5 (completely satisfied). To assess respect for patient rights the respondents were asked 'To what extent do you feel the patient rights are respected in your ward?' scored on a 5-point Likert scale of ranging from 1 (complete respect) to 5 (complete disrespect).

The Moral Distress Scale is a 24-item Likert format questionnaire developed to measure the frequency and intensity of moral distress among nurses. Each item is rated on two different scales, a frequency scale from 0 (never) to 4 (very frequently) and a level of intensity scale from 0 (none) to 4 (high intensity). The questionnaire was adopted from works published by Corley (Corley, Minick, Elswick, & Jacobs, 2005; Corley et al., 2001) and translated to Persian by Joolaee, Jalili, Rafiee, and Haggani (2011). Turnover intention was assessed using the Michigan organisational assessment questionnaire which is a 3-item scale with a 7-point Likert format ranging from 1 (strongly disagree) to 7 (strongly agree) developed

by Cammann, Fichman, Jenkins, and Klesh (1979) and translated to Persian by Nadiri and Tanova (2010).

3.3 | Validity and reliability

The content validity of demographic/work characteristics questionnaire was approved by consulting with 10 experts in the Nursing Faculty. Joolaee et al. (2011) reported content validity and Cronbach's alpha for moral distress scale (0.86). In the present study, the internal consistency score was calculated ($\alpha = 0.89$). The turnover intention scale had already been translated into Persian and showed very good reliability ($r = 0.85$) (Nadiri & Tanova, 2010).

3.4 | Ethical considerations

The study protocol was approved by the Ethics Committees of the University of Social Welfare and Rehabilitation Sciences. Confidentiality was maintained throughout the study.

3.5 | Procedure

After receiving the required permissions, the researcher met with prospective nursing staff participants and explained the research objectives to them. The researcher supplied all staff with a questionnaire/envelope package and nurses were instructed to fill in the questionnaire in their own time, seal it in the envelope and place it in a sealed box positioned discreetly within the nursing offices. Nurses were told that participation was voluntary and that they would not be advantaged or disadvantaged in any way by choosing to participate or not to participate.

3.6 | Data analysis

The data were entered into SPSS Version 16. The moral distress scores, turnover intention, satisfaction with job and income and respecting patient rights were reported as means and standard deviations (± *SD*). The Shapiro-Wilk test was used to test for normality ($p > 0.05$). The relationship between variables was examined utilizing Pearson correlations (Table 1). *t* Tests were used to compare levels of moral distress and turnover intention with categorical demographic variables (sex, marital status, shift type and ward type). The *t* tests showed that there were only significant differences with regard to different ward types (Table 2).

A stepwise multiple linear regression was used to examine the relationship of moral distress, satisfaction with job and income and respect for patient rights to turnover intention. Sex, marital status,

TABLE 1 The demographic and work related characteristics of study subjects

Variable		*n* (%)	Turnover intention	Frequency of moral distress	Intensity of moral distress	Moral distress	Respecting patient rights
Sex	Female	223 (80.8)	2.97 ± 0.72	40.87 ± 10.41	63.19 ± 15.95	104.07 ± 25.11	2.34 ± 0.89
	Male	53 (19.2)	3.16 ± 0.72	40.32 ± 10.80	66.56 ± 12.54	106.89 ± 20.76	2.03 ± 0.75
	t Test		$t = 1.78$, $p = 0.75$	$t = 0.34$, $p = 0.72$	$t = 1.43$, $p = 0.15$	$t = 0.75$, $p = 0.45$	$t = 2.27$, $p = 0.02$
Marital status	Single	166 (60.1)	2.96 ± 0.73	40.28 ± 10.66	62.18 ± 17.29	102.46 ± 26.47	2.33 ± 0.87
	Married	110 (39.9)	3.07 ± 0.71	41.50 ± 10.16	66.34 ± 11.62	107.85 ± 20.36	2.20 ± 0.87
	t Test		$t = 1.22$, $p = 0.22$	$t = 0.95$, $p = 0.34$	$t = 2.21$, $p = 0.02$	$t = 1.81$, p = 0.07	$t = 1.27$, $p = 0.20$
Shift type	Fixed	97 (35.1)	2.88 ± 0.77	39.92 ± 10.85	64.37 ± 14.27	104.30 ± 23.22	2.29 ± 0.85
	Rotation	179 (64.9)	3.07 ± 0.69	41.22 ± 10.25	63.55 ± 16.00	104.78 ± 24.97	2.27 ± 0.89
	t Test		$t = 2.08$, $p = 0.03$	$t = 0.98$, $p = 0.32$	$t = 0.42$, $p = 0.67$	$t = 0.15$, $p = 0.87$	$t = 0.22$, $p = 0.82$
Ward	Critical care	137 (49.6)	2.77 ± 0.76	37.51 ± 11.30	59.79 ± 17.25	97.30 ± 26.85	2.48 ± 0.87
	General	139 (50.4)	3.25 ± 0.59	44.07 ± 8.38	67.94 ± 11.97	112.02 ± 18.85	2.08 ± 0.83
	t Test		$t = 5.77$, $p = 0.001$	$t = 5.46$, $p = 0.001$	$t = 4.55$, $p = 0.001$	$t = 5.26$, $p = 0.001$	$t = 3.89$, $p = 0.001$
Hospital type	Private	138 (50)	3.21 ± 0.61	43.53 ± 8.97	68.67 ± 10.54	112.21 ± 17.49	2.00 ± 0.74
	Public	138 (50)	2.80 ± 0.77	38.00 ± 11.14	59.00 ± 17.82	97.01 ± 27.67	2.56 ± 0.91
	t Test		$t = 4.81$, $p = 0.001$	$t = 4.54$, $p = 0.001$	$t = 5.48$, $p = 0.001$	$t = 5.45$, $p = 0.001$	$t = 5.63$, $p = 0.001$
Education level	BSc	252 (94.7)	3.01 ± 0.72	40.65 ± 10.51	63.66 ± 15.64	104.32 ± 24.58	2.28 ± 0.87
	MSc	24 (5.3)	2.91 ± 0.81	42.04 ± 10.05	65.66 ± 12.62	107.71 ± 21.72	2.29 ± 0.90
	t Test		$t = 0.65$, $p = 0.51$	$t = 0.62$, $p = 0.53$	$t = 0.60$, $p = 0.54$	$t = 0.65$, $p = 0.51$	$t = 0.05$, $p = 0.95$

