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Title: Chief Executive Officers and Public Hospital Management in South Africa

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DECLARATION

I declare that the thesis:

Chief Executive Officers and Public Hospital Management in South Africa

Is hereby submitted to the University of the Witwatersrand for the Degree of Doctor of Philosophy and has not previously been submitted for a degree at this or any other university, and that it is my own work in design and execution, and that all material contained has been duly acknowledged.

Signature.....

Shan Naidoo September 2016

ABSTRACT

CEOs of public hospitals in South Africa are often held responsible when their institutions fail to deliver good quality care and are associated with poor health outcomes. Negative perceptions prevail and particularly in the National Department of Health it is held that the CEOs are generally not adequately qualified, inexperienced, incompetent and often inappropriately appointed. This study attempts to articulate the CEOs views (their side of the story) and in particular how they perceive the challenges that they face and what solutions they proffer in improving the running of their institutions. This research is viewed through the lens of the New Public Management paradigm (NPM), in terms of Public Sector Reform and in particular Health Sector Reform in South Africa.

Thirty CEOs of public hospitals in South Africa responded to a survey of their opinions. The majority (86%) of them felt they were unable to manage their institutions effectively. A subsequent qualitative study of CEOs and experts in public management using in depth interviews and further focus group discussions with CEOs and senior hospital managers revealed that the major challenges that the CEOs faced were financial, human resources and operational management issues. Procurement and information challenges were linked to financial and human resources deficiencies, lack of accountability mechanisms and the presence of corruption. The Performance Management System currently in place did not work appropriately and was driven by perverse incentives. Political interference was also a pervasive problem.

Their recommendations were that they needed clear and unambiguous delegations and the appropriate resources so that they can take full responsibility of their institutions. Clear accountability structures were paramount in achieving better health service management and care according to the advice of experts in public management as well as that of senior hospital managers. This requires the creation of enabling legislation and an appropriate accountability framework. The blanket application of NPM principles is also questioned. Selective application of the tools of NPM should be tested and consideration be given to the dimension of added public value in the South African public hospital context.

DEDICATION

I dedicate this thesis to my mom (Mrs Gubathea Naidoo) who passed away during my work on this research. Thank you mom for all the love and support you gave me during my entire life. Despite you not having an education yourself you ensured that all your children did as you knew that this was our only passport out of poverty and oppression.

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CHAPTER 1: INTRODUCTION

A brief background is given to understand the context of the study in terms of health sector and public sector transformation in South Africa. The Research Problem is presented which largely revolves around the challenges that Chief Executive Officers (CEOs) face in public hospitals in South Africa and a method to understand these from the CEOs perspective. The knowledge gap, context of the study, the purpose statement, the research question and justification of the study is expanded upon in this introductory chapter.

Health Sector Reform (HSR) was a particularly challenging one for the new government of the Republic of South Africa. Its effective transformation into one new non-segregated health system after the first democratic elections in 1994, was largely a political triumph for the post-apartheid ANC led government. However, the government's inability to manage the various challenges posed by the introduction of its health plan such as a district based Primary Health Care system as the basis of its health care system, its attempts at modernisation of hospital management by the introduction of a new cadre of managers, including hospital CEOs, and its weak commitment to decentralisation is largely blamed for its inability to deal with the high mortality it faces, the quadruple burden of disease(the term describing the top four causes of DALY's in South Africa), poor health outcomes measured, and a perpetuation of a hospicentric model of health care, often with substantial political meddling (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). This inability manifested itself in particular at all levels of health care management but is substantially more prevalent at senior levels of health care management and especially amongst CEOs of Public Hospitals in their inability to manage effectively (Harrison, 2009).

The unequal application of the New Public Management principles across the public sector post 1994 also makes for incoherent policies and poor implementation particularly in the public health sector (Cameron, 2009). Reversals on earlier policies of decentralisation of public hospital management have also contributed further to this (DBSA, 2010). Furthermore, there has been little regard to the international recommendations by the WHO as articulated in its "Making Health Systems Work" policy papers or that of its World

Health Review recommendations so that by the end of 2009 the South African Health System was in a worse state than it was in 1994 just based on its health outcome indicators (Harrison, 2009 and WHO, 2008). However in acknowledging the deficits within the current health system the Minister of Health, Dr Aaron Motsoaledi in 2011 announced a new strategic policy and plan for the next few years to rebuild the national health system based on a specified service delivery contract with clear health outcomes as deliverables (South Africa, 2010a and South Africa, 2010b). Within this plan he identifies the capacity building and empowerment of CEOs of public hospitals as important to his plan's success. The strategic policy has culminated in the publication of three pieces of draft legislation, two as regards a National Health Insurance (South Africa, 2011a and South Africa,2015) and a second on hospitals called a Policy on the Management of Hospitals (South Africa, 2012).

Also, a new Human Resources for Health Plan was adopted in 2011 dealing quite comprehensively with the HR capacity development issues (South Africa, 2011c). Furthermore the Green Paper on the Policy on the Management of Hospitals was published in March, 2012, and creates a defining legal framework to address the recruitment and expectations of CEOs of public hospital and hospital board members as well as the categorisation of hospitals (South Africa, 2012). The policy is in line with the Minister's 10 point plan which aims to reorganise the health system and improve the management of hospitals and in particular addresses the challenges that hamper the effective and efficient delivery of services. Some of these problems relate to the lack of enabling policies and legislation, as well as capacity constraints related to the CEOs of hospitals themselves. This is a landmark policy on the management of hospitals which further supports the rationale of the research in that it also looks at the efficient functioning of CEOs of public hospitals and is an important document informing the legal context of this study. Thus this research which proposes to assess CEOs views on their ability to perform adequately and deliver quality health care in the context of current reform policies is more than appropriate and extremely timely.

1.1. Introduction to the Research Problem

CEOs of public hospitals in South Africa face huge challenges in managing their hospitals (Bateman, 2011 and Harrison, 2010). The main challenges they face according to Bateman and Harrison are linked to their inability to make management decisions as regards strategic planning, financial management and to a lesser degree on operational management issues such as supply chain management and equipment maintenance. These failures according to the authors are largely attributed to a lack of appropriate managerial delegation, poor performance management systems, and unclear lines of responsibility and accountability.

With the introduction of CEOs to replace the previous hospital superintendents and to manage hospitals in the public sector (South Africa, 1996) there has been a move away from the old, traditional public administration approach to a more business-like approach that has been adopted by government. This new management paradigm is described as the New Public Management (NPM) and it has emerged in the public administration of most developed western countries beginning in the late 1970s and in some developing countries later in the 1990s (Lynn, 2006). However it was partially adopted by the new regime in South Africa following its democratic transition (Cameron, 2009).

An opportunity has now arisen since 2012 going forward to revisit this issue of the roles and responsibilities of CEOs of public hospitals with the articulation of a new strategic direction taken by the National Department of Health under the Minister Dr Aaron Motsoaledi. This opportunity is also addressed in the Minister's Negotiated Service Delivery Agreement (NSDA) and the National Department of Health's Strategic Plan for 2010/2011- 2012/2013 (South Africa, 2010a; South Africa 2010b) in terms of improving the quality of health services as a national priority. More recently a legislative framework has been created that also addresses this issue regarding the management of hospitals, viz. The Policy on National Health Insurance (South Africa, 2011a and South Africa, 2015) and the Policy on the Management of Hospitals (South Africa, 2012). The problem statement that has been identified is that CEOs in public hospitals in South Africa find it challenging to manage their hospitals effectively and this is elaborated upon further below.

1.1.1. The problem statement

In the South African Medical Journal (Bateman, 2011, p. 152) Chris Bateman makes reference to the inability of CEOs of the largest tertiary hospitals in Johannesburg to make timely purchasing and maintenance decisions to ensure appropriate health care delivery:

> Austerity measures at 'head office' put a R25 000 ceiling on autonomous tertiary hospital equipment procurement. Fulfilling the hospital's core mission and containing costs this way (resulting in longer patient stays) seems absurd, even given the endemic corruption and mismanagement in Gauteng's Health Department (currently unable to account for R19 billion). (Bateman, 2011, p. 152-156).

This has been highlighted again in 2012 where in the national press a special two page lead called "INSIDE A SICK SYSTEM" which had headlines such as: "State healthcare in crisis", and "Public hospitals in Gauteng sick and tired" (*Sunday Times*, 2012). This is a national problem according to the press and again highlighted the need to explore this important topic of CEOs in public hospitals and their alleged inability to manage properly. This research problem has been informed by the New Public Management paradigm which argues the case for using private sector managerial principles which focuses on effective management and realisable outcomes as its key performance measures and using a range of tools such as performance based contracting (Besosa, 2007). Management effectiveness is further defined by Mitch McCrimmon (2007) as that which entails efficiency, getting things done with least cost, and achieving set targets whilst making use of all relevant resources. However, there has been a dearth of research done on the management effectiveness of CEOs of public hospitals in South Africa and in particular on their views on their ability to manage effectively (DBSA, 2010).

1.1.2. The knowledge gap

Although research has been published on the poor health outcomes in South Africa (Coovadia, *et.al,* 2009 and Huddle, 2011) very little is known about the managerial

constraints faced by the health service managers and in particular that of the CEOs of public hospitals in South Africa and their impact on their ability to manage effectively. This also has not been elaborated upon in the context of NPM reforms adopted by South Africa post 1994.The Development Bank of South Africa (DBSA) has also tried to describe the requirements for an ideal type of hospital CEO but their reports give no in-depth insights into the challenges that CEOs of public hospitals face in managing effectively or how they can perform optimally (DBSA, 2010). This is attributed largely to a lack of competencies, qualifications and experience according to DBSA whilst other authors such as Bateman (2011) and Harrison (2010) attribute this to a lack of delegation and unclear lines of responsibility and accountability. The recent legislation on the management of hospitals (South Africa, 2012) identifies the lack of enabling legislation as well as capacity constraints which includes questions about the competencies of hospital CEOs, their lack of training, lack of strategic support and inadequate capacity to deal with operational issues as key to improving the management of hospitals (South Africa, 2012). However, this legislation fails to address the question as to how CEOs of public hospitals view the challenges they face in managing their hospitals effectively and what can be done to improve this. The views of other important players in this regard have also not been articulated before. This problem is viewed critically within the context of Health Sector Reform (HSR) in South Africa over the last two decades.

1.1.3. The context of the study

There is a pressing need to address the competencies, efficiencies and effectiveness of CEOs of public hospitals according to the Minister of Health and he raises this issue in his 10 point plan and Negotiated Service Delivery Agreement (South Africa, 2010a). He argues that the CEOs have been inappropriately employed and haven't the requisite competencies. The Minister then proffered the following solution when unveiling his 10 point plan specifically as it affects the CEOs of public hospitals. In particular, the finalisation of delegations for all health service managers at all levels of the public health system and in particular for hospital managers so as to ensure decentralisation of management. The plan also makes reference to an evaluation of all CEOs of hospitals so as to determine whether they meet the

minimum requirements for effective management of their hospitals and institute corrective measures if they do not. He argues that the new National Policy on the Management of Hospitals creates the enabling legal framework to implement these plans (South Africa, 2012). This policy's objective is to ensure that an enabling framework for the management of hospitals is to be supported by New Public Management Paradigm (NPM) principles of effectiveness, efficiency and transparency. The Minister wishes to hold the CEOs accountable through the Hospital Improvement Plan and the establishment of the Office of Health Standards and Compliance as articulated in the National Strategic Plan (South Africa, 2010b) as well as the Green Paper on the National Health Insurance (South Africa, 2011a). This research explores the challenges facing CEOs in managing public hospitals in the context of this current Health Sector Reforms.

1.1.4. The Purpose Statement

The main purpose of the research was to explore the managerial challenges facing CEOs in public hospitals in South Africa in the context of current health sector reform in South Africa. The views of CEOs of public hospitals of the challenges they face in managing effectively was sought. This was complimented by the views of public management experts as well as that of senior hospital managers which was sought in this regard. The views of the public management experts was to give a top down view and the senior hospital managers were to give a bottom up view of these challenges. The purpose of the research was also to investigate the transformation of the public health system of South Africa since 1994, with a focus on the evolution of policies as it affects the CEOs of public hospitals ability to manage effectively. The dominant model in understanding this evolution was the New Public Management paradigm as it largely informed public sector reform in South Africa post 1994 (South Africa, 1997) as well as the current international dialogue on health systems improvement that relate to effective management in the public health sector (WHO, 2008). The findings of the research are presented, analysed, interpreted and discussed in this research report. The research then recommends a set of proposals to improve the current situation as regards overcoming obstacles to effective public hospital management.

1.1.5. Hypothesis

The adoption of the NPM managerialism in the public sector has not worked as anticipated and in particular as to the effective functioning of CEOs of public hospitals and this is largely due to a lack of delegations.

1.1.6. The Research Questions

1. The primary objective of the research was to understand the management challenges faced by CEOs of public hospitals in South Africa for the period 1994 to 2015.
2. The secondary research question is how has Public Sector and Health Sector Reform policies in the light of NPM principles defined the managerial roles of CEOs in public hospitals in South Africa since 1994?
3. Finally recommendations as to possible solutions were sought from all the participants in terms of how to improve the management of public hospitals in South Africa.

1.1.7. Justification for the study

Although South Africa has had a decade of transformation in the public sector as a whole and in particular in relation to health sector reform, the challenges facing the government have increased and its health outcome measures have in fact fallen since 1994 (Harrison, 2009). The initial reforms proposed for public hospitals were largely ineffectual and CEOs in public hospitals were also often unable to manage effectively leading to a declining quality of care in public hospitals (Bateman, 2011, p 152-156 and Harrison, 2010,p 6-9). However, a new resolve by government to deal with managerial inefficiencies and poor performance in the health sector over the last decade has resulted in a number of new policies that intends to reshape the public health landscape quite dramatically through the creation of a National Health Insurance (South Africa, 2011a) and in particular the new policies on hospital management (South Africa, 2012) which directly impacts on who is employed as CEOs of public hospitals and how they are the expected to perform. But again there has been no attempt by government or research bodies to understand the situation from a CEOs

perspective and this is what this research is aiming to do. The research wants to understand the CEOs viewpoint of these challenges and have them articulate their story. A top down view from public management experts as well as a bottom up view of senior hospital mangers was also sought so as to validate or refute the claims of the CEOs.

1.2. Summary of Chapters

Chapter One:

This introductory chapter describes the background and context for the study on the management challenges being faced by the health care system in South Africa since democracy. It highlights in particular the challenges faced by CEOs in public hospitals and argues the case for studying the problems CEOs face from their perspective. The knowledge gap clearly identifies this: the story from the CEOs perspective is missing from the discourse on public health services management in this country. The research questions as well as the significance and justification for the study in the current context of dynamic policy change and restructuring of the public health system in South Africa is also presented.

Chapter Two:

The conceptual framework is placed within the New Public Management Paradigm and is the lens through which health sector reform in South Africa is viewed. This as part of a broader restructuring of the public sector generally and health sector reforms particularly since 1994. Its international dimensions as well its pertinence to local reform are also critically discussed. The review also includes an in-depth account of hospital management reform since then and which is still ongoing with draft legislation as recent as December 2015 being circulated for public comment that may affect the future management of public hospitals in South Africa. It also expands on the NPM theoretical framework that informs the context of the study.

Chapter Three:

This chapter presents the methodology section and presents the research paradigm and research design that underlie the study. It also details the research methodology and its

specific use of some quantitative and mainly qualitative methods in attempting to explore CEOs views of the challenges they face in managing hospitals and what they recommend in improving their ability to do so. Furthermore, in depth interviews of experts in public management was done to understand the problems that CEOs raise in the broader context of public sector and health sector reforms. Also a focus group of discussion with senior hospital managers was also carried out to validate the CEOs views and explore possible solutions. The data analysis and research strategy plan are also presented with a brief description of their limitations and ethical challenges.

Chapter Four:

In this chapter the research results obtained through quantitative and qualitative research methods are analysed thematically and discussed. The first section deals with the quantitative information obtained from the self-administered questionnaires. This is presented in descriptive form. Confidence limits are presented and where appropriate Chi-square tests. Because of the small sample size in depth analytical statistical analysis could not be done with any certainty. The second section deals with qualitative information and seeks to elicit information on the views of the challenges faced by CEOs in public hospitals and how to resolve them. The in-depth interviews of public management experts as well as a focus group discussion with senior hospital managers were also analysed. The triangulation of these surveys, interviews and focus group discussions is further analysed. This discussion is done in the context of contemporary challenges and opportunities as viewed by the collective and in informing what they view as possible solutions.

Chapter Five:

The discussions in the preceding chapter leads to a reflection on current health sector reform, public sector reform, and the unfolding roles of CEOs in public hospitals through the lens of NPM in chapter five. It looks at the rise of NPM in South Africa, the challenges of decentralisation, financial public service reforms and performance management in the light of recent health sector reform. It locates the views of the CEOs within the current context and critiques their challenges as well as their recommendations in improving their situation in overcoming some of the impediments to better manage their hospitals. The discussion is

also informed by the views of the public management experts as well as that of the senior hospital managers.

Chapter Six:

Chapter six presents the conclusions and recommendations. The study confirms the findings of other authors of their assessment of the challenges facing CEOs of public hospitals in South Africa. These were in relation to a lack of delegations, poor performance management systems and unclear lines of responsibilities. The recommendation to government is that to make the policies on the management of public hospitals work requires the implementation of existing policies so that services to the public are provided in ways that are economical, efficient, effective, accountable, responsive and adaptable. This can only be done if there is enabling legislation for sufficient decentralisation and effective delegations as well as for appropriate performance measurement and accountability systems to be put in place. The uses of NPM tools are questioned and this research indicates that it should be used selectively appropriate to the South African context. Consideration should be given to international trends around viewing public service through a public value perspective. Further research in this regard is also recommended.

CHAPTER 2: LITERATURE REVIEW AND DOCUMENT ANALYSIS

This chapter presents the literature review and document analysis. It is introduced by looking at the conceptual framework within the context of South African public sector reform (PSR) and health sector reform (HSR) in particular. This framework contextualises itself within the New Public Management paradigm and later discusses the evolution of NPM from an international perspective. It critiques performance management and accountability as important components of NPM as it is implemented in the South African public sector and in the health sector in particular. It also discusses the challenges faced in using performance management tools and the performance paradox that often creeps into its measurement. It then reviews the documents and literature in relation to health reforms in South Africa through the lens of NPM. This chapter reflects on NPM and its use in recent public sector reform and on other international trends as well as developing countries experiences. Africa in particular will be scrutinized with its experience of NPM and public sector reform.

2.1. The Conceptual Framework

The research will be viewing the local context that CEO's of public hospitals managerial function as it relates to an NPM paradigm which informed public sector reform and health sector reform post 1994. This will be compared to the experiences of NPM in other parts of the world and in particular in developing countries. This is done with a view to assessing its effectiveness and current implementation in various settings with a view to proffer solutions going forward. The conceptual framework as described below is to approach the research in a systematic way. This done firstly by understanding the South African (local context) of public sector and health sector reforms since from 1994.Secondly by international trends in public sector reforms (PSR) including experiences in Africa. The NPM paradigm is the lens through which this is reviewed.

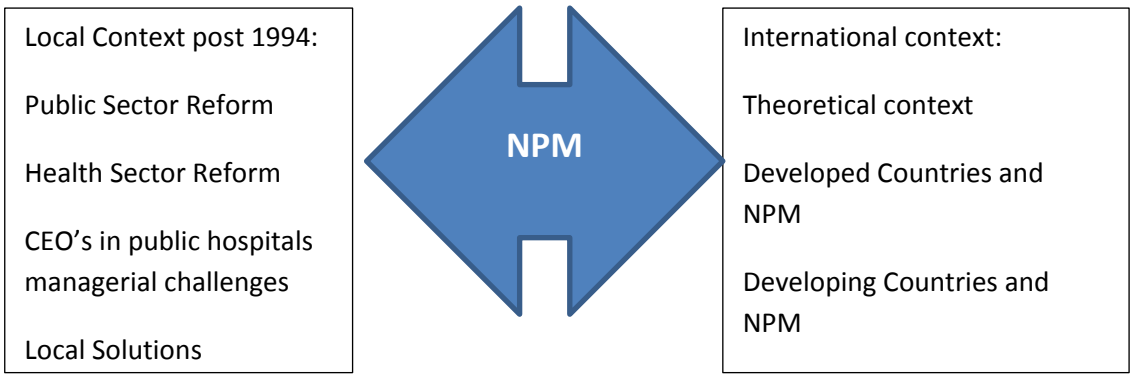

Figure 1. The Conceptual Framework

2.2. Contextualising public hospital management in South Africa: Literature Review and Document Analysis

A literature review and document analysis of the impact of public sector reform and of health sector transformation in South Africa is presented below. The functioning of CEOs in public hospital in the context of these reforms is done in depth next. This covers the South African health sector transformation from 1994 to date and looks at the challenges faced by CEOs of public hospitals in South Africa during this transformation. The inclusion criteria for the review was all literature and documents published, including grey literature, since 1994 on public sector transformation and in particular on health sector reform and its use of the NPM paradigm in informing these reform efforts.

The approach to the literature review and document analysis as regards CEOs in public hospitals in South Africa is specifically informed by the following areas: The South African Health System and its Transformation (in the context of the public sector reform locally); The New Public Management paradigm and its discourse internationally and nationally (as it informs the debates around decentralisaton, delegation, performance management and accountability); and the international recommendations by the WHO in informing the strengthening of health systems. These areas are addressed in turn in relation to whether CEOs of public hospitals are to function optimally in South Africa within its current reform agenda.

2.2.1. The South African Health System and its transformation

The history of the South African health system is one of segregation, discrimination and fragmentation (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). From the onset of Dutch colonisation in the 16th century and the subsequent British rule and then National Party rule and the consequent apartheid system there is ample evidence of inequitable health care provision by the state. Health services were racially segregated as far back as 1897 according to Coovadia, et.al. (2009). The 1919 Health Act (South Africa, 1919) devolved hospital curative care to the four provinces (Transvaal, Natal, Cape Province and the Orange Free State), and preventive care to the local governments or municipalities and this act also further entrenched the segregation of services by race and its historic inequities. Areas not covered by local governments were offered state services often through mobile clinics. The apartheid system worsened the fragmentation of health care when it created the Bantustans (the Transkei, Ciskei, Venda and Bophuthatswana) each with their own health systems. In 1983 (South Africa, 1983) this separation was further extended with the creation of own affairs health services to Indians, Coloureds, Blacks (Africans) and Whites in the rest of the country and in what was called self-governing authorities for certain designated Bantu ethnic groups (Coovadia, et al., 2009). The control and funding of these various authorities was carefully manipulated by Pretoria (Schaay, Sanders and Kruger, 2011). There were huge discrepancies in the funding of these health care departments and Whites had access to state of the art health care services in the public sector while blacks in the Bantustans had poor care on the whole. The private sector also started booming in the 1980s and they tended not to discriminate by race but on ability to pay or on access to health insurance. Under the apartheid government there were 14 separate health departments (the provincial governments, own affairs and the Bantustans having their own health departments). Health services under apartheid were hospicentric focusing mainly on curative care, with a large and growing unregulated private sector.

