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Management of rehabilitation personnel within the context of the National Rehabilitation Policy

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CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND

The recognition of disability as a development issue, has led to its inclusion in agenda-setting and public policy internationally as well as nationally (DFID, 2000; ILO, UNESCO & WHO, 2004; McLaren et al, 2003; Matsebula et al, 2006). In addition, evidence demonstrating that disability is both a cause and consequence of poverty facilitated a broadened understanding of disability, contributing towards social transformation. Rehabilitation[1] is a fundamental concept in disability policy and is seen as the process without which many people with health problems leading to impairment and/or disability[2] would not be able to participate fully in society. Access to rehabilitation services has therefore been accepted by many developed and developing countries as a precondition for the equalization of opportunities for people with disabilities (UN, 1993).

Although advocacy from people with disabilities has facilitated the process of policy reforms towards an enabling rights-based framework, Oliver, 2003 argues that services for people with disabilities "somehow do not get delivered", resulting in them being locked into a dependency syndrome (Oliver, 2003: pg 314). Several reasons are cited, ranging from professional incompetence to statutory obligations not being fulfilled. This study seeks to explore issues of service delivery for people with disabilities from a health perspective.

[1] Rehabilitation is defined as "the process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures … from more basic and general rehabilitation to goal-orientated activities." United Nations, 1993.

[2] 'Impairment' and 'disability' are terminology used to promote understanding of the medical and social models of disability, where impairment refers to structural changes in the body requiring medical intervention, while disability is related to social restrictions requiring changes within society (Oliver, 2003)

Since 1994, health sector reforms in South Africa have resulted in policy changes in the provisioning, financing and regulation of health functions, with the guiding principle of improving equity and efficiency within the overall health system. A distinction is made between policies affecting the rights of people with disabilities (relating to advocacy and agency), versus policies affecting the delivery of rehabilitation services within the broader context of service delivery. This study deals with the latter, limiting the scope to the function of provision of rehabilitation services within public health, where the policy of health sector decentralization has been a focal area.

Traditional services to meet the rehabilitation needs of people living with a disability, were previously narrowly viewed as a therapy service, and provided only by a certain category of staff i.e. from specialized services at a higher level of care or the private sector. While reforms were taking place in the broader public health sector with the aim to avail services to the majority of people, the functions and scope of rehabilitation were also reviewed. In the absence of a national policy prior to 2000, a newly formulated policy, the NRP, was aimed at guiding rehabilitation personnel in service delivery (DoH, 2000a; GHD, 2005). The implications on the management, professional and resource allocation of this policy are major.

1.2. STATEMENT OF THE PROBLEM

The conceptualization of rehabilitation as a service has assumed an ambiguous understanding between national policy makers and professionals required to implement the policy at an operational level. National policy states that rehabilitation is an 'essential service' and views it as a unified and integral part of PHC (DoH, 2000a). This requires the various professions that contribute to the service, to develop a common 'identity' as rehabilitation service providers with a shift away

from past practices of profession-specific delivery. This ambiguity is reflected in the way the several professions that contribute towards the service, are managed. In this regard, rehabilitation managers and leaders in the field were challenged to plan effectively within the new policy framework and to provide a changing perspective on the nature, purpose and structure of their services, within the parameters of the NRP. Yet, in Gauteng, an emphasis on managing specific professions is still prevalent and aligning rehabilitation service delivery with the new policy framework appears to have been neglected.

1.3. JUSTIFICATION FOR THE STUDY

The national policy calls for the integration of various professions at the point of delivery, requiring them to work together towards identifying common rehabilitation goals through teamwork. Managing different professions together means influencing and changing old patterns and structures in the work environment. The contribution of qualitative data is needed to understand how managers and staff at the micro-level are coping with policy reforms, and whether there is evidence of change being facilitated at both operational and strategic levels in line with the new policy framework.

In addition, national policy seeks to incorporate the social model of disability into health policy and national plans of action. The social model frames disability from a human rights perspective, with people with disabilities central to decision making at all levels. Without effective programme planning, including the establishment of rehabilitation goals, not only is the implementation of the NRP being compromised, but it can result in a negative impact on: (1) equity: when rehabilitation services continue to be viewed as a specialized service only accessible to a few (as opposed to an

essential component of PHC) and (2) efficiency: where scarce public resources are wasted, fragmented or duplicated when inputs are provided for separate professions.

Access to services depends on the availability of resources. Although HR are considered the most important resource of a functional health system (WHOb, 2000), 'push and pull factors' continue to plague public health sectors in many developing countries. The mobility of health care professionals in the South African health system is well documented and quantified (Padarath et al. 2003; Sanders & Llyod, 2005; DoH 2006a). However, research on HR functions among rehabilitation professionals specifically, is extremely scarce. Biomedical and clinical research projects dominate the rehabilitation research agenda, which have continued to improve professional development, but have done little towards service development. Thus, in the absence of adequate research on HR to inform policies guiding rehabilitation services, this study focuses on the HR related components of the NRP with a particular focus on changing the nature of management.[3].

1.4. LITERATURE REVIEW

1.4.1. Policy context for disability and rehabilitation

Access to rehabilitation services has been stated as a precondition for the equalization of opportunities for people with disabilities (UN.1993). However, there is limited literature available on rehabilitation policy or service delivery, when compared to informing other health goals. Available studies address the impact of health sector reform broadly (Roemer, 1993; Walt & Gilson, 1994; Frenk, 1995; Gilson & Mills, 1995; Mills et al, 2001; Doherty et al, 2002;) and draws on the

[3] Although the NRP makes reference to many dimensions of rehabilitation services, specific reference is made to planning of HR, changing the nature of management and capacity building - these areas draw attention to the object of inquiry in this study i.e. human resources management.

experience of doctors and nurses mainly. The smaller professional groups, despite contributing towards overall health goals, appear to be neglected (Bury, 2003; McLaren et al, 2003; Matsebula et al, 2006; King & Meyer, 2006; Hall, 1999; Cementwala, n.d). While this study focuses on the delivery of rehabilitation services within the broader context of service delivery, the policy context for both disability and rehabilitation is provided at the international and national level, to facilitate understanding of their inter-linkages and policy influence in the health sector. Similar types of studies were not found during the stage of literature search.

1.4.1.1. International

The broadened understanding of disability challenged the health service sector not only to recognize the rights of people with disabilities, but also to implement changes in the way needs are assessed and addressed. A shift is recognized from a narrow understanding of disability as a personal tragedy, requiring an individual medical response to 'fix' the person affected[4], towards an understanding of disability as a result of more complex systems of social restrictions. This resulted in the introduction in the disability discourse and subsequently into public policy, of concepts like 'empowerment', 'participation', 'equal opportunities' and 'social inclusion', which were foreign to the service sectors and to the professional world. These concepts are reflected in the social models of disability and are demonstrated in the ongoing debates and power struggles to overcome professional dominance in rehabilitation service delivery. Disability and rehabilitation became complex multi-sectoral concepts internationally, yet continues to be delivered in a uni-sectoral paradigm.

[4] Mike Oliver refers to this as the individual model. The chapter on "Disabled People " in *Social Policy (Alcock, Erskine & May, 2006)* provides perspectives on the individual and social models in social policy and service delivery issues.

In the 2006-2011 action plan, WHO sets out to strengthen national rehabilitation programmes for its member states. WHO recognises that rehabilitation is rarely included in the curriculum of public health, or other parts of the education system and that existing documents and policies are often fragmented and inadequate for effective implementation (WHO, 2006). For developing countries with scarce resources, international role-players have developed strategies for the integration of rehabilitation services within the PHC approach (ILO, UNESCO, WHO, 2004). The concept of CBR[5] was advocated as a strategy to integrate rehabilitation into PHC services because access to appropriate rehabilitation services remains a problem internationally, more especially in developing countries.

1.4.1.2. National

South Africa has adopted the WHO approach for improving access to rehabilitation services, within the context of overall health sector reforms. Disability and rehabilitation moved beyond health and social development sectors; with education, labour, transport, justice, and housing sectors, as service providers, also mandated to include disability within their programmes. The disability movement in South Africa mobilized strongly for the rights of people with disabilities during the policy development stage, culminating in two historical milestones for people with disabilities: (1) the Constitution of RSA (Act no: 108 of 1996) and (2) the White Paper on an INDS, 1997 [6]. In response to the INDS, the DoH formulated the NRP with the goal of making rehabilitation services accessible to all people with disabilities.

[5] CBR is defined as "a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities." (ILO, UNESCO & WHO, 2004).

[6] At the time of writing this research report, a revised version of the White Paper on an INDS, 1997 was circulated: the *National Disability Policy Framework* (Presidency, 2008).

Despite national efforts to integrate disability functions into mainstream policies and programmes, services addressing the needs of people with disabilities remain predominantly within the health and social sectors. The Employment Equity Act (Act 55 of 1998) has not had the desired impact on people with disabilities. By 2005 it achieved less than 0.5% of its targeted 2% of people employed with a disability in the public sector (OSDP, 2003). The OSDP was established to coordinate, monitor and facilitate the implementation of the INDS. However, "implementation of the INDS by government has been disappointingly slow" (SAHRC, 2002: 20), demonstrating that the process of integrating disability and rehabilitation issues across the different sectors has been a challenging one. Rehabilitation service providers were therefore assigned new roles and responsibilities towards improving access to rehabilitation services and were required to redefine the nature and purpose of rehabilitation practice within a changing international and national policy context.

1.4.2. Reforms defining the public health sector

1.4.2.1. Provision of health services

In the provision of services, health sector decentralization is characterised by the development of the DHS, devolution of health functions to provinces and decentralized hospital management. DHS in South Africa is still in its infancy, since it only received legal thrust with the promulgation of the New Health Act (Act 61 of 2003) in 2004. However, the delayed legislation for DHS has caused confusion and uncertainty at operational levels. The DoH started implementing the DHS when the restructuring of Local Government was still in its early stages of transformation. Due to district boundaries still being consolidated at the time, DoH set up interim regional structures, which were deconcentrated units of the provincial health department. Currently health districts are in alignment

with municipal district boundaries of local government. The changes from interim regions to definite district boundaries, together with the introduction of new lines of communication and structures, had a direct impact on the planning and coordination of health and rehabilitation services. Health workers, including rehabilitation professionals, had to absorb these policy changes, plan accordingly and implement them in service delivery.

The devolution of health functions to the nine provincial departments is another characteristic of health sector decentralization. The GDH is responsible for implementing national health policies specific to the province, taking into consideration local contexts and needs that may be different from other provinces. The NRP, although regarded as a national policy framework, is "not intended to prescribe specific operational procedures…it is anticipated that provinces will use this document as a framework to develop operational policies." (DoH, 2000a: pg 3). GDH thus developed a policy framework on disability, which makes some reference to rehabilitation services. Operational guidelines for rehabilitation as a service were unavailable for Gauteng Province, although profession-specific protocols are available with guidelines based on diseases or impairments e.g. spinal cord injuries, stroke, head injuries, etc, according to profession-specific interventions.

1.4.2.2. Overall public service sector

All officials employed in the public service are subject to HR policies as defined by the DPSA. Facility managers across the public sector are guided by these HR management policies in the employment of professional services. Several factors are reported to impact on the capacity of service providers as public officials in the provision of services (Mills et al, 2001 and Brynard & De Coning, 2006). In this study, two dimensions among rehabilitation professionals in their day-to-day activities when providing a service are explored:

- The technical dimension in terms of policies and professional norms and standards.
- The managerial dimension in the way resources are utilized - physical (environment, space, and equipment); human; and financial.

