

**PROVIDERS' RESPONSES TO THE PATIENTS' RIGHTS CHARTER
IN SOUTH AFRICA: A CASE STUDY IN POLICY IMPLEMENTATION**

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Declaration

I, Nika Thandiwe Raphaely, declare that this research report is my own work. It is being submitted for the degree of Master of Public Health in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Nika Thandiwe Raphaely

7th day of September 2009

For my staunch friends
Candice, Julia, Natalie, Agnès and Dale
who have been better friends
through darker days
than I ever imagined

Abstract

The Patient Rights' Charter is one of several progressive health policies in South Africa with disappointing implementation in practice. Barriers to implementation have already been described. Policy analysis theory and empirical studies suggest that power and resistance may contribute to implementors' responses to policies. This secondary analysis of existing semi-structured interviews with health providers in Limpopo explicitly examined the influence of power and resistance on their implementation of the Patients' Rights Charter.

Open coding yielded themes of implementation experience, to which a deductive analysis applied a heuristic framework, derived from the literature, to examine power and resistance.

The critical importance of implementors in translating policy into practice, and of discursive manifestations of power, were reiterated. Resonances in the data of the functionalist 'sick role' brought together surveillance, expert knowledge and the loss of health workers' influential voice, in a way not previously discussed. Implications for future management strategies are considered.

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Nomenclature

PRC	South Africa's Patients' Rights Charter
parent study	A joint study in 2004-5 by the Centre for Health Policy (University of the Witwatersrand) and the School of Public Health and Family Medicine (University of Cape Town), which explored implementation of the PRC in Limpopo (Centre for Health Policy) and the Western Cape (UCT group). This research is a secondary analysis from a power perspective of existing data from that study's Limpopo case study (with permission of its authors and of the University of Witwatersrand Ethics Committee).
DOH	Department of Health (of the Republic of South Africa)
patients	To avoid inconsistencies, users of health services will be referred to throughout as patients. This is partly due to the tracer policy's name and does not imply that patients are passive and lacking agency in their use of health services.
providers	As providers of health services, this research explored managers', doctors' and nurses' responses to the PRC. The parent study's authors used providers to refer more narrowly to providers of clinical services (doctors or nurses). To avoid confusion, this dissertation will use 'health workers' when referring to doctors and nurses.

1. Introduction

In the fifteen years since South Africa's transition to democracy, several progressive policies have been introduced. However, their implementation has produced limited impacts (Harrison et al., 2000) and unintended consequences (Penn-Kekana et al., 2004; Walker and Gilson, 2004). These problems with implementation have drawn attention to the critical importance of front-line health workers (Walker and Gilson, 2004).

The South African Patients' Rights Charter (PRC), launched in 1997, is one of these progressive policies. Its preamble states that it sets a common standard for achieving the right to health services guaranteed in the Constitution, in contrast to the denial or violation of fundamental human rights experienced by the vast majority for many decades (Department of Health, 1997).

According to the national patients' rights charter every patient has the right to:	Every patient or client has the following responsibilities:
A healthy and safe environment	To advise the health care providers on his or her wishes with regard to his or her death
Participation in healthcare decision-making	To comply with the prescribed treatment or rehabilitation procedures
Access to health care services which include: receiving timely emergency care; treatment and rehabilitation; provision for special needs; counselling; palliative care; a positive disposition displayed by health care providers; health information including about services	To enquire about the related costs of the treatment and / or rehabilitation and arrange for payment
Knowledge of one's own health insurance or medical aid scheme	To take care of health records in his or her possession
Choice of health services	To take care of his or her health
Be treated by a named health care provider	To care for and protect the environment
Confidentiality and privacy	To respect the rights of other patients and health providers
Informed consent	To utilise the health care system properly and not abuse it
Refusal of treatment	To know his or her local health services and what they offer
Be referred for a second opinion	To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes
Continuity of care	
Complain about health services	

Table 1: The Patients' Rights Charter (Department of Health, 1997)

Similar charters in several countries have been unpopular amongst front-line health workers (Sbaih, 2002), and their implementation has fallen short of expectations (Angell, 2000).

Effective implementation of the PRC in South Africa is especially important for several reasons. Transformation of the health sector must overcome challenges including the authoritarian culture of apartheid, in which abuses of patients' rights by health workers were common (Baldwin-Ragaven et al., 1999). Poor and uneducated users must be empowered to achieve better health despite the historical and current contexts. The PRC was intended to leverage and accelerate change for patients (Sebokedi, 2002).

Policy analysis theory argues that implementation is political and often contested, rather than rational and straightforward (Gordon et al., 1999). Empirical studies of health policies emphasise the importance of these complex aspects of implementation, which are rarely strategically managed (Tendler and Freedheim, 1994). Policy analysis allows consideration of ways in which actors, context, process and content can influence how policies are experienced in practice (Walt and Gilson, 1994). Challenges arising from the context of South African health policy (Jewkes, Abrahams and Mvo, 1998; Schneider and Stein, 2001) and implementation processes (Walker and Gilson, 2004) have been described previously. Actors' mixed responses to previous health policies in South Africa have been explored (Penn-Kekana et al., 2004; Walker and Gilson, 2004), and recent studies are beginning to probe issues underlying these responses (Nkosi et al., 2007, Lehmann and Matwa, 2008). These and international studies (Reich, 1995; Kwon and Reich, 2005) have suggested that particularly threatening policy content can generate specific resistance from the actors responsible for its implementation.

In order to achieve more successful implementation, research must go further than describing obstacles. One approach is to probe issues which may contribute to implementation obstacles,

such as power and resistance. These are central concerns of policy analysis, tackled at macro (distribution of power in societies) and micro (exercise of power within relationships) levels. Implementation theory suggests differing understandings of which actors most influence how policies are delivered (top-down versus bottom-up perspectives) and the processes (such as translation and reformulation) by which intended policies are altered in delivery. Power and resistance are implicit, in how actors are influential and in why their interests are challenged or strengthened by policies. Broader social science theories of health and illness have raised power as a fundamental issue (Lupton, 2003), and empirical work on the South African health sector confirms this (see literature review). However, the potential influence of power over health worker responses to policy has rarely been directly investigated (Erasmus and Gilson, 2008; Lehmann and Matwa, 2008). This research will begin to address this previously neglected area.

As a tracer policy for power issues influencing implementation by health providers, a Patients' Rights Charter offers the quintessential material, as it seeks directly to redress previous power imbalances in provider-patient relationships. Three studies have found implementation of South Africa's PRC to be disappointing. Whilst the first two assessed and described the PRC's limited impact on quality of care (Bloch et al., 2001; Sebokedi, 2002), the third sought to evaluate the PRC's effectiveness in promoting and realising the right to health within the context of post-apartheid South Africa's reconstruction (London et al., 2006; hereafter referred to as the parent study). Its objectives included describing providers' awareness and utilisation of the PRC, describing its impact on provider behaviour, and identifying gaps and obstacles in effective implementation of the PRC, with recommendations to overcome these. Implementation was found to be limited by barriers including a top-down culture, ineffective training and insufficient materials. Amongst other challenges for implementation, the authors discussed the importance of power, identifying evidence of its influence within key

relationships, including patient-provider and provider-manager relationships. One recommendation suggested a need for further thought about and strategies to offset the risk posed to providers by PRC implementation,

‘given that it [the PRC] fundamentally affects the power relationship between provider and patient’
(London et al., 2006, section 1.3.2, pages not numbered)

Thus the problem is that, while previous studies have shown that PRC implementation has been disappointing and that implementors have had mixed responses to health policies, further work is needed to understand issues such as power underlying these responses.

Exploring power is not straightforward, requiring skilful researchers to generate sufficiently rich data which then require intensive, reflective analysis (Erasmus and Gilson, 2008).

Although the parent study gathered rich data which identified the importance of power, its study design and time constraints prevented the data from being fully interrogated for manifestations of power. This research is, therefore, a secondary analysis from a power perspective of existing data from one of the parent study’s provincial case studies (with permission of its authors and of the University of Witwatersrand Ethics Committee).

The objectives of this research are consequently:

- to identify and describe to what extent and how power and resistance may have affected implementation of the PRC by health providers in Limpopo in 2004
- to explore possible strategies that might tackle any power issues undermining implementation of the PRC in South Africa

These objectives are reflected in the following research questions:

- When providers talked about the PRC, what issues arose underlying their responses?
- How do these issues illustrate power and resistance influencing implementation of the PRC?
- Do these findings point towards possible strategies to tackle these underlying issues?

2. Literature review

Policy analysis argues that power is central to the policy process (Walt, 1994). If policymaking is ‘a struggle between groups with competing interests’, then ‘understanding policymaking requires an understanding of the nature of power, how it is distributed and the manner in which it is exercised’ (Buse et al., 2005, p.20). A recent paper called for more explicit empirical investigations into power’s effects on implementation (Erasmus and Gilson, 2008).

Theoretical approaches to implementation, and what they say about power, will be briefly outlined and illustrated with empirical studies of health policy implementation. Three theoretical positions in the broader social sciences, which explicitly consider power in healthcare and add a socio-cultural dimension, will then be presented. Finally, the heuristic framework used in this research to examine issues of power and resistance, which was derived from these literatures, will be explained.

2.1 Key insights from policy implementation

In a recent review of the development of relevant theory over 20 years, one of its leading practitioners described how the study of implementation emerged during the 1970s and 1980s (Barrett, 2004). Perceptions of ‘implementation failure’ stimulated interest in the process by which policies were translated into action, and whether this was merely a technical process under the control of policymakers (‘top-down’) or also subject to negotiation and reshaping by implementing actors (‘bottom-up’).

Top-down theorists distinguished the political processes of agenda-setting and policy formulation from a later stage of implementation, which was viewed as an administrative activity by which subordinate-level actors should obediently turn policies into practice. Theorists aimed to reduce the gap between policy intentions and results by identifying the

unattainable idealised conditions that would be required to reduce it (Buse et al., 2005). By contrast, bottom-up theorists argued that such conditions could never be met, because the policy process was intrinsically not linear or rational. They also suggested a greater role for implementing actors, as active participants in a complex process which informs policymakers (Buse et al., 2005) and which shapes the way policies emerge in practice:

‘Policy may thus be regarded as both a statement of intent by those seeking to change or control behaviour, and a negotiated output emerging from the implementation process.’
(Barrett, 2004, p.253)

Thus policy analysis understands policy to be what is practised, rather than only what formal policy documents say. Reformulation, resistance, and different ways implementors frame policies are some of the processes by which policy content is altered during translation into practice.

Reformulation can occur through selective and incomplete translation, as when provincial and facility managers in South Africa narrowed the scope of a rural community health worker policy from that intended by policymakers (Lehmann and Matwa, 2008). Reformulation can also produce positive unintended consequences when implementors extend the scope of intended policy content, such as the wider health and social benefits generated by community health workers in Kenya (Kaler and Watkins, 2001).

Implementors’ resistance to policies is one important aspect of reformulation and can be overt or more passive. When South Africa’s new Termination of Pregnancy policy sought to provide greater access to abortions, providers actively resisted it in protesting that this was not their job (Walker, 1996) and passively resisted it in declining to deliver the services outlined (Harrison et al., 2000). Similarly, a study showed providers resisting implementation of

prevention-of-mother-to-child-transmission policies by withholding information from HIV-positive mothers (Seidel, 2000).

Exploring why implementors resist health policy reveals a range of motivations. Withholding information (about risks of vertical transmission) from young HIV-positive mothers was a strategy by nutritional nurses to protect their privileged employment position, which was based on their expertise around breastfeeding (Seidel, 2000). An Australian study found nurses withholding information from patients in order to resist a policy of patient participation in decision-making, because they felt they knew best and wished to preserve the power imbalance that greater knowledge gave them (Henderson, 2003). South African nurses resisted providing abortions because they resented the policy being imposed on them, they feared that they would be forced to undertake abortions, they felt their workload was already overwhelming and they felt judgemental of younger women requesting abortions (Harrison et al., 2000).

Policy analysis can clarify such mixed motives for resisting policy, by unpacking actors, content, context and process (Walt and Gilson, 1994). Considering actors helps to understand that their interests range from protecting their jobs or decreasing their workload, to less tangible issues such as their privileged status (Seidel, 2000) or deeply-held religious beliefs (Harrison et al., 2000). Focusing on policy content suggests that some policies are particularly challenging for implementors (such as abortion or patient participation in decision-making) but even policies with which implementors agree can generate resistance. Although they agreed with the principle of removing user fees in maternal health and primary health care, South African nurses complained that this policy had increased their workload (Schneider and Gilson, 1999) and encouraged patients to 'abuse' health services (Walker and Gilson, 2004). The policy context can help to understand resistance, either as organisational context (such as the South

African department of health's rush to introduce several progressive policies within a few years) or as norms in wider society (such as the high rate of teenage pregnancies in KwaZulu-Natal fuelling providers' resistance to offering abortions). Finally, the process of implementation can exacerbate resistance, often in poor consultation and communication making implementors feel that the policy has been imposed on them (Harrison et al., 2000).

When the data are rich enough to yield this level of detail, the ways in which implementors frame issues can help to understand their responses to policies. In the context of multiple new policies introduced with inadequate training and support in South Africa, a senior nurse understood new financial management regulations as threatening her with imprisonment, causing significant anxiety and a desire to leave her public sector job (Penn-Kekana et al., 2004). Implementors often reveal judgements about other actors in the way that they frame policies. KwaZulu-Natal nurses felt that access to abortions would encourage irresponsible young girls to behave even more irresponsibly, with one saying 'Mandela has given them this right, now they are going to kill because they want to enjoy sex' (Harrison et al., 2000, p.426).

One influential bottom-up theorist attempted to draw together many of these themes. Lipsky's analysis of 'street-level bureaucracy' emphasised the contextual challenges for public sector workers who faced chronically inadequate resources, infinite demand for services, and conflicting goal expectations of their employing organisations. In response to these circumstances and in view of the substantial discretion they had in interacting directly with clients, they developed coping mechanisms to control the stress of daily work (Lipsky, 1980). These coping mechanisms often deviated from or opposed the explicit goals of their employing organisation, and distorted the impacts of policies. Coping mechanisms included 'modification of client demand, modification of job conception and modification of client conception' (Hudson, 1997, p.395).