Therefore, the health system inherited by the newly elected democratic government in 1994 had numerous challenges and in particular the large inequalities in health care provision to the various race groups, between rural and urban areas and more strikingly

between private and public sectors. There were also inequities in the allocation of resources between levels of care (primary care getting the least) with over 80% of resources allocated to hospitals. Academic and other tertiary level hospitals accounted for 44% of total public sector health-care spending. Only 11% of spending was allocated to non-hospital spending. The latter points are extremely pertinent to this research exercise as it indicates the huge financial responsibilities placed on CEOs of hospitals by virtue of the resources that are allocated to them to manage (Coovadia, et al, 2009).

The ANCs Health Plan (developed with the WHO and UNICEF), published in 1994, (ANC, 1994) was the post-apartheid model envisaged for health system reform. It was based on a primary health care approach using the district health system as its implementation model. The new government had some notable successes and this included the consolidation of the 14 health departments under apartheid into one national and nine provincial administrations. Health services were open to all (desegregated), and primary health care became accessible without cost to users. In terms of the new National Health Act (South Africa, 2004) the primary health care services (as part of the district health system) and hospital services were defined as provincial responsibilities. This allowed for the control of these health care functions to be held at the provincial head office level. The national department was responsible overall for health policy.

Despite these achievements the ability to further implement this new vision was constrained by poor human resource capacity, inadequate planning and stewardship, lack of appropriate leadership and management, the increased demands on the public health system by the quadruple burden of diseases (the four main causes of morbidity and mortality in South Africa), and curtailed spending in the public health sector (Bongani, Fisher, Lalloo, Sitas, Tollman & Bradshaw, 2009). However, David Harrison (2009, p. 1-33) in his discussion document: “An overview of Health and Health Care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains”, describes the post-1994 public health sector restructuring as having accomplished significant improvements in terms of access, rationalisation of health services and its bureaucracy and more equitable health expenditure.

He does concede that these early gains were eroded by a sudden increased burden of disease mainly related to HIV/AIDS, TB, Injury and Non-Communicable Disease epidemics that were running concurrently. Harrison also opined that there were poor health systems management in place and low staff morale in some areas leading to poor quality health care relative to total expenditure.

The Hospital Revitalisation Programme (a flagship infrastructure development programme of the ANC led government after 1994) was largely a capital expenditure driven project to improve hospital infrastructure and partially successful according to Harrison (2009). In relation to operational efficiency Harrison commented on the inefficiencies in the management of the South African public health system, reflected by the over expenditure of its health budget in the past financial years. He also referred to the poor differentials in the management of district hospitals as a case in point: the average length of stay across districts varied from 2.2 to 8 days, and the usable bed utilisation rate varied from 50% to 90%.

Harrison (2009, p. 32-33) makes the following recommendations in improving operational efficiencies by clear separation of political and management roles and responsibilities to enable senior health managers to focus on service management, by devolution of defined management responsibilities, accountability for performance, appropriate use of knowledge management for decision making, improved financial management, effective use of time and instituting efficient processes for improving the quality of care amongst others. Harrison contests that because of political interference there has been a lack of devolution of clear management responsibilities, a lack of financial management ability, an inability to make informed decisions and a lack of accountability at nearly all levels of management in the health services. These arguments as posed by Harrison (2009) are extremely important in the context of this research. They emphasise that the problems related to lack of devolution of management responsibilities as a major impediment facing health service managers in the delivery of quality health care. Specifically as regards the devolution of management authority Harrison (2009) and Schaay, Sanders and Kruger (2011) highlights this issue as an urgent priority in relation to the slow institutionalisation of the district health system and

the lack thereof in relation to the decentralisation of staffing, budgeting and expenditure control to hospitals.

The argument thus far is that despite the fragmented services inherited from the apartheid system great strides have been made in addressing access and the development of a new national health system based on the primary health care approach and one emphasising equity. However due to the increased burden of diseases, lack of management capacity and resources, as well as a lack of devolution of clear management responsibilities and lack of concomitant accountability, the resilience of the health system to deal with the current challenges was severely compromised. More disturbing also is that there is a decline in life expectancy and an increase in all causes of mortality across both males and females and across all races as described in the recent South African Health Review (2010). So, beginning since 2009 we have witnessed the start of a regression in the overall health of South African's as measured by life expectancy, mortality and morbidity patterns and this is a reflection of the inability of the health services to deal with these problems for well over a decade now (South African Health Review, 2010). It is therefore, in the light of the above discussion that a review of the evolution of policies which influenced the way CEOs were deployed during the Health Sector Reform since 1994 as well as their future roles and responsibilities will now be critically discussed.

2.2.2. CEOs in public hospitals in post-apartheid South Africa

The post-1994 era in South Africa has been characterised by a high number of new legislative and policy reforms. The new democratic order and the change of the apartheid regime also provided an opportunity for the introduction of significant Public Sector Reforms (PSR) in the Public Service and Health Sector Reforms (HSR) in the National Health System (NHS). However, HSR in South Africa has been a protracted process that was already set in motion before the change of government, gained momentum since 1994 and is still unfolding (Van Rensburg, 2004). As part of this wider reform the National Department of Health (NDoH) adopted decentralisation of hospital management as a key policy in pursuit of a more efficient, effective, responsive and accountable public sector hospital system (South Africa, 1997). This was a key policy aimed at defining the functions, roles and

responsibilities of the new cadre of hospital managers (now called CEOs) that were taking over from the old hospital superintendents and hospital secretaries. The overall aim of this strategy was to delegate authority and decision making powers from provincial departments to the new cadre of hospital managers (South Africa, 1996). But this did not happen as anticipated and the results are described in the sequence of events that unfolded below.

In 1997, the NDoH produced a White Paper on Transformation of Health Service Delivery (WPTHSD) (South Africa, 1997) which raised specific concerns relating to the management of public hospitals. These concerns related to the inefficient management of resources, inequitable and inaccessible services and poor management structures and systems. In addressing these concerns the WPTHSD proposed amongst other things the following principles: the roles and functions of hospitals to be redefined so as to be coherent with the primary health care approach, rationalisation of hospital services, facilities, staffing and infrastructure investment, decentralised hospital management to ensure efficiency and cost effectiveness and that hospital boards be established to improve local accountability. The proposed decentralisation of hospital management represented a fundamental policy shift at that time in the decision making processes among National, Provincial health departments and Hospitals. Provincial health departments were to "delegate significant decision making powers to hospital managers, including the authority to make decisions relating to personnel, procurement, and financial management" (South Africa, 1997, p. 28). With regard to personnel administration, the WPTHSD proposed a fundamental shift from personnel administration to Human Resource Management, and in it indicated that, "authority for almost all line personnel management functions will be delegated to institutional level, hospital managers will decide on most appointments, performance appraisals, and promotions and will be responsible for disciplinary and grievance procedures" (South Africa, 1997, p. 18). However, this policy as regards hospital managers was not implemented for nearly a decade after its adoption. So although the appropriate recruitment of hospital managers with the necessary delegated power and authority was seen as a key policy imperative of the national government it never really materialised for nearly a decade after the white paper was published. The reluctance in its implementation

was always political according to most authors on the subject (Harrison, Cameron, Coovadia, et. al).

Nearly ten years later, the President of South Africa Mr Thabo Mbeki in his State of the Nation Address in 2006 highlighted this lack of delegations and accountability of hospital managers as follows that: “To improve service delivery in our hospitals, by September this year we will ensure that hospital managers are delegated authority and held accountable for the functioning of hospitals” (South African, 2006, p. 14). It is therefore critical to reflect on the challenges that the process of decentralisation faced and why the authority that was intended to be delegated to hospital managers in managing their hospitals effectively over the years from the WPTHSD until now did not take place. International literature indicates that HSR are politically problematic and the most powerful health sector actors are often satisfied with the status quo and this applied to the South African experience as well (Glassman, Reich, Laserson and Rojas, 1999 & Collins, Omar, and Tarin, 2002). The problems of implementation of hospital decentralisation ranged from a lack of a determined system of policy formulation and implementation, political and bureaucratic opposition, to the lack of managerial ability and skills at the health service level (Collins et al., 2002). It is therefore important, firstly, to understand the decentralisation of hospital management policy process and, secondly, the level of authority and decision making powers that were intended to be delegated to hospital managers as a result of the decentralisation. This all harkens back to what was named the Hospital Strategy Project (South Africa, 1996).

2.2.3. The Hospital Strategy Project

In 1995, The National Department of Health awarded the Hospital Strategy Project to a consortium made up of consultants from the Monitor Company, Health Partners International, and the Centre for Health Policy and representatives from the National Labour and Economic Development Institute (South Africa, 1996). This was a contract to analyse major issues and problems confronting the public hospital system at the time, as well as providing possible strategies to address them. On the problems facing public hospitals the final report noted that there was an over-centralisation of power which has led

to a systematic underdevelopment of management skills, particularly in areas such as human resources, financial and labour relations management and to an attitude of action after permission. The proposed policy recommendations were to implement a National Policy on Decentralised Hospital Management. This was in line with the prevailing understanding of the New Public Management principles albeit not fully adopted in the HSR processes (Cameron, 2009). The following were important elements of this policy: delegation of considerable powers over human resources, finances, procurement, and other important management functions to hospital management; a change in the role of Provincial Health Administration from its executive and administrative line management role, to one in which its principal functions were to set guidelines and policy, as well as to provide essential support for hospital management; the establishment of democratic, accountable Hospital Boards as statutory bodies, with defined governance powers; development of effective management structures and systems and the recruitment, development and retention of skilled hospital managers (South Africa, 1996).

The HSP further proposed the following implementation strategies (HSP, 1996): a core package of essential measures to be put in place by the Department of Health and Provincial Health Administrations, constituting the minimum necessary requirements for decentralisation to be effective; criteria for granting decentralised status that sets out the plans, systems, and capacities necessary before delegations of authority can be delegated; a staged timetable for implementation, with flexibility for provincial and hospital variation; the National Department of Health to negotiate the legislative context in which the decentralised policy will be implemented, and provide the necessary support to Provincial Departments; Provincial Departments to be ultimately responsible for implementation of the decentralised hospital management; and Provinces to produce detailed implementation plans covering, governance and accountability, general management, staffing and personnel management, labour relations, management capacity, systems development, management of clinical processes and communication strategies for its implementation. The HSP submitted their final report to the National Department of Health. Some members of the HSP served in the initial Departmental Committees such as the Hospital Coordinating and National Hospital Policy Committees. Nine drafts of the document, “Decentralisation of

Hospital Management Policy", were produced and presented to different committees and stakeholders during this period. The ninth and final draft was presented to the Hospital Coordinating Committee (a Ministerial Steering committee overseeing the HSP) in May 1996. There were differing views on the position of the Department with regard to this report, but what is clear from the local research is that any work or discussion that has since followed on decentralisation of hospital management is based on the HSP report. The HSP report was comprehensive on analysing the prevailing situation and presented practical strategies and solutions going forward. Decentralisation of hospital management was to be implemented concurrently with the establishments of the District Health System (DHS). However the policy priority of the Department at that time was Primary Health Care (PHC) and the DHS was seen as a critical step in achieving universal health care coverage. At this time many proponents of DHS argued for a move away from the hospicentric health system to a comprehensive PHC system based on the DHS. Hence, during this period resources and policy focus were shifted away from hospitals to PHC. This might have seriously undermined the momentum on the implementation of the decentralisation of hospital management policy. However, several strategies were clearly defined by the HSP and the WPTHSD, and what was required was detailed implementation plans to forge ahead with implementation. Specific structures and systems were put in place to coordinate and fast track the implementation process. However, this did not occur and various ministerial advisory teams were subsequently put in place to take this process forward.

2.2.4. The Inter-Departmental Task Team for Decentralisation of Hospital Management

In 1997, a number of local and International Technical Assistants were appointed by the National Department of Health (NDoH) to assist in driving the decentralisation of hospital management policy process forward. An inter-departmental task team for decentralisation was set up to coordinate the implementation of the decentralisation of hospital management policy. The task team was comprised of representatives from the following stakeholders: The National Department of Health which held the Chair and Convenorship; The European Union (EU) provided Technical Assistance to the National Department of Health; representatives from the Department of Public Service and Administration,

Department of State Expenditure, Department of Finance; Universitas Hospital; Potchefstroom Hospital; Western Cape Health; Johannesburg Hospital and the Advisor to the Minister. A four stage process of decentralisation was proposed (South Africa, 2000) as follows: National, Provincial and Hospital preparation; Hospital application for decentralised status; Provincial Assessments of hospitals preparedness for decentralised status; If successfully assessed and the hospital met the criteria for decentralisation a charter of interdepartmental delegation is conferred upon the hospital and key management posts. The main focus areas were Corporate Performance Management Agreements; Business Planning; Cost Centre development; Management with audit tools; Personnel and Team Competency Assessments; Development Plans; and the Twinning of South African Provincial Hospitals with European Counterparts and in particular with French hospitals.

The Inter–Departmental Task team agreed on very extensive criteria for considering approval for decentralisation. An audit tool was developed and piloted at the then Johannesburg Hospital. Some areas of the criteria included the following to be in place (South Africa, 2000): a defined period of in-budget service delivery; evidence of a strategic plan and the capacity to implement; a business plan to include projected activity levels by cost centre and quality standards; monitoring and evaluation tools for the implementation of the business plan; the capacity to improve Human Resources Management(HRM), and a Human Resources Development(HRD) plan; an appropriate operational structure; recruitment, performance management and disciplinary procedures with the capacity to effect; all staff to have job descriptions; a service delivery improvement plan with indicators and service standards; budget and expenditure control mechanisms; Union support and the establishment of hospital boards amongst others. Provincial Departments were expected to constitute evaluation teams and use the above criteria to evaluate different hospitals for decentralisation. However, functions that were the responsibility of other Departments outside the Department of Health such as the Departments of Public Service and Administration (DPSA), Finance and Public Works were posing serious challenges with delegations. For example, the DPSA is the principal Ministry for HRM functions in the Public Sector. A Ministerial Task Team was then set up to deal with these obstacles.

2.2.5 The Ministerial Task Team on Decentralisation of Hospital Management.

In 1999, due to the slow progress on the implementation of the policy on decentralisation of hospital management a Ministerial Task Team comprising of representatives of the NDoH, Public and Private Hospitals representatives, Unions, and International Health experts was appointed to review progress and make further recommendations. In August 1999, the Ministerial Task Team produced an interim report, which was presented to the newly formed MinMEC (a Ministerial Committee chaired by the Minister of Health and having all the Members of the Executive Committees of Health of all the provinces sitting as committee members) where it was adopted. The report made the following recommendations: An immediate review of the roles of National, Provincial and District Health Departments within a decentralised management framework, the launch of a communication strategy on the issue; adoption of cost centre management in public hospitals; placing performance management agreements in all public hospitals; appointment of CEOs or General Managers in all hospitals; and these appointments to be based on competencies and open to competition and not confined to doctors only. In order to achieve this form of decentralisation, the use of corporate Performance Management Agreements (PMAs) was proposed. The key areas of the PMAs were business planning, objective setting and delegations. However, in 1999, legal advice sought by the DPSA raised concerns about the use of PMAs specifically in that they are legally unenforceable within the current Human Resources Management Framework (HRM) and the PFMA requirements (South Africa, 2006) and cannot be used as prescribed. In order for PMAs to be adopted complex legislative changes would be required (South Africa, 2000). Based on this legal advice and the complexity of adopting new legislation allowing for the use of PMAs the Department silently abandoned the idea of PMAs. However, implementation of these recommendations continued in a patchy way across some provinces up until 2007. The following Table (Table 1) presents the summary of the key process followed during the decentralisation of hospital management as it relates to HRM between 1994 and 2007.

Table 1: Summary of Process during the decentralisation of HRM function

Period	Key Legislation/ Policy decision
1994	National health Plan for South Africa Reconstruction and Development Programme Public Service Act, 1994
1995-1996	Hospital Strategic Project Constitution of the Republic of South Africa
1997	White Paper for the Transformation of Health System in South Africa
1999	9th and Final draft of Decentralisation of Hospital Management. Policy presentation to Hospital Coordinating Committee Ministerial task team on decentralisation of Hospital Management MINMEC and PHRC interim report on decentralisation of hospital management First Performance Management Agreement between hospital CEOs and Provincial HODs.
2001	Public Service Regulations
2002 – 2006	Formal HRM delegations NW Province – effective 2002 and Gauteng Province 2006

2.2.6. Institutional Arrangements for the Human Resources Management Function

The institutional arrangements at a human resources management level were also complex and difficult to follow making implementation of hospital management decentralisation a near impossibility. The following Figure (Figure 1) represents the institutional arrangements

for Human Resource Management during the decentralisation process. The DPSA had the overall responsibility for the Public Service Act (and its regulations) which is the key legislation upon which the HRM function in the public service is based. It places enormous responsibilities and powers with the MECs and the Head of Departments in the various provinces.

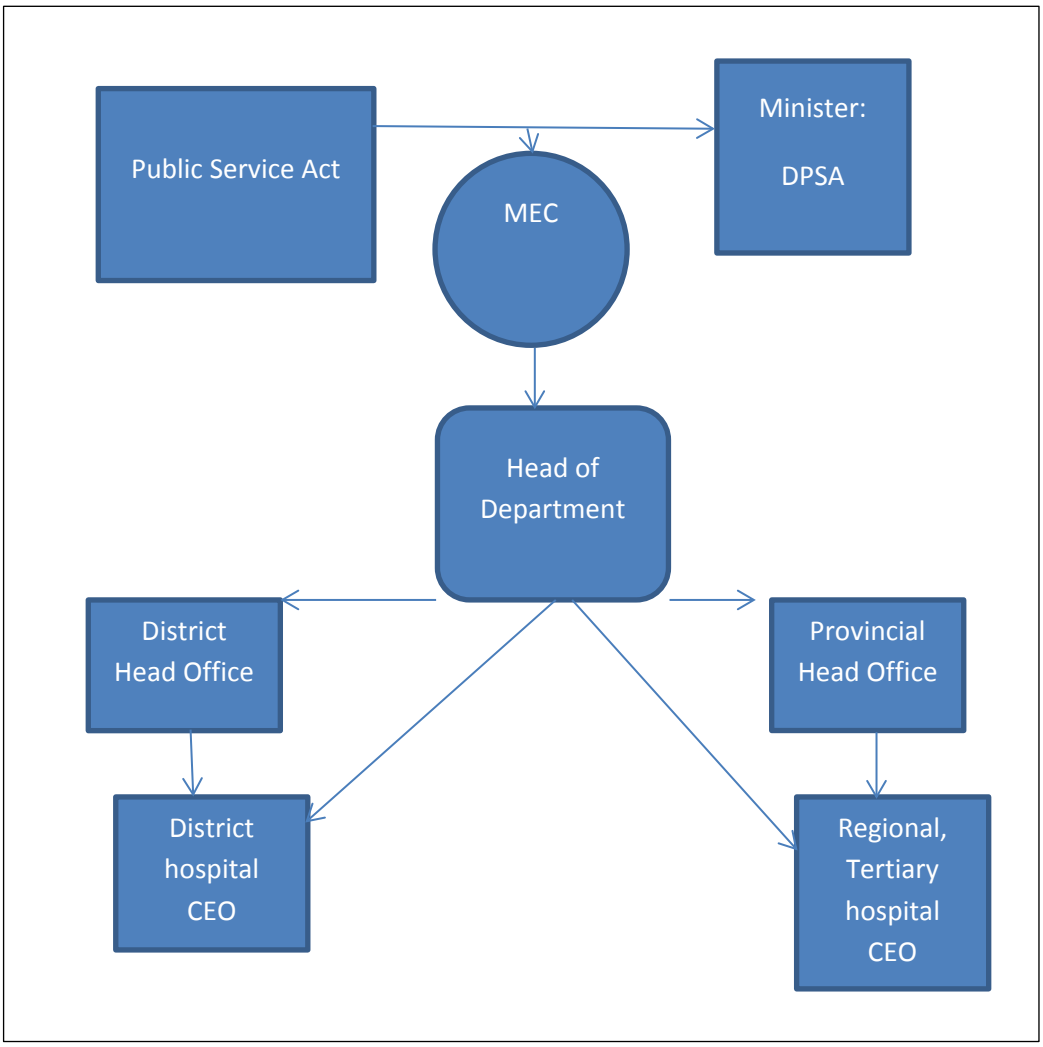

Figure 2: Institutional Arrangements for Human Resource Management Function

The MEC and or HOD may voluntarily delegate functions to officials in the provincial head office, district offices and hospitals according to this model. However, the approaches across provinces were not uniform. Gauteng developed specific criteria (See Table 2 below) as competencies expected of CEOs in 2009 but never implemented it (South Africa, 2009). The main reason for the lack of implementation was the unclear directives from the DPSA as

well as a lack of enabling legislation and regulations and in my opinion a lack of political will. However the guidelines do indicate the intention of the province to give more delegations to the CEOs and therefore holds the CEOs more accountable on core managerial aspects, and client, stakeholder and shareholders satisfaction (Table 2). Its application did not materialise in any substantive way. The provincial governments also introduced the mandatory setting up of functional hospital boards but these were largely toothless political appointments that were more ceremonial in nature than acting as proper governance structures. Despite these efforts the power of budget determination, procurement, large expenditure determination (above R25000) and senior appointments as well as advertisement of posts were all centrally determined (Bateman, 2011).

Table 2: Competencies expected of CEOs

Core Management criteria: **1. Implementation of the Turnaround Strategy.** **2. Alignment of the hospital's performance with the Annual Performance Plan.** **3. Implementation of the Governance Framework, Quality Assurance and the Monitoring and Evaluation Frameworks.** **4. Sound Financial Management and Accountability.** **5. Effective and efficient management and administration of the Hospital.** **6. Client orientation and customer focus.** **7. Change Management, Knowledge Management, Service delivery innovation,**
Problem solving and analysis, Communication, People Management and Empowerment **Client Satisfaction:** **1 Implement the Service Transformation Plan, Service Packages and "Health Status Indicators/index" (HSI) to:** **a. Improve the health seeking behaviour of clients.** **b. Increase the appropriate utilisation of health services by relevant clients.** **c. Improved service delivery efficiency. Improved client care.** **d. Improve client positive experience at all related health service points.** **e. Improve quality of care.** **f. Ensure effective and efficient medical and nursing care.** **g. Ensure implementation of National Health Programmes.**
Employee Satisfaction: **1. Increase employee participation in improvement of health service delivery.** **2. Increase employee utilisation of work environment to improve productivity.** **3. Improve employee achievement of performance expectations.** **4. Increase number of employees meeting quality standards through training.** **5. Increase employee motivation to achieve service delivery targets through recognition and rewards**
Stakeholder Satisfaction: **1. Increase stakeholder participation in support of GDoH service delivery.**

2. Increase stakeholder awareness of GDoH service delivery. **3. Increase stakeholder satisfaction through compliance to legislative mandate.** **4. Increase stakeholder satisfaction through sound governance practices**
Shareholder Satisfaction: **1. Increase shareholder funding in support of conformance to health service package specification at all service levels.** **2. Increase shareholder satisfaction through conformance to prescribed support services management practices.** **3. Improve institutional performance against "Health Status Indicators/index" (HSI).** **4. Improve shareholder contribution to Gauteng Department of Health strategy.** **5. Increase shareholder awareness of DoH services participation.**

Adapted from the Gauteng Criteria (South Africa, 2009)

2.2.7. The White Paper on Transforming Public Service Delivery (Batho Pele White Paper).

An important policy that provides the framework for institutionalising all of the New Public Management principles into the public service was adopted as early as 1997 and was called The White Paper on Transforming Public Service Delivery (WPTPSD), (South Africa, 1997, p. 1). It sets out eight transformation principles amongst which it states that "transforming service delivery is the key". It elaborates upon this by stating that "a transformed South African public service will be judged by one criterion above all: its effectiveness in delivering services which meet the basic needs of all South African citizens". "Improving service delivery" was the White Paper's ultimate aim. It further emphasises that public service managers require new management tools to implement service delivery successfully. The tools are those of the new public service management (NPM tools) and are described as follows: "assignment to individual managers of responsibility for delivering specific results for a specified level of resources and for obtaining value for money in the use of these resources; individual responsibility for results matched with managerial authority for decisions about how resources should be used; delegations of managerial responsibility and authority to the lowest possible level; and transparency about the results achieved and resources consumed"(ibid). The White Paper on Transforming Public Service Delivery

(WPTPSD) established a policy design for the delivery of public services which views the citizens as customers and aims to hold public officials to account for the services they deliver. This approach was encapsulated in the name that was used for this iniative, viz. Batho Pele (a Sesotho adage meaning “People First”).