The first dimension deals with public policies and standards guiding rehabilitation professionals, as well as professional norms and standards set by the Councils[7]. Since health professionals are required to register with the Council as a prerequisite for employment, they are bound by professional norms and standards which guide their professional practice. The second dimension deals with the way in which resources are utilized or managed and is directly linked to productivity. This dimension places attention on managerial capacity, where scarce public resources are utilized in the most efficient manner to meet set objectives, thus reflecting on public sector performance. Rehabilitation managers therefore have a dual role: professional development as well as public service development.

1.4.3. Implications of policy changes on rehabilitation professionals

Macro-level policy reforms and HR policies aimed at redistribution, recruitment and retention, impact on the HR functions at the micro-level. Four policy reforms are highlighted: (i) decentralization of hospitals; (ii) compulsory community service; (iii) rural allowance; and (iv) scarce skills allowance.

The decentralization of hospitals was aimed at improving facility management, accountability and efficiency through the establishment of hospital superintendents as CEO's. Despite the transfer of authority to hospital managers, the functions of recruitment and retention of HR are still centralized.

[7] Rehabilitation professionals employed in Health are represented on the Health Professions Council of SA (HPCSA) while Social Workers are represented by the SA Council for Social Services Professions (SACSSP)

In the planning of HR, community level posts were created for rehabilitation professionals for the first time in 1996, as part of the PHC team to complement secondary and tertiary levels of care. This was the first initiative to change the perception of rehabilitation services from being entirely specialized to an essential service, as stated in the NRP. Since rehabilitation personnel had never been employed at district or clinic level before 1996, this was a new experience for managers. With the creation of new posts, managers had to evaluate and restructure current methods of service delivery, identify the roles of rehabilitation staff at different levels of care and develop an effective referral system. Role clarification and defining the scope of practice at each level of care is crucial for effective rehabilitation service delivery. Thus, managers were given the direct responsibility of improving the management and efficiency of rehabilitation services within their facilities.

To combat the problem of shortage and maldistribution of health care workers in the public sector, compulsory one year community service for newly qualified professionals was introduced. The first set of new graduates from the rehabilitation fields commenced compulsory community service in 2003[8]. Evidence shows that the period of community service has resulted in several challenges particularly for those health professionals who rely on specialized resources (Reid, 2002). For rehabilitation, community services have facilitated the redistribution of HR to rural areas, although supervision and support remain the biggest challenge.

Rehabilitation professionals were also included as a target group by DPSA to qualify for the rural and scarce skills allowance which is a retention strategy introduced to address the skills shortage within the public sector. All rehabilitation professionals employed in the public sector qualify for the

[8] Medical students started compulsory community service in 1998, while dentists and pharmacists started in 2000 and 2001 respectively.

scarce skills allowance, while the rural allowance is additional, aimed at attracting personnel to serve the rural areas of South Africa. Rehabilitation professionals employed in the public health sector were thus introduced to various policy changes at all levels in the last ten years, necessitating a need to revisit past and current practices. These policies constitute an important part of the phenomenon this study is interested in.

1.4.4. Service integration

Service integration, promoted within the broader public service sector, is defined as those functions and activities that are aimed at the formation of a unified and comprehensive range of services in a geographical area, where the intent is to enhance the effectiveness of the delivery of services (King & Meyer, 2006). However, this relates to the more common understanding of integration as a managerial one, because in the Health and Social Services sectors, it is intended to bring about changes at the clinical level. In clinical care, much has been written on the outcomes of integration, but there is little clarity on the implementation of this concept at the point of delivery (King & Meyer, 2006; Browne et al, 2004; De Jong & Jackson, 2001; Hall, 1999). Literature points to various designs and models of an integrated system with most initiatives remaining at a single programme rather than at a systemic level.

King & Meyer, 2006 propose that the provision of care needs to be conceptualized in terms of the *functions and activities* when implementing integration. Three types of approaches to service integration are outlined: (i) systems/sector-based service integration which ensures the availability and accessibility of services across agencies or service sectors in a geographical area; (ii) agency-based service integration which aim at integrating the delivery of services between programmes

within a single agency; and (iii) client-based service coordination which is based at the micro-level and occurs inter-professionally (King & Meyer, 2006) Implementation of the NRP implies that an integrated rehabilitation service should be translated from policy into managerial and professional practice at a systems level, taking into account the many agencies involved which impact on clients.

1.5. CONCEPTUAL FRAMEWORK

A conceptual framework for this study is provided at the operational level of service delivery and represented in a systems perspective, incorporating inputs, processes and outcomes. The provision or delivery of services is the most familiar function of a health system and is defined as the way inputs are combined to allow the delivery of a series of interventions or health actions (Management Sciences for Health, 2007). This is represented in figure 1.1. below.

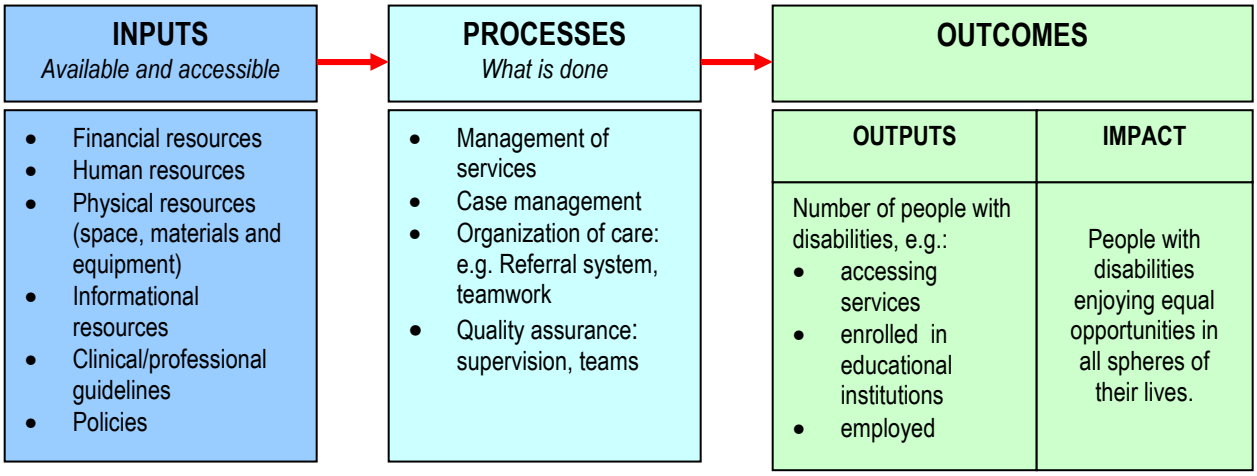


Figure 1.1. *Conceptual framework for a systems approach to service delivery*[9]

With the introduction of several policy reforms impacting on rehabilitation service providers, there was a need to review other inputs made within the South African health system. This study will work with an operational concept of output as defined in the NRP i.e. improved access to rehabilitation

[9] Adapted from *Health Systems Assessment Approach*. Chapter 8, Management Sciences for Health, 2007

services for people with a disability[10]. Reduced length of hospitalization, readmissions and reducing the need for long-term chronic care or social assistance are reflected as further outputs, impacting positively on the quality of life of people with disabilities. Within the overall planning framework for the public sector, process issues are crucial in converting inputs into measurable and targeted outputs towards meeting the goals and objectives set. This study thus explores the management of human resources, as a fundamental component of this process, within the context of new policy guidelines in the provision of rehabilitation services.

1.6. AIM AND OBJECTIVES OF THE STUDY

This study seeks to explore the factors influencing the management of human resources in the provision of rehabilitation services in Gauteng Province, within the context of the NRP. Combined with the perceptions and challenges experienced by managers, this study aims to provide insight into the practical issues in the implementation of the NRP.

1.6.1. Specific objectives:

1. To describe how rehabilitation services are managed at primary, secondary and tertiary levels of care within a defined health district.
2. To compare the way these rehabilitation services are managed with policy guidelines and with existing norms and standards for Occupational Therapy, Physiotherapy, Speech Therapy and Social Work professions.
3. To identify and describe the integration challenges experienced by the four groups of rehabilitation professionals at operational and managerial levels within a decentralized health system.
4. To make recommendations for facilitating the process of policy implementation.

[10] Access has many dimensions, i.e. financial, geographic, attitudinal, cultural etc. While there may have been access to various rehabilitation experts in the past, this study explores and questions access to rehabilitation as a service.

CHAPTER TWO

METHODOLOGY

There is currently a need to better understand the 'push factors' driving service providers away from the South African public health sector and explore why the public sector is not attracting adequate numbers of rehabilitation professionals. This level of enquiry requires a qualitative approach because in order for a factor to be "push" or "pull", the social and institutional phenomenon or events must be interpreted through the lenses of the health care providers' own life experiences. This study explores questions of a similar nature as "pull and push" factors, i.e. the impact of policy on human resources, and is therefore best suited as a qualitative enquiry into 'what' the challenges are for rehabilitation and 'why' they exist.

2.1. STUDY DESIGN

A *case study design* is chosen to explore this research topic. Case studies are commonly used as a method of qualitative inquiry, and can produce both quantitative and qualitative data. Stake, 2000 states that while the same case is at variance in different situations, a case may be simple or complex: it may be a child or a classroom of children, or an incident. Similarly, a hospital can be viewed as a case. The understanding is that it is a 'bounded system' with working parts, and whether "functional or dysfunctional, rational or irrational, the case is a system" (Stake, 2000: pg 436). The case study design was also used by Mills et al, 2001 where four country cases were compared, within the boundaries of defined criteria for comparative purposes, to provide in-depth evidence on the experience of health sector reforms across the countries. A case study design is thus used to address the objectives set in this study

2.2. SELECTION OF CASES

It is impossible to assess the impact of policy on service delivery if there is no service delivery and provider in the first place. The selection of health facilities as case studies depended on the availability of rehabilitation services at primary, secondary and tertiary levels of care. Many public health facilities in South Africa are struggling to secure rehabilitation staff. In addition, for an effective rehabilitation service to be provided at each level of care, more than one profession need to be located within the facility. This is crucial to assess the availability of a service as well as the extent of integration. The City of Tshwane Metropolitan Municipality (CTMM) within Gauteng Province was chosen in view of rehabilitation services being available at all three levels of care. The CTMM is divided into 3 sub-districts: central, northern and southern sub-districts. Table 2.1. shows the availability of rehabilitation services in each sub-district.

Table 2.1. Availability of services

	PRIMARY LEVEL		SECONDARY LEVEL		TERTIARY LEVEL	
	Existing health service	**Rehab service**	**Existing health service**	**Rehab service**	**Existing health service**	**Rehab service**
NORTHERN SUB-DISTRICT	CHC 1 Clinics 9 Mobile service 1	√	District Hospital 1		Academic Hospital	√
CENTRAL SUB-DISTRICT	CHC 1 Clinics 24 Mobile service 2	√	Step down facility District Hospital 1 District Hospital 2 District Hospital 3	√ √	Academic/ Specialist Hospital	√
SOUTHERN SUB-DISTRICT	CHC 1 Clinics 6 Mobile service 1	√				

Source: Annual Health report, City of Tshwane Metropolitan Municipality (2002/3)[11]

Thus, the central sub-district was chosen because it represented the availability of rehabilitation services at all three levels. All three CHC's as the primary level of care were included because of their coverage of services in the CTMM.

[11] During data collection for this study, several more clinics from the Odi Region in North West Province were being incorporated into the CTMM Primary Health Care services, thus increasing the area of coverage. This has human resource implications in the planning of services.