Manipulating client demand included strategies to control clients and to enlist their co-operation with client processing procedures, such as using symbolic limits (uniforms, location and timing of interactions), isolating clients from one another (to resist clients organising themselves to protest) and presenting street-level bureaucrats' procedures and services as benign and always in the clients' interest. Modifying job conception included psychological withdrawal, as street-level bureaucrats accepted the discrepancy between what they were supposed to do and what they actually did, discouraging innovation and encouraging mediocrity. Strategies to modify client conception included rationalising divisions amongst the clients into those most and least likely to succeed in bureaucratic terms, or deserving and undeserving (Lipsky, 1980; Hudson, 1997). KwaZulu-Natal nurses modified client demand by intimidating young girls so that few requested abortions, partially explaining the disappointing uptake of abortion services (Harrison et al., 2000). They modified job conception by arguing that their job was to deliver healthy babies, not to kill them (Walker, 1996; Harrison et al., 2000). They modified client conception by arguing that women seeking abortions after rape were deserving, but young girls with unwanted pregnancies within relationships were irresponsible and should not have access to abortions (Harrison et al., 2000).

Power is implicit in all of these concepts from implementation theory. In its most fundamental sense, power over people or resources is present in the top-down model, by which policymakers determine what implementors do. In contrast, bottom-up theory recognises implementors' power to shape how policy is delivered, however low-ranking the implementors are in a hierarchy. Lipsky also drew attention to implementors' power to shape their work patterns and working environment. The coping strategies they used included exercising power over resources (such as withholding desired services or information) and deciding how to ration services (Lipsky, 1980). In justifying these decisions by labelling some

clients as more deserving than others, they also exerted the power to judge people and the power to assign labels and commentary about people's behaviour.

The sources of implementors' power are wide-ranging. Initially, their position as implementors gives them control over which aspects of the policy are translated into action. Barrett's 'discretionary power' characterised this as the 'scope for action' implementors have in organisational settings (Barrett, 2004, p.253). Some actors, such as the provincial and facility managers narrowing the scope of the community health worker policy, draw on sources of power such as hierarchical authority in addition to their gatekeeper position in the implementation pathway (Lehmann and Matwa, 2008). It is important to note that power can also be positive or facilitative, as the power to achieve goals and to get things done (Foucault, 1980; Parsons, 1995). Against the prevailing consensus to narrow the scope of that policy, one sub-district health promotion manager drew on her skills, relationships and ideals to implement the policy more energetically (Lehmann and Matwa, 2008).

Other sources of power are more complex. Control over biomedical knowledge allowed the Australian nurses to perpetuate an unequal balance of power with their patients (Henderson, 2003), and allowed the South African nutritional nurses to protect their prestigious jobs (Seidel, 2000). By avoiding emphasising the risks of breastfeeding, these nurses demonstrated a 'second dimension' of power (first described by Bachrach and Baratz in 1962), as the power to keep certain issues off the agenda. Prestige and status as older women, and as educated nurses, gave KwaZulu-Natal nurses the power to create an intimidating environment in which young women felt unable to request abortions (Harrison et al., 2000). This illustrates a 'third dimension' to power (proposed by Lukes in 1974), by which:

'A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping, or determining his very wants.'
(Lukes, 2005, p.23)

Finally, when considering how implementation theory considers power, it is important to be clear about different senses of resistance. Resistance to an unpopular policy is primarily about its content, or how implementors frame its content. Thus KwaZulu-Natal nurses refused to provide abortion services because they did not accept the new policy, which they understood to be incompatible with their role as nurses. This example also demonstrates the importance of other aspects of implementation processes in influencing how actors frame policy. Due to poor communication with implementors, the nurses were not aware of a clause allowing providers to opt out of doing abortions, so their resentment about a policy (and an unacceptable task) having been imposed on them could have been avoided (Harrison et al., 2000).

In discussing implementors' scope for action, a leading bottom-up theorist implies that alternative sources of power may be available to implementors. Although they may lack formal authority, they may draw on resources such as their position, their knowledge of the implementation context, and their skills to solve problems arising in implementation:

‘authority relations within organizations are always reciprocal: formal authority runs from top to bottom, but the informal authority necessary for problem solving runs from bottom to top.’ (Erasmus and Gilson, 2008, p.362, discussing Elmore, 1979).

Actors may draw on diverse sources of power to enable implementation and to solve problems, or to resist a policy. They can also resist the exercise of power by other actors, which is often seen when a policy seeks to challenge a previously unequal balance of power. Examples include Australian nurses withholding information intended to empower patients (Henderson, 2003), or South African nurses labelling users seeking free healthcare as abusive of the services and undeserving of their new rights (Walker and Gilson, 2004). Some theorists of power argue that resistance to the exercise of power is intrinsic to power relations:

‘power not only encompasses the ways in which certain actors manage to control or direct the actions of others, but also the ways in which people are able to resist or subvert such control.’ (Erasmus and Gilson, 2008, p.362, discussing Sharp et al., 2000)

This is important to social constructionist understandings of power (see below) but also resonates with bottom-up theory. Just as implementors have extensive scope for action (which may facilitate or undermine the intended policy), so do the apparently less powerful have scope for facilitating or resisting domination by those who seek to control them. Lipsky argued that clients of public sector welfare services were ‘non-voluntary’ because they could not access these services elsewhere, which reduced their ability to sanction providers and emboldened providers to label them negatively. For the most part, clients cooperated and complied with providers’ strategies, so that

‘Street-level bureaucrats are not required to command. Clients control themselves in response to the superior power of the workers...’
(Lipsky, 1980, p.57)

However, even non-voluntary clients can exercise resistance to control. Strategies available to these apparently powerless clients included increasing the costs of compliance, wasting providers’ time, or manipulating the gratification providers sought (via expressions of gratitude or changes of behaviour in the desired direction) (Lipsky, 1980).

Lipsky’s analysis is helpful in demonstrating the dynamic and interactive nature of power in implementation. All actors, even non-voluntary clients, are participating in power relations. Street-level bureaucrats, or KwaZulul-Natal nurses, can resist policymakers’ authority over them while simultaneously exerting power over service users. Implementation is contested and implementors have considerable scope for influencing how policies are translated into practice. Their responses to policy context, process, content and other actors can draw on diverse sources of power and varied strategies for resistance, and can greatly affect implementation.

2.2 Three approaches to power in healthcare from the broader social sciences

Sociology and related social sciences have studied health and illness since Durkheim's work on suicide in the 1890s (Green and Browne, 2005). Three theoretical perspectives have dominated the sociology of health and illness since the 1950s and power is a central concern for all of them (Lupton, 2003). They add a socio-cultural dimension and theoretical insights to the issues raised in implementation studies, and are important for a fuller understanding of power in implementation. Each draws on different underlying beliefs about society and about power, which add meaning to issues raised by providers. For this reason, very simplified summaries of these three perspectives are presented here.

Table 2: Three simplified perspectives on power in health & illness (Riska, 2001; Lupton, 2003)

perspective	Functionalism	political economy	social constructionism
key exponent(s)	Talcott Parsons	Freidson Navarro, Waitzkin	Foucault Armstrong, Lupton, Turner
Most influential	1950s-1960s	1970s& early 1980s	1980s to present
focus of analysis in wider social sciences	Society of normative consensus, order& harmony preserved by people acting in defined roles& performing certain functions	Capitalist economic system Professionals Macro level of whole society	Questions essential 'truths': sees these as product of power relations and acting in someone's interests. All knowledges are the products of social relations.
focus of analysis when applied to health& illness	Nature of illness as 'deviance' or failure to conform to societal norms& expectations. Medicine as an important mechanism/ necessary institution of social control, to control the potentially disruptive nature of illness. Roles of doctors in distinguishing between normality& deviance, acting as moral guardians of society.	Medical dominance as outcome of a struggle between different interest groups Corporate and bureaucratic structure of healthcare. For the most radical authors: Medicine obscures social & political determinants of health by the way it frames illness as individual, so supports capitalist status quo which causes ill-health.	Disease/illness states are known and interpreted through social activity. Medical knowledge is seen as a series of relative constructions dependent on context and constantly renegotiated. Medical gaze turns individuals into cases. disciplinary power; surveillance; biopower.
key concepts for this research	'sick role'; medical judgement conferring legitimacy	Doctors' monopoly over medical knowledge	Medical power is deployed by individuals. Knowledge is socially constructed.
doctors characterised as:	Universally beneficent, competent, altruistic	Self-interested professional group, using knowledge to perpetuate inequalities.	Using language and practices to take control and silence resistant discourses.

perspective	Functionalism	political economy	social constructionism
patients characterised as:	May experience stigma, shame, vulnerability from illness. Potentially avoiding responsibility. Dependant (on others, on doctors)... Compliant, passive, grateful.	Disadvantaged, exploited. Members of oppressed social groups (this approach looks at macro level of society, not individuals).	Socialised to expect to submit to examination etc. Participate in discipline (can work through gratification or coercion) by seeking rewards for good conduct.
doctor-patient relationship	Inherently harmonious and consensual, although unequal balance of power	Conflict of interests. (this approach looks at macro not micro level).	Dynamic power relations are constantly negotiated and serve to define identities.
source of power	Inherent socially valued skills & expertise of doctors	Doctors' occupational control over medical knowledge; professionals' status & autonomy over their work.	'Power as a form of social organisation by which social order and conformity are maintained by voluntary means.' (Lupton p120)
effects of any power inequality?	Medical dominance is constructive, helps patients to cast off (dependent) sick role	'Competence gap' keeps patients dependent. Medical dominance is oppressive.	Necessary to fulfil expectations of both parties.

In the wider social sciences, functionalism is out of fashion and its idealised conception of a conflict-free society has been mocked as a product of the 1950s (Riska, 2001; Lupton, 2003).

Political economists have criticised its failure to consider a structural dimension to medical power (Lupton, 2003). Although the world of academic theory has moved away from functionalism, aspects of its analysis are still implicit in medical training and practice (own experience).

Talcott Parsons' model of the doctor-patient relationship, through the demands and functions of the 'sick role', was the first systematic attempt to understand how both parties collaborated in the distribution of power between them and the implications of this for society (Lupton, 2003). It assumed that medical knowledge was objective and beneficent.

Box 1: Talcott Parsons' analysis of the sick role

Patient: sick role

Privileges:

Regarded as being in need of care and unable to get better by his or her own decisions and will.

1. Allowed (and may be expected) to shed some normal activities and responsibilities
2. Not blamed for their condition, need not feel guilty when they don't fulfil normal obligations

Obligations:

1. Must want to get well as quickly as possible
2. Should seek professional medical advice and co-operate with the doctor

(Lupton, 2003, p.7; Morgan, 2003, p.51)

Doctor: professional role

Expected to:

1. Apply a high degree of skill and knowledge to the problems of illness
2. Act for welfare of patient and community rather than for own self-interest, desire for money or advancement
3. Be objective and emotionally detached (ie. should not judge patients' behaviour in terms of personal value systems or become emotionally involved with them)
4. Be guided by rules of professional practice

Rights:

1. Granted right to examine patients physically and to enquire into intimate areas of physical and personal life
2. Granted considerable autonomy in professional practice
3. Occupies position of authority in relation to the patient

Both political economists and social constructionists are more questioning than functionalists about the nature and roles of knowledge. Amongst political economists, Freidson wrote in the early 1970s about how it is in professionals' interests, and enhances their power, to maintain a monopoly (through restricted entry to training and through licensing authorities) on medical knowledge.

'Knowledge becomes power, and the professional stands as the human link between the two.'
(Freidson, 1986, p. ix)

Crucially, this knowledge has technical but also esoteric and mysterious components, in medicine's claims to be an 'art' as well as a science.

'Medical expertise, and clinical decision-making, is not simply the possession of relevant facts or figures, but is based on implicit 'intuitive' clinical competence which is developed over time and which cannot easily or rationally be explained.'
(Lupton, 2003, pp.117-8)

This has been revisited in the 1990s, in relation to doctors' discomfort with patients' greater access to biomedical knowledge via the internet. In defending their powerful position, medical professionals make the claim that they alone can interpret biomedical knowledge with

authority (Turner, 1995; Lupton, 2003). In addition to a discrete body of knowledge over which members have control, other distinguishing traits of professions described by sociologists include monopoly over the market for services, autonomy, an ethical code, altruism and lengthy training (Rees Jones, 2003).

Social constructionism is a convenient composite term, introduced by one of its leading proponents, to group together several schools of thought sharing the common belief that all knowledges are the product of social relations ie. socially constructed (Lupton, 2003).

Knowledge is closely linked to power, in different ways by different perspectives within this umbrella group. Knowledges can function to exert, reinforce or renegotiate power in relationships.

‘Those adopting the social constructionist perspective argue that medical power not only resides in institutions or elite individuals, but is deployed by every individual by way of socialisation to accept certain values and norms of behaviour.’ (Lupton, 2003, p.13)

Discursive power is a related concept, about how meaning is managed. Discourses gather round an issue, provide a means of ‘making sense’ of that issue and ultimately take on a reality of their own, being able to influence the issue they are describing (Lupton, 2003; Erasmus and Gilson, 2008). Thus the KwaZulu-Natal nurses’ discourses around the demand for abortion services (framing pregnant teenagers as irresponsible) influenced the demand for abortion services (because teenagers were too intimidated in that social context to request abortions). This example demonstrates the nurses exercising discursive power, by managing meaning to influence other actors, rather than influencing them through physical or other means (my interpretation, example from Harrison et al., 2000).

Perspectives within the social constructionism group have generated important bodies of work seeking to understand how power works in medicine. Although they are beyond the scope of this research, some concepts have resonances in the Limpopo data.

An extensive literature has investigated negative labels applied by health workers to patients. One recent review argued that, rather than being fixed traits (such as elderly or drunk) these were products of negotiated strategies (Johnson, 1997). The power to assign labels, and how these shape behaviour, is considered by several disciplines under the broadly social constructionist umbrella.