The Batho Pele policy is made up of eight service delivery principles as set out below. It uses the concept of the citizen as customer and describes this as useful in that certain assumptions which are as basic and fundamental to public service as they are for commercial gain (South Africa, 1997) and these are to treat citizens as customers and implies: listening and taking into account their views when deciding what services should be provided; treating customers with consideration and respect; ensuring that the agreed level and quality of service is always of the highest standard; and responding promptly when standards of service fall. This White Paper clearly indicates that government planned to adopt the New Pubic Management approach within the public services sector and to embrace as its core principles that of effective service delivery and customer centeredness using private sector management tools. But as described earlier by Harrison (2010) and Cameron (2009) this did not occur as planned and less so in the health sector. These opinions were further explored in this research.

2.2.8. The Public Finance Management Act (PFMA)

Another important piece of legislation that impacted directly on the ability of senior managers in the public services to perform was the Public Finance Management Act (PFMA) promulgated in 1999. The PFMA (South Africa, 1999) was part of the government’s financial reforms that were put in place soon after the 1994 elections. The first phase of reforms began with the establishment of a new intergovernmental system, which necessitated that all three spheres of government (national, provincial and local) developed their own budgets (called decentralised budgeting). This was facilitated by substantial financial transfers to provinces and municipalities from the national treasury. Also, multi-year budgeting was introduced through the Medium-Term Expenditure Framework (MTEF) which replaced the one-year incremental system. The final part of this first phase of reforms was

to ensure that the budgeting process was better aligned to policy, planning and budgeting. The second phase of reforms was through the adoption of the PFMA i.e. the guiding legislation. The PFMA's objective was to modernise the financial management system and demand accountability. This was also to be further ensured by reforms to the procurement system (South Africa, 1999). The third phase of reforms was the use of service delivery indicators, performance budgets and the adoption of generally recognised accounting practices (GRAP).

Other principles of the transformation agenda on public sector management can be seen in the Batho Pele White Paper, the White Paper for the Transformation of the Public Service (WPTPS) (South Africa, 1997) and more recently in the Public Service Regulations (South Africa, 2001), which provides the context for the reforms to property ownership and procurement systems, and the involvement of the private sector in the delivery of public services, again a reflection of NPM like reforms. An important principle was that managers must be given the flexibility to manage within an appropriate policy framework that met the constitutional requirements of transparency and accountability. This was to be done in terms of the conditions required by the PFMA which aimed to provide a legislative basis of best practices in requiring public service bureaucrats in ensuring that their public service departments deliver services to consumers as efficiently and effectively as possible. The PFMA clarifies the separation of responsibilities between the head of department (the accounting officer) and the political head (called the 'executive authority' which could either be a national Minister or a provincial Member of the Executive Committee). The politician (executive authority) is responsible for policy choices and outcomes, while the head of department (accounting officer) implements the policy and is accountable for the outcomes by taking responsibility for delivery of outputs defined in the departmental policy and budget. In this way, the Act empowers accounting officers by conferring on them the authority they need to carry out their responsibilities. This however meant that financial and delivery accountability rested with heads of departments and could not be devolved further according to the PFMA and many heads of department's particularly in health kept this control. However, the subsequent Public Service Regulation (South Africa, 2001) allowed for the delegation and authorisation of appropriate functions. This allowed for some delegation

of functions to employees at the discretion of the head of department but not accountability. Consequently some Heads of Departments of Health delegated a number of functions and responsibilities to CEOs of public hospitals. However this varied across provinces and these delegations often had limited financial discretions for CEOs (Bateman, 2011).

2.2.9. The DBSA and its Reports on Strengthening Management and CEOs in the public health sector

Of substantial pertinence and importance to this study is the recent work of the Development Bank of South Africa (DBSA) in relation to Health Sector Reform in South Africa. In particular and of relevance is a project carried out by the DBSA for the NDoH which looked specifically at the functioning of CEOs of public hospitals. Two reports emanated from the project: the first report entitled: "DBSA/NDoH Benchmarking Hospital Management and Developing an 'Ideal Type' for Hospital Management" (DBSA, 2010, confidential – copyright DBSA and NDoH) and the second entitled: "Strengthening Management in the Health Sector: An Assessment of Hospital CEOs and District Managers" (DBSA, 2010, confidential – copyright DBSA). These reports are discussed in detail below.

The aim of these DBSA projects, on behalf the NDoH, was to develop an understanding of: (i) The role requirements and responsibilities that hospital and district managers (health care managers at Levels 13 and 14 - these levels are a DPSA determined ranking of senior management officials in the public sector) should fulfil in order to facilitate the delivery of quality care. (ii) The ideal qualifications , experience and competencies required by health care managers at Levels 13 and 14, and how these might differ across the grades and in different types of institutions. (iii) The minimum qualifications, experience and competencies required by health care managers if they are to fulfil the role requirements, and how those might differ across the grades and in different types of institutions. This review was done in order to develop a framework or scorecard for assessing and ranking hospital managers and develop the ideal requirements for this job. Although the initial brief was to look at only Level 13 and 14 hospital managers the brief was subsequently

broadened to include District Managers which are at Levels 11 or 12 generally. The Research Methodology included a literature review (international and local), a high level review of hospital manager job profiles (both international and local), and key informant interviews from government, academia and the private sector. The report focussed on Appropriate Competencies as defined by experience, qualifications, competencies and On-The-Job support (using the WHO Health Management model). The report acknowledges its limitations however in that contextual factors such as adequate staffing, functioning support systems and an enabling environment can also influence a hospital manager's ability to manage effectively and these have not been addressed substantively.

The report on "DBSA/NDOH Benchmarking Hospital Management and Developing an 'Ideal Type' for Hospital Management" findings are summarised below:

(i) The key characteristics of hospital managers

As far as role descriptors are concerned the findings from the DBSA literature review indicated similarities but also notable differences, in the job profiles of hospital managers across different contexts. The job profiles of hospital managers in various settings are described in Table 3 below.

Table 3: Job Profiles of Hospital Managers

Developing Country	Developed Country
Public Sector	**Operational efficiency in an environment of limited resources.** **Access to services.** **Provision of outpatient services.** **Public Health programmes.** **Stakeholder management. Operational efficiency in an environment of limited resources.** **Provision of patient services.** **Financial Management.** **HR Management**
Private Sector	**Private Sector Operational efficiency in an environment of more abundant resources.** **Supply chain management.** **Facilities management.** **Marketing.** **Hotel Management. Operational efficiency in an environment of more abundant resources.** **Research and innovation.** **Financial management.** **Profit maximisation.** **Marketing.**

Source: DBSA (2010)

The Public Sector requirements don't differ much between developing and developed countries except for involvement of public health programmes and more stakeholder involvement required for the public sector. Private sector profiles tended to focus on managerial efficiencies in both developed and developing countries.

(ii) The key characteristics of Hospital Managers: Qualifications and Experience

The report found that most hospital managers have both clinical and business qualifications and experience. The perceived value, according to the report, differed according to context, and these are described in Table 4 below.

Table 4: Qualifications and Experiences required of hospital managers

	Developing Country	**Developed Country**
Public Sector	**Preference is for clinicians with qualifications in public health or health administration.** **Public sector experience is an advantage.**	**No clear preference has emerged, but emphasis seems to tend towards management experience.** **The value of clinical insight/experience is also acknowledged.**
Private Sector	**Preference is for managers (who may have a business qualification, but must have solid management and business experience) with experience of/insight into clinical and health issues.**	**Preference is for managers who have a master's degree in Health Administration or an MBA.** **Clinical qualifications not seen to be necessary (or even necessarily desirable).**

Source: DBSA (2010)

The report makes reference to a Hospital CEO survey in the US, by Cejka Search and Solucient (2005), the study which compared the characteristics of what are called Best of Breed (BoB) CEOs of hospitals to those of median hospital CEOs which had the following findings:

a. BoB CEOs are more likely to have a master's degree, and more likely to have more than one advanced degree.

b. Less than 10% of BoB CEOs had a degree in law or medicine.

c. BoB leadership team members were more likely to have a master's degree or PhD (77%) than those in median hospitals (56%).

d. In the private sector management experience is favoured.

The report also made reference to a four country study of private and public hospitals in Latin America (Bogue, Hall and La Forgia, 2007) which revealed that developing country private sector hospitals were more likely to have hospital managers with non-medical graduate degrees than were public hospitals. These hospitals also emphasised non-medical managers with business experience. Business experience was the most valued criterion for private hospital managers and the least valued for public hospital managers. However, public hospitals in Latin America emphasised physicians with government managerial experience as their preference. The report also made reference to a McKinsey Quarterly Report (2008) which showed that research on developed country public sector hospitals (for example the National Health System of the United Kingdom) indicated that clinical experience may be critical in ensuring operational efficiency and performance management. A study on NHS hospitals showed that hospitals whose general managers have a clinical background positively impact on performance, and that clinical skills help managers better understand hospital operations and to manage doctors more successfully. However the report also makes reference to an earlier study by Filerman (2003) to counter the UK experience with the following conclusion and that is that research on public health systems in developing countries indicates that both general management and public health competencies are desirable, but that if a choice was made, the decision would err on the side of general management competence.

A WHO study (Dal Poz et al. 2009) of a number of African countries (Ethiopia, Tanzania, Ghana, Togo, South Africa and Uganda) indicate that health managers tend to be clinicians (which includes doctors, nurses, pharmacists, health officers and clinical officers) who undertake management duties as an additional role and that very few managers are not

health professionals. Also that recruitment is often based on qualifications rather than ability to perform and that the Masters of Public Health (MPH) is a common technical requirement, but the WHO emphasises that it must be accompanied by appropriate management experience.

(iii). Key Characteristics of Hospital Managers: Competencies

In addition to generic management competencies, the following key characteristics of hospital manager's competencies are emphasised according to the DBSA in different contexts and is summarised in Table 5 below.

Table 5: Key Characteristics of Hospital Managers: Competencies

	Developing Country	**Developed Country**
Public Sector	**Stakeholder relationship management.** **Strong people management.** **Communication skills.** **Ability to manage "upward".**	**Self Belief.** **Self Awareness.** **Self Management.** **Drive for improvement.** **Personal Integrity.** **Setting direction.** **Delivering the service.**
Private Sector	**Information management.** **Public relations.** **Strategic thinking.** **Customer orientation.** **Ability to manage health professionals**	**Integrity and credibility.** **Visionary.** **Results-orientated.** **Collaborative.** **Values driven.** **Team building.** **Strategic thinking.**

Source: DBSA (2010).

The report further reviewed a survey of Chairs of Hospital Boards by Halstead (1989) in determining what characteristics they would covet in hospital managers. The following was

revealed: a commitment to the highest quality of health care, an unquestionable reputation and a track record of high integrity and morals, leadership skills, and being able to recruit and retain the best possible management team, decisiveness and an ability to build and promote a very good working partnerships with medical and other health professional staff. The survey concludes that individual characteristics and skills will determine the difference between a hospital manager's success and failure.

Furthermore, the report also reviewed the study on public and private hospitals in Latin America (Bogue, Hall, and La Fogia, 2007) which outlined six leadership characteristics that hospital managers ranked as critical: education, values consistent with the hospital, time availability, experience in planning, conflict management skills, and health leadership experience. The report indicated that public hospital managers placed a higher value on the following characteristics: clinical experience, ability to represent patients, education, knowledge of information systems, and political influence as important. These reports played a pivotal role in informing the South African government in developing legislation governing the appointment and functioning of public hospital CEOs and this culminated in the gazetting of a Green Paper on a Policy on the Management of Public Hospitals on the 2nd March 2012 which is discussed in some detail later.

The DBSA Report on "Strengthening Management in the Health Sector; An Assessment of hospital CEOs and District Managers." is described below:

The Development Bank of Southern Africa (DBSA) was also requested by the National Department of Health (NDoH) to assess the competency of CEOs and heads of public hospitals (hospital CEOs) and district managers with a view to strengthening health service management capacity at public hospitals and health districts. The assessment of hospital CEOs and district managers links to point four of the National Health Strategic Plan: Overhauling the health care system and improving its management.

The process commenced with research to inform the development of assessment tools and a scorecard for hospital CEOs and district managers, which was informed by the preceding

DBSA's international literature review. Following this a nation-wide assessment was conducted. High participation in the process and the cooperation of provinces indicated a strong shared interest among health managers in improving health management outcomes. This DBSA report outlines the background and objectives, methodology, process, findings and conclusions, and recommendations emerging from the study. The recommendations of this report were intended to align with other priority initiatives, including: Improving the Quality of Health Services, and Improving Human Resources Planning, Development and Management, as outlined in the NDoH report: Key initiatives to strengthen health facility and district health management. According to the report the ideal way of determining the competence of hospital CEOs and district managers would have been to review individual and institutional performance data, and compare these. However, the DBSA admitted that reliable individual performance data was not available, and given the number of factors contributing to overall institutional performance, it was impossible to come to firm conclusions about individual performance based on this data (DBSA, 2010).

Thus, based on the empirical research, the DBSA study developed a health management competency framework, scorecard, and assessment battery with which hospital CEOs and district managers were assessed. Each of these assessments were reviewed and validated by relevant internal and external subject experts and stakeholders. The key components of the hospital and district manager scorecard included: qualifications, experience, and assessed competencies.

The research hypothesised that the ideal profile of a hospital/ district manager would comprise: health and business qualifications, and extensive experience within public health. The competency framework outlined a set of 19 competencies customised to the South African public health environment. These competencies were clustered into five groups: Strategic/ Transformational, Stakeholder/ Environment, Operational and People, Core Functional, and Personal Competency clusters.

Overall, 338 hospital CEOs and 46 district managers were assessed during this process, comprising 95.52% of the study population. The analysis of employment reveals that 12% of

managers were acting in their current position. Also, 75% of managers were below the salary level 13 (i.e. are not senior management as per the public service nomenclature). An association between remuneration level and total scores for hospital CEOs was observed, with the managers of higher remuneration levels typically scoring higher than managers of lower levels (with a few notable exceptions). Amongst hospital types, National Centre, Tertiary and Regional hospital CEOs scored in the main higher than managers of other hospital types (again, with a few notable exceptions). Psychiatric, TB and other Specialist hospital CEOs scored on average lower than managers of main hospital types . Across all hospital types, hospital CEOs scored least on Core Functional, Strategic/Transformational, and the Operational and People Competency clusters, the implications of which are elaborated further in the report.

Analysis of hospital CEO qualifications of all participants highlighted the positive impact of health qualifications on assessed competency, with added qualifications in business as well as public administration effecting positively on the result as well. The ideal experience profile appeared to be between six and twenty years' experience, preferably in a public sector health environment, according to the study.

Hospital CEOs and district managers were subsequently requested to assess themselves on each competency, and on average, scored themselves much higher than their actual assessed competency scores. As far as preferred delegations were concerned, hospital CEOs indicated a strong preference for HR delegations out of a choice of HR, Finance, and Supply Chain Management delegations; whereas district managers expressed a preference for Finance delegations. Of significance in these evaluations, health service managers and in particular CEOs of hospitals were asked to outline their top constraints to performance. Lack of budget dominated as the highest ranked constraint, followed by limited delegations and lack of competence of direct reporting lines and supporting teams (see Figure 2 below).

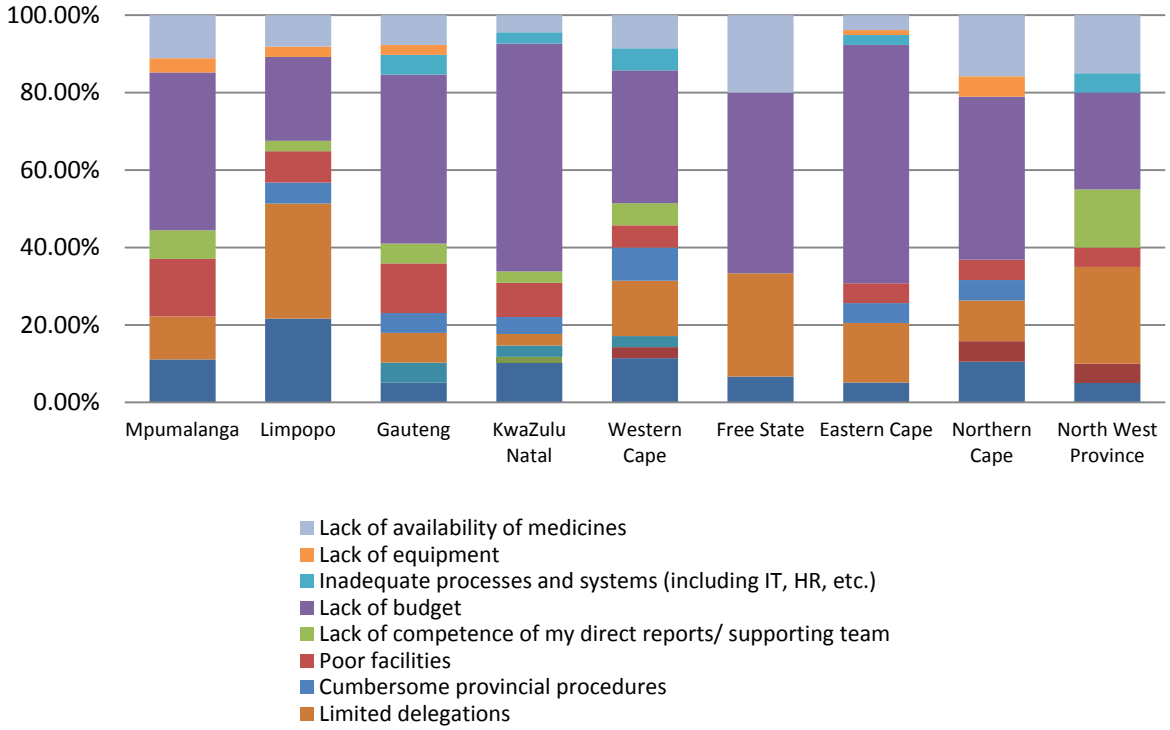

Figure 3: Constraints to performance as determined by health service managers (DBSA, 2010)

Second to lack of budget, however, there are several reasons cited as performance constraints, with provincial differences. For example Limpopo, North West, Eastern Cape, Free State, and Western Cape managers cited limited delegations as a crucial constraint following lack of budget, compared to Gauteng and Mpumalanga (who identified poor facilities as a constraint), KZN (vacant posts), and Northern Cape (lack of equipment).

An analysis of stress concluded that there was significant stress within both the hospital and district system. Furthermore, there exists limited capacity to adequately manage the existing stress. Of significance was that participants that scored higher on this dimension also displayed a greater capacity to manage stress according to the study.

The recommendations emphasised a comprehensive but flexible approach for hospital and district manager interventions based on individual need. These interventions were to include but were not limited to: training and development, mentorship and coaching, recruitment, and succession planning. The report further emphasised the importance of

having a comprehensive approach in terms of implementing any interventions to reform the system, and that manager competence is only one amongst many systemic and institutional factors to consider. These reports informed the development of the survey instrument used in this research. These two reports also led to the promulgation of the policy on the management of hospitals with a particular reference to the CEOs of public hospitals and this is discussed below.

2.2.10. The National Health Act: Policy on the Management of Hospitals

Because of a lack of enabling legislation as well as the objectives of the Ministers – 10 point plan whose aim is to improve the quality of health care and in particular the functionality of hospitals the Minister of Health gazetted a Green Paper on a Policy on the Management of Public Hospitals on the 2nd March 2012 (South Africa, 2012). This was a landmark policy in creating an enabling legislative framework that is intended to achieve amongst other things a clear set of requirements for the appointment of CEOs of public hospitals, as informed by the DBSA reports, as well as what is required of these CEOs in future. In its introduction it makes the following points (South Africa, 2012, p. 32):

> In line with the 10 Point plan's strategic point number 4 on "Overhauling the health care system and improving its management", the Department identified key deliverables to improve the management of hospitals. Whilst significant inroads have been made in addressing some of the key deliverables aligned to strategic point 4, a number of challenges continue to hamper effective and efficient delivery of quality health care. Some of the challenges identified were systemic in nature, for example, the lack of appropriate legislation and policies, while in other cases the challenges related to capacity constraints,, such as the competency levels of hospital CEOs, lack of proper training, lack of strategic support, and the lack of capacity to deal with small operational issues.

This national policy on the management of hospitals overall objective was to ensure that the management of hospitals is guided by principles of effectiveness, efficiency and

transparency. Its specific objectives are extremely pertinent to this research and are as follows: to ensure implementation of relevant legislation and policies to improve the functioning of public sector hospitals; to facilitate the appointment of competent and skilled hospital managers; to provide for the development of accountability frameworks and systems; and to ensure the training of managers to be competent in leadership, management and governance. It further goes on to classify hospitals into district, regional, tertiary and central hospitals as well as what are regarded as specialised hospitals (South Africa, 2012, p. 33).

Furthermore in s2.2 it details the appointment of competent and skilled managers and describes the job description for a hospital CEO as follows:

> The Job purpose will be to:
> Plan, direct, co-ordinate and manage health care and support services effectively and efficiently as an integral part of the health service delivery in the area served by the hospital;
> Represent the hospital authoritatively at provincial and public forums.

This section also makes reference to the most critical competencies as prescribed in senior management and middle management requirements of the Public Service Administration (South Africa, 2011). The national policy elaborates on the minimum requirements for appointment as a hospital CEO and then describes the development of accountability frameworks in terms of governance and public participation. It describes the minimum requirements for appointment to hospital boards, the functions of hospital boards and hospital board subcommittees. However there is not enough detail in my opinion. This specifically as it relates to the performance measurement of the CEOs and consequential incentives and disincentives. The roles and responsibilities of hospital boards are also not sufficiently elaborated upon. However, the new policy locates itself firmly within the Negotiated Service Delivery Agreement signed by the Minister of Health.