2.3. SAMPLING STRATEGY

The target population of this study were managers of rehabilitation services at local, provincial and national spheres. Sampling was purposeful, where managers from the three levels of care were deliberately selected for their role in human resource management, and depending on the sphere of government, on their different roles in the policy process. Managers at the local sphere represented the facilities/organizations within which polices have been implemented. Provincial managers provide support and guidance through interpretation of policy and development of operational guidelines. The national sphere was included because of its role in policy making. Thus, all three spheres of government and all three levels of health care were selected.

With regard to the professions, four professional groups out of a total of eleven for Gauteng Province were initially included: social work; occupational therapy; speech therapy; and physiotherapy[12], since these professions work directly with disability and rehabilitation at all levels of care. The other professions provide indirect services in the care of all persons accessing health services, whether disabled or not. When data collection began, a request was made by a manager from the tertiary hospital at top management level to include the profession of Medical Orthotics and Prosthetics, since it forms part of the rehabilitation service at that level. Thus, five professions were eventually included in the study.

[12] Rehabilitation services in Gauteng include 11 professions: Occupational Therapy, Speech Therapy, Physiotherapy, Social Work, Medical Orthotics & Prosthetics as well as Dietetics, Clinical Technology, Medical Technology, Radiography, Podiatry and Psychology – Gauteng Department of Health, 2005

2.4. SAMPLE SIZE

Ten managers, ranging from national, provincial to facility levels were selected. These included a senior manager for disability and rehabilitation from national and provincial spheres, and eight managers from facilities at the local sphere, representing all the levels of health care:

- **Tertiary hospital**: The five different professional heads of departments.
- **Secondary hospital and step down facility**: a senior rehabilitation manager from each of these facilities.
- **CHC's/Primary clinics**: The rehabilitation manager representing all three CHC's.

Operational staff, as service providers within the facilities, were included in the study as a method of validation of what managers were saying and doing. Senior staff were targeted because of their exposure to management issues. They were involved in three separate focus group discussions as outlined below. Six to eight participants were considered ideal for a focus group discussion.

- **Focus group 1:** Ten senior staff, representing each of the five professions at tertiary level were invited to participate.
- **Focus group 2:** The two facilities providing secondary level of care, i.e. the district hospital and the rehabilitation unit were combined for this group because of a lack of staff. Eight operational staff, representing each professional group, were invited to volunteer.
- **Focus group 3:** Six volunteers, two from each of the CHC's were invited from the primary level of care.

Thus, a total of 24 senior operational staff were invited to the group discussions, of which 19 attended when the focus groups were conducted.

2.5. DATA COLLECTION TOOLS

Four sources of data were used to meet the objectives of this study. KII's were conducted with the ten managers to capture their vast management experience while FGD's were found to be more effective amongst the operational staff because of the opportunity for interaction. A 100% response rate was achieved for the managers participating in the in-depth interviews, and an average of 79% response rate was achieved for the three FGD's .

- **KII** - A variety of open-ended questions were chosen to elicit data from managers (appendix 5). These related to the understanding and implementation of the NRP, the experience of managing rehabilitation personnel and exploring the integration challenges within a decentralized health system.
- **FGD** - A variety of open-ended questions were chosen to elicit data from operational staff (appendix 6) on the awareness, understanding and experience of being managed within their respective departments and units.
- **Participant Observation** - The observational method was useful for this study because the focus of interest is the way in which activities and interaction is influenced by how personnel are managed within a particular local setting. A single visit was carried out at each facility and observations made, were confirmed during the interviews and FGD's. A scoring template was used to record two variables: level of teamwork; and utilization of physical resources, with a scale of 1-5[13] as a measure of the extent of integration. This served to reduce bias and provide a standard structure on observations made. In addition, field notes were kept of all visits.

[13] The scoring criteria are reflected in appendix 4 where 1=Poor; 2=Inadequate; 3=Adequate; 4=Good and 5=Excellent

- **Document review**
    - *The National Rehabilitation Policy* (2000) and the *Gauteng Rehabilitation Policy* were used as the theoretical framework. The policy content was analysed to facilitate understanding of the intentions of the policy. However several other policies affecting personnel in the public sector had to be included to facilitate a deeper understanding of the HR issues affecting rehabilitation personnel working in the public sector.
    - *Clinical guidelines* for the five professions were reviewed from documents that prescribe norms and standards specific to each profession. Professionals follow clinical guidelines across all settings and managers use these to guide personnel towards delivering service standards.

2.6. ETHICAL CONSIDERATIONS

Ethical clearance has been granted at facility level from the Gauteng Department of Health and the University of Witwatersrand Ethics Committee. All the participants in the interviews and focus group discussions provided written consent to participate. Managers also provided written consent for the researcher to visit the facilities during observation of the departments. The letter indicating ethical clearance is included in appendix 7.

2.7. CONFIDENTIALITY

Assuring confidentiality was considered from the perspective of both managers as well as operational staff. This is outlined for both groups in the information sheets (appendices 1 & 2), which were given to all participants prior to signing consent.

2.7.1. Internal*:*

Members were made aware that confidentiality could not be guaranteed in a focus group discussion. However, a group rule was facilitated which aimed at respecting opinions and experiences and not divulging information outside the group.

2.7.2. External*:*

The audio-tapes were securely kept at the researcher's home where only the researcher had access to them. Participants for the interviews as well as the focus groups were informed that they would remain completely anonymous in the writing of the research report. The quotes have not been attributed to any individual. An example of how quotes would be described, was outlined for the participants: *'Focus group 1(2 or 3) Participant 1(etc) i.e. FG1P1 '*.

2.8. DATA PROCESSING

2.8.1. Data management

All interviews and focus group discussions were audio-taped and were transcribed verbatim by the author, as a method of becoming more familiar with the data.

2.8.2. Data reduction

A process of reducing the data that were derived from all the sources, was undertaken. For the KII and FGD's, an unrestricted selection of codes that capture the meanings in the transcripts were used to produce initial codes. Data items were given equal attention for each transcript or data set.

These were systematically worked through in search of patterns and meaningful groups. Data were coded inclusively, where some of the original words were used to capture the essence thereof. Frequently occurring codes to create core strategies were then used within the selective coding technique. Coding is the heart and soul of 'whole-text analysis' (Ryan & Bernard, 2000), and allows the researcher to analyse the blocks of text. As coding categories emerged, they were then linked to a theoretical model by comparing and contrasting themes and concepts. The formation of themes was then used to describe the findings. Thus, coding for the KII and FGD's were data-driven. The process of coding forms the basis for analysis. In contrast, data derived from the document reviews were theory-driven, in that the content of the policy documents and professional guidelines provided the theoretical framework for analysis. Key words, phrases and concepts were captured to demonstrate the intention behind policy.

2.9. DATA ANALYSIS

Qualitative analysis is divided into two broad categories: interpretive and constructionist (Lincoln & Guba, 2000). Phenomenology, grounded theory and thematic content analysis are techniques that fall under the interpretive approach, which is used in this study. Thematic analysis, as described by Braun & Clarke, 2006 was used to analyse the data derived. Two ways to identify themes or patterns are outlined in thematic analysis:

2.9.1. Deductive analysis: described as a top-down method, driven by a 'theoretical' interest in the area. Data derived from the document reviews fell into this category. The policies together with norms and standards guiding rehabilitation services, with regard to human resource management, formed the theoretical framework. This was used as the benchmark for practice within each facility.

2.9.2. Inductive analysis: described as a bottom-up method, where themes identified are strongly linked to data themselves, without trying to fit them into a pre-existing coding frame or researcher's 'analytic preconceptions' (Braun & Clarke, 2006). This approach was used in understanding the experiences, perceptions and integration challenges from participants.

2.10. KEY STRATEGIES TO ENSURE RIGOUR

To ensure quality of the findings and that they are worthy of attention, the following strategies were used:

- **Member checking** – A follow-up report back session was carried out with all the participants in order to ensure that the findings were representative and 'grounded'. Some valuable perspectives were given as a collective at this session.
- **Creating an audit trail** - An 'audit' trail provides evidence on how data were transformed into categories and codes. The reasoning process during the analysis phase has been carefully recorded and documented. All initial codes and frequently occurring codes/themes were manually carried out and were documented at each stage.
- **Triangulation** – This involves the use of multiple sources of information and perspectives to reduce the chance of bias. Triangulation was achieved by source, where data were collected from different sources as outlined above, and method, where different data collection methods were used i.e. individual interviews, focus groups, observations and record/document reviews.
- **Limiting bias prior to data collection***:* Guarding against researcher bias was overcome by a validation process where the researcher underwent an initial interview by the supervisor, which was recorded separately for comparison with the study results.

CHAPTER THREE

RESULTS

The findings of this study are interrelated as service delivery is a multi-dimensional concept. Results from document reviews identifying the policy intent, together with professional norms and standards will be presented first. This will be followed by a description of the environment in which these policies and standards are to be implemented within the specified district. A comparison is then made between the facilities on the way services are managed at the operational level, against the theoretical framework as the benchmark. Finally, thematic analysis is used to describe the integration challenges experienced by the participants who are expected to implement these policies.

3.1. THEORETICAL FRAMEWORK GUIDING REHABILITATION

Data extracts for policy guidelines and the professional norms and standards guiding the target groups for this study are provided in appendix 8. The two areas are presented separately below.

3.1.1. Policy guidelines

3.1.1.1. International policy context

Although the focus of this study is the implementation of the NRP, this policy could not be seen in isolation from the broader context during which it was conceptualized. The United Nations Decade of Disabled Persons (1983-1992) guided member states to implement its programme of action and adopt its *Standard Rules on the Equalization of Opportunities for People with Disabilities* (UN, 1993). Rules 2 and 3 differentiate medical care from rehabilitation, both being preconditions for

equal participation. The World Health Assembly provided resolutions on disability with prevention, management and rehabilitation being a primary goal. The continental plan of action for Africa (African Union, 2003), through objective six, makes specific reference to rehabilitation. International discourse and activities on disability emphasize access to rehabilitation services as the precondition for equal opportunities for people with disabilities.

3.1.1.2. National discourse on rehabilitation

The international policy context strongly influenced the South African rehabilitation agenda, where international discourse is found in South African policy documents which guide rehabilitation and disability. Prior to the Constitution of the Republic of SA (Act, 1996), the first charter on Disability Rights was advocated by activists from the social movement representing people with disabilities. Data extracts in appendix 8, demonstrate how the White Paper on an INDS, 1997 as well as the NRP frame their policy guidelines according to a rights-based approach. Concepts like 'intersectoral collaboration', 'active participation', ' maximum coverage' and facilitating "the realization of every citizen's constitutional right to have access to health care services" (DoH, 2000a: pg 2), were introduced for the first time in policies guiding rehabilitation.

The NRP, further, states that "managers should be supported in acquiring the skills needed to manage a decentralized health service" (DoH, 2000a: pg 15). Guidelines for establishing a rehabilitation programme call on service providers to render a comprehensive service through "close collaboration", a "clearly defined referral system" and coordination between the various levels of service delivery (DoH, 2000a: pg 8). Overall, these policies call for integration, maximising public resources for efficiency and equity in access to health (including rehabilitation) services.

3.1.1.3. Integration and decentralization discourse

Throughout the content of the NRP, reference is made to rehabilitation as a service, with minimal mention of the individual professions that contribute to the service. A logical assumption in the policy content is that the various professions are integrated and managed collectively towards meeting common goals and outcomes, with roles and responsibilities defined for each profession for effective and improved service delivery. In addition, with a move towards the rights-based approach, the policy framework emphasises the social model of disability. This implies reviewing governance issues regarding service delivery and making people with disabilities central to decision-making. It also calls for the shifting of resources to community level structures and community development activities, thus complementing hospital-based services as defined by the medical model. CBR is adopted in the NRP as a strategy to integrate rehabilitation into PHC services. National policy thus calls for integration on two levels: (1) between the individual professions that contribute towards a rehabilitation service; and (2) to integrate rehabilitation objectives with the functions of PHC services.