Foucault, within the post-structuralist tradition, wrote extensively on related understandings of power and how these function within medicine. Two relevant concepts from his work are disciplinary power and biopower. In describing the historical evolution of discipline from medieval beheading to 19th century prisons, he argued that surveillance can exert power without force and that people will feel vulnerable (and modify their behaviour) under scrutiny. Biopower falls within his notion of governmentality, which argues that biomedical science (in defining and measuring what is “normal”) is extending the power of the state into people’s personal lives (Lupton, 2003).

3.3 A heuristic framework to examine issues of power and resistance

The literature review raised several aspects of power and resistance which resonated in the data. Rather than limiting the analysis to one aspect, a heuristic framework was derived from the literature review. This framework was intended to be applied flexibly in subsequent analysis, so that inductive themes could be explored for issues of power and resistance without restricting analysis to a single understanding of how power worked in implementation.

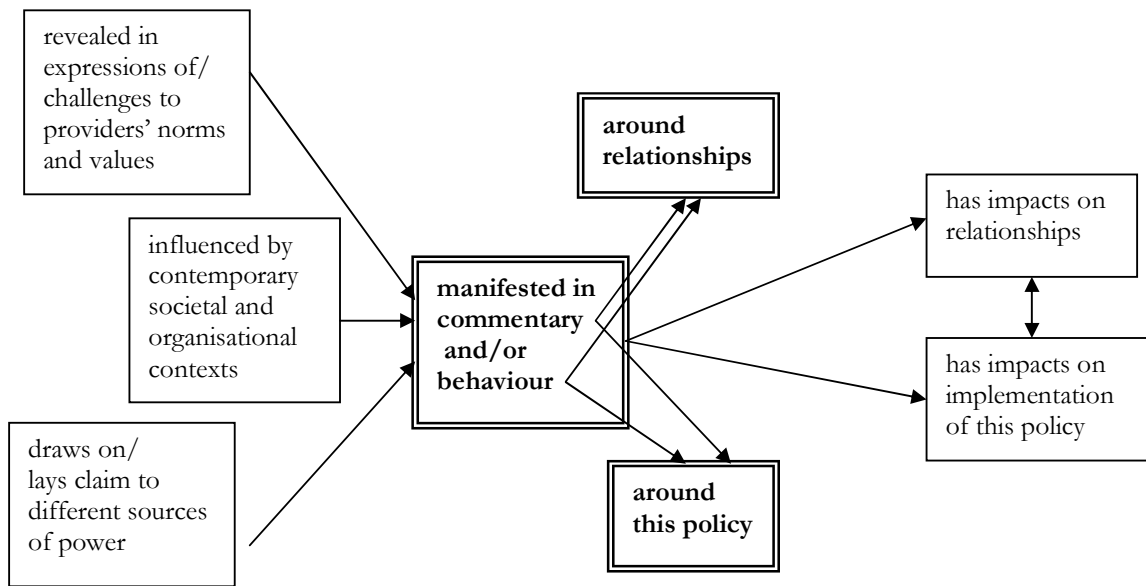


Figure 1: A heuristic framework to examine issues of power and resistance

Norms (‘expected ways of behaving’) and values (‘moral principles or standards’) required consideration for two reasons (Chambers,1999). As the sociology literature emphasises, ideas of power are not value-neutral (Lupton, 2003). Political economists criticised functionalists for the harmonious and consensual model of society implied by their conceptions of power (Lupton, 2003). Analysis of power is complex, and reflexivity requires us to identify our underlying values and criteria for judging power issues (Erasmus and Gilson, 2008). It is even more meaningful to understand interviewees’ underlying values in order to understand what they are telling us about power. The KwaZulu-Natal nurses felt morally superior in resisting the new Termination of Pregnancy (Harrison et al., 2000), drawing on religious values and social status as moral guardians of society. The strength of their feelings and depth of their unwillingness to implement the new policy would not be understood without an awareness of their moral and religious objections to its contents.

The second reason to consider norms and values is more pragmatic. Providers' expressing their norms and values revealed issues of power underlying their responses to the PRC which might otherwise have been harder to pinpoint. Implementation studies showed that policies with challenging content can generate resistance (Reich, 1995; Harrison et al., 2000) and that these included policies seeking to challenge a previously unequal balance of power (Henderson, 2003; Walker and Gilson, 2004). When Australian nurses resisted sharing information with patients, they revealed norms that expected health workers to 'know best' through a monopoly over biomedical information. Social constructionism makes the links between knowledge and power especially clear (Lupton, 2003). Political economists' argument that a monopoly on knowledge sustains the dominance of professionals, and functionalists' emphasis on providers' control of decision-making, add deeper insights into power issues implicit in Australian nurses' norms of expecting not to share decisionmaking with patients (Henderson, 2003).

Empirical studies of implementation show actors drawing on varied sources of power, although they are not explicitly discussed in power terms. A more theoretical paper recently affirmed the importance in implementation research of identifying sources of power, and gave examples including the professional role, knowledge, charisma, links to powerful actors, organizational culture and hierarchies in society (Erasmus and Gilson, 2008). Looking for sources of power in the data, as with norms and values, was valuable in this research in identifying power issues underlying providers' responses to the PRC. An awareness of which actors laid claim to different sources of power also drew attention to contextual issues of inequality. Lipsky's analysis of non-voluntary clients (that they had little power to influence providers' behaviour) was compounded by an awareness of the entrenched inequalities in South African society (London et al., 2006). Political economy perspectives extend this to

suggest that differential access to wealth, education and social mobility will affect how empowered different actors may feel and act (Lupton, 2003).

The context of implementation can affect providers' responses to policy (Walt and Gilson, 1994). The KwaZulu-Natal nurses' resistance to the Termination of Pregnancy policy was fuelled both by high rates of teenage pregnancy and by the new South Africa's unfamiliar rights culture, expressed by one nurse's complaint that 'Mandela has given them this right...' (Harrison et al., 2000, p.426). The impacts of South Africa's post-1994 policy context on implementation of health policies have been repeatedly documented (Schneider and Gilson, 1999; Schneider and Stein, 2001; Penn-Kekana et al., 2004; Walker and Gilson, 2004; London et al., 2006). The social and organisational contexts of the PRC were likely to interact with providers' norms and values, and with the sources of power they drew on, so context was flagged up in the heuristic framework as an issue to consider. In addition, open coding of the data suggested that context played a part in understanding power underlying providers' responses to the PRC.

It was most valuable to seek manifestations of power and resistance broadly, rather than to restrict findings to a single aspect, such as explicit refusal to implement the PRC. Previous implementation studies have shown power and resistance to be manifested in implementors' behaviour, such as nurses withholding information from patients (Seidel, 2000; Henderson, 2003) or refusing to provide abortions (Harrison et al., 2000). They have also been manifested in implementors' commentary, such as the ways nurses framed users as abusing free healthcare (Walker and Gilson, 2004) and framed a policy as offending their motivation for doing their job (Walker, 1996; Harrison et al., 2000). The former commentary was around relationships, whereas the latter was around a policy.

It was even more important, in this research, not to be restrictive in seeking manifestations of power and resistance, because the data only offered providers' accounts of their responses to the PRC. There was no opportunity to triangulate these data against any observations or patients' accounts, although interviews with both managers and health workers were included in the analysis. There was no reason to assume that providers' accounts would impartially reflect behaviour, and their commentaries (as discourse) may in themselves manifest power and resistance. In seeking to understand providers' responses to the PRC, it seemed logical to look for commentary around the policy itself. Open coding also revealed extensive commentary around the behaviour of other actors, and particularly how they interacted with providers. Implementation studies have shown that policies seeking to empower patients have sought to do this in their interactions with providers, seeking to redistribute the unequal balance of power in their relationships with providers (Henderson, 2003; London et al., 2006). This resonates with the sociology literature's focus, from different perspectives, on provider-patient relationships (Lupton, 2003).

Having found manifestations of power, it was necessary to consider whether and how they affected implementation. The possibility of power issues impacting specifically on implementation of the PRC was flagged up in the heuristic framework. However, the implementation literature suggested that issues of power and resistance might affect the implementation context more broadly. As the PRC (like other policies seeking to empower patients) challenges the balance of power within provider-patient relationships, it was desirable to look for impacts of power/resistance issues on relationships. Any power issues impacting on relationships were also likely to have impacts on implementation of the PRC specifically.

Thus the heuristic framework sought to focus attention on issues which the implementation and social science literatures suggested would be most relevant, while remaining open to a broad spectrum of manifestations of power and resistance.

3. Methods

Because this research conducted secondary analysis of an existing qualitative dataset, the parent study's methods for generating that dataset will be briefly described. This research's data processing and analysis steps will then be outlined, followed by comments on limitations and ethics.

3.1 Research methods used in the parent study

The parent study undertook a national rapid appraisal and two detailed provincial case studies, of which one was urban (Western Cape) and one rural (Limpopo). A case study design was well-suited to the parent study's objectives, allowing 'empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence' (Yin; quoted in Robson, 2002, p.178). In addition, 'case studies ask "how?" or "why?" questions about a contemporary set of events, over which the investigator has little or no control' (Thomas, 1998, p.306).

The Limpopo case study used three tools for data collection: observations, focus group discussions and 90 in-depth semi-structured interviews conducted in English. The interviews were conducted by experienced qualitative researchers using an open-ended, topic-centred set of questions (Mason, 1996) to elicit experiences, views and opinions. Four main questions sought to clarify implementation experiences and the interviewees' views around the PRC (see Appendices C and D). Most of the interviews elicited a range of detailed and rich data which had not been transcribed or analysed fully before this research.

In this project, secondary analysis of interview data from the parent study's Limpopo case study was conducted. The Limpopo case study's 90 interviews, with DOH district managers,

hospital managers, health workers and community members, formed the population from which a sample was taken for secondary analysis in this research.

3.2 Initial project sampling

The Limpopo case study's interviews were conducted in health facilities within two purposively selected districts, identified by provincial and local managers as sites where the highest attention had been paid to the PRC. Interviews were undertaken in the district office, district hospital and two primary health care clinics within each district, plus two of the province's regional hospitals and a tertiary hospital. Of the 90 interviews, 11 were with community members and 15 with non-professional staff, leaving 64 interviews with managers, doctors and nurses.

The focus of this specific project was on providers, so interviews with community members in the parent study were not considered. The parent study interviews with non-professional staff were also excluded, due to low data quality which partly resulted from language difficulties.

3.3 Data processing

Of the 64 original health provider interviews, 24 were recorded in the form of typed notes only (from field notes typed immediately after the interviews, because cassette recorders were not available for all interviews) and 40 as cassette recordings, none of which had been transcribed. Although transcription offered the most detailed data for analysis, it was the most time-consuming method of making data accessible from unprocessed cassettes. Pragmatic

constraints prevented transcription and formal analysis of all 40 cassettes, but all the available cassettes were heard during data processing and analysis.

12 cassettes were initially prioritised for transcription in this study according to two conditions. They were most likely to provide rich data and they represented a full range of the interviewees' cadres and facilities. This might have been important if providers' experiences had differed between cadres and facilities, although the parent study did not find this (London et al., 2006). Where only one of the managers' or nurses' interviews within a facility had been taped, it was given transcription priority because it represented the only source of detailed data from a facility which might differ from others in important respects. The 12 cassettes initially transcribed included interviews with 8 managers, 3 nurses and 1 doctor, representing all of the hospitals and district offices involved in the Limpopo case study.

Selection of cassettes most likely to provide rich data was guided by the Limpopo case study's lead fieldworker's notes and memory of which interviewers and interviews had yielded the most detailed and frank data. While it is important to be reflexive about this (Mason, 1996) and it could introduce a selection bias, this research would be less able to meet its objectives if the richest interviews had not been analysed as fully as possible.

Thus, in this study, 12 of the 40 unprocessed cassettes were fully transcribed. Alongside this time-consuming process, all other recorded interviews were heard and noted, and all the typed interviews were read. The 8 interviews with primary health care providers suggested different implementation experiences with less relevance for power and resistance, so they were excluded from the analysis. From the remaining 56 relevant interviews (64 providers minus 8 primary health care providers), the interviews included in the first step of analysis were those with the most detailed discussions of themes occurring commonly across all 56 interviews.

3.4 Data analysis

This research undertook inductive analysis, of providers' general implementation experiences, followed by deductive analysis, applying the heuristic framework seeking issues of power and resistance to these general implementation experiences.

Inductive analysis derived themes of implementation experience directly from the data in a grounded process of open coding (Glaser and Strauss, 1967) using suitable software (Atlas.ti version 5). The richest interviews (3 transcripts, 7 typed notes and 6 cassettes which had been heard and noted) were formally coded. An effort was made to include a range of interview formats, facilities and provider positions to minimise selection bias (see table 3). According to grounded theory, a sufficient number of interviews was reached when code saturation (indicated by no new codes emerging) was achieved; this was perceptible after 12 interviews and confirmed after 16 (Glaser and Strauss, 1967).

Table 3: Samples of interviews selected for inductive and deductive stages of analysis

Parameter	Total population of interviews	1 st sample for inductive analysis	2 nd sample for deductive analysis	
Number of interviews	56 relevant& available: (64 providers – 8 PHC nurses)	16: until code saturation was confirmed	20:	
			10 managers	10 health workers
Format of interview	12 transcripts, 25 typed notes, 19 cassettes	3 transcripts, 7 typed notes, 6 cassettes	7 transcripts, 2 typed notes, 1 cassette (semi-transcribed)	3 transcripts, 4 typed notes, 3 cassettes (semi-transcribed)
Position	27 nurses, 17 doctors, 12 managers		2 district managers, 3 QA managers, 5 facility managers	6 nurses, 4 doctors
Facility base	3 district office, 11 tertiary hospital, 20 regional hospital, 22 district hospital	0 district office, 2 tertiary hospital, 8 regional hospital, 6 district hospital	3 district office, 2 tertiary hospital, 3 regional hospital, 2 district hospital	0 district office, 2 tertiary hospital, 5 regional hospital, 3 district hospital
Critical positions	19	8	10	6 (4 help-desk nurses, 1 doctor and 1 nurse in charge of departments)

Analysis was iterative and reflective. Ideas about issues of power and resistance emerged both during open coding for implementation and during the literature review around implementation. The 16 interviews coded for implementation were thus reconsidered while the heuristic framework was being developed to examine issues of power and resistance. This framework sought to use broader theoretical and empirical experience to analyse the underlying themes of implementation experiences drawn from the data, to identify issues of power and resistance, using theoretical coding. The use of the heuristic framework in this second step of analysis was, thus, deductive rather than inductive (Mason, 1996).