TABLE 2 The correlation between study variables and turnover intention

		Moral distress frequency	Moral distress intensity	Moral distress	Turnover intention	Respecting patient rights
Moral distress intensity	*r*	0.632				
	p	0.001				
Moral distress	*r*	0.903	0.904			
	p	0.001	0.001			
Turnover intention	*r*	0.701	0.626	0.533		
	p	0.001	0.001	0.000		
Respecting patient rights	*r*	−0.669	−0.537	−0.587	−0.560	
	p	0.001	0.001	0.001	0.001	
Job experience	*r*	0.021	0.055	0.042	0.048	0.157
	p	0.796	0.503	0.607	0.562	0.009
Experience in current ward	*r*	0.052	0.109	0.089	0.034	0.147
	p	0.531	0.186	0.280	0.681	0.009
Age	*r*	−0.282	−0.174	−0.252	−0.107	0.157
	p	0.001	0.034	0.002	0.191	0.009
Job satisfaction	*r*	−0.810	−0.620	−0.730	−0.710	0.659
	p	0.001	0.001	0.001	0.001	0.001
Income satisfaction	*r*	−0.040	−0.075	−0.064	−0.226	0.100
	p	0.512	0.212	0.312	0.001	0.098

TABLE 3 Multivariate linear regression of factors related to turnover intention

Model		Unstandardized coefficients		Standardized coefficients		
		B	*SE*	Beta	*t*	Sig.
1	(Constant)	1.268	0.257		4.933	0.000
	Respecting patient rights	−0.129	0.046	−0.156	−2.835	0.005
	Moral distress intensity	0.307	0.107	0.184	2.873	0.004
	Moral distress Frequency	0.524	0.081	0.461	6.435	0.000
	Shift type	0.188	0.063	0.123	2.971	0.003

shift type and the scores of moral distress, satisfaction with job and income and respecting patient rights were included in the analysis. The regression included all variables, however, only moral distress frequency, intensity, respect for patient rights and shift type were significant predictors of turnover intention (Table 3).

4 | RESULTS

The questionnaire was given to 400 nurses. Two hundred and seventy-six nurses responded representing a 69% response rate. The mean age of the study participants was 30.93 years with an *SD* of 4.27 years. The mean years of nursing work experience was 8.93 ± 4.27. The demographic and work related characteristics and results of *t* tests and ANOVAs are presented in Table 1. Satisfactory Cronbach alphas (above 0.70) were reported for all instruments used in the study.

The correlations between study variables are reported in Table 2. There were negative correlations between turnover intention and respecting patient rights and, job satisfaction and income satisfaction. That is, the greater the respect for patient rights, the higher the job satisfaction and income satisfaction and the lower the turnover intention. The correlation between moral distress intensity and frequency was positive with turnover intention. That is, the greater the moral distress frequency and intensity the higher the turnover intention. The respect for patient rights was significantly and negatively correlated with moral distress intensity and frequency and positively correlated with satisfaction with job. Job satisfaction was negatively correlated with moral distress intensity and frequency.

After excluding the non-significant variables in the model (age, sex, educational level, hospital type, ward, job experience, satisfaction with job and income and marital status) a multiple linear regression model was developed. A multiple linear regression was calculated to predict turnover intention based on respecting patient rights, moral distress intensity and frequency and shift type. A significant regression equation was found, $F(4, 271) = 79.283$, $p < 0.001$, with an R^2 of 0.541. The participants' predicted turnover intention was equal to 1.268–0.129 (respect for patient rights) + 0.307 (moral distress intensity) + 0.524 (moral distress frequency) + 0.188 (shift type), where shift type was coded as 0 = constant and 1 = circular. The participants' turnover intention score decreased by 129 score for each unit of respecting patient rights score. In addition, turnover intention increased by 0.307 for each unit of moral distress intensity and 0.524 units for the moral distress frequency score. Nurses who worked in circular shifts had a score 0.188 higher than nurses with constant shifts for turnover intention (Table 3).