2.2.11. The Negotiated Service Delivery Agreement

Of importance to NPM practitioners are the use of performance contracts (Perry, 2009). South Africa under the Zuma presidency introduced performance contracts for ministers and these were called Negotiated Service Delivery Agreements (NSDAs). These are a five year performance agreement contract signed by all the cabinet Ministers with the President. It is also a contract that commits key government stakeholders and partners to the delivery of particular outputs as they relate to identified sectors of the South African government. The Government decided on 12 key outcomes as the priority indicators for its planned programme of action for the period 2010 – 2014. The priority for the health sector is improving the health status of the entire population and is described as Outcome 2: A Long and Healthy Life for All South Africans. The Minister of Health has signed this agreement and it is his personal performance management contract with the President (South Africa, 2010a). To be able to contribute to the realisation of this outcome the National Department of Health's (NDOHs) Strategic Plan for the period 2009 - 2014 lists 10 priorities as part of its 10 Point Plan for the overall improvement of the national health system (South Africa, 2009).

The 10 Point plan focuses on an essential set of strategic areas namely:
the enhanced overall stewardship and governance of the health system; the implementation of a National Health Insurance as a mechanism to finance the health service provision and delivery platforms; significantly improving the quality of health services that are provided to its citizens through a National Quality Accreditation Body; overhauling key components of the management systems and structures in the public health sector; better planning and management of human resources for health; the strategic implementation of infrastructure development and maintenance initiatives, including the use of public private partnerships; the comprehensive and aggressive combating of HIV, AIDS, TB and other communicable diseases; mass mobilisation of communities and key stakeholders to promote better health outcomes for all; the review and strengthening of the drug policy and procurement systems; and re-engineering the health system to one that is based on a primary healthcare (PHC) approach, with more emphasis on promotive and preventive

healthcare that will underlie all interventions needed to achieve the outputs (South Africa, 2009).

To understand the current context of Health Sector Reforms in South Africa it is important to have an overview of the current strategies and plans that relate to governments overall ambition to transform the health system. The appropriate starting point is to describe the NSDAs intentions as indicated in its four output areas:
Output 1: Increasing Life Expectancy
Output 2: Decreasing Maternal and Child Mortality
Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
Output 4: Strengthening Health System Effectiveness.

Outputs 1 to 3 were informed by the Millennium Development Goals (MDG's) as developed by the United Nations (2000) and are the main priorities of the Minister. However to achieve this government has to deal with Output 4 (strengthening health system effectiveness) first. Output 4 is of particular relevance to this research and is briefly discussed next. To strengthen the public health system, a number of initiatives were planned to be undertaken by the National Department of Health (NDoH) complementary to those proposed for Output one to three above. These initiatives included
the need to overhaul and improve the health services delivery platform, from a high cost curative and hospicentric care model to one that promotes cost-effective re-engineered Primary Health Care delivered as close to the community and household as is possible, supported by robust and sustainable improvements in management and supervision. This strategic imperative resulted in the promulgation of the Green Paper on the National Health Insurance (South Africa, 2011) and this is briefly reviewed below.

2.2.12. The National Health Insurance:

South Africa has taken on a new policy direction with its National Health System mapped out in its green paper on National Health Insurance (NHI) (South Africa, 2011a). The NHI plans to ensure that the public has access to appropriate, efficient and quality health

services. The policy describes four key interventions: “i) a complete transformation of health service provision and delivery; ii) the total overhaul of the health-care system; iii) the radical change of administration and management; iv) the provision of a comprehensive package of care underpinned by a reengineered Primary Health care” (South Africa, 2011a, p. 5). This is a significant step forward for South Africa and is reminiscent of the 1948 policies for a National Health System (NHS) in the United Kingdom post World War II (Naidoo, 2012).

South Africa, as mentioned before, has many challenges including a huge burden of disease, worsening health profiles of the population, poor health service management systems and a shortage of key health personnel in the public health sector (Harrison, 2010). To address these challenges the NHI policy is framed within the following social justice principles: a) the right to access health care services; b) social solidarity which makes reference to financial risk protection for the entire population; c) effectiveness through the use of evidence-based interventions; d) appropriateness which talks to the adoption of new and innovative health service delivery models; e) equity that aims to ensure universal coverage with care according to need; f) affordability that means that services will be procured at reasonable cost but recognizing that health is a public good and g) efficiency that will be ensured by creating appropriate management systems that avoid duplication across all spheres of governance (South Africa, 2011a).

The main aim of the NHI is to improve access to quality health services for all South Africans. It bases its approach on a Re-engineered Primary Health Care (PHC) system that focuses mainly on community outreach services through the use of community health workers based at primary health care clinics using a defined primary care package of services (Naidoo, 2012). There will also be opportunities for the delivery of PHC through private providers that are accredited and contracted within districts. Hospital based care packages are categorised according to the type of the hospital which range from district, to regional, to tertiary as well as central and specialised hospitals.

The first five years of NHI was aimed at testing the implementation of the policy through pilot studies and will also include strengthening the health system in the following particular areas:

- Management of health services
- Quality improvement audits
- Infrastructure upgrade
- Medical devices and equipment upgrade
- Human Resources planning, development and support
- Information management modernisation
- Setting up of an NHI Fund.

The NHI also mentions the creation of an Office for Health Standards and Compliance (OHSC) to inspect and accredit facilities and services, set norms and standards and provide for an independent ombudsman. The NHI policy provides for the payment of providers and encourages a risk-adjusted capitation system as its preferred method of payment. Some public hospitals have already outsourced the management of their hospitals through the private sector using Public Private Partnership (PPP) agreements. One such notable PPP is at the Albert Luthuli Hospital in KwaZulu Natal. These NHI proposals could have major implications for the future funding structure of hospitals and how they are managed both in the public and private sectors but details of these is absent. (South Africa, 2011a).

A specific focus of the 10 point plan, the NHI policy and the Policy on the Management of Hospitals is to improve management of health services and is again relevant to this research. This turnaround strategy for improving management proposes to introduce a common competency framework for health managers, together with predetermined standards, delegation of responsibilities and functions to the facility level. It makes reference to the DBSA work as that will be used to finalise the framework for the employment of health managers as well as inform the design of the training, support and performance management measures. Performance Management Systems (PMSs) will be introduced for rewarding outstanding performance and sanctioning poor performance. The aim is to develop a PMS that promotes accountability in a developmental and not a punitive

way. A similar focus is to be directed at the service delivery and supervisory levels respectively through skills development programmes, mentoring, monitoring and evaluation processes. This output is of special significance to this research and the unfolding of this policy implementation will inform in particular the document analysis as well as possibly the future functioning of CEOs in public hospitals. What largely informed HSR in South Africa and articulated on its policy on the NHI is informed by the theory behind the NPM paradigm. This theoretical context of NPM and its effect on Public Sector Reform (PSR) as well as that of the current Health Sector Reform (HSR) in South Africa are now discussed.

2.3. The Theoretical Context of NPM reforms

The Theoretical Framework is informed by the changes affecting the role of government from the late 1970's according to Larbi (1999). The New Right or neoliberals was increasingly criticising the size, burgeoning cost and role of government bureaucracies and was questioning its efficiency and effectiveness. The Keynesian welfare state was regarded as a monopoly deliverer of public services and fundamentally inefficient. Little consideration was afforded to the public as its customers and its results or outputs were questionable (Bereton, 1994). It was argued that it was only through the free market and its forces through competition that economic efficiency could be achieved and the public should be offered free choice of who should deliver services (Bereton, 1994: 14). There was broad agreement among commentators on public sector reforms, such as Flynn, (1993), Ferlie *et al.*(1996), Walsh (1995) and Pollitt (1993), that this New Right or neoliberal criticism of the Keynesian welfare state, and of its public administration centred on it, was largely dictated to by the opinions of liberals economists such as Hayek (1973), and by public choice theorists such as Niskanen (1971), Buchanan (1975) and Meuller (1979). According to other authors such as Jordan (1995), public choice theory was one of the New Right's most effective weapons. The main criticism of public choice theorists of the traditional public administration system was that the reward system it used did not advance effective service delivery and that the politicians and bureaucrats had no motivation to control costs (Chapman, 1979). This often led to an inherent wastage of financial resources and an in-built tendency for expenditure to grow. Routine public service delivery continuously

expanded and took precedence over real productivity. Market forces were viewed by the neoliberals as the only disciplining mechanism that could prevent government becoming bloated, inefficient and underperforming. According to Hayek (1960), bureaucrats promote this expansion of governmental functions because of self-interest and these become eventually over supplied or over-extended. This then results in the creation of an ever-growing bureaucracy with a hierarchical authority structure fixed on rigid rules. These authors further argue that over time the capacity for top-down control diminishes as bureaucratic expansion gets to a critical point where it becomes impossible to control effectively. This leads inevitably to bureaucratic failure according to Downs (1967) and Breton and Wintrobe (1975). In the search for improving efficiency and effectiveness in government, not only were reforms an economic imperative but the use of private sector management techniques and practices were preferred under the New Public Management paradigm. According to Flynn (1993, p 12) by the 1980s these ideas moved to the mainstream of government policy, particularly in the West, and collectively provided "a framework within which privatisation, expenditure controls and the introduction of markets all hang together".

The rise of New Public Management (NPM) over the past few decades was described as "one of the most striking international trends in public administration" according to Hood (1991, p 2-3). Hood attributes NPM's rise to four administrative megatrends, namely:

> (i) attempts to slow down or reverse government growth in terms of overt public spending and staffing;
>
> (ii) the shift towards privatisation and quasi-privatisation and away from core government institutions…;
>
> (iii) the development of automation, particularly in information technology and the production and distribution of public services; and
>
> (iv) the development of a more international agenda, increasingly focused on general issues of public management…

So in terms of the theoretical context that informed the conceptual framework for this research the New Public Management (NPM) paradigm was used (Holliday, 2001). The rationale behind this is that the public sector reform agenda in South Africa post 1994 was largely informed by the international trends of government reform which was driven by the NPM paradigm, and was clearly articulated in the White Paper on Transforming the Public Services (South Africa, 1997). This NPM paradigm also informed Health Sector Reforms (HSR) that took place in South Africa during the 1990s and 2000s as well as some aspects of current reform including that of public hospital management (Cameron, 2009). Theoretically therefore the research needs to explore the reform era in terms of NPM (where it began and where it is now) and its relationship to the meanings of public management (new or old) and the function of government as well as views from its detractors, starting with an international perspective as described below.

2.3.1. An International Overview of New Public Management

The New Public Management (NPM) paradigm has come to dictate the rationale behind public sector reform by bureaucrats and academics alike (Polidano, 1999). Some commentators have acclaimed it as the new paradigm of public administration (Osborne and Gaebler, 1992; Borins, 1994; Hughes, 1998). NPM reforms according to these authors are a general response to prevailing pressures on government – specifically public hostility, less budgets and the pressures of globalisation. There is general consensus about the key components of NPM which include the freeing up of line management from too much regulation, decentralisation, changing of public service departments into free standing units or commercial companies; performance based management through contracts, and the use of competition such as contracting-out and/or the creation of internal markets (Aucoin, 1990; Hood, 1991). Various other authors subsequently included privatisation and rightsizing (often downsizing) as part of the package (Ingraham, 1996; Minogue, 1998).

Hood (1991, p. 4) in his seminal publication: “A Public Management for All Seasons” elaborates on the seven doctrinal components of new public management as follows:

(i). Hands-on professional management in the public sector;

(ii). Explicit standards and measures of performance;

(iii). Greater emphasis on output controls;

(iv). Shift to disaggregation of units in the public sector;

(v). Shift to greater competition in the public sector;

(vi). Stress on private sector styles of management practice;

(vii). Stress on greater discipline and parsimony in resource use.

According to Hood, a means of interpreting NPM's origins is as a marriage of two different sets of ideas. One marriage partner was the new institutional economics. This was built on the post-World War II development of public choice, transaction cost and principal–agent theories from the original work of Arrow (1963) to Niskanenen's (1971) main theory of bureaucracy. This helped to produce a set of public sector reform principles built on competition, user choice, transparency and the use of incentive structures. The other partner in matrimony was a set of consecutive waves of business type managerialism ideas being adopted in the public sector, most in the way of the Taylor's scientific management movement (Pollitt, 1990). This assisted in producing a set of restructuring improvements and reforms underscored by professional business management expertise. This was seen as more important than technical expertise, and requiring substantive discretionary powers to achieve results (free to manage), and critical to better institutional performance, through the progressive embracing of high performance cultures (Peter and Waterman, 1982) and the move to appropriate measurement and management of organisational outputs.

According to another reputable author in this field, Kettl (2000), in his work: "The Global Public Management Revolution - A Report on the Transformation of Governance"; the point is made that since the 1980s the international reform movement in public management has been much more determined and enthusiastically underway than in any period before. Kettl (2000, p. 7-18) describes the reform as "striking" as a result of the numerous and varied countries that have implemented the reform agenda in a relatively short period of time (including Mongolia, New Zealand, Sweden and the United States). He also asserts that these reform strategies have been very similar in characteristics. Kettl succinctly describes

six core characteristics of this reform as follows: Firstly improved productivity: How can governments deliver better public services for less tax money? Secondly, marketisation: How can government adopt market-style tools to deal with the problems of government bureaucracy? Thirdly, a service orientation: How can government better serve citizens? Fourthly, decentralisation: How can governments be more responsive and effective? Fifthly, better policy: How can government improve its policy making abilities? and Sixthly, accountability for results: How can governments be held accountable for what they promise to deliver?

Public sector structures and practices that informed the old or traditional public administration was seen as obstacles to economic efficiency and acted against the development of a customer service culture according to Osborne and Gaebler (1992). They believed that the traditional bureaucratic model was too mechanistic and inflexible. This challenge of traditional public administration they believed had led to the development of an alternative paradigm (NPM) which stressed management rather than administration and was much more flexible in dealing with dynamic environments than its predecessor (Osborne and Gaebler, 1992). They proceeded to identify ten threads (Osborne and Gaebler, 1992 p. 19-20) which entrepreneurial public organisations have in common, i.e. they:

- Promote competition between service providers,
- Empower citizens by pushing control out of the bureaucracy,
- Focus on outcomes not inputs,
- Are driven by goals and not by rules and regulations,
- Redefine clients as customers and offer them choices,
- Prevent problems before they emerge,
- Earn money not spend it,
- Decentralize authority, embrace participatory management,
- Prefer market mechanisms to bureaucratic mechanisms,
- Catalyse public, private and voluntary agencies to solve community problems."

These core characteristics of NPM reform as described by Kettl (2000) and Osborne and Gaebler (1992) informed the conceptual framework of this study as it is the lens through which the research questions was viewed. It assisted the research in assessing health sector reform in South Africa since 1994 as well as its implications for CEOs in the management of public hospitals. Furthermore, Kettl (2000, p. 8-15) also describes two models of reform. The Westminster reforms, shaped by the experiences of New Zealand and the United Kingdom governments (as well as Australia and Canada) and the American style re-invention which although being implemented later and much more incremental was more sweeping in its reforms in Kettl's opinion. These two strategies defined the basic models that have powerfully shaped the global reform debate around the world according to Kettl. Africa and South Africa in particular have adopted these reforms albeit piecemeal according to Oluwu & Wunsch (2004) and Cameron (2009). However this is explored in depth after the international overview.

There also has been many arguments (ideologically charged often) about the advantages and disadvantages of the NPM according to Polidano (1999) which focuses on the need to adopt or otherwise of NPM reforms in principle. However, Polidano concedes that supporters and critics alike often accept the general assumption that the new public management principles are applicable universally. The universality assumption of NPM is supported by the fact that NPM catch-phrases features conspicuously in the language of civil service reformers all around the world (Thomas, 1996).

According to Polidano the political proponents of public administrative reform move into action behind a vanguard of rhetoric. Polidano asserts that the pretentious language draws on prevailing ideas that are internationally fashionable. But the question Polidano poses is whether the "new paradigm" has gone beyond rhetoric? (1999, p. 3).

Kettl (2000) concludes in his comprehensive historical overview of New Public Management reform in the West is that it meant to replace traditional, hierarchical, inflexible, authority-driven public service bureaucracies with newer, market-based, competition driven institutions. However he does conclude that the international reform process is not a

simple effort to replace government services with markets. Also implementation reforms differed across countries and from the literature the Westminster reforms aligned itself much more to the NPM paradigm than did the American re-inventing of government in terms of the operationalisation of its reforms and its use of NPM tools across all government sectors. There was much greater privatisation and corporatisation in the UK than in the USA where most of the reforms were at federal level rather than at state level and the USA made greater use of the non-governmental and non-profit sectors than the UK.

Other analysts such as Halligan (2007) and Lynn (2006) have analysed NPM from a different perspective, whether its underlying market philosophy is valid and whether it has truly accomplished what it has claimed. Some analysts such as Drechsler (2005) have even argued the whole notion of a NPM and if so what is its real value? These contestations as well as their views on public sector reform of the last few decades are explored further below.

Halligan (2007) commented on the public management reform era, and like Kettl, (2000) says that we have seen remarkable and sustained transformation of public administration in countries internationally over the last few decades. Halligan (2007) describes a different view of reform generations and models in his discussion on NPM. He uses the term first generation reformers to denote countries that are considered to be the pioneers in NPM such as New Zealand and Australia (i.e. the 1980s) in contrast to the other countries that subsequently followed. The first period of reform according to Halligan replaced traditional public administration with a set of reforms supported by business management principles. The sequence of these reforms according to Halligan is described somewhat differently to that of Kettl (2000). Halligan asserts that in the late 1970s and early 1980s a new management paradigm was developed and implemented in public administration internationally that superceded the importance placed on inputs and processes with one on outputs, outcomes and results. This was the first generation of NPM according to this author (ibid). The main initial reforms focused on improving the management of the core public service (including deregulation, decentralisation and downsizing the senior public service) as well as improving the performance of its financial management systems. This was followed by agentification, corporatisation and later privatisation. The mid-1980s saw a

weakening of the reform momentum. A new way was required that was associated to an emerging global macro-and micro-economic reform agenda, the most substantial being a move to influence the organisation of the operations of government. The first phase of this second generation of reforms displayed an adoption of NPM principles in many respects. However, the main theme was management improvement. This commitment to neo-liberal reforms in the 1990s resulted in the public service becoming much more decentralised, contractualised and privatized (Halligan and Power, 1992). This reform agenda focussed on competition of service delivery, contracting out, a customer focus, sticking to core business, and the introduction of the purchaser/provider model. These same principles have also been adopted by the policy on the NHI (South Africa, 2011). The focus according to Halligan covered a flexible personnel system; a core public service that focused on policy, regulation and oversight of service delivery; and substantial use of the private sector. New financial management systems were introduced that was based on budgeting on an accrual basis, the use of outputs, outcomes and results reporting, and extending devolution to budgetting and financial management (Boston et. al. ,1996; Kettl, 1997 and Scott, 2001).

The devolution of responsibilities from central departments to line agencies was an important feature with a lesser role for previously dominant public agencies being a significant consequence. The third generation reforms, so obvious in the developing Australian experience, have four dimensions that are planned to bring together major aspects of governance according to Bogdanor (2005): stewardship through guiding delivery, coherence through a whole-of-government approach, and a greater responsiveness to government policy. These four dimensions are planned to achieve the following: recovery of the central agency as the main player with a more direct influence over other public service departments; whole-of-government as the new way of coordination; central monitoring of department or agency on implementation and delivery; and departmentalisation through absorption of statutory authorities. Together these new reforms provided the basis for integrated governance. This whole-of-government agenda had a concentration element in so far as central agencies were driving systemic policies across several departments. The outcome has been a tampering of decentralisation through strategic management control from the centre and a realigning of the relationships of centre and line agencies. Underlying

all of this was an important political control aspect according to Halligan (2007). So on reflection of three decades of NPM, Halligan identified that the core principle of the 1980s was to ensure that departments provided policy advice and had to manage effectively and efficiently and that the language of the mid-2000s was to ensure effective delivery as well as policy direction with the latter primarily defined in terms of outcomes. This again deals with overcoming managerial constraints as well the importance of outcomes as performance measures, two important issues that this research intended to understand more about in the public hospital setting, but from a CEOs perspective.

The view of events as proposed by Lynn (2006) is that the new discourse on public management has had a more systematic evolution that has been initially centered on a business-like paradigm called the "New Public Management" or "managerialism" (Hood, 1991, p. 3). This in his opinion replaced the traditional, Weber style, bureaucratic government on a nearly global scale. Lynn (2006) describes the evolution of the traditional public administration, informed by the scientific management theorists adequate for the industrial revolution and the two world wars, being replaced by public management and then the new public management paradigms. This is an economic relook at the efficiency and relevance of government and huge bureaucracy to its new incarnation of focusing on the predominance of the principle of governance that has emerged in its discourse. Lynn argues that effective management of public organisations is critical to the success of any government's policies and perhaps even of democracy itself. This rapid growth in its development was due to the economic crisis of the 1970s and 1980s and a more tight-fisted approach to the management of public finances. He also includes factors such as heightened expectations of citizens on government's ability to deliver on promises made after the end of the Cold War, increased interdependence between economies (globalisation), an growing pressure for regulation and the need for dependable and prudent administration of government functions as well as the increasingly popular appeal of neo-liberal ideologies and policies. Lynn concludes that because of these reforms national and international management consultancies began to proliferate and flourish and academic interest in these developments increased hugely. Also, according to this author a new vocabulary emerged in the 1980s and 1990s with words such as new public

management, reinventing government and state modernisation and reform entering the vocabulary of policy makers, public management practitioners and scholars worldwide. Lynn further elaborates that the discourse on public management experienced a major transformation in the 2000s that realigned the relationship between the state and society, between government and citizen, and between politics and management and an emphasis on governance presently as the overarching determinant of understanding NPM and its implementation.

Other authors such as Christensen and Laegreid (2007), and like Halligan (2007) also posits that the New Public Management had generations of reform. The first generation of NPM reforms, which started about twenty years ago, was based on a pulling together of new institutional economic theory, public choice theory and new management theory and the central focus of this ideology was its prescription on a new public-sector focus on efficiency, decentralisation, disaggregation, increased competition, adoption of private sector management principles and increased use of performance based contracts. NPM was seen as advocating both decentralisation (let managers manage) and centralisation (make the managers manage) (Hood, 1991). Decentralisation is another important concept for this research in that it intends bringing decision making closer to the people that require services and allows managers to make discretionary managerial decisions so that the overall efficiency and effectiveness of service delivery is improved. Decentralisation reforms often involve legal acts (i.e. the legislative frameworks), and as the experiences in Health Sector Reform (HSR) in South Africa have indicated thus far this was not in place in the last decade until now (South Africa, 2012). However, delegation is a specific form of decentralisation where responsibility, authority and resources are transferred, and is dependent on competencies of individuals at all levels of management, but accountability still resides in the centre and is also a focus of this research (Oluwu & Wunsch, 2004). These generations of reforms as described by experts in the field are important to this research as they inform reforms in developing countries and those countries particularly in Africa who are at various stages of reform.