The deductive stage of analysis applied the heuristic framework to a slightly different sample of 20 interviews. The concept of critical positions had arisen from the implementation literature, which suggested that providers employed in critical positions for implementing a specific policy might have greater influence or different experiences from providers in less critical positions. Help-desk nurses and quality assurance managers (at facility and at district

levels) were in such positions with respect to the PRC. In addition, managers and health workers with managerial responsibilities might be in positions critical for issues of power and resistance. Providers employed in these critical positions were therefore included in disproportionate numbers in the sample analysed deductively for power and resistance. Two of the less interesting transcripts were not used for deductive analysis, and the relevant sections of 4 other exceptionally rich recorded interviews were transcribed and analysed for issues of power and resistance.

In writing up, results were presented around themes of implementation experience initially generated by the inductive analysis. Only those themes which revealed issues of power and resistance were discussed, in keeping with this research's objectives.

Extensive quotes were included in the results section. This was partly because the data were very rich and had not been analysed from this perspective previously, which was one justification for doing this secondary analysis. It also contributed to validity, allowing the reader to appreciate the recurrent commentaries which interviewees offered in reply to different questions. The discussion section explored the significance of these commentaries as expressions of discursive power.

3.5 Methodological rigour

Three criteria for methodological rigour are reliability of methods, validity and generalisability of analyses. In qualitative research, reliability is about avoiding misrepresentation, or carelessness in recording and analysing data, rather than replicability of results. Validity focuses on validity of data generation and of interpretation, relying on an accurate and reflexive presentation of methodology. Generalisability of qualitative data, such as those

derived from case studies, is theoretical rather than empirical, reflecting on and contributing back to theory (Mason, 1996).

Undertaking inductive analysis to seek themes of implementation experience before commencing the deductive analysis of power and resistance contributed to validity in several ways. Going through all the interviews, and openly coding a sample of the richest rather than those which theory suggested might be most relevant, reduced any effects of selection bias. It was important to explore implementation experiences directly from the data, despite the availability of the parent study's report, to question and confirm whether this research's analysis found similar experiences predominating in the data. Before discussing power, the first objective required implementation theory to inform these experiences and to clarify whether and how providers' responses affected implementation. Justifying a focus on power and resistance required implementation theory's insights into providers' responses to suggest that power was relevant, and required the data to support this. Comparing the inductive analysis of implementation experience to the parent study's findings provided an additional benefit to validity, in a degree of observer triangulation.

3.6 Limitations

As this research is a secondary analysis, its author was not involved in collecting the data. However, this threat to validity should be limited by both supervisors' participation in the parent study, for which one was the Limpopo case study's lead fieldworker.

Other possible limitations include poor interviewing, sources of bias in the questions asked and unsuccessful attempts to elicit information, such as asking questions not understood by interviewees (Mason, 1996). These were minimised by conducting secondary analysis of rich data generated by experienced researchers in the parent study.

A greater limitation arises from the absence of patients' perspectives in this research. Although it only claims to explore providers' responses to the PRC, these include commentaries about patient behaviour and are not balanced by any representation of patients' voices.

3.7 Ethics

The parent study was granted unconditional ethics approval (Appendix B). All participants signed consent to be interviewed and, where cassette-recorders were available, to be recorded. The interview cassettes were not destroyed before this secondary analysis, as they had not been completely transcribed. Unconditional ethics approval (Appendix A) was then granted for this research. In order to maintain anonymity, transcripts and analysis used codes rather than names of participants or facilities, in both the parent study and this research.

4. Results

The parent study found implementation barriers such as a top-down culture, ineffective training and insufficient materials. This research broadly agreed but, as its focus is specifically about providers' responses to the PRC, its results will be presented around recurrent themes within providers' responses which emerged inductively through open coding. These themes arose when open codes were clustered to form analytical categories, revealing senses in which providers felt aggrieved about the PRC and which suggested issues of power and resistance. Unless stated otherwise, no significant discrepancy occurred between interviewees.

4.1 Inductive themes emerging

4.1.1 Managers felt disempowered

Managers said that the PRC's content was good and necessary, but three broad strands emerged when they spoke of feeling unable to implement it. In their relationship with higher levels of the DOH, accountability was felt to be required of them but not reciprocated, and sufficient resources for implementation were not made available. There was a pragmatic commentary, about how the policy was simply not compatible with realities in facilities and in society. In addition, some managers revealed a lack of confidence in their ability to achieve implementation when they spoke about relationships with health workers.

Managers spoke of a top-down culture for implementing the policy. They felt compelled to ensure that patients were treated correctly, by a broader rights culture including newspaper and radio critiques of health worker attitudes, as well as by demands from higher levels for reports on individual complaints. Unpredictable inspection visits occurred to monitor facility-level compliance. Yet their efforts to implement the PRC were undermined by the priorities of politicians or higher-level DOH managers:

A > So, although we have a Quality Assurance Co-ordinator. You may find that she also is channelled by what the Provincial Office would like her to do. What is urgent at that time, what is it that they must report on, for the purposes of writing reports and submitting to the Premier's office, some of them because they normally work with the Premier's office most of the time. Although they're in the Department of Health but they have to send reports every now and then. So that I wouldn't say I've actually... there has been a time when we had actually concentrated much [on the PRC]. Except perhaps, during a period when it was being introduced and people were trained and so on. But, it's sort of a bit quiet.

Q > So, what's the current flavour of the month? What are the guys from Province pushing down at the moment? (laughing)

A > It's, what is this? Treatment for [pause] for HIV.

(Quote 1: district manager)

One manager was keen to provide information to help the DOH defend a lawsuit, but frustrated by higher levels' unwillingness to share information down to facility level.

Q > ...you are ever suspicious, you are ever waiting for the lawsuit to...

A > yeeeeeee! (laughs) you know? Because I was told that, er [pause] Presently the department has about 69 lawsuits.

Q > outstanding?

A > yeeeeeeeees. And 29 are not defensible.

Q > are not defensible?

A > yes.

Q > ouch.

A > so you can

Q > (laughs)

A > [pause]and I don't know if my hospital is there, in court, you know? And [pause]

Q > don't you know?

A > no.

Q > are they not telling...?

A > they haven't divulged it.

Q > Shew. Then don't you think they should?

A > Well, it's important, it's important.

Q > in the sense that you are ultimately responsible for...

A > and, and, in actual fact they should, so that we can... trace, and see what happens. And look what we did at that time. Because that will help to, to [pause]in the settlement.

(Quote 2: CEO, regional hospital)

Concrete support required for implementation included materials (such as posters and pamphlets) and funding for key positions or training workshops. The parent study asked managers directly about implementation materials such as pamphlets, posters and videos.

There was a consensus that insufficient materials were available, both in quality and quantity. Illustrating the top-down culture, most interviewees did not know whom to ask for materials and a minority said that their requests had been denied. Many facilities showed initiative in translating posters themselves into locally prevalent languages and photocopying them, but interviewees felt that the posters they produced in this way were less eye-catching than posters produced by the DOH for other policies. As described by the parent study, the cascade model of training was not popular and very few interviewees had received training in the PRC specifically. Furthermore, almost all the interviewees in this sample were not confident about the content of the PRC, with only one interviewee (a hospital CEO) able to mention all of the PRC's rights. A quality assurance manager complained being unable to access training for herself in the PRC, despite being expected to train others about the policy.

In terms of finding the PRC impossible to implement in their current contexts, managers spoke about a mismatch between the policy's contents and realities in health facilities and in society. Material issues included money for materials and training but also for improvements to facilities, which several managers said were insufficient to preserve confidentiality. Managers also echoed health workers' commonest theme, that human resource shortages in the face of vast patient numbers created a stressful situation. Staff shortages were commonly blamed for long waiting times and some interviewees spoke about how this produced pressure to cut corners:

Q > The question I want to ask you is: do you think enough is being done to integrate the Patients Rights Charter into the daily work routines of people? that it is very much a policy that is coming outside? that it adds, people see this as adding more to what they really have to do and it is not really integrated?

A > No, I think on that note I think enough has been done, but what makes people to complain is perhaps because of lack of resources. As I have indicated, some of the contributory factors are beyond our control [pause].

Such that if I am alone in the clinic and there's about 5 or 10 people who have been there for more than 3 hours, what is my turnaround time there to those patients? I have got pressure. So it's not an issue of "I don't understand" or "I don't have to" or "I don't want to" or "I have not been informed properly", but it's because issues are beyond my control [pause].

That makes me to feel "Ag, as much as I would want to record these things, if things are, take 3 minutes to do this, maybe I should have done that for this person, I should have checked the blood pressure to this one maybe, maybe 2 or 3 people have gone home or such things, but because of such things which are beyond our control" [pause].

We are talking about gross staff shortages. The issue of the budget is also contributing towards the whole thing.
(Quote 3: district manager)

Several interviewees talked about how staff shortages made it practically difficult for health workers to spend time listening to patients, explaining issues and generally treating them like empowered individuals. A few especially insightful interviewees spoke candidly about how these pressures influenced health workers' attitudes towards patients:

A > I think the biggest problem is that there's shortage of skilled staff across the board, you know, the allied health professionals, the nursing staff, the medical staff. There's a shortage of skilled personnel, so due to the shortage, the existing staff always has to run around and try and make sure that things work. So, I think employment of more staff would improve the implementation of the Patients' Rights Charter because we [would] have more people to actually respond when help is requested by patients, and not, you know, put you in line, like at the call centre. That if you ask for help, you know, you have to wait, you know, then it will be number 1, number 2, number 3 [pause].

(Quote 4: Doctor, head of department, tertiary hospital)

Less concrete issues which managers said made the PRC particularly difficult to implement included health worker attitudes towards patients, and the consequences of patients being so disempowered by structural inequalities in society. Historical economic and educational disadvantages made it especially difficult for patients to be confident enough relative to health workers to assert their rights:

A > um, what I mean is [pause] The health worker knows her rights. Very very well. And if any of those rights is breached, they react immediately. You know. And they will seek redress of the issue immediately.

Q > do you mean breached by a patient, or breached by a manager like yourself?

A > breached by a manager, you know?

They will [pause] They don't, they haven't [pause] We haven't had a complaint where a patient breached their rights. Because after all they are always in a position of power. So the patient is there to receive and they are giving, giving most of the time. It is very rare that you come across a difficult patient, who is reported to have been difficult, and has been rude to the [pause] to the staff. Obviously [pause] there are, there are [pause]. **(Quote 5: CEO, regional hospital)**

A few managers spoke explicitly about how health workers were socialised to expect patients to act passively. The PRC's contents were specifically challenging to this functionalist expectation of healthworker - patient relationships:

Q > Does the Charter really serve a purpose? I'm asking because ... doesn't it just duplicate what nurses know what to do already? Nurses and doctors and...?

A > I don't think so, I don't think so.

Q > You don't think so?

A > I don't think so, I think it serves a purpose. Because it doesn't mean that in the early days we didn't know that secrecy was important, we know [pause] we knew these things. But if one is actually trained to, if you are told that this is important, because I think this is was also a gap in our training, perhaps training as nurses.

Q > Mh

A > From my time, probably up to now. I am not quite so sure because I am no longer in the training field.

Q > Mh

A > That you also came from a background that would say the patient is someone who takes, and you give and then they take, such things. So, it really needs, it's important, it should be. I think there we need to be trained to understand it exactly what it means to people.

(Quote 6: district manager)

Finally, some interviews suggested that health workers were resisting the implementation through expressing hostility to managers, for example in doctors refusing to wear name badges, or saying that managers didn't understand medical progress and how facilities should be run. Health workers' resistance could be passive and non-confrontational:

A > Though as you indicated of the issues of the, between nurses and doctors. To a certain extent we had a difficult [pause] area around the name tags with the doctors, that to achieve that one it was a bit difficult.

Q > With the doctors?

A > With the doctors.

Q > They didn't like it?

A > Ja. It's, it's not, when I was trying to talk to them, it wasn't the issue of saying they don't like it, it was "we forgot, we forgot". It was more frequent that they forget, that I even thought that maybe they don't like it. But as time goes on we drilled and it's becoming better now.

(Quote 7: CEO district hospital)

However, it was sometimes more overtly hostile:

A > ...and I think sometimes people who are in management just don't have an insight of clinical medicine, as it pertains to the various specialities. And some actually come and suggest things that were done, maybe, before I even went into medical school. And that since I went to medical school, this is not how we treat [*] patients.

I think, in the teaching of the Charter, the management must also be taught that there are things which are scientific now, and obviously if we have learnt that a certain method of teaching does not work - we need to do something else actively, to make sure that the patient does not need to stay unnecessarily long and that patients do not actually end up with a bad result. We don't have the support of management.

(Quote 8: Doctor, head of department, tertiary hospital)

** identifying this doctor's specialty, omitted to preserve confidentiality*

4.1.2 Health workers said "it's not fair!"

Health workers' sense of injustice was expressed through three recurring themes. Several claimed that patients' complaints were handled unfairly by managers, who would listen to patients' accounts of episodes but not to health workers' accounts. They protested that health workers were not valued and did not have rights of their own, to counterbalance patients' rights. Many also commented on more emphasis being placed on patients' rights than on responsibilities.

Confirming the parent study's results, this research found that patients' right to complain was a key issue for interviewees. Several managers had a nursing background and sympathised with health workers' comments about this. Most interviewees said that they did not object to the principle of patients complaining but to the way complaints occurred and were handled. Many

complaints were felt to be inappropriate (explored below). In addition, health workers felt that they did not have opportunities to defend themselves, and that nobody was interested in their side of the story. They wanted managers to explain to patients why their work environment made it difficult for health workers to deliver a flawless service, but instead, they often felt blamed and unsupported:

Q > What kinds of support?