5 | DISCUSSION

The findings of the present study support the contention that there is an association between the strains of moral distress, poor respect for patient rights, job dissatisfaction, and shift type and turnover intention. In terms of causality the findings indicated that moral distress intensity, moral distress frequency, lengthy circular shifts and poor respect for patient rights all significantly predicted turnover intention. The health care reforms in Iran which have increased health care coverage and led to patient massification, that is, greatly increased numbers of individuals accessing health care within the public health service, have exacerbated all the aforementioned strains.

The findings of this study align with previous research that has shown that when implementing such reform plans, patient rights tend to suffer and thus more attention should be paid to the unintended outcomes of reforms that manifest in increased workload and shortages of personnel (Gerlinger, 2010; Jones, 2010; Parekh & Barton, 2010). Such reforms put more pressure on health workers, especially nurses (Dyrbye & Shanafelt, 2011; Salarvand, Azizimalekabadi, Jebeli, & Nazer, 2017). When workload increases, nurses are more likely to face moral tensions and to experience moral distress (Corley et al., 2005; Karanikola et al., 2014). In such situations the likelihood of a turnover intention in the profession (Atabay et al., 2015; Atashzadeh-Shoorideh, Ashktorab, Yaghmaei, & Alavi Majd, 2015) and the likelihood of not respecting the rights of patients will increase (Yarney, Buabeng, Baidoo, & Bawole, 2016). This cycle of increasing workload, non-observance of patient rights, increased moral tensions and a desire to leave the workforce will exacerbate the ever-increasing shortage of nursing personnel.

The findings of the present study suggest that in combination these factors may produce a toxic environmental cocktail that further exacerbates nursing staff shortages, as those within employment who suffer high degrees of moral distress and low job satisfaction are likely to leave the profession. This can serve to intensify the situation for those that remain in employment as they struggle to cope with ever-increasing workloads. In such an environment, for those remaining, perceptions of the ethical work climate can continue to deteriorate, leading to even greater moral distress. This creates a relentless downward spiral in which job satisfaction continues to be further eroded and more and more nurses express a turnover intention which, in turn, may manifest in actual turnover. Thus, it appears that although Iranian health reform, by expanding insurance coverage and service delivery and making it cheaper may lead to more people utilizing the public health sector more often. The work overload that this reform implies has led to an erosion of standards and in the long term will lead to a further decline in the number of nursing personnel.

6 | CONCLUSION AND RECOMMENDATIONS

The present study (aligned with previous literature) has indicated that health care reform in Iran, with its noble intention of expanding quality care to the entire population in Iran, has led to serious unintended consequences. These are: increased workloads, increases in moral distress, poor compliance with patient rights, increases in job and income dissatisfaction and increased turnover intentions. These unintended consequences bode poorly for the quality of health care and thus for the long term success of the reform programme. Based on current findings we recommend that when implementing such programmes, it is important to assess staff conditions, as they are the cornerstone upon which the success of the programme hinges. The impairment of human resources within such programmes can endanger and drastically compromise the entire programme's efficacy. In addition, there needs to be greater stewardship presiding over the entire health care system. There is a lack of universal protocols and guidelines governing implementation, and leadership across the system is fragmented. It is thus required that there is a greater emphasis on integrated and coordinated stewardship in order to ensure efficient implementation (Heshmati & Joulaei, 2016). Without such coordination health sector reforms are less likely to be sustainable and purposeful and will not lead to an improvement in efficiency, equity and effectiveness. Heshmati and Joulaei (2016) and Koiek and Gharib (2013) note that a "master plan" is required without which the system becomes chaotic and harmful. Coordinated stewardship to implement reform effectively must take into account infrastructure, facilities, human resources and financial resources (Ferdosi, Kabiri, Keyvanara, & Yarmohammadian, 2017). It is also noted that the percentage of gross domestic product assigned to public health expenditure is still low and needs to be amplified (Ferdosi et al., 2017). Increased expenditure needs to be directed towards enhancing resources within hospitals that are part of the reform programme. This will require that more nursing personnel are hired and that attention is paid to providing commensurate wages for health care workers dealing with the massification resultant from increasing patient access. In addition, more funding

has to be provided to hospitals in order to ensure that there is sufficient allocation of resources in terms of equipment and that such equipment is fully functional.

Finally, from the perspective of patients, there needs to be a greater awareness created around patient rights. Patients need to be aware of their right to respectful treatment and the channels that can be followed if and when their rights are compromised. Hospital management and hospital ethics committees also need to be sensitized to dealing with rights violations, when such violations are reported to them, in a fair and equitable manner.

ETHICAL APPROVAL

The study protocol was approved by the Ethics Committees of the University of Social Welfare and Rehabilitation Sciences. Confidentiality was maintained throughout the study.

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