Gauteng Province developed a policy framework on disability, concentrating on the management of disability issues in the workplace. While "integrated, barrier-free and comprehensive service delivery" is outlined for all sectors, there are no further strategic or operational policies guiding rehabilitation professionals employed in the health sector in Gauteng. Operational procedures are available for specific components of a rehabilitation programme, e.g. "*Assistive Devices"*[14]*;* or for specific diagnostic groups, without an overall strategy or plan guiding the service.

[14] A document developed by DoH: "Standardization of Provision of Assistive Devices in South Africa", is available to guide the process of overcoming the backlog for these devices. This was a priority set at national level and is the only indicator for disability for which financial resources were made available directly with the help of National Treasury.

3.1.2. Professional norms and standards

The targeted rehabilitation professionals in this study follow three sets of guidelines: (1) *professional* – through ethical and statutory functions outlined in the Health Professions Act (Act 56, of 1974), National Health Act (Act 61 of 2003) and Social Services Professions Act (Act, 110 of 1978) for Social Workers; (2) *public service* - where HR policies guide employees of Government, as defined by DPSA; and (3**)** *technical* – through norms and standards that guide professionals. Policy areas and specific data extracts for each is outlined in appendix 8.

The DoH ensures professional competence through the establishment of professional boards, community service, and continuing education and training as a prerequisite for registration to practice. The object of the professional boards is to guide and liaise with training institutions to influence the practice of each profession[15]. The roles and functions of national and provincial health departments, outlined in sections 21-25 of the National Health Act (Act 61 of 2003), state *planning, coordinating and managing* of services and resources. Specific emphasis is placed on 'preparing strategic medium term health and human resources plans' (section 25(3)(a). Provincial rehabilitation documents are available to guide diagnostic-specific illnesses (e.g. stroke, spinal cord injuries, head injuries etc). While some guidelines make reference to 'working with other team members', there are minimal guidelines defining how teamwork is to be operationalized. Managers therefore depend on their own experiences and paradigms to ensure that this takes place. Furthermore, clinical guidelines are made available to the professions through the separate professional structures at the provincial level.

[15] Sections 15A(b)(c)(d)(e), as outlined in appendix 8

DPSA in general recognises that HR cannot be seen as an administrative function only. The inclusion of both transactional as well as transformational[16] functions of HR during reforms within the public service sector (DPSA, 1996), has led to the establishment of PALAMA[17] to train and develop leaders and managers within the public sector. Since this initiative provides generic training of junior, middle and senior level management, rehabilitation managers employed in the public health sector have the opportunity to develop individual capacity as managers. Administratively, an important principle outlined in the White Paper on HR management in the public sector is that organizational structures need to be closely aligned to the strategic service delivery goals of the organization. This implies that hospital managers and provincial coordinators were required to provide direction and leadership in this regard in order to meet the changing needs and priorities of society within the new framework of government policy. The NRP represented this change.

Professional norms and standards as documented by HPCSA under the respective professional boards, state that each profession shall "confine to clinical diagnoses and practicing in the field of physiotherapy[18] in which he or she was educated and trained and in which he/she has experience" (refer to appendix 8). Social workers, by virtue of the nature of their profession, have public policies explicitly outlined in their protocols, including the NRP. Speech Therapy makes reference to the NRP and the INDS, to guide target outcomes. However, this is confined to the Speech Therapy profession. Overall, the professions are guided in practise according to profession-specific outputs based on 'clinical diagnoses' which continue to keep the professions rooted in the medical model. Since each profession is registered with separate professional boards, the structure and function of

[16] The White Paper on the transformation of human resources management in the public sector outline 'transactional' HR as planning, recruitment and retention functions, while 'transformational' functions deal with leadership, diversity, management structures and employee wellness (DPSA, 1996)

[17] PALAMA stands for "Public Administration Leadership and Management Academy, PALAMA replaces the old name of SAMDI (SA Management and Development Institute)

[18] The same statement is made for Occupational Therapy and Speech Therapy within the HPCSA.

professional boards within the HPCSA promotes individual, profession-specific protocols despite the call for partnerships with other professionals. This perpetuates the medical model and is in conflict with the call for integration and practise within the social model as stated in the NRP. There is no alternative structure within HPCSA that facilitates and guides integration of the professions or promotes and develops rehabilitation as a service.

Thus, in the recruitment and retention of rehabilitation professionals in the public sector, these policies and guidelines are expected to work together to impact positively on service delivery. What is being witnessed is a conflict between these structures.

3.2. MANAGEMENT OF REHABILITATION SERVICES

Data derived from observations made at the facilities are aimed at meeting objective one as stated in Chapter Two. These observations were recorded on a scoring sheet with two variables: (i) teamwork and (ii) utilization(sharing) of resources. Scoring criteria are stated in the methodology section and appendix 4, with a scale of 1-5 for sharing of resources, and seven sets of criteria for positive teamwork. The results and percentage of the scores obtained at the site observations are demonstrated in table 3.1., with a maximum score of 25 for sharing of resources and 7 for level of teamwork. These two variables measure integration at the service/operational level. While integration could mean different things from different perspectives, for rehabilitation goals to be met realistically as the policy advocates, integration calls for teamwork and sharing of resources.

Table 3.1 Results of Site Observations

FACILITY	SHARING OF RESOURCES	%	LEVEL OF TEAMWORK		%
			YES	NO	
Tertiary Hospital: Social work	7	28	2	5	28.6
Physiotherapy	5	20		7	0
Occupational Therapy	5	20		7	0
Speech Therapy	7	28	1	6	14.3
Orthotics and Prosthetics	5	20	2	5	28.6
Average	5.8	23.2	1		14.3
Secondary Hospital	12	48	2	5	28.6
Step-down Facility (rehabilitation centre)	20	80	7		100
Community Health Centre 1	20	80	7		100
Community Health Centre 2	24	96	7		100
Community Health Centre 3	20	80	7		100

At the only tertiary hospital included in this study, each of the 5 different professions occupied their own spaces as separate units. Therefore, they were each visited and scored separately. Each department is headed by the assistant director, with the chief, senior and junior therapists organized in a hierarchical structure. Services are managed according to the different professions, with a budget provided separately for each department. Patients are referred from one department to another, so that profession-specific services are rendered to them. During the interviews and focus group discussions, managers from the different professional groups expressed pride in the 'high-tech' equipment allocated to the separate departments and reported that due to their departments being well resourced, they were not compelled to share resources. What was observed is that common equipment was duplicated in the separate professional units and teamwork was observed within selected clinics only, e.g. the Ear-Nose-Throat (ENT) Clinic and the Paediatric Clinic.

Secondary level of care is offered through three district hospitals which are all geographically based within the central sub-district. Only one of the district hospitals provides a complete rehabilitation

service, with the appointment of staff at the senior level[19]. For the variable of *sharing of resources,* they scored higher (score: 12) than the tertiary facility (average score: 5.8), but with similar levels of teamwork for both. Gauging from the interviews, this was attributed to the fact that there was a shortage of space and equipment, resulting in the different professions being compelled to share resources with an unexpected outcome of some degree of teamwork. The staff report directly to the superintendent through the election of a team leader, who has no seniority to the other colleagues but acts as the 'manager' and liaises with hospital management. This was reported to be frustrating for all team leaders interviewed, because they were neither remunerated for the added responsibility, nor were they able to provide quality services for which they were employed. Inevitably, these impacts negatively on service delivery.

> "I think firstly they must give us some financial remuneration for being team leaders because we take on a lot of headaches. We run the whole service; we are in charge of all the staff. If something goes wrong…the finger is pointed at us" (FG2P1).

The step-down facility scored high on both variables. Each rehabilitation profession has a chief therapist as a supervisor for their respective staff, and reports to the assistant director (AD) as rehabilitation manager, who is a nurse with specialized rehabilitation experience. With a post structure of 30 professionals including support staff, under 1 AD, there is a flat organizational structure with a wide span of control. This was reported to be an extremely frustrating situation by the AD herself who expressed concern with regard to adequate supervision and support. Despite this difficult situation, operational staff reported that management made a more conscious effort to facilitate teamwork, which resulted in a positive impact on staff morale. In addition, the way resources were used in this facility facilitated greater teamwork.

> "…we mentioned shortage of space – that it was really a blessing in disguise. Now we are together because of shortage of space. (FG3P5)

[19] According to public sector salary scales, senior level is represented at level 7 while assistant directors as managers/heads of departments are at level 9-10.

The rehabilitation services based within the CHC as 'stand alone' primary care facilities, scored high on both variables. Teams are functioning at each of the three CHC's with a team leader. One team (consisting of the 4 professional groups), is required to provide outreach services to several clinics within a wide geographical area. All 3 team leaders are social workers who remain on the same senior level post despite acquiring further expertise and management experience. Team leaders report to the district rehabilitation manager who is the acting AD currently and manage specific community projects, patient treatment programmes and resources at each facility, including staff and financial resources. They contribute to decisions on budget allocation, based on priorities from their own sub-districts. The approach used, as reported by the manager, and confirmed by the operational staff, is more democratic based on the principle of empowering teams to make decisions and provide inputs on the strategic and operational issues affecting their services.

> "…so now I would take small budgets from each sub district and combine them, and that becomes the rehab budget…because they are more participatory now, they know I don't hide anything from them." (manager 5)

In describing the environment, each facility followed hierarchical organizational structures, with staff establishments in accordance with profession-specific levels and positions. The primary level services had also initially inherited a hierarchical structure, but changes were recently made where teams were introduced within each CHC as a more effective way of managing the service. The hospitals demonstrated more authoritative management styles in contrast to the democratic style at the district/ primary level which facilitated the process of change.

3.3. COMPARISON BETWEEN POLICY AND PRACTICE

A comparison is made between the facilities, on the extent to which practice at facility level is aligned to policy, as defined by the two variables. This meets objective two of the study. If several professions are requested to perform one function as policy intends, coordination of activities and combining resources through teamwork is seen as an effective and desirable process leading to the specified outputs. Facilities demonstrating a high level of teamwork and a greater sharing of resources are more aligned to policy. Since this study used both an inductive and deductive analysis in the methodology[20], the policy content is used as the theoretical framework with which to compare alignment of the facilities. The content of the NRP was shown to be strongly influenced by international policies. A perfect score for these two variables is thus regarded as a benchmark.

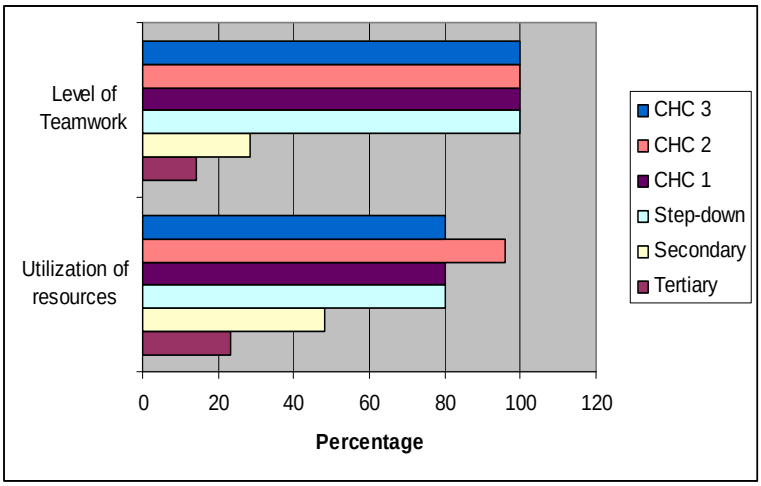


Figure 3.1. *Comparison between facilities on alignment to policy*

Figure 3.1. shows that the primary care facilities (CHC 1, CHC 2, CHC 3) and the step-down facility are on par or moving closer to the benchmark, with the two hospitals (tertiary and district) being further behind. The comparison illustrates that the facilities at the primary care level are more

[20] Chapter 2 outlines these 2 approaches using thematic analysis as defined by Braun & Clarke, 2006.

successful in aligning practice to policy, than secondary and tertiary hospitals. This success is linked to design because of the conscious effort towards change, implemented in management style and structure, as demonstrated earlier.