A > Um, I think, like, as I am saying [pause] with those constraints. Management needs to be understanding. Ja, they need to - to be seen to be accommodating. Like, if the patients [pause]. I mean, if a patient made a complaint about a member of staff. I think management needs to [pause] also look at the side of the service provider. But most often, they would, they are seen to be tending to [pause] to, to [pause]. To take the view of the aggrieved, or the patient. Without taking into [pause]. I mean, trying to explain the situation of the patient, I don't think it's wrong. Like, saying OK I understand you are angry because you were not served on time. But, unfortunately, it has to be like that because of this reason [pause].

Q > Ja?

A > Or, maybe you were told to come the following day, but because of that reason, unfortunately it had to change. But we are sorry about it. We are trying to [pause]. We are working on it. It, it, it [pause]. It comes alright. Next time when you come you will find our service is much better. I know the patient needs to be protected. But the workforce [pause] it would be helpful [pause] if that would, need not, to be felt to be a scapegoat. Because the reason they get more demoralised, if they are not [pause] uh [pause] protected. Ja.

(Quote 9: nurse in OPD, regional hospital)

This fed into a broader sense of injustice, that health workers were not valued. A recurrent theme was that patients had rights and a charter, but health workers did not.

Q > Are you concerned about your rights as a health care provider?

A > As health professionals, do we really have those rights?!? (*laughs*)

Yes [pause]. I am.

Actually I'm not comfortable that patients have got a lot of rights and we have got almost no rights.

That's why I'm saying, in this Batho Pele thing, there must be 2 boxes. A box for their complaints and a box for ours.

(Quote 10: doctor, medical ward, regional hospital)

Only one interviewee (a QA coordinator at district level) volunteered anything about health worker complaints, which she said were valid and that it was important to provide a forum, such as open staff meetings, in which health workers could voice their concerns. This was in marked contrast to all other interviewees. Health worker complaints she cited included staff attitudes, shortages of medicines, problems with facilities (malfunctioning toilets, falling ceilings), linen shortages and also posts that had been filled without being advertised.

Waiting time was cited as a common topic of patient complaints, and health workers spoke of not being allowed to eat lunch or to have a short rest because patients would complain about having to wait. A sense emerged that, while patients were given extra rights by the charter, health workers were denied the basic rights of citizens or even of humans:

Q > Does the Charter benefit staff members in some ways?

A > Well [pause]. We don't [pause]. Because we end up not being Batho. You know, they say Batho Pele, but somehow we [pause] are not Batho. You know, you will come in, you ask - I am hungry, can I please go to lunch.

It's a problem.

But we are a human being, we need to go eat.

But they will tell you, no, there are patients waiting.

Even the patients, they will start complaining... the doctor left us. For 30 minutes while we were waiting there.

Whether it's 1 o'clock or not, they don't care [pause] they were at the hospital, they were waiting, you walked out [pause] of the room.

So I think [pause] there is a problem with the balance, between the rights and the responsibilities, and the rights [pause] for us [pause] as health workers.

(Quote 11: doctor in OPD, regional hospital)

Health workers' critique that their rights were not protected was so prevalent that it was specifically discussed in interviews with managers. This quote reveals a sympathetic manager's awareness of the authoritarian, top-down culture prevalent in the DOH, but also how this could make health workers feel undervalued, disgruntled and driven to resist PRC.

Q > so what would your supervisor say to the nurses, if the nurses would complain and say this is looking after the welfare of the patients but it's not considering us?

A > They will tell them, this is the government of the day, this is what the government of the day says. You must do as you're told.

Really, you will be told that, and even if you are not satisfied, nobody would listen to you.

They will say, if you are not ready to do what you are told then, it's up to you.

Q > what does that mean, it's up to you?

A > If you feel you cannot take it any longer, you can go. And even the managers, I remember one of the superintendent generals [pause] once said that, to say, if you feel you cannot take it, then you go.

Better go out before you are pushed out. I remember he once said that – better go out before you are pushed out

Q > and if you are already feeling resistant, it makes you more angry?

A > Yes, it makes you more angrier and [pause] not to implement the charter. Mmm. And you will then [pause]. So you will take it on the patients, you will take your anger on them.

It was 1999-2000, when [pause]. He has left the department now, he was the HOD. But he once said that [pause]. If you don't want to implement what you are told, then, you better go out before you are pushed out.

(Quote 12: district QA manager)

Health workers also expressed feeling undervalued in other ways. These included complaining about not being included in planning services:

A > ...I think, as someone who has demonstrated a lot of interest in making sure that, you know, that patients get a better deal. I think they should take me into their confidence and I should know what are the plans. But, you know, I just work mainly because I think patients here also deserve a good deal. And mainly because patients who come to this hospital are people who vote for the ANC, which is an organisation which I have supported since I was a child. And when the ANC say 'A better life for all', I think I should also contribute in whatever small way. By coming here, I think, I do what I can within limitations. But, I think more could be done.

(Quote 13: Doctor, head of department, tertiary)

This doctor provided revealing data on several topics, which were echoed less outspokenly by other interviewees who nevertheless made some similar points. A relatively standard story about human resource shortages suddenly veered off, complaining that he was not listened to, blaming managers' incompetence for poor implementation and ultimately accusing them of hostile and punitive treatment of health workers:

A > ...And then the other problem is that when you look at patients, for instance in the clinic that I have to do on a Friday, sometimes we have 234 patients. For how many doctors? I think about... I'm the only specialist, 3 or 4 medical officers and one intern. So about 5 to 6 doctors seeing 234 patients, I think this is wrong because there is no way we can do a proper job. So, what we sit and do there is to see who is very urgent that, you know, we need to do something now, today or next week? Who is in such a position that we can postpone? And who can be treated, you know, wherever he was referred?

So this is a big problem. I thought, just getting a clerk, a booking clerk would help alleviate the situation. And since I arrived here in '96, I'm still crying for a booking clerk, because I think with a booking clerk, we can book less people. Spread them over a longer period. Because now we don't have a booking clerk so people just come from the whole province on a Friday, and they must be seen, you know, it's almost like a sorting station or you sort out who has a big problem, which has a small problem. It's not really proper medicine.

So, I think the rights of the patients actually get compromised by the hospital management, the provincial management by not having a plan, how do we move forward. And, seeing specialists sometimes, as the enemy. I don't believe that I am the enemy of the state, nor am I the enemy of patients. Nor do I think other colleagues or nurses or health professionals or even clerks are enemies of patients.

But sometimes, you know, when it comes to professionals, you feel, the people in management think you are the enemy and that they must keep on, you know, punishing you for whatever sins you have done and I ...

(interrupted, end of side A of cassette).

(Quote 14: Doctor, head of department, tertiary hospital)

The final thread in health workers' sense of injustice, of a greater emphasis on patient rights than responsibilities, required careful scrutiny. Caution was required because the health worker (but not the manager) interview guide asked this question directly (see Appendices C and D), so interviewees did not volunteer it without a prompt. However, the question was neutrally balanced and the strength of health workers' replies revealed it to be the subject of strong feelings requiring further consideration. Responses characterised patients in ways that made the reader uneasy, not least for their negative attributes in the context of the PRC. Several quotes citing responsibilities are included below, to illustrate how health workers used this complaint as a starting point for a range of other criticisms of patients. In addition, these criticisms ascribed moral qualities to patients which were suddenly general character judgements, going beyond clinical encounters.

In protesting about the greater emphasis on rights than responsibilities, health workers characterised patients as being irresponsible alongside a spectrum of other negative qualities, ranging from undesirable and unreasonable:

Q > Do you think the Charter strikes a good balance between rights and responsibilities?

A > There is no balance. People are more demanding about their rights and not taking responsibility. For example, they come in dirty [pause]. Some patients come and have not had their baths. Some seek help late and yet would come and demand instant help from the hospital.

(Quote 15: help desk nurse, district hospital)

through unreasonable and selfish:

Q > Are patients accepting the responsibilities that the Charter gives to them?

A > They are trying but weekends and nights they don't. Many don't understand. We have to keep teaching and reinforcing it.

Q > Do you think the Charter strikes a good balance between rights and responsibilities?

A > No, there is no balance. With the rights, they are taking. With the responsibilities, they don't care much.

(Quote 16: help desk nurse, tertiary hospital)

to dishonest and deliberately misusing services.

Q > OK. Um, about patients, are they accepting the responsibilities that the charter gives to them?

A > Ja. I think partly they are, partly they are, but like, as I'm saying [pause] To this day, people are like, like more to cheat than to be honest. Ja. I mean generally, everywhere where you will go you will see that people who like to rather cheat you than to do something that will remember them [pause], something good that will remember them by. Ja. So you find patients who are not, who do not take their responsibility because they want to [pause] misuse the services [pause] the rights. Ja.

(Quote 17: nurse in OPD, regional hospital)

Exploring these and other responses found interviewees also characterising patients as ignorant, both about health and about how the health system worked. These themes are important because they illustrate not only how providers felt implementation of the PRC was difficult, but also how their responses were influenced by power and resistance.

4.1.3 “Patients don’t know enough about health”

Three recurrent criticisms fell within this accusation. Underlying interviewees’ complaints about patients’ right to refuse treatment was frequently an argument that they did not know enough to make good decisions. A second criticism ascribed traits to patients which implied their ignorance about health issues such as nutrition, cleanliness and a healthy environment. Finally, the charge that patients demanded high-level or emergency care for trivial problems suggested that they were unable to evaluate the seriousness of different symptoms.

The right to refuse treatment, like the right to complain, clearly illustrated something important about providers’ responses to the PRC. Interviewees made it clear that this right was generally unacceptable to providers. Two problems were consistently raised: that patients did not understand the biomedical implications of refusing, and that refusal highlighted conflicting agendas and uneven balances of power. However they addressed the latter, all interviewees talked about explaining to or teaching patients about the former.

Only one interviewee discussed the right to refuse as one unremarkable implementation target amongst others. However, even this most neutral interviewee spoke of the patient's right to refuse in terms of being imposed upon:

Q > In all these things that you have done, have you had certain priorities?

A > [...waiting times... hospitality issues....]

...How do we make sure that when a patient who is coming to the casualty, they are not lying on a stretcher that is without a mattress or without the blanket?

And how do you make sure that when a patients says, look I don't want this operation because of 1,2,3 [pause]. We say, we, okay fine, we understand that, but let us explain to you what you will gain from having the operation[pause]. But still if you feel you don't need the operation we will see to it in an alternative way, if there is an alternative.

Basically just saying to the patient we cannot impose on you....

(Quote 18: CEO, regional hospital)

One health worker perceived patients who refused treatment as abusing or taking advantage of the system. She spoke of a new era, in which the previous norm of health worker dominance over patients no longer applied:

Q > Have the requirements of the Charter been integrated into the day-to-day working routines or is it more of a policy coming from outside, being added on to what people are doing?

A > The first thing is, we know how to handle patients now. Gone are the days when health professionals can do anything to a patient [pause] but [pause] the disadvantage is, people abuse it. For example, the right to refuse treatment.

Even if we explain the disadvantages, they can still refuse.

People somehow [pause] take advantage of those [pause] of the system.

(Quote 19: doctor, medical ward, regional hospital)

The most insightful CEO talked about the need to engage health workers in discussing their attitudes, drawing a distinction between overt conflict, subtler rejection by patients of health workers' dominance, and more overt rejection by health workers of patients' right to access treatment if they are not prepared to comply:

A >But we also find that, er, we are challenged by especially the attitude of staff [pause]. Which shows that they do not relate this to their day to day performance. That's when I would point into [pause] the awareness campaign. Where, we move from one ward to the other, to talk to the staff about this: What does it mean? And how, how, how do they bridge, [pause]. For example, if a patient refuses hospital treatment. The staff will be cross with this patient. And they start to reject the patient afterward they are, you know, you are refusing our treatment, so you can go, and you will take our things, you will take our medication, you will take it and there. And, and [pause]. We had to make the staff understand that there is nothing wrong in the patient refusing hospital treatment. It's not out of conflict, unless if there are problems around that.

(Quote 20: CEO, regional hospital)

Another CEO, while parroting the common theme of unreasonable patients asserting their rights over responsibilities and refusing treatment without any “reasonable reason”, showed an awareness of hierarchical tensions within the facility. He was aware of the danger that, in top-down promotion of a DOH policy, a manager might not “get clearer and closer and closer” to the implementation coalface, to understand how health workers felt patients were really behaving.

A > ... But I would say, maybe we also need to strengthen, as I indicated, to say at times, it's emphasised more on the rights of the patient than knowing that they are also having the responsibility.

Q > Mh

A > Of which it's in all the levels, even in the institution, you might find that as the CEO, I am actually saying “The rights of the patient, the rights of the patients”, but when you look at it in detail, you'll find that maybe that patient reported that were being violated, but if you don't get clearer and closer and closer you might miss the fact that it wasn't, in reality, that he was violated to that extent.

Q > Mh

A > Maybe it was the understanding on what to do. Because at times you'll find, just to give an example, maybe you are giving the medication and the patient says, “I have got the right to refuse”.

Q > Ja

A > Not knowing that as a patient he has got a responsibility towards her own health.

Q > Mh

A > Just without any reasons or reasonable reason, he'll just say “I have got the right to refuse”, refusing, so, maybe they also need to share to say “By the way when I come to the hospital, my responsibility is to take the medication and become cured and go back home”.

Q > Mh

A > So, those are the things that maybe we really need to check when implementing the Charter.

(Quote 21: CEO, district hospital)

Similarly, another CEO illustrated the tensions between health worker agendas, rather than between health workers and managers:

Q > To what extent is the Charter a source of conflict between managers and health care providers, and health care providers and patients?

A > It is causing tension between employees such as doctors and nurses. A doctor might, for example, want to do an operation. The patient will refuse and the nurse will act as an advocate, which might irritate the doctor. These things can escalate to quite a serious level.

(Quote 22: CEO, tertiary hospital)

In describing patient ignorance about hygiene, nutrition and a healthy environment, two contrasting discourses emerged. A few interviewees, all relatively senior nurses, expressed irritation at patients who did not keep the hospital environment clean. The narratives resonated with others of selfish patients shirking responsibilities and abusing their rights, while invoking commentary around hygiene and cleanliness:

Q > Do you think the Charter strikes a good balance between rights and responsibilities?

A > Yes.

Q > how?