In practice the NPM paradigm is constantly evolving, according to Christensen and Laegried (2007), and the main trends were initially towards more horizontal and vertical specialisation resulting in a more disaggregated and often incoherent public sector. In the second generation of public sector reforms –following two decades of initial NPM reforms according to Bogdanor (2005) – there has been a move away from decentralisation, disaggregation, and single purpose organisations towards a whole-of-government (WOG) approach. This according to the authors is a trend evidently seen in Australia and New Zealand, regarded as the pioneers of NPM, and was also happening in other goverments as well(Bakvis & Juillet, 2004 and Kamarck, 2004). WOG is an attempt to better coordinate all levels and sectors of government so as to improve public service delivery (ibid). The South African government has also attempted this approach by establishing a Planning Ministry and a Monitoring and Evaluation Ministry in the Office of the President. The Cabinet also operates within a framework of clusters. However the challenge of having appropriate oversight, adequate public accountability, a general lack of transparency and an increase in corruption in the awarding of tenders (often seen globally) within the NPM paradigm has seen the shift of focus of NPM from efficiency towards an emphasis on governance according to Lynn (2007).

This later changes in public administration reform according to Pollitt and Bouckaert (2004) was to reform the structures and process of public sector organisations with the objective to make them run better. These include structural and process changes. Structural changes include: retrenchment or downsizing the public sector organisation, aggregating or disaggregating the departments in order to improve coordination or encourage specialisation, privatisation, decentralisation and corporatisation or agentification. While process changes include: hands on professional management, private sector approaches to management practice such as performance management agreements, flexibility in operations and practice, and the adoption of market type mechanisms which includes modernisation of service delivery methods.

Public sector reform in Africa has been varied with some countries taking up NPM reforms more than others (Economic Commission for Africa, 2003). The African State is believed to

be stretched to the point that urgent reform is needed. What is recommended are reduction in the size of its governments, refocusing on core services to the public and reengineering of its activities using business process reengineering principles. The Commission recommends better incentives for effective performance to be put in place so as to strengthen economic sustainability and improve the efficiency of the state. Many of these proposals are inspired by NPM principles, the main proposal was to put in place, within those sectors of the public service that are not privatised, the performance incentives and the competitiveness that exist in the business environment. The move towards meeting civil society needs more efficiently and effectively forms part of a package of reforms in the public sector making way for the introduction of market orientated public management methods. A significant number of African countries such as Ethiopia, Ghana, Mauritius, Senegal and Uganda, have embraced substantial reforms planned at improving the quality of life of their populace, and establishing new government institutions to establish efficient and effective public service delivery systems. However, the Commission states that despite the amount of resources invested in reforms by these governments, little progress has been made. Accessible health services, education and housing still remain out of reach for many communities. With a few notable exception of successful cases of public sector reform (such as Botswana for example), public service delivery remains at a sluggish state according to the Commission. The following recommendations are made by the Commission:

for the successful implementation of public sector reform programmes in Africa:

i) African public services should adopt NPM, which includes, Performance Oriented Civil Service, Total Quality Management, Decentralisation, Pay Reform, Commercialisation and Customer-Driven Government.

ii) Performance contracting and commercialisation techniques should be recommended for the management of public enterprises that are not privatized;

iii) Fundamental changes in the accounting system should be introduced, to accommodate cash accounting as well as accrual and capital charging;

iv) Government should institutionalize a competent, efficient and accountable system of governance that offers an enabling environment for private investors.

The regulatory and law enforcement functions need to be performed strictly to protect consumers and citizenry from unscrupulous investors; and

v) African governments should establish Work Improvement Teams (WITs) as a means of enhancing the quality of services, through increased productivity and teamwork. Governments need to emphasise reforms that enhance efficiency in the public services, value for money, financial and managerial activity.

(Economic Commission for Africa, 2003, p. 50)

In both developed and developing countries, the damaged perceptions of the public service was exacerbated further as governments held the expensive public sector responsible for its budget deficits and fiscal crisis, and they therefore introduced market-driven policies and service reforms in line with the NPM paradigm to try and address these(Haque, 2004). The globalisation of NPM has also been influenced by various international actors such as the World Bank, the International Monetary Fund, the World Trade Organisation, the Asian Development Bank, the African Development Bank, the Inter-American Development Bank, and the United Nations Development Bank according to Haque. The push for neo-liberal policy preferences in developed nations, encouraged these international institutions to have an anti-state policy stance, and imposed private sector based public sector reforms (in line with the NPM model) on developing nations during the 1980s and 1990s. There are also mega-regional organisations - including the Organisation for Economic Co-operation and Development (OECD), the North American Free Trade Agreement (NAFTA), the European Union (EU) and the Asia-Pacific Economic Cooperation (APEC) – which all have advocated NPM style reforms in the public sector – often as a conditionality of the loans that they offered. In addition, many international management consultancy firms and public management experts have played a significant role in packaging and selling the principles of NPM to governments worldwide (Haque, 2004).

In questioning if NPM is appropriate for Africa, Vyas-Doorgapersad (2011) in his review of its implementation in Africa has found this varied. The common elements of NPM as practised in African countries according to this author include:

(i). Decentralisation or decentralising management which involves disaggregating and downsizing of public services. Decentralisation includes deconcentration, delegation, devolution or privatisation. This has not happened in the present health sector reform in South Africa or anywhere else in Africa in any substantive way particularly as regards direct delivery of health services.

ii). Contracting out is an alternative term for outsourcing which means contracting, sub-contracting or externalising non-core activities to free up cash, personnel, time and facilities for activities. This has potential within current health sector reforms particularly as regards laundry, cleaning services, security and food provision in the short term and the envisaged purchaser-provider split of health service delivery in the long term. But this will require massive investment in training and use of appropriate financial and health information systems to be put in place with the appropriate professional and technical support.

(iii). Performance Contracting which is an instrument to reform state-owned enterprises. Performance based contracting in Uganda, Democratic Republic of Congo and Rwanda is an outcome-based approach to improving health services delivery (Johannes, et. al., 2011). So far this has been inappropriately implemented in the South African public health sector and what is need is an overall review bringing elements of what is required by the OHSC, the NHI and linking individual performance to institutional performance appropriately.

(iv). Corporatisation is an emerging trend that involves converting civil service departments into free standing agencies or enterprises, either as a part of the civil service or completely outside it. South Africa has embarked on this form of NPM in its creation of many of its State Owned Enterprises (SOE's) such as the establishment of the Companies and Intellectual Property Registration Office (CIPRO) but with mixed results (Chipkin and Lipietz, 2012).

Some of the other new techniques that have been adopted in some parts of Africa include performance management systems (Botswana, South Africa, Uganda); pay and grading reform (Ghana, Mozambique, Guinea and Tanzania), operational and management control systems (South Africa, Ghana, Nigeria and Mauritius), total quality management and information and communication technologies in service delivery in many African countries. (Vyas Doorgapersad, 2011). These again have some successes but mostly have not been sustained. Larbi (1999) argues that the new public management approach may not be a

panacea for the problems of public sector management particularly in crisis states, but a careful and selective adaptation of some elements to certain sectors may be beneficial.

A review of the NPM literature also indicates an emerging opposing view focusing on the weaknesses of NPM and whether it's still relevant or not (Boston, 2009). Drechsler, (2005, p. 10) articulates this quite well in his paper on "The Rise and Demise of the New Public Management" where he concludes that: "The price paid for NPM reforms has been high…The optimal solution for this is a genuine post-post NPM system, Weberian-based but with the lessons from NPM learned, …..which puts the human person into the center of administrative decision making."

Some of these changes point to failings of the NPM. Privatisation, corporatisation, decentralisation and agentification without independent and autonomous monitoring and evaluation (appropriate accountability frameworks) of these institutions may produce corruption and lead to abuse. Incentivisation in the absence of disincentivisation does not work. Whole-of-Government, collaborative government, public-private partnerships or joined-up government is not sustainable in the absence of shared trust between the associated partners according to Pollitt and Bouckaert (2004). Also, one cannot have a good quality of government without competent civil servants. The permanent adaptation of NPM is defined succinctly in the following sentence: "different circumstances demand different managerial tools". This represents public value pragmatism according to Alford and Hughes (2008, p. 130). The aggregate of terminology according to these authors informs the key mechanisms of NPM, which are people: "People for People" as the new NPM mantra. The new PM needs capable and dedicated managers, who carry out the appropriate policies and provide public services to the citizens in a manner that are efficient, effective, ethical, accountable, responsive and able to adapt easily to different conditions. This can only be done if there is sufficient decentralisation and delegation as well as appropriate performance measurement and accountability.

The focus of this research therefore was to unpack these principles as viewed from the CEOs perspectives as well as understand them in the context of NPM reforms and policies that

pushed for the decentralisation of management, the development of performance and accountability mechanisms, as well as the appointment of competent and skilled CEOs of public hospitals in South Africa. The research also explores how these changes in the current South African public health system impacted on CEOs of public hospitals (as senior health service managers) ability to deliver good quality of care. In terms of the new Policy on the Management of Hospitals (South Africa, 2012) there is elaboration on the structure and functioning of hospital boards as well with the aim of improving governance and accountability at public hospital level. The requirements and roles and responsibilities of the CEOs of hospitals are also broadly defined. Administration is necessarily embedded in public law and political institutions and customs, and the consequences of state-building forces for governmental institutions and performance is of fundamental importance (Lynn, 2006). In the South African context the lack of enabling legislation was assumed to be a major impediment in implementing hospital management reform but it appears that now with the necessary political will and the enabling statutes that were proposed such as the Policy on National Health Insurance (South Africa, 2011a) and the Policy on the Management of Hospitals (South Africa, 2012) this has changed. There is now some policy direction and an enabling policy framework to ensure government delivers on promises it makes.

As the NPM becomes more results orientated the significance of the results measuring process (i.e. performance management) has increased markedly. This however is inextricably linked to delegations and accountability within a legislative framework. It must be noted that there has been substantial literature expressing disapproval of NPM protagonists views in that they ignore the history of reinventing government (Williams, 2000) and that are often too naive in their criticism of traditional public administration (Riccucci, 2001). However for purposes of this research the NPM paradigm (as described above) is used as it is the prevailing public administration structure in advanced capitalist societies and is being increasingly used by developing nations. It is also still relevant locally as the South African government is using its principles and tools albeit not wholeheartedly because it does not want to create the impression that it is buying into its neo-liberal ideological roots as argued by Cameron (2009).

The theoretical framework based on the NPM paradigm and its key dimensions of improved productivity, marketisation, service orientation, decentralisation, appropriate policy and capacity in the public sector also informed the evolution of public management in South Africa. Its manifestation in particular as regards CEOs of public hospitals in South Africa is examined. What we can conclude is that the NPM paradigm has been influencing public sector reform in South Africa since 1994 and to a lesser extent health sector reform. The recently adopted legislation and policy announcement clarifies the future of the health system generally and that of CEOs in public hospitals in particular and places the research questions within a much more certain context than what prevailed in the past. What will be researched is whether these reforms as guided by NPM principles have worked or not as viewed by the CEOs themselves as well as by other key informants as outlined in this research. One such principle is that of performance management.

2.3**.2. Performance Management**

Importantly linked to the issue of New Public Management and its relationship to the effective management of public hospitals is the discourse on performance management and management accountability, and its measurement and research in the public sector in particular (Perry, 2009). These are also some of the NPM tools referred to by Kettl (1997, 2000) earlier on in this review. As can be seen from the discussion above NPM has become more results orientated and the importance of performance management has increased dramatically. However research on performance management is challenging and Perry (2009) elaborates on the development of criteria that informed this research agenda.

In New Zealand, personalised performance contracts have supplanted the rigid rule- and process-based civil service system. Public service managers are recruited on fixed term contracts and negotiate their performance outputs with their seniors or even with ministers depending on the level of appointment. There are performance rewards for excellent work and they can be dismissed if they are not meeting their negotiated outputs or targets. The agency managers (who are on performance contract to democratic governance structures independent of government), in turn, often hire their own senior managers and hold them

accountable through performance contracts. This performance managed, output based, contract-governed system has nearly entirely superceded the nation's traditional civil service system in New Zealand. (Kettl, 1997, p. 446-462).

With regard to developing criteria for this research reference is made to the work by Perry (2009). Perry argues that the criteria he developed in 1991 are still pertinent today and can be used for research on understanding human resource management generally. These criteria are useful for developing the research questions and determining what types of questions should be used to assess a strategic human resources research agenda. This is also useful in assessing performance as viewed by the practitioner (or as in this research CEOs of public hospitals in South Africa) and enquiring about their views of their ability to perform, what performance management systems are in place, have they sufficient delegation, are they held accountable and what do they recommend in improving their ability to perform better. The latter issue of delegations and concomitant accountability is according to the literature review and document analysis key to understanding some of the limitations faced by CEOs of public hospitals in South Africa.

The performance management implementation and its effect on hospitals particularly in developed countries have had a variety of impacts according to Christensen, Laegried and Stigen (2014, p. 120). They reviewed a new performance management system implemented in Norway using a Management By Objectives and Results (MBOR) performance management tool. They found that it undermined the informal trust based approach that traditional public administration relied upon and replaced it with a performance management system based on distrust and technical instrumental features. However performance management is seen as an essential part of the armamentarium of NPM and has been adopted within the South African public sector (South Africa, 1997) and this research also intended to assess its usefulness as perceived by the CEOs of public hospitals.

Dzimbiri also argues the case for performance management systems implementation in the public sector in Botswana (2008). Dzimbiri defines performance management as: "a strategic and integrated approach to delivering sustained success to organizations by

improving the performance of people who work in them and by developing their capabilities of teams and individual contributions" (Dzimbiri, 2008, p. 43-57). To improve the quality of public services delivered and to satisfy the consumer (the citizen), the Directorate of Public Service Management (DPSM) of the Botswana government set out to develop initiatives that was planned to improve public service delivery. From 1994 to 1997 the DPSM introduced a variety of reforms such as the introduction of Work Improvement Teams (WIT), a Performance Based Reward System (PBRS), Decentralisation and an Organisation and Methods (O&M) Review. However poor public service delivery continued. Government came up with another initiative of improving public service delivery processes by introducing Business Process Reengineering. This mainly through the use of performance management systems (PMSs) to secure efficient and effective public service delivery and to ensure the improvement and sustainability of higher productivity levels. The PMSs were piloted in a few ministries and eventually adopted by government. The outcomes of implementation and in particular as regards service delivery were positive ever since the introduction of PMSs. The main challenges were that it was not equally enforced in all ministries, there were not sufficient champions (performance coordinators) to drive these changes in a sustainable way and there were often insufficient funds to ensure performance payments that were adequate or appropriate. Other challenges relate to knowledge/information gaps, institutional roles and responsibilities, authority positioning and reform fatigue. Dzimbiri believes that PMSs have the possibility to improve the performance of the public system and augment its ability to provide efficient service delivery to the nation. Performance Management Systems are still an important NPM tool that needs to be customised to the institution or public service that uses it. Another question for this research is whether our public service PMSs are appropriate to our setting?

The view by Perry (2009) who has developed a strategic agenda for future performance management systems research informed the proposed research as well. Perry introduced several criteria for assessing important research for building our understanding of the human resources management field. These were informed by an analysis of the contents of leading human resource management journals. The journals collectively provided extensive evidence of human resource management research across many sectors and between

domestic and foreign contexts. The process informed the development of five strategic research agendas covering compensation, motivation, culture and political context, efficacy and effectiveness, and training and development. The selection criteria proposed was used in the development of the research questions and informing the agenda of this research, which focused on CEOs perceptions on issues of efficacy and effectiveness of the management of public hospitals mainly, and to a lesser degree to the other issues of motivation, culture and political context. These strategic research agenda items also assisted in developing the appropriate research questions for the in-depth interviews in particular. An area closely linked to issues of performance measurement is that of performance accountability and this is discussed next.

2.3.3. Performance Accountability

Another aspect of this research is to look at performance accountability from the viewpoint of the CEOs and other key informants of public policy and of public hospitals in South Africa. A worldwide expert in the area on accountability is De Lancer Julnes (2006, p. 1) and in her seminal article on the issue of accountability makes the following arguments that in the United States, commentators have settled on "oversight and compliance" as the most reliable description of the accountability concept. Related to this the operationalisation of performance accountability and for the purpose of this research the accountability will be understood as holding someone responsible for something or some action. Thus, De Lancer Julnes describes being accountable as being responsible for one's actions and subsequent consequences. This implies a direct causal relationship between actions and results, a point of contention for some commentators. The mechanism for holding a person or employee accountable is the domain of what Roberts (2002, p. 660) calls performance-based accountability, which "requires the specification of outputs and outcomes in order to measure results and link them to goals that have been set, in accordance with the norms of management practice".

Performance-based accountability according to De Lancer Julnes (2006) demands the need for performance measurement. This also requires the continuous collection of information

about an institution's service outputs and results as measured against its planned goals and objectives. This main importance of focussing on results for both accountability and performance measurement has been linked with the increasingly negative perception of how the public view how their taxes are being spent (Schein, 1996). The perceived poor delivery of services by government has created pressure from civil society demanding much more accountability in terms of outputs and results. Performance measurement with an emphasis on results or outcomes has been hailed as a way to deal with these pressures for results-based accountability (Hatry, 1997). Ferlie (2000) also looks at the question of accountability much more comprehensively. He suggests that one should first distinguish between political and managerial models of accountability. Political accountability ensures that those with democratic authority (such as politicians) are answerable for their promises and actions to the people. In contrast managerial accountability is ensuring that those with delegated authority deliver the agreed outcomes of performance (such as management by objectives or outcomes). It is more confined, circumscribed and less contestable than political forms of accountability (Ferlie, 2000, p. 121-138).

This development of the accountability concept from the assessment of inputs and outputs towards that of outcomes was also driven by the United States of America's federal government under the then US Vice-President Al Gore's National Performance Review initiative and which culminated in 1993 with the passing of the Government Performance and Results Act (GPRA) (Kettl,2000). Under the GPRA, federal agencies were to report on quantitative performance measures and targets. Hatry (1997) argues that this evolution of accountability was not limited to the United States and that similar practices unfolded in New Zealand and Australia. However De Lancer Julnes cautions in drawing lessons from elsewhere since her target audience is American but she does concede that the larger point as regards the internationalisation of performance measurement, with various countries providing lessons for each other are useful and noteworthy.

To summarise, De Lancer Julnes (2006) points out that the need for accountability in the government of the United States is determined in terms of the performance or results of actions of the public services. In this regard good performance has come to mean whether

the community or the constituents are satisfied with the way public services have been rendered. Current performance monitoring measures are called Managing for Results according to the author (ibid). These management improvement strategies were aimed at connecting the measures of performance to project or programme outcomes, and had to report continuously on the achievement of levels of performance. Governments can now show to their constituents what value for money they are getting for their taxes, how effectively their tax dollars are spent, and how expenditures benefit constituents' lives. The NSDA signed by the Minister of Health and The Strategic Plan of the National Department of Health details the deliverables promised to its citizens in a similar manner (South Africa, 2011a and South Africa, 2011b). The new Policy on Hospital Management creates the framework for accountability of the CEOs of public hospitals in South Africa through its job requirements and the establishment of hospital boards as its preferred governance structure in a very prescriptive manner (South Africa, 2012).

Performance measurement has been at the centre of current management reforms to improve accountability. As defined by De Lancer Julnes (2006, p. 161): "performance measurement is the regular and careful monitoring of planned implementation and outcomes". De Lancer Julnes concludes that given the increasing demands of calls for more accountability of government institutions by citizens the world over it is rational to put forward the argument that performance measurement will continue to be a major consideration in addressing such demands. This research assesses performance management systems and its applicability and usefulness from the perspective of CEOs of public hospitals. A top down view of experts in policy and management and a bottom up view by senior hospital mangers is also sought in this regard. However performance measurement by itself has its own challenges and what one has to guard against is the issue of performance paradox.

2.3.4. The Performance Paradox in the Public Sector

Authors van Thiel and Leeuw (2002) posit that there has to be awareness and caution about the possible negative consequences of performance measurement in the public sector, aptly

termed the performance paradox. They argue that whilst countries worldwide devote more attention and spend more money and time on performance measurement and evaluation of the public sector efficiency and effectiveness than ever before, there are unintentional consequences that may not only challenge conclusions about public sector performance but can also adversely influence that performance. They comment that the New Public Management (NPM) approach used by many governments ascribe a high priority to measuring outputs and outcomes. These governments aimed to develop and implement new policies and management activities from the information they got from the measurement of performance and this was intended to make policy implementation much more efficient and effective. However there have also been many unsuccessful attempts at introducing results-based management.

Results based management has also been adopted by the South African government, in particular its cabinet, to measure the performance of Ministers and their departments. The authors do acknowledge the need for measuring outputs and outcomes if we want to improve government's performance. However, they also describe that a number of unique characteristics of the public sector can be counterproductive to developing and using performance indicators, illustrated by different examples and these are described below.

NPM practitioners convinced politicians to focus on their main business, which is making policies to achieve political goals but that implementation should be left to the market or quasi-market environment. This separation of policy and administration is to be managed through performance contracts which details what tasks are to be carried out and by whom and what incentives were to be received and under what conditions. The executive agents' performance is defined in terms of performance indicators, such as the number of goods or services rendered. Input management has thus been replaced by a results-based orientation according to de Bruijn (2002). This appears to have also influenced current thinking around the implementation of the NHI (South Africa, 2011).

The performance paradox explains that there is a weak association between performance indicators and performance itself and the performance shortfall is caused by the general

inclination of performance indicators to lose measurable validity over time. According to van Thiel and Leeuw (2002) the deterioration of some performance indicators is due to four actions. The first is positive learning: that is, as performance improves, indicators lose their ability in detecting poor performance. The second is perverse learning, that is, when organisations or individuals have learned which aspects of performance are measured (and which are not), they use that information to game (falsify) their assessments. The third, selection, refers to the substitution of poor performers with better performers (akin to the healthy worker effect), which results in only good performers remaining, and the indicator loses its discriminating value. And fourth, suppression occurs when changes in performance are ignored.

A comment by van Thiel and Leeuw (2002) is illustrative. These authors report on the percentage of crimes solved by the Dutch. The percentage of crimes solved was decreasing in the period under study and indicated therefore that the police's performance was deteriorating. However, there were more perpetrators arrested, prosecuted, and punished than ever before, which should have indicated an improvement in performance. The authors show that crime patterns have changed in a way that invalidates this (well recognised) indicator.

Another example of the performance paradox is a case of overrepresentation which looked at the UK National Health Service (NHS). It was negotiated as part of a performance indicator that patients should not be on a waiting list for an operation for longer than 2 years. This measure seemed to work, as the average waiting time for an operation decreased. However, on further investigation it was found that because the waiting time was only counted after the first hospital consultation, consultations were postponed to decrease the waiting time (perverse learning). The indicator therefore did not accurately reflect performance, as the average waiting time did not improve at all but was merely pushed forward in time. The indicator reported an improvement where there was none. The two examples according to van Thiel and Leeuw (2002) indicated that a performance paradox can be invoked unintentionally (the police example) or deliberately (the health care example).

Accordingly, van Thiel and Leeuw (2002) and de Bruijn (2002) recommend that to counteract these unintended consequences of performance measurement in the public sector, performance assessment systems must take into account the unique features of the public sector. The challenging nature of the use of performance indicators often requires the use of not one but many indicators, referring to distinct aspects of policy implementation (both tangible and intangible) and taking into account the interests of the various stakeholders (politicians, managers, funders, providers, purchasers, and consumers). They recommend that equilibrium has to be balanced between too much and not enough measure pressure. The authors make mention of an example of a performance monitoring framework that appears to take into account these issues and was developed for the Council of Australian Governments (COAG) by the Productivity Commission to benchmark the performance in the education, health, housing and community service sectors. South Africa has still to develop such detailed performance monitoring frameworks in my opinion.