3.4. IDENTIFYING THE INTEGRATION CHALLENGES

Identifying integration challenges experienced by rehabilitation personnel at operational and managerial levels explores the reasons for some of the successes and difficulties. Four broad themes have emerged from the data. The data derived were rich and complex, serving to demonstrate the multi-dimensional nature of factors influencing public sector performance, specifically in relation to the provision of rehabilitation services. Thus, some themes include sub-themes, as shown in table 3.2., to facilitate understanding of how the themes were derived as well as to capture the complexity of the data.

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Table 3.2. **Themes and sub-themes**

	THEMES	SUB-THEMES
1	**Predominance of professional insecurities**	• Trends in resource allocation seen as expressions of the threat to rehabilitation • Confusion between rehabilitation as an essential service or a specialist service.
2	**Service provision OR maintaining professional boundaries?.**	• Lack of awareness of public policies impacting on rehabilitation services • Differing approaches to improving access and coverage for people with disabilities in service provision
3	**Inadequate teamwork with dysfunctional referral systems.**	• Role confusion between the professions and between the levels of care • Teamwork and coordination: whose responsibility?
4	**Ineffective management and poor leadership**	• Recruitment and retention of human resources. • Lack of leadership within rehabilitation

3.4.1. Predominance of professional insecurities

The four professions targeted in this study expressed varying levels of insecurity and feelings of being threatened. Competition among professions, fighting for recognition and attitudinal barriers, were frequently used phrases across all four groups. Each group appears to be at a different stage in the development of their professional identity. Occupational Therapists and Speech therapists needed the recognition from other team members and management to define their 'self', stagnating at the basic stages in the development of their professional identities. The lack of trust amongst each other and the constant need for acknowledgement from management, especially from doctors and health managers, resulted in professional rivalry and miscommunication. Social workers are attempting to create a new identity within the health sector, where roles and responsibilities are differentiated from those social workers employed in the Social Development sector. As each profession struggles to affirm an identity, difficulties are expressed in team work and motivation of staff.

> "…because of the role conflict, or professional jealousy or what you call it…competition. It's the attitude because it's not them driving it. It's a difficult thing and there is wasted energy. The main thing is there should be a combined focus, in other words, people must have the same objectives and I'm not sure if people have the same objectives at the moment". (Manager 7)

> "We get salaries from health but are guided by social development" FG1SP9

3.4.1.1. Trends in resource allocation seen as expressions of the threat to rehabilitation

There was consensus amongst all the managers that rehabilitation is seldom prioritised, and receives little attention by top management structures, especially hospital management. The degree of recognition is measured by the level of resources allocated to the different professions, whether separately in the hospital, or as teams at a

> "At one stage we were told that rehab is not going to be concentrated in the hospitals so much, but more in the clinics. You see the budget getting less at the hospital level but you don't see the budget coming to the clinic level" (FG3P4)

primary level. Resources (HR, physical and financial) are reported to be allocated on the basis of saving lives and curative approaches in the overall health system (therefore more to doctors and hospitals), with the quality of life being neglected. At the primary level, where expensive equipment is not utilized, the lack of adequate posts for increasing human resources and improved salaries, are reported to be the greatest threat to sustaining services.

3.4.1.2. Confusion between rehabilitation as an essential or a specialist service

> "We don't all want to be managers. Some want to specialize" (FG1P2)

Although there was a general understanding of PHC principles, professionals working in the hospitals placed greater emphasis on recognising rehabilitation services as specialized, with reference to the individual, medical approach. Managers as well as operational staff expressed concern at the lack of career-pathing for those rehabilitation professionals who want to specialize, since there are no posts which recognise those who have further specialist qualifications. Where rehabilitation services are provided from PHC clinics greater coverage is reported with more people with disabilities able to access rehabilitation services. However, the negative side to this was also pointed out by several operational staff. There is a loss of 'clinical details' when attempting to reach out to so many clients resulting in "watered down sort of information" (FG2P1). Professional insecurities again surfaced with a need to maintain profession-specific areas to maintain integrity. While operational staff at the primary levels attempted to define the essential component of rehabilitation service through describing their activities, there was little consensus from their colleagues from the hospitals on the differing roles and responsibilities between essential and specialist services.

3.4.2. Service provision or maintaining professional boundaries?

3.4.2.1. Lack of awareness of policies impacting on rehabilitation services

National health regarded the NRP as a progressive policy and stated that it helped raise awareness for rehabilitation services. The provincial rehabilitation policy was reported to be operationalized, despite limited success for operational policies to be aligned to national policies. However, the majority of participants at the local facility level, including facility managers, were not aware of the NRP and the INDS, or what the implications of broader changes in health policy were. Four managers (out of ten) were aware of and had a copy of the policy, but could not relate to its content. Three managers were aware of the NRP and conversant with its content. Participants focussed on the professional and technical components of their work, through describing frustrations and obstacles in their efforts to fulfil the professional duties they were trained to carry out. Maintaining professional boundaries was emphasized by all, especially amongst those working in hospitals.

3.4.2.2. Differing approaches in improving access and coverage for people with disabilities in service provision

Various approaches to service provision for rehabilitation were expressed, with the general understanding that services were not reaching many people with disabilities. Participants from the hospital followed the individual, medical approach to service delivery, others spoke of the group or 'client-based' approach in making the disabled person central to the rehabilitation process, while at the primary level, participants spoke of the concept of CBR as part of the essential PHC package. However, identifying the most appropriate approach to service provision was varied among the participants, especially among managers from the different spheres of government: national,

provincial and facility level. Resistance to the concept of CBR as a strategy within the PHC approach was expressed by nine out of the ten managers from all three spheres of government. CBR was viewed as an NGO-driven initiative, which was not intended to be implemented within the formal health system. In addition, training institutions were criticised for their bias towards professional development, as opposed to service provision and service development. All the operational staff reported that there was limited guidance on service delivery from protocols. Thus, participants are faced with a dilemma between service provision in improving coverage and ensuring access, as defined by their employing organization (being government), and in maintaining profession-specific boundaries as defined by their professional norms and standards.

> " I think training institutions need to stay in touch with developments, public sector development and I don't think they always do…but making sure that this whole community development aspect is in the curriculum…it is important for them to stay in touch with what happens in the province (manager 8)

3.4.3. Inadequate team work with dysfunctional referral systems

Concern was raised by all participants at the lack of an effective referral system between the facilities and between levels of care. These were expressed through various problems experienced in patient follow-up and continued long term care. Persistent underlying themes were related to role confusion, lack of team work and coordination of services.

> "…we are all trying to see where they fit and how the referrals will work between the different areas, because I think at the moment nobody is actually clear how it will work and what kind of patients can be referred up and down and wherever, and how the regions would work, because that is not sorted out at the moment. It has been a grey area even before we started" (Manager 3)

3.4.3.1. Role confusion between the professions, and between the levels of care

Participants reported that staff from the secondary hospital are expected to provide tertiary level of care and the tertiary hospital continues to provide primary and secondary levels of care on an outpatient basis because of difficulties with down referrals or follow-up at clinics. The most evident role confusion was expressed from the Medical Orthotics & Prosthetics profession, where even higher level management was reported not to understand where they fit in. From a clinical perspective, roles between the professional groups overlap. Where professional groups were reported not to be "mature enough" in their professional identities, this role overlap was found to be threatening to some. In the majority of cases, this problem was reported to arise with junior or newly qualified rehabilitation professionals. Managers attributed this to their training, which has to be 'unlearned' in their working careers. The negative effect of this role confusion on patient care and on service delivery is evident in poor rehabilitation outcomes.

> " At the end of the day people need to realize what is their scope of practice, be clearly aware of standards…There definitely have to be clear limitations in what you can do. I think if once people realize exactly what their roles are and what the other team members roles are, they will have respect for the boundaries and be more clear cut on what each does". (Manager 1)

3.4.3.2. Teamwork and coordination: whose responsibility?

Participants distinguished between ideal teamwork and what was practically happening on the ground. Ideal teamwork was reported to be based on "mutual respect and shared responsibility with recognition of individual skills and professions" (Manager 7). It involved setting goals together and shared decision-making on the use of resources. Team leaders, debated to be doctors by some while others said it could be anyone from the health team, were found to be necessary for the functioning of teams. Adequate management experience and non-interference in clinical work were prerequisites outlined for team leaders. However, ideal teamwork in the public sector is reported to be non-existent by operational staff in the hospitals, stating that it is dependent on personalities and

choice. Hospital managers in contrast report that teamwork does exist in specialized units like "paediatrics or ENT" (Ear Nose Throat). At the district level, the lack of promotion and unavailability of posts that match the duties of the team leader is reported to demotivate staff.

> " I'm not sure that we have protocols that guide teams. What I do know that we all have job descriptions and that these job descriptions don't necessarily encourage this. But if there are certain personalities and behaviours that can work with other people then teams work - but it shouldn't be a personality issue. It would be good to have a protocol that says you will be cordial/respectful etc, but we don't have this." (FG1P8)

The task of coordinating services between the professions, the facilities and between the levels of care was understood as crucial, especially amongst the managers. However, the person/group responsible for this was not clear. Two managers noted that it was the task of the provincial coordinator, while others did not attribute the responsibility of coordination and teamwork to any one particular authority, rather that protocols and job descriptions should stipulate teamwork and that teamwork should be a conscious management function and effort.

3.4.4. Ineffective management and poor leadership

It was reported that "with decentralization the intention was that managers will be able to manage, but the experience has been different" (manager 10). This sentiment was echoed through all levels of care amongst the participants, where managers themselves expressed frustration with the system and staff complained of the frustration of being managed. Participants made direct reference to problems with leadership and HR issues within rehabilitation and within the health sector more broadly. Overall, it was reported that there was a lack of support in the management and provision of rehabilitation services.

Operational staff reported that managers were unaware of what they did and that they are not valued as employees. Rehabilitation was not represented on decision-making structures at facility level, which was dominated by doctors and nurses. Administrative inefficiencies, because of unskilled officials, resulted in rehabilitation professionals performing administrative functions themselves to reduce frustrations and overcome delays. These activities took up valuable time when they are expected to perform professional duties as well. While many of these issues were expressed through complaints and frustrations, one manager reported that rehabilitation managers themselves did not address and manage change adequately. Managers needed a "mind shift" but instead were "resistant to change" (Manager 7). Rehabilitation managers provided insight into their own management experience, where in the light of receiving no management training (nurses and doctors are reported to be prioritised for management training), they had to perform management functions by learning on-the-job and from knowledge and support obtained from colleagues. Financial management was reported to be a 'vicious cycle' where over-budgeting became the norm because of fears of getting less. At the tertiary hospital level, budgets were given to separate professional groups, resulting in 'competition' among the professions for recognition from top management. In contrast, financial planning for rehabilitation at district/primary care level was reported to be successful in using budgets as a resource for integration between the professions.

> "You are literally constantly putting out small fires" (FG3P4).