A > Like I've already mentioned, that [pause] Their right is to stay in a safe and, you know, a clean and safe environment. Or we need to give nutrition. Or what else? I've forgot.

But [pause] you find that the patient himself, neh? Eh, leaves the plates dirty. Goes to the bathroom, gets into the bath, and wash, leave the bath dirty.

It is a responsibility, because she find it clean; she must leave it clean for the next person to come and [pause] have a bath. Ja.

(Quote 23: nurse in charge of surgical ward, regional hospital)

By contrast, some helpdesk and junior nurses seemed to enjoy including a component of health promotion in their work, and incorporated cleanliness into this:

Q > What are the main things that the Charter requires from people who work in health facilities?

A > We must respect the patient and then the nurse must provide confidentiality and the nurse must not be cruel to the patient, be compassionate and provide information and direction. They must be taught properly. They have right to referral. The patient must be taught about issues such as blood transfusion. They must be taught how to call ambulance. We are teaching about the diet because there are many people who are having conditions such as diabetes, balanced diet for growing children...

Q > Describe a typical working day before and after the introduction of the Charter.

A > Every morning, I give health education to patient and those who escort grandmother or grandfather. I am teaching them to be responsible at home. They must be kept clean and clothes clean and everyday when they come we tell them, you don't need to come everyday. We teach them about the Batho Pele box everyday...

(Quote 24: help desk nurse, regional hospital)

Although stories of patients demanding inappropriate care were attributed to a lack of biomedical knowledge, such stories were presented critically, as selfish patients making unreasonable demands:

Q > Do you think the Charter strikes a good balance between rights and responsibilities?

A > I mean, it's a general problem with us South Africans. Since we got the new Constitution, we think that we all have rights to everything.

We just totally forgot that [pause] rights go along with responsibilities.

So, it's not only here, it's everywhere. Probably they do the same thing when they go to other facilities that they use, that belong to the government [pause].

Q > Can you give me some examples?

A > I think most of the time it's when [pause] we try to accommodate them.

You know, a patient will come in [pause] probably who have already concluded what's wrong with them.

And then you [pause] you examine them, and you decide what are the right things to do. But they [pause] they can be expecting you to do something else.

So then they will start having a problem, like they think [pause] they fell.

We examined them and we think [pause] there is not a broken bone here.

But then they will demand an x-ray.

And then when it's done, negotiating with them, they just demand an x-ray.

Because they think, they have paid, so if they want an x-ray, they should get an x-ray.

Like relatives who come here bringing a patient [pause] that they consider very sick. We check them out, give them pills to go home, they start complaining, because they expected you to admit the patient.

So it becomes a problem when you don't admit the patient, because they expected you to admit the patient.

Q > And what do you do during cases like that [pause] when the relatives want [pause]

A > I think [pause]. Usually it's easier when the patient can talk. Because then you start explaining to the patient what's wrong with them, and what you can help them with, and what they can do for her at home.

So even if [pause] most of the time, I get helped by the patient themselves.

Because the patient will just tell the relatives 'I don't want to be admitted, I want to go home'.

Because then in that case, you tell them [pause]. She wants to go home. And it's also my strongest opinion that the patient should be at home.

Q > OK. and what about x-rays?

A > X-rays [pause] it depends. It depends. You negotiate. If it doesn't help [pause] you just [pause] even do end up filling out the x-ray form. Because it doesn't affect [pause] anything.

If the x-ray department, it's open, they can go to an x-ray.

The only problem is at night. Because you can't call out someone to come and do an x-ray when it's not indicated.

Q > But you can if it is indicated?

A > Yes. Because at night, we only deal with emergencies, like I said.

So, if someone comes with a non-emergency, they should be satisfied enough that I as a doctor at least saw them. They can't demand that everybody in the hospital should be up and answer [pause]. Because they came to hospital.

(Quote 25: doctor in OPD, regional hospital)

The analytical issues raised here will be discussed in the next section.

4.1.4 “Patients don’t understand the system”

Against the ubiquitous backdrop of patients’ complaints, providers commented disapprovingly that patients did not understand how the health system worked. At best, providers wanted patients to be given explanations invoking the system’s constraints. However, providers sometimes blamed patients’ lack of understanding for unreasonable behaviour which exacerbated problems for health workers and for other patients. The three issues discussed in this way were waiting times, the right to choice of facility and to referral, and access to emergency care.

All but one interviewee volunteered the problem of long queues and long waiting times. As with patient ignorance about health, help-desk nurses were happy to explain the reasons:

Q > What has been done to implement the Charter in this facility?

A > We teach patients to write in suggestion box. If they see mistake or see right thing, because the patient they are many but the staff are few, we have to explain to them to please be patient for doctors to come. Because the doctors, maybe he is in the theatre, the patient must be informed. We must explain to them, “today we are not enough we are only 3 or 4 nurses”.
(Quote 26: help desk nurse, regional hospital)

As before, however, health workers in more senior roles indignantly blamed unreasonable patient behaviour for contributing to the problem:

Q > Give me an example of how they would put pressure on you?

A > They put pressure, for example due to the shortage of staff, I told you that there is shortage of staff?

Q > Yes

A > You find that the patient comes in, you are only 3 [pause] Did you see how big is this ward? it does that and that [pause]

Q > Ja, all the way

A > [pause] and stuff, so it has 3 wards inside, it is medical, it is surgical, it is gynae, it is orthopaedic, are you listening?

Q > Yes

A > All these are combined in this ward, now when you look at the off duties, people must go home, they must rest, it's their right to rest [pause] now you find that only 3 are there, then there comes a patient [pause] maybe for example today it was doctor's day, one sister is busy with the doctor that side medical, the other sister is this side, the orthopaedic and surgical with another doctor, mainly there's just a junior on the passage and people come here, now they claim that junior [pause]

You see, sometimes people don't understand our category, they can't say this one is senior, this one is junior, but they will put pressure on that one, do this, do that, attend to our patient, can't you see we have been long waiting, such things, you see [pause] only to find that she knows what she must do and she cannot go above her scope. Some of the things, she must wait until the sister finished with the doctor [pause] Even those patients, they need to be seen by doctor, we must assist him with [pause] And now you find that there is that commotion. In most places, people they were told that when we come here you must attend us within 15 minutes. (Quote 27: Chief Nurse & QA coordinator, district hospital)

Patients' behaviour around the right to choice of health services was presented as selfish and unreasonable, and blamed for depriving other patients of hospital care:

Q > OK. Um, does the charter have any disadvantages for patients?

A > Um, ah, I don't think much [pause]. Although sometimes, as I'm saying, people will like to misuse a good thing. Ja. Like if we know we have got a right here, you might misuse it to your advantage. Ja. Like they might start neglecting their responsibilities. But I don't think the charter, it's [pause] it cannot be implemented effectively now. It's just that it's got minor mishaps here and there.

Q > OK

A > Um, to add to that I can say [pause] The patient has got an access to healthcare. But the patient might need to be referred to a health service of a lesser quality. And the patient might feel, no no no, I don't want to go there.

You will tell them, OK, look, the service you are asking for here. There is such a service in the clinic.

And the patient will tell you - no no no, I don't want to go to the clinic, I want to come to the hospital.

Then eventually I think the patient's [pause] the charter is not helping the patient well. Because now he's taking the space for other patients who could have been helped. Yeah.

(Quote 28: nurse in OPD, regional hospital)

It also was said to cause problems for nurses, caught between the system's hierarchical demands that they justified referrals, and patient demands to see a doctor:

A > The charter wishes [pause]. The patient has got the right to [pause], to ask for permission to be referred to the next level of treatment [pause].
Yes, it's difficult to implement that one, because when they come to a clinic, they always want to be seen by a doctor, they always want to be referred, they always think that [pause] the treatment that they need is not at the clinic, they need to be referred, and you cannot just refer [pause] each and every one [pause].
But they have [pause] a right according to the Patients' Rights Charter, to be referred to the next level of treatment. And you have got to specify: why are you referring the patient to the next level. So it's difficult when we explain that [pause]. I think you don't need to be referred to the hospital, because of 123 [pause] and they always say, but the Patients' Rights Charter says I have got the right to be referred to the next level [pause].

(Quote 29: Quality Assurance coordinator at district level)

A recurrent issue, particularly for doctors, arose when patients chose to seek care for non-urgent problems outside working hours, when access was intended to be for emergency treatment only. Despite describing patients who seek access at night and complain about waiting times as clearly unreasonable, doctors still felt vulnerable to punitive scrutiny following their complaints:

A > I know a patient should go to any hospital.
But what we are experiencing here is [pause]. Patients are bringing people who have been ill for 6 months. They come at 2am.
When you start asking, you find - they have got worse 5 days ago.
It's 2am. It's the weekend at the end of the month.
It's month end, it's the weekend, it's at night.
There are lots of accidents.
But even if you are attending to someone who is bleeding, they complain about being delayed.
And the next thing you know, you are being discussed. In the committee.
These are the things that must be addressed.

(Quote 30: doctor, medical ward, regional hospital)

In the face of such unreasonable behaviour, nurses were again caught between hierarchical pressures (of trying to avoid upsetting powerful doctors) and the immediate pressure of patient demands:

Q > Okay, do you think the charter is it helping the relationship between the patients and health workers or is making it more difficult more strained?

A > Look, if the public was to understand the meaning of the charter, which at the moment I doubt that they do because at the moment the majority, or let me say there's quite a number of people[pause] members of the public, who are using the charter as a tool to intimidate nurses and health workers[pause] I'll give you an example. Access to free health, right?

The person will drive from wherever, come into the hospital and demand at 10 o'clock at night to be seen because he has been having a headache for[pause] since 5 months ago[pause] but demand to be seen at that time. That is abusing that charter.

And what does the staff do? If they don't call the poor doctor, who had been on call for the whole year, they are in trouble because this man is going to report. If they didn't call the doctor.

If they call the doctor and the doctor doesn't come, it's still their fault why he didn't come.

(laughs) Do you get what I am saying? It's still their problem why he didn't come.

And you know what they end up doing? They end up saying: here is the number of the doctor, phone him. And again they are rude.

So that's the abuse which is there. Some of the abuse which is there. So if you take those little instances, it puts a lot of strain on the health workers... considering that they are few.

(Quote 31: CEO regional hospital)

4.2 Which rights were cited by interviewees

In terms of crude frequency, patients' rights to complain (coded 102 times) and to a positive disposition displayed by health workers (56 times) were mentioned most. The next cluster (of rights to access to healthcare, to health information, to choice of services, to a named health worker, to refuse treatment and to confidentiality) were mentioned between 15 and 22 times each. From another perspective, the rights to complain and to a positive disposition were both mentioned by all interviewees. Approximately 63% of codes for specific rights came from manager interviews and 37% from health worker interviews, which may reflect managers' greater familiarity with the PRC or the different questions asked of each group. However, it may be immaterial due to the overlap between groups, including managers who identified themselves as nurses in a managerial position and health workers with managerial responsibilities.

Of least interest to interviewees, the rights to information about insurance schemes and to continuity of care were only mentioned by one interviewee (a hospital CEO). The rights to

participate in decisionmaking and to informed consent were not mentioned often, and very rarely by health workers (2 and 1 health workers, compared to 4 and 6 managers respectively).

The most frequently cited right not included in the PRC was about time waiting, which was cited by all interviewees except two (a hospital CEO and a district QA manager). This contrasts sharply with the right to timely emergency care in the PRC, which was mentioned only 9 times (5 by managers, 4 by health workers).

The potential significance of which rights were most cited and how rights were misunderstood will be considered below.

4.3 Applying the conceptual framework to the inductive themes

4.3.1 Managers felt disempowered

Managers' narratives of disempowerment differed in tone to the other inductive themes.

Issues of power and resistance were discussed in matter-of-fact, relatively neutral terms.

Narratives in this theme lacked the sense of betrayal prevalent in other themes and underlying norms and values were not invoked by managers.

In speaking of their relationship with higher levels of government, district and facility managers described a top-down organisational culture in which higher levels' sources of power over them drew on formal authority, encompassing the ability to determine priorities, to withhold funding or information and to threaten or sanction managers. Wider contexts influencing their agendas included an emphasis on HIV/AIDS and a broader rights culture, prevalent both in society and in the department of health (the latter more commonly cited through Batho Pele than the PRC). Manifestations of this disempowering relationship were

relatively straightforward, and the strongest emotions expressed were frustration and resignation. The extent to which managers felt disempowered was palpable in their complete lack of resistance to the ways in which higher levels undermined their implementation efforts.

In discussing ways in which they found it impossible to implement the PRC in the face of current contextual realities, managers were speaking of limitations in their sense of agency, of power to achieve implementation. Sources of power they wanted to draw on included their roles, skills and energy as managers, to enable them to access funding for more staff or better facilities. However, they acknowledged that the scale of resource shortages was “beyond our control”. Health worker commentaries on resource shortages frequently blamed managers, but managers expressed an inability to overcome the shortages or the greater challenges from wider society.

In facing resistance and hostility from health workers, managers did not have resilient sources of power to draw on and their lack of confidence is therefore understandable. Both quotes 7 and 8 cite resistance from doctors, whose greater professional status and power than nurses enabled them to mount more overt resistance. In quote 7, doctors were objecting to being asked to wear name tags, but the doctor in quote 8 was attacking managers’ credibility in “teaching of the Charter”. Both quotes show the PRC’s contents were challenging to doctors’ expectations of autonomy and accountability only to their own values and bodies, rather than to patients or managers. Doctors in quote 7 initially refused to comply with a manager’s request that they wear nametags, although they drew on their status and autonomy as a professional group in noncompliant behaviour, rather than seeking overt verbal confrontation. In contrast, the doctor in quote 8 claimed power from esoteric (“insight of clinical medicine”) and scientific knowledge and a prestigious training (medical school) to discredit management’s inferior knowledge and status, over which he claimed superior knowledge on management

outcomes too (length of stay and poor results). In facing such challenges, the sources of power available to facility and district managers were relatively weak. They had little confidence that they could perform the core tasks of their role effectively, they felt undermined by higher levels, and their formal authority over doctors was constrained by insurmountable human resource shortages.

4.3.2 Health workers said “it’s not fair!”

In contrast to the previous theme, this deep sense of injustice spoke to health workers’ underlying expectations about their role and how others should value it.