2.3.5. The New Public Management paradigm and its effect on public sector management in Africa and South Africa

The African experience of NPM was somewhat different to that of the western world according to Nicholas Awortwi (2006). Awortwi states that a number of African States have used market and private sector management techniques as prescribed by the New Public Management (NPM) paradigm to reform the government sector with varying degrees of success. The main reason for this according to Awortwi is that most African countries lack a professional bureaucracy upon which NPM critically relies upon. He suggests that the training and capacitation of government officials is important for the NPM changes to occur and makes a plea to training institutions to take up this challenge. But despite this Awortwi is emphatic that Africa is beginning to transform and he says this is because of globalisation imperatives, rolling back of state functions, public sector efficiency requirements and internationalisation of NPM, amongst other changes that have altered the way government is doing its work. However, Vyas-Doorgapersad (2011) concludes in his review that there has been varied results and few successes in the African experiences of NPM implementation.

The impact of the New Public Management paradigm on the public sector also had an impact in South Africa. Professor Robert Cameron (Cameron, 2009) answers two research questions. Firstly, to what degree has the South African public service been transformed by NPM reforms as compared to other reforms? And secondly, what has been the impact of these reforms? He suggests that although one of the main components of NPM was the move to the decentralisation of authority and responsibility to managers, in practice this has not occurred. There has been restricted delegation to Managers or Director-Generals by Ministers at National level as well as from Members of Executive Committees to Heads of Departments at Provincial level. He also contends in his paper that there has been a push towards a stronger central state in recent years with the idea of the developmental state and a joined-up government approach taking precedence over the initial NPM attempts to decentralise in the early year's post 1994. South Africa did attempt following some international NPM trends by for example reducing public service staff in the 1990s but this had negative repercussions as it led to an exodus of skilled staff.

After 2000 there has been recognition of the shortage of skills in the public sector and a move to targeted growth in order to create an appropriate and sustainable cadre of skilled and professional staff. Another NPM reform that was widely adopted was corporatisation in the form of public entities (over 800 State Owned Enterprises have been created in South Africa since 1994). However the majority of these public entities was created in the Ministries of Transport and Trade and Industry and was more to deal with functional efficiencies than following the NPM ideology. Contract appointments, and the creation of a generic performance appraisal system were also NPM reforms adopted in an attempt to create a more flexible human resources system but this has been patchy at best according to Cameron (2009) and inconsistently applied as were the rest of the NPM reforms. Cameron concludes that at the end of the day the ANC government (with strong pressure from its alliance members) was not fully committed to right wing Public Sector Reforms. In fact the then Minister of Public Services, Geraldine Fraser-Moleketi (2006), admitted that the government wanted to use NPM skills, tools and techniques without buying into its neoliberal ideological framework. This suggested a less than enthusiastic commitment to

NPM reforms and therefore relatively little attempts at decentralisation and an avoidance of delegation of authority to senior managers which confirms the central theme of this research. Polidano (1999) also concludes that in developing countries NPM ideas are quite prevalent but more so at the level of political rhetoric rather than practice. He also examines the argument as to whether the NPM is appropriate for developing countries generally or not and in particular because of the prevailing problems such as corruption and poor administrative capacity.

Further evidence of this reluctance to decentralise and delegate responsibilities to managers was confirmed by an earlier study by McIntyre and Klugman (2003) that showed that managers at the regional, district and facility level have a perception that they are excluded from the decision making processes and thus felt undervalued and disempowered. Although the study focused mainly on interviews with national, provincial and local health managers the findings also confirm the premise of the study that there is insufficient delegation of authority and that managers are annoyed that they are merely expected to implement decisions made by those above them without the appropriate support.

2.4. The World Health Organization's and other international proposals on improving health systems

The World Health Report 2000 called "Health Systems: Improving performance" (WHO, 2000), was the first World Health Report (WHR) that addressed the importance of having a good and fair health system as well as assessing its performance as critical in determining its impact on the health outcomes of any populations groupings. This report also informed HSR in South Africa. The report assists in understanding the real goals of health systems with its defining purpose being the improvement and protection of health. It also suggests that if policy-makers are to act on performance measures they need to have a clear understanding of the key functions of a health system which are viz. providing adequate health care services, producing the appropriate human and physical resources that make service delivery possible, raising and pooling the resources used to finance health care, and most

importantly addressing the issue of stewardship i.e. providing strategic direction for all of the different stakeholders involved.

In further developing its health systems strengthening framework the WHO defined six building blocks critical for an effective health system (WHO, 2007, p. 3) as follows:

1. Quality Health Services which deliver effective, safe, equitable, personal and non-personal health services to those that need them, when and where needed. It also emphasises the paramount importance of good management to maximise health service coverage, quality, and safety and efficiency and that autonomy which encourages innovation should be balanced by policy, programme consistency and accountability.
2. A productive health workforce that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given the available resources and circumstances are fairly distributed and staff that are competent, responsive and caring.
3. An appropriate health information system that ensures production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
4. A well- functioning health system that ensures equitable access to essential medical products, vaccines and technologies of assured quality and cost effectiveness and which are scientifically sound.
5. A good health financing system that raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.
6. Leadership and governance (although mentioned as the last building block this is the most significant, as all of the abovementioned will not succeed if this building block is absent or weak).

The WHO also elaborated further upon this in its series on Making Health Systems Work in its Working Paper No. 10 (2007) called “Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and

Management in Low-Income Countries 29 January – 1 February 2007, Accra, Ghana (WHO, 2007, p. 2-3) where it makes special mention in its proposed framework on the following as regards managers in the health services:

1. Ensuring adequate numbers and deployment of managers throughout the health system,
2. Ensuring managers have appropriate competencies (knowledge, skills, attitudes and behaviours),
3. The existence of a functional critical support system (to manage money, staff, information, supplies, etc.) and,
4. Creating an enabling working environment (w.r.t. roles and responsibilities, organisational context and rules, supervision and incentives, relationship with other actors).

In terms of creating an enabling environment the WHO framework requires clarification of the extent of autonomy, and clearly defined roles and responsibilities, a good match between roles and structures, the presence of national standards, rules and procedures and so on. The report highlights the importance of delegation of authority (over staff, budgets, etc.) as a particular challenge in the working environment in the health sector which relates to this research's main focus and recognises this as an international problem (WHO, 2007). The WHO does not make use of any NPM tools but argues the case for a move to strengthening health systems using their generic tools.

The literature review covered the theoretical framework of the study. In this it looked at an international overview of NPM, why it occurred and how it played itself out in different parts of the Western World either developing in the Westminster Model such as the UK or the Re-inventing Government Model in the USA. It also looked at the views of detractors of NPM and questioned its validity in today's world. Performance Management and accountability is also reviewed as a concept and its difficulty in research and application. The performance paradox is also discussed as a consequence of too much performance management. The literature review and the document analysis of the South African

experience with NPM and health sector reform and the role of CEOs are discussed as well. What is evident is that there has been tremendous transformation in the public sector and in particular the health sector in South Africa. The challenge of using the tools of NPM and not buying into its neo-liberal ideology has and will still be a key concern to the ANC led government. The South African government did adopt policies and legislation to implement the NPM paradigm and its most notable successes were in the Transport and Trade and Industry Ministries. The White Paper on the Transformation of the Public Service as well as the Public Finance Management Act was the most important pieces of policy and legislation enabling NPM reforms. However this has been patchy in particular in the Health Sector where reforms intended to decentralise health management and hospital management in particular has not sufficiently materialised.

The recent promulgation of the Policy on the Management of Hospitals and the current reforms undertaken by the Minister of Health (with the signing of his Negotiated Service Delivery Agreement) has set the health system on a more structured and determined effort to improve health services in general and hospital management in particular. With this comes more accountability at all levels of the services. The DBSA determination on what is an ideal CEO and the recent assessments of CEOs are also discussed. The literature review and document analysis highlights the challenges that CEOs have faced in defining their roles and responsibilities since 1994 to date and it contextualises this research within the public sector and health sector reforms that have taken place since 1994. The WHOs views on what is required for effective health systems are also presented. In terms of the literature review and document analysis there has been insufficient decentralisation of health management and that the politicians still exert a huge amount of influence on the ability of health service managers to perform. There has been insufficient enabling policies and legislation for CEOs of public hospitals to manage effectively until now. In terms of this research the argument is made that NPM is an appropriate lens to view health sector reform and the challenges CEOs face in the management of public hospitals in South Africa.

2.5. Conclusions

The major policy debates of the 1980s and 90s informed broad structural changes in government management practices in the UK and US and eventually other countries as well. Governments across the globe allowed new ideas such as NPM to lead a move away from the archaic centralised administrative practices of outdated governance to emerge from these trends in thought around management practices related to transaction cost economics, new institutional economics, public choice theory and new management theories. This is reflected on work by Kettl (1997, 2000, p. 67) and is articulated by Kettl as: "Management reform is not fundamentally about management. Elected officials do not pursue management reform for its own sake but because they believe it helps them achieve a broader political purpose".

This tension is and always has been between politics and management. The battle between what elected officials want, and delivering on what they promised to their constituents on the one hand and what management does and is allowed to do on the other hand. A sober evaluation of the evidence from the various studies, projects, findings, and recommendations of the various consultants, Ministerial committees and task teams indicates that to improve overall hospital service delivery decentralisation is critical within the South African context. Adoption of NPM principles can occur within the current legislative reforms such as the WPTPSD and WPHSR. What is needed is a reform of financial management, human resources management and procurement efficiencies, and to minimise wastage and corruption. That decentralisation of authority regarding these matters has to be devolved onto hospital CEOs and senior management within an appropriate accountability framework. This view is supported by all of the evidence adduced to above and by the State President Thabo Mbeki himself in his State of the Nation Address in 2006. That it has not been put into effect can only be attributed to a comprehensive failure of Government to implement policy imperatives until now. However current reforms under the leadership of the new Minister of Health, Dr Aaron Motsoaledi, indicates a determination to push reform, improve hospital management and restructure health care delivery fundamentally so as to improve the quality of health care to all South Africans.

CHAPTER 3: METHODOLOGY

The methodology introduces the research paradigm and argues why the qualitative approach is the dominant form of the research. It is followed by the research design and the research methodology. This research is essentially a sequential mixed methods approach combining a quantitative element with two qualitative elements subsequently viz. in-depth interviews followed by focus group discussions. This section discusses the activities of the research regarding the collection, collating, consolidating, and analysing of data to form an argument for the thesis. Validity of the study through triangulation is discussed followed by the limitations and ethical issues.

3.1. The Research Paradigm

The research paradigm used for this study was largely qualitative with an element of quantitative research, so it can be referred to as a mixed methods approach. However a brief discussion drawing on the literature will clarify how I decided on this particular approach. Creswell (2003) suggests that for designing a research proposal a general framework or context should be used to provide unambiguous guidance on all aspects of the study, from determining the general philosophical assumptions behind the investigation to the detail of the data collection and analysis methods to be used. Creswell also elaborates on three frameworks that exist for designing a research proposal: quantitative, qualitative and mixed methods approaches. As this study has elements of both qualitative and quantitative research paradigms it can be regarded as mixed-methods. However the strength in this particular study is that following quantitative survey of CEOs opinions on management challenges they face a further set of in-depth interviews with these CEOs were carried out to explore these issues and proffer solutions from their perspective. To add to the understanding of the context of these challenges in-depth interviews were also carried out with experts in public management and a focus group with senior hospital managers. These participants were all purposefully selected and this approach adds much more validity to the findings and is truly a reflection of mixed methodologies intent in my opinion. According to Creswell (2003) mixed methods approaches have come of age and he argues that to include only quantitative or qualitative methods falls far short of the major research approaches being used currently in the social sciences. Furthermore, other developments in

social sciences research have been advanced by for example Newman & Benz (1998) argue that the situation is less about qualitative versus quantitative research methodologies but how social sciences research practice lie on a continuum between the two. The most that can be said in modern day social sciences research is that studies tend to be either more quantitative or qualitative in nature. Bergman (2008) argues that these differences need to be re-examined and reconceptualised in order to benefit the mixed-methods approach. He argues that it contributes to a more robust approach to epistemology and lends itself easier to triangulation and therefore validation of findings.

Creswell (2003) postulated that although the mixed methods approach is not as well developed than either the quantitative or qualitative strategies in social sciences research, it is much more pertinent today than ever before. Mixed methods research involves the collecting and analysing of both forms of information (qualitative and quantitative) in a single study. Creswell further elaborates that in acknowledging that all methods have their limitations, researchers today, feel that any biases that emerge in any single method can be neutralised or cancelled if other methods are also used. Green, Caracelli & Graham (1989) proposed that the usefulness of the mixed methods approach is that one may help enhance or inform the other. Also one method can be nested within another method so as to provide deeper insight into the different levels or units of analysis. The reasons for the mixed methods approach have led writers around the world according to Creswell (2003) to create new techniques for mixed methods of inquiry. This has developed into the numerous forms of mixed-methods research described in the literature such as multi-methods, convergence, integrated and combined, and furthermore shaped procedures for research. In particular three general procedures in which these strategies have been used are:

1. Sequential procedures are where the researcher seeks to build upon or elaborate on the research results of one method with another method,
2. Concurrent procedures are where the researcher converges quantitative and qualitative data simultaneously so as to provide a comprehensive and detailed analysis of the research problem and,

3. Transformative procedures are where the researcher uses a hypothetical lens as an overarching point of view within a study design that uses both quantitative and qualitative data.

In this research I used the sequential procedure i.e. quantitative research (self-administered questionnaires) followed by qualitative research (in-depth interviews followed by focus group discussions) so as to get a more reliable and valid insight into the challenges faced by CEOs of public hospitals in South Africa. This choice is elaborated upon further in the methods section below.

3.2. The Research Design

A research design according to Badenhorst (2007) is like a route planner. It is a set of clear guidelines and instructions on how to answer a particular research question. The research question is the ultimate destination of the route. Durrheim (1999) defines research design as the strategic framework for actions that serve as a bridge between research questions and execution of the research. More plainly, research design according to Durrheim (1999) is a planned systematic observation guided by research questions and a design that is specifically planned in order to ensure fulfillment of the specified purpose of the research.

This section outlines the design of this study. The study design was carried out in phases, the first being an in-depth literature review and document analysis of public sector and health sector reform both internationally and specifically to South Africa. This was followed by a cross-sectional descriptive survey of a sample of 60 CEOs using a self- administered questionnaire. This was followed by in-depth interviews with 12 CEOs (from the sample of 60) and in-depth interviews with three policy management experts that work at the University of the Witwatersrand. This was followed up with focus group discussions with a few of the CEOs (from the sample of twelve included in the in-depth interviews) and four senior hospital mangers. The experts provided a top down view of PSR and HSR in particular and the senior hospital mangers provided up a bottom up viewpoint of the challenges facing CEOs of public hospitals in South Africa. The design includes an elaboration of the

methodology applied in carrying out the research and a discussion of data analysis within an interpretive paradigm using thematic analysis. In this research the researcher adopted a sequential mixed method approach with the qualitative paradigm as the main methodology. The quantitative paradigm is used initially in the use of a questionnaire survey of 60 CEOs of public hospitals so as to provide empirical evidence for the assumption that they lack clear responsibilities and accountabilities and that these are the main factors that impedes their effective management of hospitals. This furthermore informed the design of the next stage of the study which was in-depth interviews with 12 CEOs of public hospitals drawn from the initial sample of 60. This was followed by a smaller focus group discussion with a few selected CEOs from the 12 interviewed before with a view to verifying the thematic analysis findings and offer recommendations to improve the current situation if required.

The 12 in-depth interviews and focus group discussions with the CEOs were analysed and reflected upon. Subsequently, in-depth interviews were held with three experts in public management and with insightful knowledge of public sector and health sector reform in South Africa (Annexures 9 and 10). A focus group discussion was also held with a select group of senior hospital managers in order to validate the research findings as these were at a level just below the CEOs on the challenges faced by hospital in management of the institution and possible solutions. The latter two processes added more depth to the research in that it contextualised the CEOs perspectives (by having the experts view, a top down view) and further elaborated upon the lived experience of CEOs in running public hospitals (by having a focus group discussion with senior hospital managers, a bottom up view).

3.3. The Research Methodology

The third major element that goes into the research approach according to the Creswell model (2003) is the specific methods of data collection and analysis. In terms of the mixed methods research approach both predetermined and emerging methods were used in the form of document analysis, questionnaire survey, in-depth interviews and a focus group discussion. The one informed the other sequentially.

Creswell (2003) recommends that it is important to consider the full range of possibilities for data collection in any study, and to organise these research methods by their degree of importance in a predetermined way, their use of closed-ended versus open-ended questioning, and their focus for numeric versus non-numeric data analysis. In this study both open- and close-ended questions were used with multiple forms of data drawing on all possibilities with text and statistical analysis used where appropriate.

This section discusses the activities of the research regarding, collating consolidating, and analysing data to form an argument for the thesis. According to Creswell (2003) these activities develop in response to a need to elucidate the purpose of mixing quantitative and qualitative methods in a single study. As described before this study followed a sequential mixed method but utilised the qualitative research method as the main methodology. The premise of the study is based on the aforesaid research questions.

The study gathered data through a combination of a critical appraisal of the literature, document analysis, questionnaire survey, in-depth interviews and focus group discussions. With regard to the questionnaire survey the group's response was sought in relation to their views on their ability to manage public hospitals effectively, their delegations or lack thereof, the importance of clear performance management structures with appropriate authority and their willingness to be further interviewed for the study. This served to inform the development of the subsequent in depth interviews. In depth interviews were conducted with a purposive sample of these CEOs to explore their responses further in relation to how they viewed their ability to manage effectively. The purposive sample was selected from the survey study as those CEOs that agreed to be interviewed were selected on the basis of experience and where they work. This was followed by a smaller selected group of CEOs taken from the in-depth interview group, where suggestions on how these challenges are viewed as a group and how can it be appropriately addressed. The CEOs were drawn from the database of the University of the Witwatersrand's (Wits) School of Public Health where over 60 of the these CEOs details are kept – this from a National Department of Health's initiative to train CEOs in hospital management through an arrangement made

with the Universities of the Witwatersrand (Wits) and KwaZulu-Natal (UKZN) in 2005. Wits have largely focussed on Gauteng, Limpopo, the Free State, North-West, the Northern Cape and Mpumalanga Provinces, and hence the sample was drawn from these provinces (which approximates about 60 in total). Subsequent to this a further three in depth interviews were done with experts in public management that have particular insights in public sector and health sector reform in South Africa. Following on this a further focus group discussion was held with senior hospital managers from the public hospitals in Gauteng to gain an understanding of their perspectives of the challenges that CEOs face in running public hospitals and what are the possible solutions. This all was done to provide a very rich data set for the analysis.

3.3.1. The Quantitative Methodology

A quantitative approach according to Creswell (2003) is one in which the researcher primarily uses post-positivist approaches for developing knowledge, employs strategies of enquiry such as interventions or surveys, and collects data on predetermined instruments that yield appropriate statistical data. The quantitative methodology in this study was a survey of 60 purposefully selected CEOs using a self- administered questionnaire. The survey assessed in a quantitative manner whether managing effectively is a challenge, why it is a challenge and whether delegations or a lack thereof is a major determinant of management effectiveness for CEOs of public hospitals in South Africa. The research anticipated that although the total number of CEOs surveyed was about 60 a good response rate was anticipated and that truthful answers will be gleaned from the research because of the relationship established through the Hospital Management Programme. The purpose of conducting the survey was three fold; to acquire factual information on some aspects of the demography of the CEOs, the characteristics of the hospital (is it tertiary, regional, or district); to identify aspects in management effectiveness as defined by the CEOs (are they able to manage effectively) and is the latter closely associated with delegations of authority and performance measurement processes.

The other main reason for using a survey was to negotiate with CEOs for further access in order to engage in detailed data collection through an in-depth interview and subsequent focus group discussion (see Annexure 2 for the informed consent form). It was hoped that the CEOs would feel comfortable with further interviews once they had responded to the survey questions which indicated the reason for the research. Since the survey respondents were sought through a prior academic relationship (viz. the MPH Hospital Management programme) it was expected that this approach would put the CEOs at ease with the researcher.

The survey instrument was designed such that it sought confidential responses but requested CEOs who were willing to be further interviewed in an in-depth interview and focus group discussion to disclose their willingness to participate. The questionnaire was emailed back to the researcher.

The survey questionnaire was pre-tested on current MPH Hospital Management students. Pre-testing helped to identify problems that respondents may encounter in responding to the questions. The pre-testing also helped to check whether different respondents would interpret the questions the same way. Ultimately, the pre-testing of the survey instrument was expected to rule out biases or poor wording of the questions.

3.3.2. The Qualitative Methodology

A qualitative approach according to Creswell (2003) is one in which the researcher makes knowledge claims based mainly on constructivist perspectives or advocacy/participatory perspectives or both. The qualitative approach also uses methods of inquiry such as narratives, phenomenology's, ethnographies, grounded theory studies, or case studies. The researcher therefore collects open-ended, emerging data with the main intent of developing themes. As indicated earlier, this study utilised the qualitative paradigm as its main research methodology. The justifications for a more elaborate use of qualitative interviews for this research are founded on the purpose of this study. This research intended to capture the lived experiences and practises of CEOs of public hospitals in relation to management

challenges and delegations of authority, accountability and performance management and how they personally view these. To add depth to these opinions and to assist in understanding them further the views were sought of experts in the areas of public management and of senior hospital managers reporting to CEOs.

According to Denzin and Lincoln (2000) qualitative researchers believe that rich descriptions of the social world are critical in understanding complex social conditions such as found from first person accounts. Other reasons given on the importance for a qualitative study are drawn from Merriam's argument (1998). Merriam argues that qualitative research seeks to obtain an in-depth understanding of a phenomenon in order to discover what meaning people have constructed about that particular phenomenon. People attach new meanings and values to the issues that are confronting them in a rapidly changing public management environment. CEOs in particular have been given the attention of the Minister of Health, the provincial head offices and the media and these have initiated changes as discussed earlier that may have been perceived differently by the public (South Africa, 2010). It was therefore important to understand these pressures from a CEOs perspective as well as from experts in public administration and senior managers reporting to CEOs of a public hospitals. (Bateman, 2011).

Furthermore, according to Neuman (2011) qualitative researchers see almost all areas of social life as essentially qualitative. Qualitative data is not vague or deficient but highly meaningful. Qualitative research takes ideas from the people they study and places them within the context of a natural social setting. This was highly applicable to this study.