3.4.4.1. Recruitment and retention of human resources

All participants reported that recruitment and retention of staff was the one major challenge facing all rehabilitation professionals. Apart from administrative red-tape and delays experienced through the Gauteng Shared Services Centre (GSSC) and HR departments, managers find that rehabilitation

> "Its not pick of the crop anymore – you have 8 posts, 3 apply and you have to take all three." (FG3P4).

professionals are not even applying for jobs in the public sector after they have completed their compulsory community service. The frustration of high staff turnover was reported to be a major obstacle in planning for services. Current staff cannot find relief through locums and have difficulty in attending continued professional education, development and training due to staff shortages and increased workloads. In many instances where further skills training had been attended, the expertise is said to be lost to the private sector, with little or no integration of knowledge.

Junior staff found themselves fulfilling management duties to ensure the smooth running of their units at the expense of valuable treatment time with patients, because there were no posts for team leaders. With staff shortages, managers in turn had to perform clinical duties to continue with service provision and meet the demands of patients and the public as front-line providers, which resulted in neglect of essential management duties. Higher level management expected quality, but staff reported that they were experiencing burnout and are barely coping with minimum service standards. Nationally, there is a call for a different culture of management that embraces flexibility and innovation but at facility (local) level it is perceived as "a continuous drive from higher up to do something" (Manager 6), thus increasing the pressure on managers to manage their resources effectively while also being accountable to the public for service delivery.

> "In our department, it doesn't matter what position you in, you land up doing everything – from seeing the patient to management"
> (FG1P5

The skills and qualifications of managers were also debated. While existing managers complained that management training was limited and selective, two managers argued that compulsory management training and post-graduate qualifications should be a requirement for all managers. Within the CTMM specifically, where rehabilitation managers remained in the same position for more than ten to twenty years, especially at the tertiary hospital, the young and emerging managers

reported that there was a "need for fresh blood in old management circles" because there was a "lack of capacity building and empowering others" (manager 1). Obvious management failures combined with poor salaries in attracting staff and little recognition for the work of rehabilitation professionals within the public sector was reported to be negatively affecting staff morale.

3.4.4.2. Lack of leadership within rehabilitation

Issues relating to poor leadership and lack of strategic direction were expressed from different perspectives. While change was perceived as a good opportunity to put new structures in place by those in leadership positions, national, provincial and facility (local) levels presented conflicting views and experiences. National explained how change is managed by institutional structures that are supportive of goals and objectives and that four to five districts in Gauteng have structures in place. Provincially, there was a call for more AD posts at district level to initiate services because 3 AD posts were taken away at that level. The district manager called for an aggressive approach to establish a structure, and added that people are waiting for this structure. Many operational staff reported that existing platforms and structures to facilitate interaction (referring to provincial forums), are ineffective because there is limited time to interact and that the forums are not addressing issues of role clarification.

> "Eventually to finalize a structure that is working for everybody. There is some kind of involvement, but I think there should be an aggressive approach to that. In my opinion, there are people who are waiting for the structures. There is nothing on the positive note to say that they are driving us towards it. You will hear that there is another district hospital coming up. But how are they involving the people who are working there? I don't know." (Manager 5)

The province was seen as the driving force from both the national and local participants. Gauteng Province was expected to administer the policy formulated at national level through developing guidelines. Facility managers echoed that there was a need for a "dynamic leader for rehab at central office" (manager 3) stating that generally, indecision and the lack of accountability from

provincial health managers were detrimental to rehabilitation services. The provincial manager found herself pressurised between dealing with professional issues, management issues, inter-sectoral issues and the frustrations of general administration hiccups and bureaucracy. Currently, eleven professions are reported to be under provincial management, including five groups from this study as well as others[21] not directly involved in disability issues. According to the experience of the provincial manager, there is a need to cater for the smaller professions in the same way as those more established, even though smaller professions have no structure or treatment guidelines.

3.5. OUTLIERS

While outliers do not fall into the mainstream pattern of themes from the body of data generated, they shed light from a different perspective in understanding the subject matter. Two outliers were found in this study: gender, racial and professional insensitivity towards rehabilitation professionals and the placement of graduates for community service.

3.5.1. Gender, racial and professional insensitivity

> "I experienced especially with the white Afrkaans speaking males, who were the supers at the time…they were terrible, they were paternalistic. They would have the attitude like 'shut up, I know best'…that condescending attitude"
> Manager 6

This theme was expressed explicitly at the local (facility) level. Reference was made to the dominance of white male doctors from the past, which influenced the prevailing attitude against rehabilitation professionals, represented mostly by females. The status accorded to doctors within the health team was reported to create a power struggle in decisions made about patients. Sub-ordinates to the doctor are predominantly females forming a hierarchy of control and decision-

[21] As noted earlier, rehabilitation services in Gauteng Province include the five professions in this study as well as six other professions which are fall directly under the management functions of the provincial rehabilitation coordinator.

making, with nurses being second to doctors and all other supporting members of the health care team having little recognition or decision-making power. This had a significant impact on the working environment within the facilities to the further detriment of relationship-building and teamwork amongst health care workers.

3.5.2. Community service

Problems with community service were raised as a concern by participants at the primary level of care. Resistance to teamwork from new graduates performing community service, together with their negative attitudes (described as “arrogant and patronising” FG2P2), was found to be added stress for the already over-burdened permanent staff. It was reported that the initial plan was that community service placements would serve as additional HR, but that they are now occupying permanent public sector posts, although they still require supervision. These factors result in a negative impact on service delivery because the shortage of staff was not addressed through the placement of community service graduates.

3.6. SUMMARY OF THE FINDINGS

The management of HR and rehabilitation services at the selected facilities demonstrates a gap between policy and practice at the tertiary and secondary levels of care, when compared with the intention of the NRP. In addition, polices and norms and standards that aim to guide HR in the provision of rehabilitation services in the public sector are not aligned to each other. These directly influence HR performance and service outcomes. Integration challenges, as expressed through the direct experience of rehabilitation service providers, have further highlighted the social and institutional phenomena impacting on service delivery.

CHAPTER FOUR

DISCUSSION

With evidence of a gap between policy and practice in the provision of rehabilitation services, resistance to change, establishing a professional identity and major capacity constraints at all levels of the service further hindered the implementation of an integrated rehabilitation service. These areas are further elaborated on, in relation to the findings in this study. A framework, outlined by Grindle & Hilderbrand, 1995, which aims to understand the dimensions of capacity for improving public sector performance, is applied as an analytical tool in discussing the capacity constraints that emerged.

4.1. LIMITATIONS OF THE STUDY

Before elaboration and discussion around the major findings, it is important to point out the limitations of this study. The findings highlighted important policy implementation challenges. Being qualitative in nature, the study did not aim to generalize. However, the theories generated used a pool of respondents at the national, provincial, and local/operational levels in the public health sector, leaving little room for other opinions or experiences.

Bias was noted during the selection of sites which depended on the availability (at all three levels of care) of the professional groups targeted. Facilities representing a full team of rehabilitation professionals were found to be scarce, often with only one or two professionals in employment. These factors resulted in the selection of an urban metropolitan district. It is conceivable that the selection of a rural or peri-urban district would have produced a different scenario of the management of rehabilitation services, where geographical differences in staff availability and

contextual issues could act as further facilitatory or constraining factors in the implementation of the NRP. Observations at the different facilities presented another bias when visits had to be pre-arranged with the managers, which may have influenced staff positively or negatively towards an 'outsider/intruder' in their natural work setting. Various staff on site were consulted and researcher bias was overcome by the use of an observation template for a standard approach to site observations.

4.2. RESISTANCE TO INTEGRATION BY REHABILITATION PROFESSIONALS

Although there are different designs and models of an integrated service or system, its operation depends on local factors such as existing policy and procedures, inter-agency agreements and resources (King & Meyer, 2006). In addition, successful health care integration is also said to require leadership and 'champions', both clinical and managerial, to maintain commitment and manage change (De Jong & Jackson, 2001). Participants in this study, including managers and leaders, demonstrated strong resistance to integration in various ways.

When senior managers were required to work together in the management and integration of several rehabilitation professions, it meant doing things in new and non-traditional ways. The majority of rehabilitation managers continued to manage HR in the same way as prior to 1994, when the five professional groups were managed separately without the guidance of a national policy. A separate hierarchy of professionalism was maintained by the senior managers who responded to change out of insecurity and fear of losing their professional identities. Insecurities and turf battles, seen as the 'soft issues' in this policy process, highlighted the local context, which was defined by the historically difficult working relationships between the rehabilitation

professionals. An effort to facilitate integration was seen as a threat by the professionals to their individual identities, even though they may intuitively or privately understand and concur with the goals of service integration. The threat to their professional identities was further mediated by the availability of resources. Hospital managers especially, competed in securing state-of-the-art equipment, and maintained separate budgets for their own professional units in order to utilize the skills they were trained for. Rehabilitation professionals in this study contributed to the widespread view that integration will dilute the professions, thus it was pursued from neither a managerial nor a clinical perspective within the secondary and tertiary facilities, sustaining the silo approach to service delivery. From a managerial perspective, resources had to be made available for an integrated rehabilitation service to promote service development, as well as ensuring that the individual professions are able to provide the professional expertise.

Valentine, Fisher & Thomson, 2006 introduce the concept of 'participation' as a measure of the effectiveness of implementing an integration policy. Integration is said to rely on people building relationships at individual, organizational and professional levels and was found to be successful in organizations that *consciously* designed strategic processes and changes to existing structures to build and maintain these relationships. In the management of rehabilitation services, as observed through the facility visits, a conscious effort and commitment to integration was not reflected in planning for teamwork and utilization of resources. Resistance to change, motivated by preserving their individual professional identities, detracted the 'older' managers as role models, from their purpose in the public sector. In turn, the assumption by policy makers that policy statements and time were sufficient conditions for people to embrace new perspectives and participate fully in the process, contributed further to the failure of integration.

4.3. THE DEVELOPMENT OF PROFESSIONAL IDENTITY

Professional insecurity, being one of the key impediments towards service integration in this study, is symptomatic of chronic stress experienced by rehabilitation personnel in the process of professional socialization. The struggle for developing a professional identity which is acknowledged and valued not only among the broader health care team, but within society generally has been an ongoing one for rehabilitation professionals[22] (McMichael, 2000; Lindquist et al, 2000). The inductive approach used in analysing the data from the service providers themselves, identified the common theme of professional insecurity. This deserves further unravelling for a deeper and better understanding of the local context for rehabilitation.

The development of a professional identity starts with the educational process where students are socialized in the values, attitudes and beliefs of their chosen profession and a commitment to a professional career (Lindquist et al, 2006). This process continues into the working career where this identity is tested within a context of diversity and dynamism. While schools of health sciences exist to develop professionally mature practitioners who can render health care appropriate to the needs of society, the socialization process differs from one group of professionals to another in an attempt to distinguish a unique skill and service from other professions. Costello, 2004 states that during professional socialization, two tasks must be mastered: (i) a body of knowledge and skills defining the profession and (ii) the internalization of an appropriate professional identity. The internalization of an identity depends on personal attributes as well as on exposure to various professional and academic environments, role models and society at large. Having a strong

[22] International literature is available on the development of professional identity amongst rehabilitation professionals specifically, but anecdotal evidence is available locally. This study directly involves documenting the experiences of rehabilitation managers with more than 20 years experience: the majority of them have made direct reference to this form of struggle.

professional identity is necessary for the professional to practise with confidence and authority that convinces others of his or her competence. Professional socialization therefore involves transformation (Hammer et al, 2003); the transformation of individuals from students to professionals which is an active process that must be nurtured throughout the professional's development.