Patients’ right to complain challenged the core of functionalist expectations about how people should behave in ‘the sick role’, which requires patients to take a passive role, to cooperate with health workers’ advice, and to acknowledge health workers’ beneficence, superior knowledge and authority (see Box 1). This model also claims autonomy for the professional role, expecting health workers to be guided by rules of professional practice rather than to be accountable to patient or manager wishes (Box 1: Lupton, 2003, p.7; Morgan, 2003, p.51).

Almost every interview suggested that this functionalist model was prevalent for health workers. Most interviewees echoed aspects of it, and a few challenged it explicitly as the established norm. A handful of interviewees talked about how health workers were socialised into it during their training.

In protesting that complaints were often not valid and were not handled well by managers, health workers were passing critical commentary on both patients and managers, drawing power from claims to superior knowledge and judgement in doing this. This could be a defensive strategy, in the context of a unanimous sense of vulnerability and discomfort with

being subjected to the scrutiny arising from patients' right to complain. This vulnerability was exacerbated by their organisational context, in which health workers felt judged by patients, managers and hospital PRC/Batho Pele committees. They also felt defensive about scrutiny from wider civil society, in unfavourable media portrayals or in legal action.

Q > Are people really justified in...

you used the phrase "they are synchronized Americans", so I am thinking, do people often go to the newspapers and radio stations, or is it...?

A > Fear is real, fear is real, you ask any nurse in the ward, ask any nurse in the ward, why did you keep this person there, they will say "they will take us to the newspaper"

Q > They do that, they actually take you to the newspaper?

A > Of course they do.

Q > Quite often?

A > It happens, it happens, they phone the newspapers, they phone the Batho Pele hotline as it's called which goes to the premier's office, and they complain, and the first thing that comes from the premier, and this is where the problem is, whereby the employer does not first investigate and find out what is wrong.

Q > They jump on you?

A > They jump on you and investigate later and it has happened many times (both laugh).

Q > How do they jump on you? If someone were to complain about you what would happen, would someone be calling you from the province?

A > They will call me from the office, "we have got a complaint please send us a report".

(Quote 32: CEO, regional hospital)

Health workers' commentaries reflected ways in which their sense of vulnerability was exacerbated by wider society's vocal rights culture. They drew on its language in describing rights to eat, to rest, and to be treated with respect as essential to being treated as 'Batho'. They felt excluded from the new rights culture, manifested superficially in their saying that they did not have these rights and were not also treated as Batho. A deeper sense of exclusion was palpable in their commenting that nobody listened to them, and they were treated as the enemy. They claimed the moral high ground as a source of power, in drawing on the language of rights, in appeals to professional norms and beneficent motives, and occasionally in claiming political connections (quote 13). Health workers who referred to South Africa's

former struggle for democracy seemed to be arguing that they had earned a right to inclusion in the new dispensation's rights culture.

Commentary around relationships with managers was persistently negative. In saying that they wished managers would explain to complaining patients how difficult their working conditions were, health workers may have been revealing an expectation of being perceived as beneficent. However, they also wanted managers to show support for health workers. Instead, in saying that they were not allowed to present their side of the story, health workers argued that managers did not value their input, either into deciding the merits of the complaint, or in solving the health system's problems. Feeling excluded, unfairly blamed and scapegoated was offered by several health workers as a rationale for resisting implementation, which the more insightful managers understood.

Commentary around patients and their behaviour was striking for several reasons. In labelling them as irresponsible or not deserving of the rights granted by the PRC, health workers justified resisting implementation. This was clearest in saying that patients were neglecting their responsibilities, implying that they had broken an unspoken bargain (reminiscent of the functionalist sick role) which released health workers from a duty to grant the rights. In assigning critical labels, health workers were exercising a power to pass judgement and assert themselves as superior, which undermined the PRC's stated goal of reducing the power imbalance between patients and providers. Ironically, in claiming this power to pass judgement about patients, health workers were claiming the right to complain about them, which they frequently protested had been denied by the PRC.

4.3.3 “Patients don’t know enough about health”

This theme aroused less emotion, although patients’ right to refuse treatment directly challenged functionalist expectations of passive, grateful patients who comply with prescribed treatment. Health workers’ power from superior biomedical knowledge was uncontested by interviewees, and all agreed that patients needed things to be explained and taught to them.

Manifestations of this power imbalance included some familiar elements, such as health workers labelling patient behaviour as unreasonable. The commentaries around this theme were offered when providers were asked whether the PRC was used by patients to threaten workers, or as a source of conflict.

Interestingly, this theme revealed power imbalances in relationships between doctors and nurses, or between managers and health workers, as well as between health workers and patients. While the data do not prove that these imbalances arose from implementation of the PRC, explicit evidence of imbalances did arise from commentaries about the policy.

When nurses mobilised imagery of hygiene and cleanliness, they were drawing on long-established moral values of pure angelic nurses (Marks, 1994) in contrast to slovenly, unreasonable patients. They were claiming moral rectitude, and hygiene as an expression of scientific knowledge, as sources of power. In their alleged enthusiasm for teaching and explaining to patients, nurses were asserting new behaviours in implementing the PRC. It was more junior nurses who professed this enthusiasm for explaining things to patients, in contrast to senior nurses who displayed only irritation about patient ignorance. Junior and helpdesk nurses were at the bottom of the hierarchy of health workers, and a benefit of patronising patients was that it gave them the upper hand in a power relationship. However, despite the

dominating nature of this relationship, there is no evidence that it disadvantaged patients, and it seemed to indicate enthusiasm and support for implementation.

4.3.4 “Patients don’t understand the system”

When the conceptual framework was applied to commentaries around waiting times, two strands of analysis emerged, both concerning the relationships between health workers and patients.

The junior nurses or helpdesk clerks who happily explained long waits (quote 26) were conveying a sense of power which drew on their expertise in how the system worked. Its ultimate source was in their status and position, as privileged insiders of the health system.

By contrast, the more senior health workers who were more critical of patients over waiting times were speaking to functionalist expectations of the sick role. They were claiming expert knowledge and their status as professionals in claiming the right to judge patients’ behaviour. Their commentaries about how patients should behave differently in accessing services were reminiscent of street-level bureaucracy strategies of modifying conceptions of client demand, and their commentaries labelling patients as selfish and unreasonable echoed Lipsky’s strategies of modifying conceptions of clients (Lipsky, 1980).

4.4 Applying the conceptual framework to which rights were cited

Two issues are striking about the rights selected by interviewees for discussion: the disproportionate selection of some rights over others, and some inaccuracies in the way specific rights were understood. These should not be overstressed and the latter may be

influenced by insufficient training and materials. They may provide additional illustrations, however, of underlying power and resistance affecting providers' responses.

As discussed above, the PRC's giving patients the rights to complain and to comment on health workers' attitudes offended providers' underlying expectations about a functionalist-style doctor-patient relationship. Their subsequent commentaries about unreasonable and undeserving patients justified resisting implementation and effectively prevented a redistribution of power in their relationships with patients. In contrast, the technical issues of insurance schemes and continuity of care were unimportant to health workers, as they did not challenge underlying expectations or health workers' relationships with patients.

It was striking that the right to refuse treatment was so much more prominent for health workers than the rights to informed consent and to participate in decisionmaking. Although there was no explicit reason for this discussed by interviewees, it is possible that health workers' commentaries about the PRC, that it was a tool for patients to use in abusing and intimidating health workers, lent themselves more to the confrontation implied in the right to refuse.

Similarly, the commentaries around waiting times were prominent: that patients complain about waiting, that they access services unreasonably with the unintended consequence of increasing waiting times, and the policy encourages them to use this issue in threatening health workers. The only reference the PRC makes to waiting time is the right to timely emergency care, which is intended to speak to a different issue, and which was mentioned relatively infrequently by interviewees. Two explanations were possible for providers' disproportionate attention to waiting times. Evidently, as managers said and some health workers implied that it was the subject of many patients' complaints, it became prominent in implementation

irrespective of the policymakers' intentions. However, given its prominence in providers' responses to patients' charters in the UK and internationally (Sbairh, 2002), it could be important in the way providers frame these charters. From these data, commentaries about this aspect of the PRC were negative, and it offended functionalist expectations of passive, grateful patients.

5. Discussion

This analysis of rich interview data from the Limpopo case study confirmed that the PRC did, as intended by policymakers, challenge the pre-existing balance of power between providers and patients. Providers' responses to the policy revealed a range of underlying issues of power and resistance. There were a few behavioural manifestations of resistance to the policy, such as doctors refusing to wear name badges. There was one mention of behavioural resistance to the exercise of power, when authoritarian treatment from managers provoked providers to take out their frustrations on patients (quote 12).

The pre-eminence of commentaries, over behavioural manifestations of power and resistance, concurs with previous suggestions that discursive ways of resisting implementation processes may be 'more prevalent and important than very organised, direct and instrumental resistance' (Erasmus and Gilson, 2008, p.364). The implications of this could guide strategies to tackle power and resistance in providers¹. Previous empirical work has shown South African nurses framing policies and patients negatively (Harrison et al., 2000; Walker and Gilson, 2004). This research found that providers' commentaries worked to resist implementation of the PRC, in helping to justify why it was impractical or undesirable to implement. The commentaries also involved features of discursive power. Having complained that nobody listened to them, providers were claiming the power to protest, to have opinions and to pass judgements. Some of the ways providers framed the PRC revealed power issues directly, such as nurses and managers saying the charter was being used as a tool to intimidate health workers. Other commentaries provided more indirect evidence of power issues underlying provider responses to the PRC, such as commentaries around surveillance.

¹ personal communication, Ermin Erasmus 2009

Surveillance was an unwelcome change for health workers following introduction of the PRC. They felt the critical scrutiny of waiting patients when they went to eat or even while attending to emergency haemorrhages. One nurse spoke about feeling watched all the time by “the third eye”, by which he may have meant the PRC itself. Foucault’s pioneering work on surveillance described how continual observation could make prisoners docile without the use of force (Lupton, 2003). The burden of civil society’s scrutiny, via the media and legal system increased pressure on health workers to modify their practice.

Managers also felt these pressures, in addition to the risk of being called to account by higher levels if civil society criticised health workers in their facility. One CEO said that not only did she have to ensure that patients’ rights were protected, but she had to be seen to be doing this. Another manager wished she could install hidden cameras to confront health workers with evidence of their punitive behaviour. This illustrates how Foucault described surveillance, ultimately, to work. Eventually the observed subjects internalise the fear and modify their behaviour, whether or not it is being observed (Lupton, 2003). In addition, this critical scrutiny would be uncomfortable from functionalist and political economy perspectives, as they both entitle the health worker to autonomy as professionals.

The second thread revealing power which emerged indirectly from commentaries was the pervasive influence of providers’ norms and values. Commentaries around patients not knowing or understanding enough to be granted rights such as refusing treatment or participating in decisionmaking revealed normative resistance to the PRC’s intended redistribution of power. Previous implementation studies have spoken of negative labelling of patients as an unintended consequence of sub-optimal implementation processes (Schneider and Gilson, 1999) and how this can have negative impacts on vulnerable groups’ access to health services (Harrison et al., 2000; Walker and Gilson, 2004). Lipsky discussed labelling as

an exercise of discursive power, which also had concrete impacts on clients' chances of success both in accessing services and in wider society (Lipsky, 1980). However, this research drew attention to an added dimension, of providers' continuing adherence to functionalist expectations of the 'doctor-patient' relationship.

This was surprising. Social scientists have moved away from functionalism (Lupton, 2003). Internationally, medical and nursing training since the 1980s has tried to replace ideas of patriarchal if beneficent health workers with more politically correct concepts such as patient ideas/concerns/expectations (own experience) and patient participation in 'The Nursing Process' (Marks, 1994; Henderson, 2003). Yet the extent of providers' indignation revealed in the Limpopo data suggested their sense of a broken contract, and many of the norms and values they expressed echoed Talcott Parson's original framework for the 'sick role' (Box 1: Lupton, 2003; Morgan, 2003). In giving patients an influential voice for the first time, their right to complain was the commonest aspect of the PRC discussed by interviewees. Patients' rights to choice of facility and to refuse treatment were particularly unacceptable to health workers, who had previously had the power to withhold access to and control decisions about treatment. Talcott Parsons' sick role prescribed a passive role for patients, who should seek and follow professional advice. More fundamentally, functionalism granted doctors the power to pronounce whether patients were legitimately ill or malingering. With these underlying expectations of their role, the PRC's failure to give the voice of health workers any privileged influence generated extensive protest.

If widespread expectations persist amongst providers that patients should be passive and grateful, while health workers should retain all authority and autonomy, then the PRC stands little chance of successful implementation. Education to support implementation will need to go beyond cascade training for providers about the contents of the PRC (London et al., 2006).

Values clarification programmes were suggested to address health workers' concerns about the South African Termination of Pregnancy policy. These aimed to clarify and understand health workers' concerns, but also to develop a framework for helping health workers relate these to the needs of their clients and to resolve dilemmas they faced (Harrison et al., 2000). The study investigating nurses' responses to free primary healthcare in South Africa suggested that shared understandings of policy goals should be generated in order to engage the ways nurses framed their jobs as a resource for implementation (Walker and Gilson, 2004). Supporting implementation of the PRC, and other health policies intended to empower patients in South Africa, needs a similar initiative. Whilst it would be challenging to tackle such deep-seated norms and values and to persuade providers to move from a functionalist position to supporting policies seeking to empower patients, it is difficult to see how implementation can succeed unless this is achieved.

This research identified providers drawing on multiple sources of power, which strategies to support implementation could attempt to mobilise. Bottom-up theory emphasises the importance of implementors in delivering policy (Buse et al., 2005). The concept of discretionary power, as implementors' scope for action, emphasises the power of implementors arising from their critical position in translating policy into practice (Barrett, 2004). As an example of this, the KwaZulu-Natal study found that 'Health workers' refusal to provide abortion services confers power on them, in the sense that they can deny services to women seeking care' (Harrison et al., 2000, p.429).