3.3.3. The Mixed Methods Approach

Creswell (2003) argues that the mixed methods approach is one in where the researcher bases knowledge claims on pragmatic grounds (e.g. consequence-oriented, problem-centred, and pluralistic). It involves collecting data either concurrently or sequentially to better understand research problems. The data collection involves gathering both numeric information (e.g. on the survey instrument in this study) as well as text information (e.g. on

the interviews and focus group discussion as well as the document analysis) so that the final data set has both quantitative and qualitative information. This research used a mixed methods approach with quantitative and qualitative research methodologies sequentially employed. This research based its inquiry on the assumption that collecting diverse types of data best provides a deeper understanding of the research problem. The study began with a broad quantitative survey in order to generalise results to the study population and then focused, in the second phase, on detailed qualitative, open-ended interviews to collect in-depth views from the participants. For example if the majority of CEOs in the survey acknowledge that a lack of delegations was a key obstacle to effective management then the subsequent in-depth interview took that into account. The survey also serves as gaining an entry point into this group of CEOs, making them aware of the study overall and inviting further participation. This was followed by a focus group discussion with a sub-group of the CEOs interviewed so as to validate the findings of the in-depth interviews and to proffer solutions going forward.

This was further extended to include in depth interviews of experts in public management to understand the context of the functioning of CEOs in public sector hospitals and current public sector and health sector reform. A focus group discussion with senior hospital managers of public hospitals was also carried out to further understand and validate the CEOs views and to look at possible solutions going forward. So in this situation the advantage of collecting both closed-ended quantitative data and open-ended qualitative data provided appropriate and in-depth information to best understand this research problem. This approach of mixed methods research captures the best of quantitative and qualitative approaches. This research follows Creswell's interpretation of the mixed methods approach to a degree but is much more dependent on the qualitative aspects in terms of its findings and analysis in that the first survey of CEOs using a self-administered questionnaire is used to generalise findings of the study population as well as to develop a detailed view of the meaning of a phenomenon or concept by these individuals through the in-depth interviews and to a lesser degree the focus group discussions.

3.4. The Data Collection

Four methods were proposed to collect data; document analysis, survey questionnaires, in-depth interviews and focus group discussions. Data was collected in four main phases as follows:

3.4.1. Phase 1: Initial Document analysis

Various documents containing data relevant to answering the research questions were analysed to inform the study. Thereafter, data relevant to this research was extracted from those documents and noted in the research notebooks. This initial phase of document analysis aimed to:

1. Describe and critically evaluate New Public Management and Health Sector Reform policies applicable to CEOs of public hospitals in South Africa.
2. Identify gaps in policies and plans in addressing the needs of CEOs to manage effectively.
3. Demonstrate complexity of the implementation of policies identified in 1 above and what future plans there are to address these.

Documents used were the relevant policy documentation from the National Departments of Health and Public Service, research done and published in the mainstream literature as well as research not published in peer reviewed journals but appropriate to the study. Any other sources of documentation such as newspaper articles as well as other media reports were used discretionally as cited before in the literature review and document analysis. This is presented in chapter 2 as background and in chapter 5 in the results and analysis. This was important in informing the development of the questionnaire and subsequently the in-depth interviews.

3.4.2. Phase 2: The Questionnaire Survey

A questionnaire survey of 60 CEOs was done initially (see Annexure 1 for the self-administered questionnaire). This was intended to explore in a quantitative manner the

challenges CEOs face in managing their hospitals and what delegations meant to them. The sample was taken from a database of CEOs from the MPH Hospital Management programme run at the School of Public Health from 2006 to date. All 60 CEOs from the class were then purposively selected and sufficient responses from each province and different types of hospitals were anticipated. A very good response rate (50%) was achieved as 30 of the 60 CEOs contacted participated in the survey (Ehrlich, Joubert, 2014). The questions were all closed-ended so that the questionnaire lends itself to quantitative statistical analysis. It was e-mailed to the participants, and confidentiality as well as anonymity was assured by coding the data and keeping the identifiers and codes under separate lock and key with the researcher. This was used when the sample was selected for the in-depth interviews. Informed consent was given by all the participants. The questionnaire was kept short so that it was easily filled in and returned. A high response rate was expected because of the existing relationship that the researcher had with these CEOs as MPH students. The CEOs were informed telephonically before the questionnaires were sent out and two reminder phone calls were followed through within the subsequent two weeks.

3.4.3. Phase 3: In-depth Interviews

From the 30 who responded to the self-administered questionnaires and who agreed to participate in the in-depth interviews a sample of 12 was selected for the in-depth interviews. Informed consent was first sought. The questions were open-ended and issues raised from the survey were further explored in depth. The main focus was to explore the CEOs lived experiences in terms of the challenges they face in managing hospitals, how they view their management effectiveness, the importance of performance management systems in their settings and particularly their delegations or lack thereof. Ultimately I wanted to explore their views on what they would possibly recommend to policy makers or senior managers in assisting them to manage their hospitals better (see Annexure 5 for the in-depth interview schedule).

The sample for the in-depth interviews was drawn using a purposive sampling method. CEOs from all the provinces targeted by the survey were included. CEOs that have operated for a

minimum of three years were chosen since entry level CEOs would not have yielded useful management related information. Also, the type of hospital being managed was considered in selecting the CEOs. Upon completion of the survey, those who had indicated an interest and willingness to be interviewed were followed up and assessed for their availability to be interviewed. It should be noted that in-depth interviews were conducted after a brief review of survey responses. A brief review of the survey responses aimed at obtaining an understanding of the perceptions, experiences and opinion of respondents from the survey and was used in formulating the interview schedule for the in-depth interviews. In-depth interviews with the willing CEOs sought to elicit a deeper understanding and interpretation of issues raised in the broader information produced in the preceding self-administered survey. Henning, Rensburg and Smit (2004) advised that the researcher needs to identify desirable participants who will travel with him on the journey to answer the research questions. The CEOs who responded positively to the in-depth interview had hospitals of varying sizes and responsibilities and this was important as it added nuances to the data from all hospital sizes. The respondents were contacted by phone to determine a date and venue for the in-depth interview. The in-depth interviews were intended to be conversations where the researcher is primarily a listener guiding the respondents into smooth transitions of topics albeit in a natural flow of information as provided by the respondent. At the end of each interview session, I affirmed in summary what the respondent meant. The affirmation was done by summarising the thoughts accrued and asking the respondents whether that was a correct interpretation of what the interviewer said. Interviews were not scheduled back to back. Rather a minimum of a day was allowed between interviews to enable the researcher to figure out the responses and write down process notes (things that happened but were not obvious from records) as well as analytical notes (ideas that arose upon meditating on the interview that risked getting forgotten) while the issues were still fresh in my mind. The responses were recorded with an audiotape and transcribed on the afternoon or evening of the interview session. Also, my reflections (views and feelings) were also recorded in the field notes immediately after the interviews before they were forgotten to aid in analysis of data.

The essence of interviewing the CEOs was to unpack the officials' understanding of issues raised by the survey (which is informed by the research questions) with regard to management effectiveness and delegation. The researcher also sought the CEOs experiences while administering the in-depth interviews. The strategies of interviewing adopted for the CEOs were in order to elicit rich data. The interviews were audio taped (see Annexure 6 for permission to audio tape).

After the interviews and focus group discussions with the CEOs were conducted and analysed a further set of in depth interviews were carried out with three experts in public management (with particular knowledge of public sector and health sector reform in South Africa). This was done so as to add context and further depth to the research and in particular add an objective outside perspective of the local discourse on NPM, PSR and HSR.

3.4.4. Phase 4: The Focus Group Discussion

After the in-depth interviews were done and analysed a sample of six CEOs who participated in these in depth interviews were selected to participate in a focus group discussion. Informed consent was sought and it was anticipated that the six CEOs from various provinces would join in the focus group discussion. Only two CEOs of the six who agreed arrived. Another two sent their responses to my proposed questions by email. The focus group discussion was facilitated by myself and focussed on clarifying management challenges as informed by the in-depth interviews with the main aim in making recommendations to improve management effectiveness with a special focus on delegations (see Annexure 7). The focus group discussion did not add significantly in addressing the issue of management directly affected by a lack of delegations and poor performance management systems. However they added some insight into the lack of awareness and involvement in the current health sector reform initiatives. A further focus group discussion with senior hospital managers that report to CEOs of public hospitals was held so as to get their views on the challenges facing hospitals in managing effectively. This was intended to add depth to the research and to validate the findings of the CEOs interviews and focus group discussions as well as offer another perspective to finding

possible solutions to the challenges. Focus groups are useful for concept exploration, generating new ideas and testing them, and determining distinguishing opinions between various groups (often stakeholders). Focus groups are often used as a means of triangulation with other data collection methods. Also, a guided discussion in focus groups more closely equates the unrestrained give and take of social discourse that goes into opinion formation which is often lost in the structured in-depth interview. Some believe that they are not intended to build consensus or make decisions but can inform the debates and discourse around research problems (Neuman, 2011).

3.5. The Data Analysis

Merriam (1998) defines data analysis as the process of making sense of the data that involves the consolidation and interpretation of what research participants have said. Regarding analysis, Merriam (1998) contends that data collection and analysis are best done simultaneously in qualitative studies. Blanche and Kelly (1999) add to Merriam's argument by stating that there is no clear point in time when data collection ends and data analysis begins in a qualitative research. Instead, data collection fades out gradually while data analysis fades in such a way that the researcher is mainly collecting data at the beginning and mainly analysing at the end.

The literature review and document analysis informed the development of the self-administered questionnaire. This was kept simple so that only key areas thought to be important could be covered in a simple yes, no, don't know format. The survey responses were analysed using a standard statistical package, Epi info version 7, widely used to derive findings in health sciences. The analysis of the survey comprised mainly descriptive statistics in the form of frequency of responses chosen in the survey. The responses were further analysed with analytical statistics using t-tests and confidence intervals where appropriate. The sample size was too small to do in-depth any further analytical tests. Non parametric tests such as Chi-Square tests were carried out to assess if there were statistically significant differences between the various groupings whether it be by province, experience or demography. However because of the small sample sizes it did not provide any valuable

information. The data is presented with Confidence Intervals. The data also subsequently informed the development of the qualitative data collection tools viz. the in-depth and the focus group interview schedules.

The qualitative data was analysed using a thematic analysis technique (Aronson, 1994). Atlas ti was used. In thematic analysis the task of the researchers is to identify a limited number of themes which adequately reflect the textual data (Braun and Clarke, 2006). The in-depth interviews lend themselves to the following themes in terms of how CEOs view management challenges in the public sector in South Africa, how do they understand management effectiveness and how do current delegations or the lack thereof assist or mitigate against them managing effectively. Also, does the current performance management system assist or impede them in their ability to perform well. The focus group discussions main aim was to proffer solutions or recommendations in terms of the above thematic considerations. The focus group were also asked on their awareness and engagement with current health sector reform initiatives. These interviews (both in depth interviews and focus group discussions with the CEOs) were further tailored for in depth interviews with the public management experts. This was done in order to understand the challenges that the CEOs face in the current context of public and health sector reform in South Africa (top down). The further focus group discussion with the senior hospital managers was held to get a bottom up view of the challenges that CEOs face and what possible solutions there are. However the study was also open to any other themes that emerged.

3.6. Validity

The validity and reliability of data was promoted by the use of triangulation of the survey, the in-depth interviews and the focus group discussions. Blanche and Durrheim (1999) define triangulation as the use of many different methods in collecting data and reaching out for data from as many sources as possible. Triangulation is an effective technique that enables the validation of data through cross verification from more than two sources, or in the social sciences research arena, it refers to the application and combination of several

research methodologies in the study of the same phenomena so as to get consistent answers. Blanche and Durrheim go on to explain that the researcher can triangulate both the methods by for instance analysing data both qualitatively and quantitatively. In this research, both method and data were triangulated. The multiple sources of data, which includes the survey and in-depth interviews followed by the focus group discussions, was a data triangulation strategy employed to enable the researcher to obtain different inputs from people. This multiple use of data collection methodologies employed in this research contributes to the depth and validity of the findings in a unique way in that two sets of in-depth interviews were held (with CEOs and public management experts) and two sets of focus group discussions were held (with CEOs and senior hospital managers). This data was then checked for congruency in the messages that it could be sending as possible answers to the research questions.

Method triangulation was also employed since the document analysis data was analysed to give a contextual picture of the challenges facing CEOs of public hospitals in South Africa and the concurrent unfolding of policies that impact on their roles and abilities to function adequately. In addition to the triangulation above, adequate time was spent in collecting data so that the data became saturated. Depth and richness of data was considered a strength in promoting the quality of research so that the results were as empirical as much as possible. The approach of utilising information derived from preceding interviews to draw information in subsequent interviews was aimed at digging deeply, richly and holistically in order to validate data. Consequently, the two sets of in-depth interviews were used to promote depth and richness of data. The data generated was enriched and further validated by the two sets of focus group discussions through the triangulation process.

3.7. Limitations of the Research

The main limitation was that the majority of participants of this study were CEOs attending the MPH in Hospital Management at the University of the Witwatersrand. This limited the sample size considerably since there are many other CEOs of public hospitals in South Africa. The decision to sample from only five of the provinces in the country was due to limitations

in terms of both monetary and non-monetary resources such as time. This limitation, on the advice of the defence panellist, was subsequently addressed by interviewing three experts in public management and a further focus group discussion with senior health service managers within public hospitals. However, by collecting data from multiple sources in order to derive the varying nuances that were likely to yield adequate data for a thick, detailed and truthful description and understanding of the research question.

3.8. Ethical Issues

Ethical permission to conduct the study was given by the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand (No. H121001, Naidoo). All information collected from the CEOs were anonymised and kept confidential, except for the focus group discussions where confidentiality could not be guaranteed (see Annexures 2, 3 and 4). No names were captured on the self-administered questionnaire or in the in-depth interviews. Codes were used to anonymise the survey and in-depth interviews and the names and codes of respondents were kept in a safe place. Personal autonomy was respected through an informed consent information sheet where the CEO as well as senior hospital managers who were invited to participate (in the survey, in-depth interviews and focus group discussions), and the confidentiality as well as the right not to participate was assured. The potential benefit of the study was explained and no harm expected was also elucidated. However the in-depth interviews with the ascent from the experts was not kept confidential. A feedback process was explained as there is an ethical need and responsibility to report back on the findings.

3.9. Conclusion

The Research Methodology is described in this chapter. The Research Paradigm that was used in this study is largely qualitative and the rationale for this was to get an in-depth understanding of how CEOs of public hospitals view their managerial challenges. A sequential procedure was adopted using document analysis followed by quantitative research (a self-administered questionnaire). This was followed by qualitative research (in-

depth interviews and by focus group discussions). The document analysis was a critical appraisal of the literature, government documents as well as unpublished literature. The quantitative research was a cross sectional descriptive survey of thirty CEOs (sample size was 60). This was followed by the qualitative research which included in-depth interviews of 12 CEOs as well in-depth interviews of experts in public management. The research was concluded with a focus group discussion of a few of the CEOs that were interviewed as well as a purposive sample of senior hospital managers. Quantitative data were analysed using a standard statistical package (Epi Info version7) and qualitative data were analysed thematically using Atlas ti. Validity and reliability was promoted by the use of triangulation. The main limitations of the study were that it confined itself to CEOs that attended postgraduate training at the University of the Witwatersrand and were known to the researcher. Furthermore the study was limited to 6 provinces in South Africa and CEOs were purposefully selected for the qualitative part of the research. All information collected from the CEOs was anonymised and kept confidential.

This study would not have been validated if the research only based its findings on the views of hospital CEOs only. To deal with this limitation (measurement bias and information bias) the research question had to be viewed through other perspectives. In depth interviews were therefore conducted with experts in public management to understand the context of the research problem in relation to current public sector and health sector reform context of South Africa. A further focus group discussion was also held with senior hospital managers of public hospitals. This to get another opinion (from health policy experts offering a birds eye view from the top down) as well senior hospital managers on how the CEOs of public hospitals view the challenges they face and to explore possible solutions from their perspective being closer to the coalface.

CHAPTER 4: RESULTS AND ANALYSIS

4.1. Introduction

The results and their analysis are presented in this chapter. The initial phase of the research was the literature review and document analysis as described in chapter 2 and this informed the subsequent (sequential) methodology of the quantitative research (the questionnaire survey) as well as the qualitative research (in-depth interviews and focus group discussions). These two aspects of the results as well as its analysis are presented in this chapter. The analysis, interpretation and triangulation of these findings are also presented.

4.2. The Quantitative Analysis

The MPH in Hospital Management training programme at the Wits School of Public Health had a total of 90 students for the intake period 2006 to 2008. Of these 90 students 30 had exited the programme before completing. The remaining 60 were all contacted by email and invited to participate in the study. They were all sent self-administered questionnaires and information sheets for written informed consent (see Annexures 1 and 2). The questionnaires were sent twice in December 2012 and again in January 2013. A total of 30 responses were received (Response Rate of 50%) and the results are described below. This was as an good response rate as the usual expected response rate in a postal questionnaire is below 30% (Ehrlich and Joubert, 2014, 113-114)

Age

The mean age of the respondents was 52, 5 years and the range was 40 years to 62 years. (t-test 0.67, p value = 0.51). These were in line with the DBSA requirements as far as average ages of CEOs are concerned. They view as a marker, indirect as it may be, of experience.

Years worked as a CEO

The mean years worked as a CEO was seven point seven years and the range was one year to 13 years. This demonstrated that in the main the CEOs had substantial hospital management experience. The mean required or suggested by the DBSA was about 6 years of experience in any form of health management before appointment to a CEO position

Educational Qualifications

All the respondents had some form of higher education ranging from Bachelors in Nursing (BACur), Medicine (MBBCh), Masters in Public Health (MPH) to Masters in Business Administration (MBA). These are presented in Table 6 below. There is a spread from health professional degrees to master's degrees in health and administration. The most common qualification was the MPH (nine out of the 30 had an MPH as an additional qualification). This also meets the suggested requirements as espoused by the DBSA findings.

Table 6: Educational Profile of CEOs

	Frequency	Percent
BACur	1	3.33%
BACur, DPH	2	6.67%
BACur, MPH	1	3.33%
BACur,DPH	1	3.33%
BACur,MPH	1	3.33%
BComm	1	3.33%
Bcur,DPH	1	3.33%
Bcurh, MPH	1	3.33%
BDentTx	1	3.33%

HonBach	1	3.33%
Masters	2	6.67%
MBBCH, MPH	1	3.33%
MBBCH,MPH	1	3.33%
MBBCh+	1	3.33%
MBBCH+	2	6.67%
MPH	9	30.00%
MPH, MBA	1	3.33%
MPH,MBA	1	3.33%
ND, NHD, DPH, MPA	1	3.33%
Total	30	100.00%

In summary then the 30 CEOs who returned the self- administered questionnaires would have easily met the criteria of the Policy on Hospital Management (South Africa, 2012) and the criteria for appointment as recommended by the DBSA (2010).

Gender and Race

The majority of respondents were male (53%) and Black African (86%) and represents a fair reflection of racial transformation in public hospital management. In terms of the transformation agenda of the government this can be regarded as a success where females were nearly half of the CEOs surveyed and the majority were Black African. See tables 7 and 8 below.

Table 7: Gender profile of CEOs

	Frequency	Percent
Female	14	46.67%
Male	16	53.33%
Total	30	100.00%

95% Conf Limits F 28.34% - 65,67% and M 34.3%-71.66%.

Table 8: Race profile of CEOs

	Frequency	Percent
Black	26	86.67%
Coloured	1	3.33%
Indian	1	3.33%
White	2	6.67%
Total	30	100.00%

Hospitals and Provinces

The majority of respondents worked in District Hospitals (60%) and were from the Gauteng Province (53%). See Table 9 and 10 below.

Table 9: Distribution of CEOs by type of hospital

	Frequency	Percent
Central	3	10.00%
District	18	60.00%
Regional	8	26.67%
Tertiary	1	3.33%
Total	30	100.00%

Table 10: Distribution of CEOs by province

	Frequency	Percent
Free State	4	13.33%
Gauteng	16	53.33%
Limpopo	3	10.00%
Mpumalanga	2	6.67%
Northern Cape	1	3.33%
North West	4	13.33%
Total	30	100.00%

The majority of respondents as indicated above were from District Hospitals, followed by Regional, Central and Tertiary hospitals. This reflected the proportions of these hospitals in the country. The District Hospitals operate at district level and have family physicians as their main medical work force. The Regional Hospitals have a few more specialist services with substantial specialist medical support. Tertiary hospitals provide for much more specialised and sub specialty services and are often the last resort in the referral pathway. The central hospitals (there are only ten in the country) offer sub-specialty services (such as transplant services) and are often linked to academic training institutions. Most of the

respondents were from Gauteng Province and the rest were from the Free State, Limpopo, Mpumalanga, Northern Cape and North West Provinces.

Familiarity with Department Policies on Management

The majority of participants (93,3%) responded 'yes' to the introductory question on whether the respondent was familiar with departmental policies that govern the way they managed and is presented in figure 3 below.

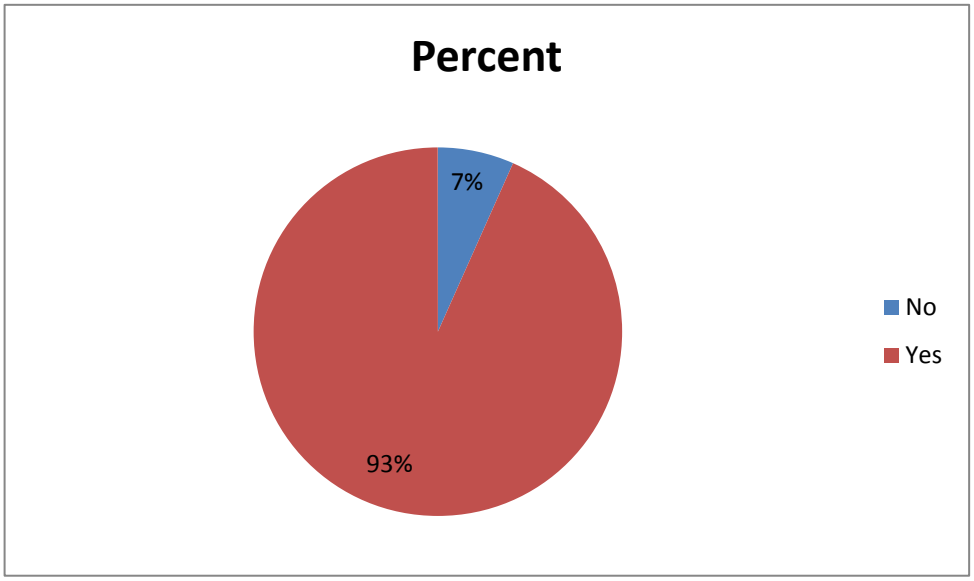

Figure 4: Familiarity with Department Policies on Management

95% Conf Limits No 0.82%- 22.07% and Yes 77.93%-99.18%

It appears from these responses that there are some enabling policies for management at a decentralised hospital level throughout most provinces.

Performance Management Systems

Eighty seven percent responded 'yes' to the question on whether there are performance management systems for CEOs in place in their provinces as presented in figure 4 below.

Performance management and appropriate accountability frameworks are critical in the implementation of NPM managerialism approach. It appears that some of these NPM tools, i.e. performance management and accountability, are being used currently.