It appears that in the educational process of the developing professionals, different socialization processes have not adequately prepared the rehabilitation professions investigated in this study to adapt and further develop the core skills and attitudes taught at university within the external working environment. Rehabilitation professionals are trained and registered as 'specialized' professions for employment in the public sector, while health policies require the rendering of integrated services at the PHC level, once employed. Expectations for rendering specialized services are difficult to meet for service providers in the public sector and frustrations have been shown to arise if resources are not allocated according to level of training. Evidence of each group attempting to assert their 'uniqueness' or their 'self', whether newly qualified or as longer serving professionals, demonstrates that they are struggling to move beyond the early stages of developing a professional identity.

Similar findings from studies carried out with other colleagues show that social work has an identity crisis in terms of its self- perception (McMichael, 2000; Costello, 2004); that occupational therapists and physiotherapists display potential for a weakening professional identity and that role ambiguity and uncertainty in relation to teamwork are evident in how they construe their identity (Lindquist et al, 2006); and poor inter-agency and inter-professional collaboration result in the concept of 'collective efficacy' being difficult to operationalize at a systemic level (Johnson et al, 2003). The

DoH depends on the different professional boards to maintain a certain technical proficiency, however, regulatory functions and guidance by the professional boards should not be in conflict with policies of the DoH, specifically with the NRP. This is crucial for effective HR performance and service outcomes.

Doctors and nurses, as well as pharmacists, have increased efforts to enhance professionalism (Hammer et al, 2003; Taylor & Harding, 2007; Molnar et al, 2006). However, there is a need to move beyond ethical rules and etiquette in lecture form, towards more innovative ways of internalizing professional identities. While rehabilitation professionals have been struggling at the foundational stage of developing professional identities, policy reforms necessitated the adoption of a new 'rehabilitation' identity, adding a second level of transformation. Neither professionals in practice nor public sector managers of rehabilitation services have demonstrated the will, leadership or capacity to take this dual transformation process forward.

4.4. IMPLEMENTATION OF POLICY: BY DESIGN OR BY DEFAULT?

The evidence of management failures and the gap between policy and practice, demonstrate that lack of 'implementation capacity', as the minimum condition for successful policy implementation, is a critical explanatory variable for rehabilitation professionals. Brynard & De Coning, 2006 state that the concern is not simply '*what'* capacity is required but also '*how'* this capacity can be created and operationalized.

If policy implementation includes all the many activities[23] that happen after the statement of a policy is made, the experience of rehabilitation in Gauteng Province shows a lack of overall planning, strategy generation and development of operational policies, especially at the provincial level. The concept of CBR continues to be a 'bone of contention' in South Africa, with confusion as to whether it should be a philosophy, a programme or a strategy – each having very different implications. As a programme, it has remained predominantly within the scope of NGO's. As a strategy, it lacks direction and the operational guidance necessary to be placed within the essential PHC package. Thus, because of the failure to implement the objective of changing the nature of management as stated in policy, rehabilitation services continue to be managed at most as a project with short-term goals, emphasising intervention at the level of individual case studies.

A policy analysis approach brings into focus other factors that influence policy outcomes. Using the policy analysis triangle outlined by Walt & Gilson, 1994, the influence of contextual factors, as outlined in the literature review and document analysis, influenced the content of the NRP. Even though CBR and the social model of disability were regarded as the progressive alternatives to improve access to rehabilitation services, it threatened the 'street-level bureaucrats' as front-line service providers, being rehabilitation professionals in this case. The policy process attempted to follow a bottom-up approach in its formulation, but evidence demonstrates a top-down rational approach in its implementation. Initial power was vested in politicians, people with disabilities and 'progressive professionals' during the policy development phase. However, the power has shifted to those street-level bureaucrats as service providers during implementation, who continued with

[23] Brynard and De Coning (2006) describe these activities as 'policy instruments' including planning, strategy generation, programme management, project management, operations management, contracting, privatization and public-private-partnerships.

'business as usual', without acknowledgement of the NRP. Thus, implementation of policy is rather by default, i.e. that which continues to exist because change was not intentional.

4.5. CAPACITY CONSTRAINTS WITHIN THE PUBLIC HEALTH SECTOR

Research involving other health care workers within the context of decentralization shows that capacity constraints are characteristic of poor public sector performance generally (Grindle & Hilderbrand, 1995; Mills et al, 2001; De Villiers et at, 2006). Introducing policy reforms for the entire public sector since 1994, and reforms for rehabilitation services in 2000 through the NRP meant managing change. The experience among rehabilitation professionals confers with evidence from the other studies and shows that managers at all levels were not empowered to manage change. Grindle & Hilderbrand, 1995 define capacity as the ability to perform appropriate tasks effectively, efficiently and sustainably, and outline five dimensions of capacity. This is applied as a framework in analysing the data.

4.5.1. The action environment

The broader economic, political and social context of health sector reform outlined in the literature review demonstrates the impact of these factors on the entire health system. The behaviour and performance of the rehabilitation managers in this study are also reflective of the broader health system. Confusing priorities and problems with implementation of decentralization policies define the action environment. Improving administrative and service delivery effectiveness through autonomy and decision-making at more local levels, did not result in increased productivity and improved performance for rehabilitation services in Gauteng Province. Senior rehabilitation

managers were challenged to influence the management process directly, but capacity and leadership problems constrained the process.

4.5.2. The institutional context

This dimension includes such factors as the 'rules and procedures' set for government operations and public officials, and have served to broaden the conceptual understanding of capacity. Rules and procedures are needed for getting things done and getting them done right for day-to-day functioning in service delivery. Mills et al, 2001 outline that even though the process of policy formulation may be relatively straightforward, it is during implementation that fundamental conflicts between reform policies and the institutional structures and capacities of a country are likely to become apparent (Mills et al, 2001). Where 'rules' have not been defined for the provision of rehabilitation as a service, demonstrated through role confusion, lack of coordination and differing approaches in this research study, one could argue that managers and service providers depended on their own experiences and conceptual understanding of the situation. These experiences in turn, differ from manager to manager and organization to organization, thus requiring attention at least on the setting up of rules. This study identified three key agencies that play a role in setting up these rules in the delivery of rehabilitation services: the DoH itself as the agency of government in the provision of services; HPCSA through the various professional boards in guiding and regulating the professions (SASSA for social workers); and DPSA as the agency that regulates the employment of public officials.

In the provision of rehabilitation services, government has assumed the function of provider of services to the majority of people with disabilities. Rehabilitation managers and leaders in the field

did not demonstrate leadership or capacity to establish rehabilitation functions within the PHC package, as prioritized by national health. Rehabilitation policy has had little impact on moving away from the individual biomedical approach to rehabilitation, demonstrating that reprioritization and reorientation towards PHC means going beyond policy statements by influencing the way services are managed, changing the structures and responsibilities, as well as addressing allocational inefficiencies in the broader public health sector to make more resources available. Curative care within hospitals, especially at the tertiary level, continues to be better resourced as evident from other research (Doherty et al, 2002). In addition, red tape in securing resources, inefficient utilization of resources and duplication of functions as reported by the participants are reflective of the constraints experienced in the broader health system. This study concludes that in addition to bureaucratic inefficiencies, lack of clarity on roles and functions between national, provincial and facility levels, together with lack of planning and strategic direction within the DoH and GDH, are all factors that have further constrained the capacity to deliver rehabilitation services.

When government depends on the HPCSA/SACSSA to act as an agency to guide the professions, it would be expected that norms and standards set by the professions are aligned to national policies for effective and efficient service delivery. In the case of rehabilitation professionals, policy imperatives do not concur with professional norms and standards. National health calls for integrated rehabilitation services within the social model of disability, while standards define the individual and medical approach to intervention. Furthermore, registration with the different boards, with norms and standards set by separate professional inputs, further deviates from efforts in implementation of policy objectives set by DoH. The assumption that all agents working within the health system possess full information on the 'rules of the game', is usually overcome by institutional arrangements made between the different agencies. It appears that formal institutional

arrangements regarding service delivery (as opposed to professional development) have been neglected for rehabilitation, leaving the 'rules of the game' undefined or unclear, thus perpetuating the incapacities of those expected to deliver services.

DPSA, as an 'employment agency' for government, seeks to ensure that the public sector is an attractive employer of choice among rehabilitation professionals. While issues of remuneration are known to be a major 'push factor' from the public service, transformative efforts (as opposed to transactional) in human resource management by the DPSA has not impacted positively on rehabilitation service providers. This study has shown that the strengthening of HR management systems should also include active recruitment for leadership development, with an aim towards strengthening commitment in the public health sector. When health officials leave the public sector, and are attracted by any of the 'pull factors' from other employers, they are subject to new rules that define their new working environment. Anecdotal evidence demonstrates that those rehabilitation professionals entering the private sector are required to work within teams, facilitated by a rehabilitation manager, who may not be from the same profession. Whether there are personality clashes or not, there is no choice but to work within the team approach. If the rules of the game change, behaviour also changes. There is a strong need for DPSA to ensure that the contract between government and the professional (employee) is respected or taken seriously; and to effectively communicate the vision and mission of the public service. Rules defining a professional as an employee of the public sector seem not as important as rules of the profession they belong to. These demonstrate how the institutional context is constraining the delivery of effective rehabilitation services in the public sector.

Two agencies not directly identified in this study are the OSDP and the educational institutions involved in the undergraduate training of rehabilitation professionals. The task of the OSDP is to coordinate, monitor and facilitate the implementation of the INDS within other government sectors, highlighting the need for rehabilitation services to be recognized across the sectors. While these are not under investigation in this study, participants have stated that the health sector is still seen as the major role player in the delivery of services for people with disabilities. With minimal inter-sectoral collaboration, this perpetuates the understanding of disability and rehabilitation as a medical issue only[24]. Institutional arrangements have to include these sectors for further integration towards agreed outputs and improved outcomes on realizing the rights of people with disabilities.

Participants have further reported on the inappropriate training of rehabilitation professionals, where attitudes and insecurities are already learnt at undergraduate levels. The curricula need to reflect the changing needs and socio-political landscape of the country, as well as to keep up with professional development through research and evidence-based practice. Aside from the educational institutions, the roles and responsibilities of professional associations are questioned. Practitioners and academics alike have direct responsibility for their own development, through active involvement in their respective professional associations. Although these areas are not included in this study, they point to the need for reviewing the functions of all the actors and agencies involved in the task of rehabilitation service provision.

[24] Rehabilitation International's position paper on the right to (Re)habilitiation argues that there is a misconception that a discussion of (re)habilitaition belongs under the right to health and that this should not be a starting point if we are to move away from the perception that disability is a health issue. (Cementwala, M.A.)

4.5.3. The task network

The task network refers to the set of organizations involved in accomplishing any given task. Performance is affected by the extent to which networks encourage communication and coordination and the extent to which individual organizations within the network are able to carry out their responsibilities effectively (Grindle & Hilderbrand, 1995). The involvement of different levels of care, different spheres of government and evidence from both objective (policies, norms and standards) and subjective inputs (KII and FGD's), confirm the role of different organizations in performing the task at hand. The poor rates of follow-up within an overcrowded and overstretched public health system are not unique to rehabilitation services. Continuity of care, as with other chronic problems in health care, depends on an effective referral system between the three levels of health care. Since each level, represented by managers based at the different facilities (hospitals, community health centres and clinics), is managed as a separate organization, an effective referral system depends on formal arrangements between facilities.

Role confusion, lack of teamwork and poor coordination, are reported to be characteristic of the referral system in this study. Access to services at all levels and quality of care is therefore compromised when clients become 'lost' in the system, or worse, fall out of the system. Networks are further defined as organizations within and outside the public sector, including NGO's (private-for-profit and faith-based organizations). However, the scope of the study could not include other organizations involved in the delivery of rehabilitation services, although NGO's have filled many gaps in the provision of rehabilitation services in the past and continue to do so. Thus, the lack of an effective task network within the public sector, has been shown to constrain capacity to deliver rehabilitation services.