Yet the KwaZulu-Natal nurses also 'seized the moral high ground...and this assumption of morality also empowers health workers in relation to other women' (Harrison et al., 2000, p.429). The Limpopo interviews analysed in this research found providers drawing on the moral high ground through claims to professional codes and values, protestations of how hard

they worked, and assertions that they only wanted the best for patients. They also drew extensively on expert knowledge as a source of power, mobilising it to justify resistance to the PRC (patients don't know enough to refuse treatment) but also in rare examples of pro-active, positive discretionary power. If possible, strategies to support implementation could engage some of these potent sources of power in generating shared goals (as suggested by Walker and Gilson, 2004). In the most successful example of PRC implementation described so far, a recent study found that one hospital's PRC-related activities had increased, partly due to the hospital's involvement with an accreditation process through a regional quality accreditation council. Although many of the required activities overlapped with those needed for PRC implementation, it was more acceptable to providers to have them framed in terms of quality accreditation than in terms of patient rights (Nkosi et al., 2007).

Finally, the findings of this research included a real sense of disempowerment amongst providers. This was partly apparent in commentary claiming sources power which attempted to resist the empowerment of patients, as discussed above. The PRC explicitly aimed to challenge the power imbalance between providers and patients (London et al., 2006) and many manifestations of power could be understood as attempts to resist this. These examples illustrate the theoretical position that power within a relationship encompasses resistance (Sharp et al., 2000), so shifts in the balance of power will trigger resistance. They also re-emphasise the importance of relationships to implementation. As this research aimed to show, many provider responses to implementation of the PRC were more profoundly about negotiating and renegotiating the balance of power within relationships.

But providers also felt disempowered in other ways, around implementation of this policy specifically and in working in public sector health facilities in general. In keeping with other South African implementation studies, providers felt overwhelmed by patient numbers in the

context of overstretched human resources and overcrowded health facilities (Penn-Kekana et al., 2004; Walker and Gilson, 2004; London et al., 2006). Implementation processes left providers feeling excluded and not confident in the policy content (Penn-Kekana et al., 2004; Walker and Gilson, 2004). Higher levels of the DOH dictated the agenda for district and facility managers. Hierarchical relationships undermined implementation to the extent that they impeded managers in their work (in higher levels failing to make funding or materials available) or created stress for nurses (fearing doctors' responses to patient demands which were not medically justifiable, such as referral to hospital or seeking medical evaluation at night). Furthermore, providers felt very disempowered in frightening situations within PRC implementation, when they were denied the power to act to minimise a perceived threat. Examples included the CEO denied information about whether her hospital was being sued, and health workers denied an opportunity to give their version of episodes triggering patient complaints.

It is tempting to consider these sorts of commentaries as protesting against the unfairness of it all and arguing the impossibility of implementing the PRC in the contemporary context. In this sense, they function as manifestations of discursive power and as justifications for resisting implementation of the PRC, which exemplify street-level bureaucrats' strategies to modify conceptions of their jobs (Lipsky, 1980). However, an awareness of discursive power does not deny the difficulties faced by South African health providers. Lipsky argued that such strategies were functional, to enable implementors to cope with overwhelming workloads, and to help them manage the dissonance between policy intentions and reality in a way that protected their motivation to continue in difficult jobs (Lipsky, 1980). The work on nurses' responses to free primary healthcare in South Africa also found such strategies were functional, as 'coping mechanisms that, by categorising and blaming patients, allowed them to face the frustrations of their working environments' (Walker and Gilson, 2004, p.1259). An

empirical study into implementation of the UK patients' charter found that complaining behaviour by nurses increased with their feelings of stress and loss of control. Nurses' complaints also formed part of a pragmatic strategy which was functional in reformulating the policy to make it workable in their implementation context, although the policy as implemented differed from that stated formally in the patients' charter (Sbairh, 2002).

6. Conclusions and Recommendations

This research has reiterated the critical importance of implementors in translating policy into practice. Whilst other studies have shown implementation of South Africa's PRC to be disappointing, this research has conducted a secondary analysis of rich data from a previous study (London et al., 2006), examining the influence of power and resistance in providers' responses to the policy.

Regarding the first objective, the majority of manifestations of power and resistance were found in providers' commentary, rather than in their behaviour. Commentaries addressed both the policy and the behaviour of other actors. They drew attention to the importance of relationships in considering power in implementation. In making these commentaries, providers were exercising discursive power. Some issues they raised resonated with Foucauldian concepts of power, especially surveillance and the use of expert knowledge as a source of power. Many commentaries revealed norms, which were shared between managers and health workers, of a functionalist relationship between health provider and patient. An awareness of the functionalist model of the 'sick role' brought together commentaries around surveillance, expert knowledge and the loss of health workers' influential voice in the South African health sector, in a way not previously discussed in the literature. Providers' commentaries revealed normative resistance to the policy, and were themselves discursive acts of resistance.

Addressing this research's second objective, the following suggestions briefly consider how to tackle the power issues summarised above:

- 1) Implementors' discourse should be taken seriously by policymakers and managers, as recommended by a previous study (Walker and Gilson, 2004). Providers'

commentaries revealed issues which will, until they are addressed, prevent successful implementation of policies seeking to empower patients.

- 2) Empirical studies have shown that policy content which is challenging to implementors can generate resistance. As this is predictable, policymakers should consider strategies, before implementation commences, to manage providers' responses. These will be more effective before resistance is entrenched by adverse media coverage and providers' inaccurate understandings of policy contents (Harrison et al., 2000). Such strategies should address implementors' norms, values and other concerns, rather than merely aim to communicate top-down information.
- 3) Acceptability of future policies to providers should be a focus for policymakers in framing policies (Nkosi et al., 2007). Early consultation with implementors, before policy formulation is completed, could suggest how policies could be framed in terms more acceptable to implementors. A successful example of PRC implementation arose from framing activities in terms of quality accreditation, which was more acceptable to providers than a focus on patients' rights (Nkosi et al., 2007). Policy contents and implementation strategies should also be framed in ways that mobilise providers' norms and values as sources of power to support policies, not to resist them (Walker and Gilson, 2004).
- 4) A values clarification programme must tackle providers' norms and values (Harrison et al., 2000), particularly around patient behaviour and the provider-patient relationship. Providers will appreciate that their norms and values are heard, and policymakers should consider these in formulating future policies. Any attempt to challenge providers' norms and values must be conducted in consultation with health workers

and managers, rather than in a top-down authoritarian process. Disappointing implementation of the PRC has shown that attempts to impose legislation on providers without their participation can trigger resistance, which may be discursive and/or behavioural.

- 5) Higher levels of the DOH should engage in open forum communication with facility managers and health workers. It is vital for improving morale that providers are given outlets to voice their concerns, and a belief that higher levels are willing to hear them. Bottom-up theory predicts that implementors' expertise in the realities of implementation could offer valuable contributions to policymakers (Walker and Gilson, 2004) and providers' commentaries in this research supported this.
- 6) Proactive discretion by implementors should be encouraged by higher levels of the DOH, with innovative local implementation strategies being rewarded and publicised, so other facilities can consider replicating them if they seem suitable. This could be undertaken within facilities, at district or regional level, and with support of higher levels of the DOH. Health worker of the month awards within facilities could be publicised by local media, or framing activities in terms health workers found acceptable could be shared in regional manager support networks. The emphasis should not be on prescriptive strategies, however, but on communication channels to replicate successful strategies designed by implementors.
- 7) Managers should be empowered, with mentoring, peer support, skills development and better access to resources to support implementation of policies. Supportive channels should be created to help them deal with abuses of hierarchical power².

² personal communication, Lucy Gilson 2009

- 8) Further research should explore providers' responses to these strategies, as well as other issues underlying providers' responses to health policies in South Africa.

The PRC was intended to help redress the entrenched inequalities inherited by post-1994 South Africa. In seeking to redistribute power in provider-patient relationships, the policy generated resistance. This research suggests that some patients were beginning to exercise new rights, but that this was largely unacceptable to providers of health services. Issues of power and resistance underlying providers' responses to the policy must be tackled before successful implementation can be achieved. The PRC thus exemplifies the need, especially for progressive policies whose content implementors may find challenging, for policymakers to plan for strategic management of implementation.

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8. Appendices

Appendix A: Ethics approval for this research

Appendix B: Ethics approval for parent study

Appendix C: Parent study's management interview guide

Appendix D: Parent study's staff interview guide

Appendix A: Ethics approval for this research

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

R1449 Raphanele

CLEARANCE CERTIFICATE

PROTOCOL NUMBER MH60435

PROJECT

Providers' Responses to the Patient Rights Charter in South Africa: A Case Study in Policy Implementation

INVESTIGATORS

Dr H Raphanele

DEPARTMENT

School of Public Health

DATE CONSIDERED

06.05.05

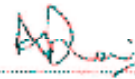
DECISION OF THE COMMITTEE*

Approved unconditionally

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

DATE 06.06.15

CHAIRPERSON


(Professor A Doozi)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor: Prof L Gibson

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10605, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I/we are authorized to carry out the above mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research procedure as approved I/we undertake to consult the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix B: Ethics approval for parent study

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

R14/49 Gilson

CLEARANCE CERTIFICATE

PROTOCOL NUMBER MM040327

PROJECT

Operationalising health as a human right: A monitoring tool to support implementation of the patients' rights charter in the health sector

INVESTIGATORS

Prof L Gilson

DEPARTMENT

School of Public Health

DATE CONSIDERED

04.03.26

DECISION OF THE COMMITTEE*

Approved unconditionally

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

DATE 04.06.28

CHAIRPERSON

Phillip Jones
(Professor PE Chantson-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor: Prof L Gilson

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

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Appendix C: Parent study's management interview guide

1. **What are the things you have done to implement the Patients' Rights Charter? When you think of all you have done to implement the Patients' Rights Charter, which areas/actions have you prioritized?**

- Why have you prioritized these things?
- Do you think the provincial authorities have the same priorities? If not, explore whether managers think the provincial priorities are appropriate or not.

2. **Are you receiving enough support in the implementation of the Charter?**

- Who is supportive, who is not supportive?
- What kinds of support are you receiving?
- How would you describe the supply of Charter materials from the provincial and national departments of health? Do they provide you with enough materials or the right kind of materials? How would you go about getting more materials if you have run out?
- Have the people who work in this facility received training on the Charter? Who has or has not been trained? When did they receive the training? Who provided the training? Plans for future training?
- If I understand correctly, Charter training is provided through a "cascade model", in other words a few people are trained and then have to go out and train other people, and so on. Have you experienced any impacts from this "cascade" training? Do you think this is an effective way of providing training? Do you have any suggestions for doing things differently?

3. **Just speaking generally, what is your opinion of the Charter as an intervention to improve quality of care and to make health workers and facilities accountable?**

- Does it really serve a purpose? Doesn't it just focus on things that health workers already know they should do?
- Do you think the Charter has the potential to improve the quality of care? Is it already improving the quality of care?
- What difference has the Charter made to the way you do your job from day to day?
- What different has the Charter made to the way health workers do their jobs?
- Are the provisions and requirements of the Charter really integrated into the work routines or is it perhaps more of an external intervention that has been added on to the work in facilities?
- To what extent is the Charter a source of conflict between managers and health care providers and health care providers and patients?

4. **In your opinion, what do health workers think and feel about the Charter?**

- If you get the answer about having no rights themselves, ask where that argument is coming from, whether it is a valid argument and what is being done to counter that argument.
- Do you think the Charter results in better or worse relationships between staff and patients? Why?

5. **We are interested in whether the materials associated with the Charter (posters, pamphlets, cassettes etc.) are reaching patients and members of the community. Which materials are you using in this facility and what is your opinion on their effectiveness?**

- Are these materials available in the most appropriate languages?
- What do you think of the argument that there are so many messages and people are so used to the posters that they don't really see what's on the posters?
- Do you think people can understand the information on the posters, pamphlets etc.?
- Do you use any other means to reach patients or the community such as talks etc.? How effective are these efforts, compared to, say, the display of a poster?

6. **I would also like to ask you about complaints.**

- Please take me through the process whereby a complaint is made and handled, step-by-step. How long does this whole process take?
- Are you aware of any other channels that patients could use for complaints such as a provincial toll-free line, a national toll-free line, the MEC's office etc.?
- Approximately how many complaints do you receive per month? What kinds of things do people complain about?
- How does one practically evaluate a complaint? Does an anonymous complaint, for example, carry the same weight as someone knocking on your door and complaining about the treatment? On average, approximately what proportion of complaints that you receive is, in your opinion, valid?
- Could you give me some indication of the number of complaints that you are able to resolve satisfactorily? What would be an example of a typical unsatisfactory outcome of a complaint?

Do people's complaints provide any evidence that they have read the Charter? Are they, for example, referring to the Charter in their complaints?

Appendix D: Parent study's staff interview guide

1. I would like to ask you some questions about the Patients' Rights Charter. As you understand it, what is the purpose of the Charter? What are the main things that the Charter requires from people who work in health facilities? What has been done to implement the Charter in this facility?

- Does this facility have enough materials (posters etc.)? Are these materials available in the most appropriate local languages?
- Have the people who work in this facility received training on the Charter? When did the training happen? Who conducted the training? How useful was the training?

2. How has the Charter affected your day-to-day work? Are you doing anything differently now, compared to before the introduction of the Charter?

- Describe a typical working day before and after the introduction of the Charter.
- Have the requirements of the Charter been integrated into the day-to-day working routines or is it more of a policy coming from outside, being added on to what people are doing?

3. Has the Charter affected your relationship with patients / members of the community? How?

- Does the Charter benefit staff members in some ways? How? Has its implementation in certain ways negatively affected staff members? How?
- What are the benefits of the Charter for patients / community members? Does it have any drawbacks for them?
- Are members of staff sticking to the responsibilities they have in terms of the Charter?
- Are patients accepting the responsibilities that the Charter gives to them?
- Do you think the Charter strikes a good balance between rights and responsibilities? Probe if respondents are concerned about their own rights as health care providers?

4. What are the main problems that the facility is experiencing with the implementation of the Charter?

- Are there things in the facility or in the health system that prevent people from implementing the Charter?
- Do staff members need support in the implementation of the Charter? What kind of support? Are they receiving adequate support? Who is being supportive? Who is not being supportive?

What, in your opinion, would make this Charter work?