4.5.4. Organizations

Organizations are regarded as the building blocks of the task network. Several factors have been reported to affect organizational output and shape the behaviour of those who work within them. Grindle & Hilderbrand, 1995, found in their study carried out in five developing countries, that in assessing public sector performance, strong organizational cultures, good management practices and effective communication networks were more the drivers of effective performance than rules and regulations or procedures and pay scales.

At an organizational level, rehabilitation managers in the public sector seem not to have been able to influence change as active participants and have entered the broader debates on effective public service delivery to a limited extent. They appear to have been the 'observers' during the reform process. The culture[25] instilled and sustained over the years by the more experienced rehabilitation managers, was one of fear of change which was promoted on the basis of upholding the individual professions. Due to their specialist training, rehabilitation personnel developed a self-image where they tended to value their skills and reputation among their colleagues more than their employing organizations. Myron (1988) describes this as 'conditional loyalty'. With a lack of awareness of public sector policies generally, the degree to which rehabilitation personnel identified with the organization they worked for versus their respective professional bodies was brought into question.

Management failures however are not a new phenomenon within the public health sector (De Villiers et al, 2006; Lehmann & Sanders, 2002; Subedar, 2005). Understanding rehabilitation as a service within the broader health care environment helps to understand the behaviour of

[25] 'Culture' in this context is adopted from the perspective by Myron (1988) specific to health institutions, who states that culture within a health organization is based on shared beliefs and norms and values, which create homogeneity and identification by individuals with the organization and what it stands for.

professionals employed in the public sector. Hospitals and clinics as organizations follow hierarchical structures in order to manage their many different functions. When various rehabilitation personnel are managed according to a structure independent of each other, as findings in this study demonstrate, identifying common rehabilitation goals, combining inputs for more effective outcomes, and monitoring and evaluating activities become difficult tasks to accomplish - although not impossible. It calls for effective management and stronger coordination. However, when professional goals were in conflict with the administration (organizational goals) of improving access and increasing coverage, facility managers are helpless in influencing the institutional context without effective leadership.

Successful implementation of the NRP depended on reviewing organizational structures, when structures no longer served new organizational goals. The intention of integration was not in line with the organizational structures of the past and present, where there can only be one head of department. This calls for a reform of the current organizational structures, as tools for change within the public health service. A rapid appraisal of the managerial capacity of selected South African District Hospital's in 2006, similarly concluded that organizational structures should be based on clear operational units and that management should reflect this through a strong emphasis on management teams (De Villiers et al, 2006)

Understanding how alternate providers of rehabilitation services organize and manage their services, helps to enrich the discussion at this stage. In the private sector, the employment of a rehabilitation manager with 'inter-disciplinary teams' and common working spaces, is a strategic management function to facilitate focussed goal-setting (Wundrum, 2007). 'Engineered consensus' was a term used to encourage teamwork and coordination by a rehabilitation manager, who is not

required to give professional guidance, but to manage the service. The private sector in South Africa facilitates team work through effective and 'conscious' management functions. The USA model of 'managed care' and rehabilitation teams has attracted local professionals due to its positive impact on patient care, staff motivation and efficiency. Similarly, 'clinical governance' as a policy initiative introduced in 1998 in the UK, aimed at improving the quality of clinical care, through promoting an integrated team approach in health care using a uniform governance framework (Som, 2006). Canada, in turn, introduced the concept of inter-disciplinary health teams as a patient-centred approach towards effective decision making in all aspects of health care (Kabene et al, 2006).

Examples from other countries as well as the private sector, despite the differing contexts, illustrate that the explicit function of management for teamwork and coordination of tasks, is crucial for facilitating integration at an organizational level. Teamwork should be a strategy for effective integrated service delivery in the public health sector, requiring each organization to outline a functional structure and operational plan to put teamwork into action. In the absence of effective planning for teamwork, informal processes define the way services are delivered, thus impacting negatively on performance.

4.5.5. Human resources

This dimension focuses on managerial, professional and technical talent and the extent to which training and career trajectories affect the overall performance of a given task. This relates to the education and recruitment of HR into public sector careers, but more importantly on the utilization and retention of individuals as they pursue such careers. Grindle & Hilderbrand, 1995 argue that

effective utilization of HR within organizations is the most important factor in determining whether public officials are productive or not. However, for the rehabilitation professions involved in this study, both career trajectories and the utilization of HR within the facilities, were factors influencing productivity.

Managerial incapacity, resistance to integration and the lack of a 'rehabilitation identity' resulted in poor utilization of existing rehabilitation professionals at the secondary and tertiary levels of care. Innovative approaches at the primary care facilities remain successful initiatives at the level of case management or projects, without being adopted as 'best practice' models at the systems level. These efforts have little chance of surviving within an institutional context that constrains inter-agency and inter-professional performance within the public sector. Resistance to integration has been associated with the socialization of the professions, where educational institutions are given the direct responsibility of shaping the attitudes of newly qualified professionals[26]. However, practitioners and academics both have the obligation to instil strong identification with the profession as well as to rehabilitation as a service.

The direct reference to gender insensitivities in the findings draw our attention to the hierarchy of power and trust that exists between health care professionals, particularly amongst the rehabilitation professionals. Gender inequalities, which permeate broader society, may have negatively influenced the performance of rehabilitation managers who remain predominantly female, while hospital managers and doctors were mainly male in the past. Even though the current

[26] This association had been made by several experienced rehabilitation managers in this study. In addition, literature supports the notion that the source of resistance and conflict between health care professionals arises from the socialization of the professionals and development of professional identities (Kabene et al, 2006; King & Meyer, 2006; Lindquist et al, 2000; McMichael, 2000)

wave of 'feminization' of the medical profession could produce a different or new kind of power struggle, rehabilitation professionals were unable to exercise authority in decision-making within the hierarchy of the medical team. HR managers need to be aware of behaviour and attitudes as the soft issues in the utilization of HR, demonstrating that the understanding and practice of HR management need to move beyond a personnel function to a more strategic function in order to influence transformation and organizational development positively.

Problems with the recruitment and retention of HR, are not unique to the rehabilitation profession. HR in South Africa's health system continue to be in crisis, despite the introduction of specific policy reforms to improve the production, recruitment and retention of health care professionals in the public sector (Wadee & Khan, 2007; Sanders & Llyod, 2005; Kabene et al, 2006; Subedar, 2005, Schneider et al, 2007). Although the 'National Human Resources Plan for Health' (DoH, 2006a) provides an overall framework to address the HR crisis in health, serving as a reference point for provincial HR plans, the management of HR is not adequately addressed. An increase in the production of professionals regarded as scarce skills, as rehabilitation professionals are, does not necessarily translate into their availability, commitment and productivity in the public sector. Attention is needed on making the working environment attractive, both for improving productivity as well as for career development. Promotion into higher level post structures as recognition of further clinical qualifications, are not available for rehabilitation professionals. Addressing capacity issues therefore, must move beyond individual performance based on skills and training opportunities, towards addressing broader capacity constraints of the health system.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. CONCLUSION

The study provides evidence of important policy implementation challenges with regard to the HR component of the NRP, in the provision of rehabilitation services. Policy reforms need to be effectively communicated to those expected to implement them. Changing the nature of decades-old management styles, establishing a new rehabilitation identity and building capacity within a decentralized health system as outlined in the policy content, is a complex process, being dependent on effective planning and strategy formulation. In addition, the implementation of policy should have been accompanied with change management in order to provide an integrated rehabilitation service. Rehabilitation professionals have demonstrated that relationships among the various service providers have to be proactively managed in order for integration and teamwork to be operationalized. The policy of decentralization was ultimately not a positive experience for rehabilitation managers due to poor leadership, poorly defined centralized functions and capacity constraints at all three spheres of government.

An analytical framework used in understanding public sector performance demonstrated that the broader dimensions of the socio-political environment, the institutional context and the task network all interacted to constrain implementation capacity at the organizational and individual levels. If people with disabilities, as a targeted group in South Africa are to enjoy their rights as every other citizen of the country, the process starts with access to quality rehabilitation services. Effective and innovative HR and change management is thus, key to successful policy implementation.

5.2. RECOMMENDATIONS

In fulfilling the fourth objective of the study, recommendations are made in facilitating the implementation of the NRP. Removing barriers at the level of service provision, in an attempt to develop capacity and improve performance, is difficult without taking into consideration the institutional context within which HR and organizations function.

5.2.1. Facilitate a process of change management for rehabilitation professionals.

Awareness of policies, critical dialogue and analysis of current health reforms and policy changes affecting the rehabilitation professions are needed to ensure relationship building and survival of the professions within a dynamic context. Each profession needs to identify how it can best contribute towards service delivery within the public sector while still maintaining a strong professional identity. It is therefore recommended in table 5.1. that the process starts with the professional associations representing the four professions in this study. Spaces should be created for active participation and a platform be provided from which this dialogue is facilitated.

5.2.2. Develop strategic direction for inter-agency and inter-professional arrangements

Roles, responsibilities and functions between the different agencies within the public sector need to be clarified in order to avoid duplication, confusion and conflict. Recommendations are made in table 5.1. to develop institutional capacity aimed at impacting positively on organizations and HR at the operational level. The 'rules of the game' for rehabilitation service delivery, in the form of policies and norms and standards are guided by many actors as discussed in chapter 4. In order to

facilitate policy coherence, the recommendations made in table 5.1., serve to improve service delivery through highlighting the various roles and responsibilities of the various agencies responsible for improving access to rehabilitation.

Table 5.1. Recommendations and responsibilities

Recommendation	Responsibility
1. Professional associations for Occupational Therapy, Physiotherapy, Speech Therapy and Social Work, to undertake a process of professional reorientation and provide strategic direction with regard to public sector service delivery through the facilitation of dialogue and debate at inter and intra organizational levels.	Respective **professional associations** for Physiotherapy/Speech Therapy/Occupational Therapy and Social Work
2. Implement a communication strategy to increase awareness of policy reforms affecting rehabilitation services. 3. Strengthen oversight functions for provincial rehabilitation policies with service development as the primary objective. 4. Evaluate the rehabilitation component of the essential PHC package and guide provinces in implementation. 5. Develop indicators for rehabilitation services at district, provincial and national levels to secure adequate resources.	**DoH**
6. Review registration of the professional rehabilitation groups with the different professional boards 7. Explore the feasibility of a single registration point for professionals who contribute to rehabilitation.	**HPCSA**
8. Review current organizational structures for rehabilitation services and develop alternate structures as a tool for change for aligning practice to policy. • (appendix 9 outlines an alternative organizational structure specific for rehabilitation professionals).	**DPSA**
9. Review current training curricula for all rehabilitation professionals to evaluate their alignment with national policies in promoting rehabilitation goals	**Educational / training institutions**
10. The OSDP must provide strategic direction for rehabilitation professionals to implement the social model of disability.	**OSDP**
11. Consider Public Private Partnerships (PPP's) with those actors outside the public sector	**NGO's**

5.2.3. Recommendations for further research

a. Quantitative assessment of outputs on what services are delivered where, with what resources and the impact/outcome thereof. More specific indicators will need to be developed within the public health sector specifically.

b. Evaluate the planning and implementation of rehabilitation structures in other sectors i.e. DoE, DoL, DSD, etc to assess the extent to which these support efforts within DoH. The measurable indicators outlined, need to be regularly monitored within the new National Disability Policy Framework.

c. The question whether disability and rehabilitation policy should be legislated need to be explored within the South African context. Legislating rehabilitation policy within health may reinforce the stigma of disability as a personal health/medical issue.

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