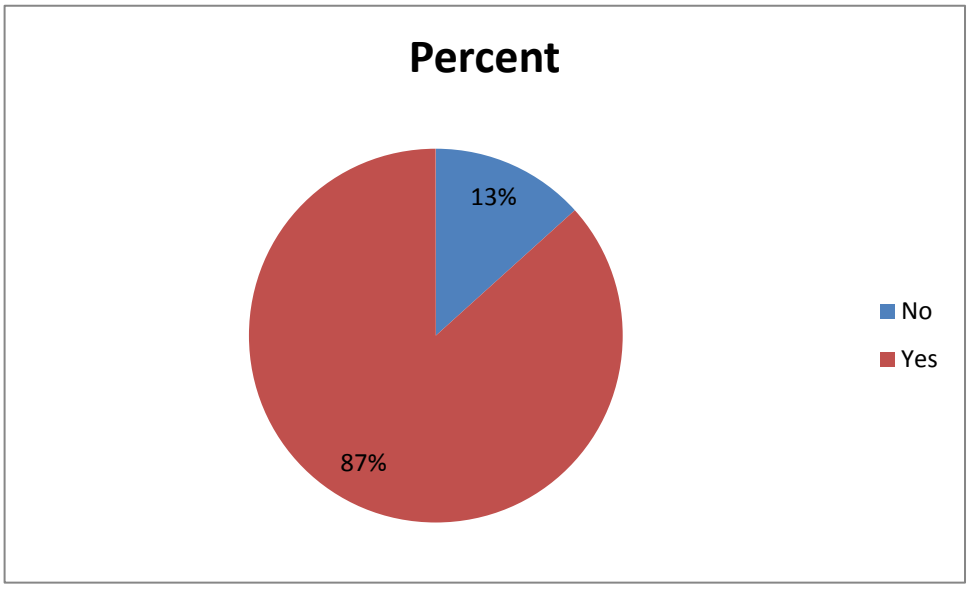

Figure 5: Awareness of Performance Management Systems in place

95% Conf Limits No 3.76%-30.72% and Yes 69.28%-96.24%

Management Delegation Guidelines

Seventy nine percent responded 'yes' to the questions of whether there is management delegating guidelines for CEOs in their provinces as presented in figure 5 below. So contrary to my hypothesis that the lack of delegations is the main reason that CEOs cannot manage effectively there does appear to be some delegations in place. This was to be investigated further in the in-depth interviews.

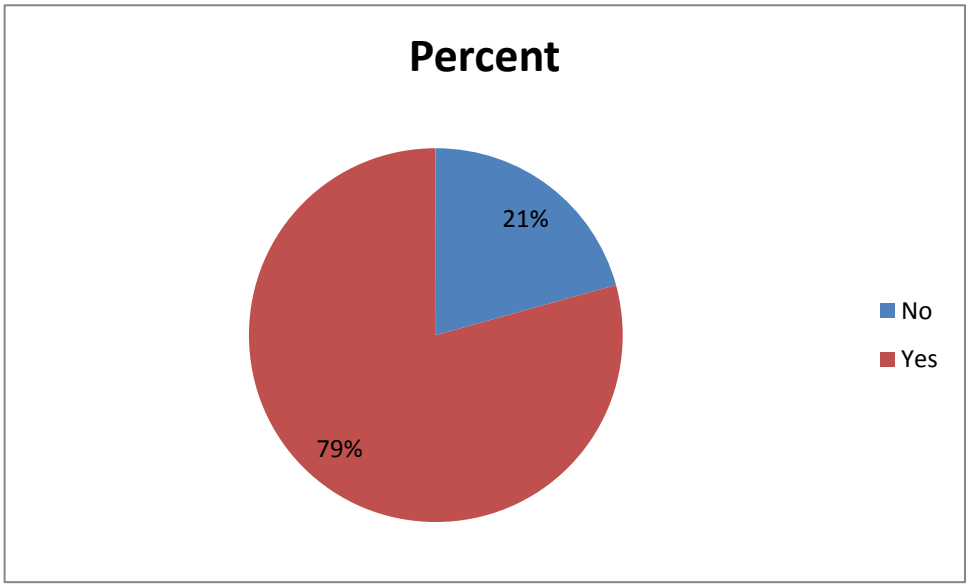

Figure 6: Awareness of Management Delegation Guidelines in place

95% Conf Limits No 7.99%-39.72% and Yes 60.28%-92.01%.

What are CEOs measured against?

On the questions on what CEOs in the province are measured against 57 % said 'no' compared to 43% who said 'yes' as regards budget. An equal number (48,3%) responded positively as well as negatively as regards being measured against health outcomes. When asked whether CEOs are being measured against staffing 73% of the respondents said 'no' and 27% said 'yes'. And as regards being measured against quality of care 73% said 'yes' and 27% said 'no'. See table 11 below. This gives the impression that some other NPM tools as regards quality of care and health outcome measures are also being used.

Table 11: What are CEOs measured against?

	Yes	No
Budget	43.3%	56,7%
Staffing	48,3%	48,3%
Quality of Care	26,7%	73,3%
Health Outcomes	73,3%	26,7%

Ability to manage effectively

The majority (86,2%) of respondents said 'no' to the question on being able to manage effectively in the current circumstances. This is probably the most important finding of the self-administered questionnaire survey. So despite their being departmental policies, some delegations and measures of performance the majority of CEOs believe that they unable to manage effectively. Effectively can be a broad term to describe both efficiency and effectiveness and was explored further in the qualitative interviews. It is described in figure 6 below.

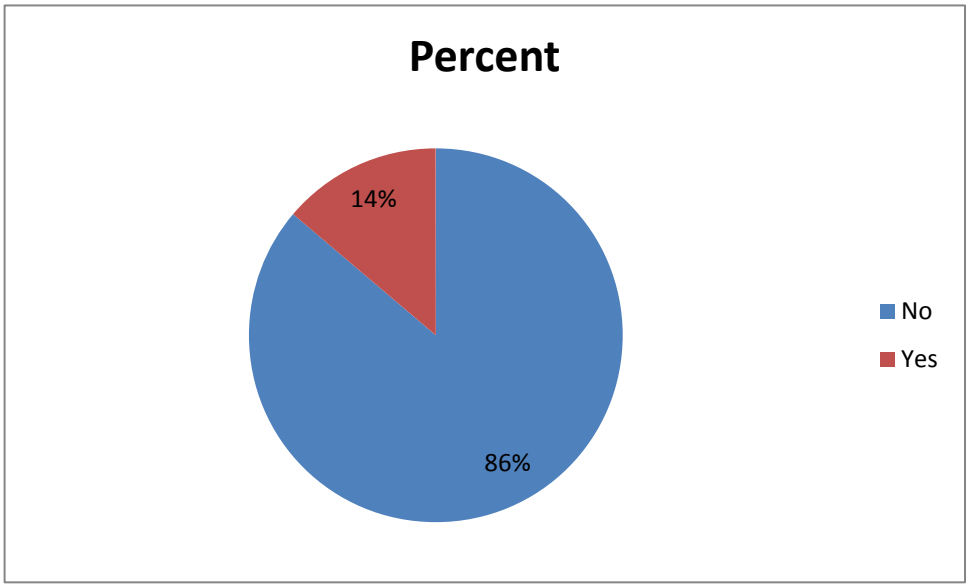

Figure 7: Ability to manage effectively

95% Conf Limits No 82.78%-99.92% and Yes 0.08%-17.22%.

Are there sufficient delegations to manage effectively

The majority (96,7%) of respondents said that they had insufficient delegations to manage their budget and most (73,3%) of the respondents said that they had insufficient delegations to manage health outcomes. All (100%) of the respondents said that they had insufficient delegations to manage staffing. Seventy percent said that they have insufficient delegations to manage quality of care. Figure 5 indicated that there was awareness and presence of some delegations but when asked specifically on budget, staffing, health outcomes and

quality of care but when asked around the delegations of these management issues the majority felt that they had insufficient delegations except for health outcomes. This contradiction is explored in the qualitative part of the study. See Table 12 below.

Table 12: CEOs opinions on having sufficient delegations to manage effectively.

	Yes	No
Budget	3,33%	96,7%
Staffing	0%	100%
Quality of Care	26,7%	70%
Health Outcomes	73,3%	23,3%

Areas of performance that can be improved.

The majority (90%) of respondents agreed that budget is an area of improvement that should be considered to improve performance. Most (96,7%) of the respondents felt the same about health outcomes and about quality of care and slightly fewer (93,3%) felt the same about staffing as demonstrated in Table 13 below. The question on the degree of delegations that needs to improve particularly around budget, health outcomes as well as quality of care is now a recurring theme that CEO's feel that they are unable to address adequately.

Table 13: CEOs opinions on which areas of delegation need to improve so that performance can be improved

	Yes	No
Budget	90%	6,7%
Staffing	93,3%	3.3%
Quality of Care	96,7%	0% (3,3% DK)
Health Outcomes	96,7%	0% (3,3% DK)

The main criteria for assessing performance

Most of the respondents felt that budget control (73,3%) and health outcomes(75%) should be some of the main criteria for assessing CEOs performance in the public sector. This is described in figure 8 and 9 below. This interesting finding indicates that although the CEOs agreed that they lack sufficient delegations as regards budget control and health outcomes in particular, they believed that these should be used in the measurement of their performance.

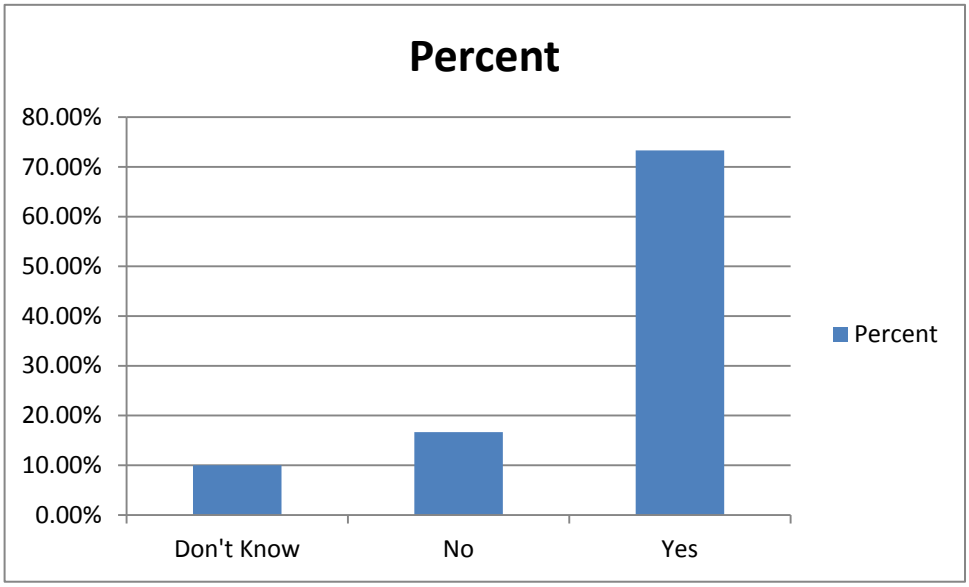

Figure 8: CEOs opinion of Budget control as main criteria for assessing performance

95% Conf Limits Don't Know 2.11%-26.53%, No 5.64%-34.72% and Yes 54,11%-87.22%.

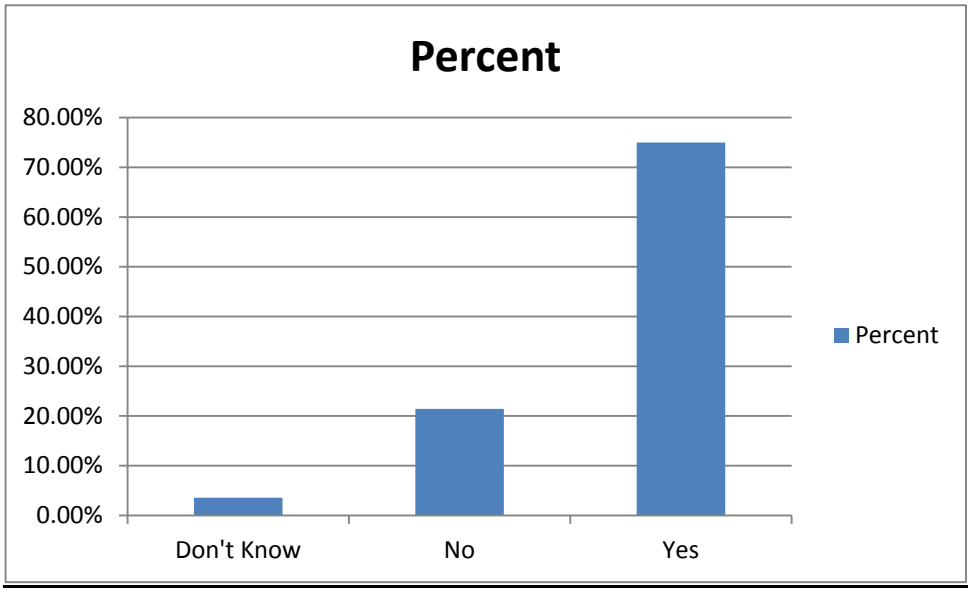

Figure 9: CEOs opinion of Health Outcomes as main criteria for assessing performance 95% Conf Limits Don't Know 0.09%-18.35%, No 8.30%-40.95% and Yes 51.33%-86.78%.

4.2.1. Conclusions of the quantitative survey

When asked about whether CEOs were measured against budget, staffing and quality of care less than half said that they were measured against these parameters (43% for budgets, 48% for staffing, and 27% for quality of care). Also 73% said 'yes' to being measured against health outcomes. However when asked about being able to manage effectively 86% said 'no'. This was an important majority response. So despite having some enabling policies and delegations and wanting to be measured against health outcomes most CEOs believe that they cannot manage effectively in their current circumstances. When asked if there were sufficient delegations to manage effectively 97% said 'no' to budget, all (100%) said 'no' as regards staffing, 70% said 'no' as regards quality of care but 73% said 'yes' as regards health outcomes. This strange contradiction can be explained by the fact that the health outcomes are largely a measure of the clinical care component of the hospital which is largely the responsibility of the health professionals and not that of the CEO. When questioned about which areas of delegations needed to improve for their performance to be improved the majority said budget (90%), staffing (93%), quality of care (97%) and health outcomes (97%). This mirrors the deficits in the delegation question that the CEOs responded to earlier. So it appears that the CEOs were asking for substantially

more delegations in the areas of budget, staffing, quality of care and health outcomes. As regards the main criteria for assessing their performance 73% felt that budget control should be used and 75% felt that health outcomes should be used. This is a similar finding to the DBSA findings that CEOs identify lack of budget, followed by limited delegations as key constraints to them performing optimally (2010). Performance management should preferably be measured against budget control and health outcomes according to the CEOs.

The self-administered questionnaire gave some insight into how CEOs viewed the challenges they face, what they think about their current delegations, what delegations they would like to have more of and what performance measurement criteria they should be measured against. However because this survey was largely exploratory and was used to inform the in-depth questionnaire these findings must be assessed in this context.

4.3. The Qualitative research

In-depth Interviews of hospital CEOs and experts in policy management as well as focus groups with a small group of CEOs and senior hospitals were carried out. The results are presented thematically, integrated and triangulated.

Twelve CEOs of the 30 CEOs who returned the self- administered questionnaire and agreed to take part in the interviews were purposefully selected for the interviews. All 12 contacted agreed to participate and were subsequently interviewed. Two CEOs were interviewed face to face and the rest were telephonically interviewed. Further in-depth interviews were carried out with experts in policy management based on the inputs from the CEOs. Subsequently focus group discussions were carried out with a purposefully selected group of CEOs and another with a group of senior hospital managers. The experts in policy were selected based on their known expertise in the field. Two were from the Wits School of Governance (WSG, Professors Van Den Heever and Fitzgerald), and the other was from the Wits School of Public Health (WSoPH, the Health Policy SARCHI chair Professor John Eyles). The interviews were recorded and transcribed. All the responses were collated and specific categories drawn into which the responses were allocated. They were subsequently

analysed using Atlas.ti, a Qualitative Data Analysis software. The analysis was thematic and four main themes (coded) were identified. These correlated well with the questions from the interview schedules. In this section, the responses to the in-depth interviews are detailed and presented in a way that enables the reader to grasp the salient points made by the respondents. The themes and sub-themes where appropriate were analysed systematically, integrated and triangulated, and are presented below.

4.3.1. Major challenges faced as a CEO of a public hospital

The major challenges the CEOs faced according to the in-depth interviews and focus group discussions were Finance, Human Resources (HR), operational management issues, delegations, performance management, accountability, communication with the respective provincial head offices and health sector reform. These themes are discussed separately below.

The first major theme that emerged was that of finances. This was probably the biggest challenge that the public hospitals face according to the CEOs. However as the triangulation shows these various challenges are inextricably linked and cannot be seen in isolation

4.3.2. Finance

From the interviews and focus group discussion financial issues were the overriding challenge faced by CEOs of public hospitals. Nearly all the CEOs complained of a lack of funds, inadequate budgets, and difficulty in accessing funds appropriately. One CEO said that: “You will never have enough budget as a request and in terms of managing the finances,… the appropriate skills of people with financial management were also a difficult one to get”. (Interview 1)

The lack of financial capacity in managing finances was also a major contributing factor for most CEOs. A CEO from the North West province elaborated on this concern as follows:

> In terms of finance we were saying that we should have a fully functional section on finance and supply chain management that is headed by an assistant director, we don't have that, our assistant director admin does everything, with HR, finance and maintenance.(Interview 1).

Inadequate budgeting was a major concern of all CEOs. They are not involved in the budget process and it is not linked directly to their performance management system. One CEO opined that: "You work on a historical based budget and this is inadequate". (Interview 2).

Another CEO concurred with this opinion and further said that: "Staff costs rise in excess of budgeted increases which are often determined on a historical basis. Staff costs were 62% of total budget seven to eight years ago and are now close to 70% of total budget".(Interview 5).

According to most of the CEOs interviewed goods and services were always under budgeted and often led to overspending. Adjustment budgets were never sufficient and CEOs often had to take the blame for overspend. CEOs submitted regular requests for head office intervention or assistance but these requests were often ignored. This is also largely due to a lack of clear delegations according to them.

The senior hospital managers complained that the budget increases often don't keep up with inflation and are on average a 5% increase on the previous year's budget. They also blame the lack of experience and insight at head office that informs the current poor budgeting processes. The budgeting system was an accrual based budgetary system and the focus group also raised it as an inappropriate budgetary process. Most of the CEOs recommended the use of zero based budgeting. "You work on a historical based budget and this is inadequate" said one CEO in the interviews. Another one said that: "Goods and services are always underfunded and often led to overspend."

A bigger concern with finances was the issue of procurement. This is ultimately controlled by treasury at provincial head office according to the group. Any purchase above R500 000

must be advertised and anything below R500 000 can be handled by the hospital but this too has challenges. Hospitals can purchase about 80% of items on contract, 10% as emergency and 10% as urgent. According to the one hospital manager he believes that they have good delegations in Gauteng. The other managers disputed this by saying that there are inappropriate items on contract. Also the issue of sole suppliers was a vexing one and posed a challenge when these sole providers are unable to deliver the appropriate supplies. This is particularly problematic when it comes to critical items. Although the CEOs have discretion there are strict rules that regulate procurement and these change yearly according to some members of the group. It is often necessary to go through head office even if one is dealing with a sole provider. This confirms the views as expressed by Eyles(expert interview, 2015) as well who believed that the current tender system and the use of preferred providers allows for corruption creep particularly at provincial head office level.

According to the senior hospital managers certain purchases needed to go through a Bid Adjudication Committee (BAC) and these become a tedious process when you want to purchase large items such as renal dialysis machines. With the current R500 000 limit you can only purchase two of these at a time even though you may need ten in a particular hospital. There is also a problem when you want to purchase two of these machines for adult patients and two for paediatric patients simultaneously. The Auditor General then sees this as a split order and raises it as an unauthorised expenditure query. There is also a problem with consumables because these are recurrent expenditures but the paper work required is very repetitive and onerous. Every new purchase of the same consumables requires BEE certification, SARs clearances and so on. The one manager who felt that R500 000 is appropriate believed that CEOs are to blame for insufficient spending ability and he commented as follows: “CEOs interpret rules differently and there is no need to blame head office all the time”. The other health managers agreed that procurement has improved. The main challenge and this is agreed upon by all the participants is the lack of technical capacity at the hospital itself and particularly in Finance and Supply Chain Management (SCM) departments and the lack of appropriate systems to support these. It seems that SCM is a new profession in public administration and there are insufficient qualified people to be

employed in these positions. Also once a person is employed in SCM they never move according to the participants. This is because once they learn the system and how they can work it to their advantage they then know how to benefit from it and are happy to stay in that position forever. This is where corruption creeps in according to the focus group members. So delegations although appearing to be somewhat sufficient is not implementable well particularly in HR, Finance and SCM because of this lack of human resource capacity as well as the possibility of corruption creep.

The issue of financial accountability is of paramount importance but problematic according to all the senior hospital managers. “If the procurement officer does not procure he is not held accountable”, said one participant. He blames head office and does not take responsibility. The hospital managers all agreed that so long as the HOD is the accounting officer and if he does not pass this accountability to CEOs the status quo remains. The only way to change this is to hold people accountable for outputs and outcomes according to the group. “At present no-one is held accountable for anything, even if there is a shortage of food and drugs” said one senior hospital manager. The senior hospital managers proposed that clinical executives (these are the senior hospital managers other title) need to have clearly defined roles and responsibilities. They believe that there are too many layers of bureaucracy at the larger hospitals and it becomes difficult to manage the different clinical units when the clinical heads (chief specialists in the various specialities) report directly to the CEOs. The one participant said in desperation; “Sometimes I feel that I am a paper pusher – a glorified clerk”.

In relation to finances Prof Fitzgerald (expert interview, 2015)commented on the PFMA (the Public Finance Management Act) which intended to bring financial accountability to the heads of institutions but he criticises it in that it does not allow for financial discretion “you cannot react to unforeseen challenges as you cannot shift moneys from line item to line item”. According to him it has in fact taken a lot of financial discretion away from executives and pushed it to Treasury according to Fitzgerald. This leads to a lack of efficient expenditure overall. Financial Officers work in fear of the PFMA “and act paranoid” because one can be liable to criminal prosecution under the act. But this has rarely been the case. He

strongly affirmed that the PFMA took away strategic discretion. Financial procedures also often take weeks to administer. The PFMA did not do what it intended to do. It did not stop corruption and financial mismanagement. The PFMA moved us away from decentralisation. He also believed that because of this we have moved to a “pseudo centralised state”. There are trappings of centralisation but according to him five to six provinces are “out of hand”. They had all the corruption, financial mismanagement and patronage continuing unabated. He also felt the same about some municipalities. At one stage a single Public Service Act was being drafted to make all public servants as part of one public sector. Resistance from local government (SALGA in particular) and the provinces put an end to that idea. Prof Fitzgerald felt that it was feasible to have one public service covering all three spheres of government but because of the lack of political support this idea died.

Professor Fitzgerald (ibid) elaborated on the financial challenges that government institutions face. Currently the Public Service Commission has no oversight over local government according to Fitzgerald. Provinces have health and welfare budgets and these accounts for 80% of their total expenditure. The provinces can also move moneys around between different sectors and this is at their constitutional discretion. Because of this they will never give these functions up according to Fitzgerald. He also opined that during the Mandela and Mbeki periods lots of public officials came into the system and wanted to move government to a more efficient and productive state, a post-bureaucratic world. However they were often seen as “schizophrenic” where the left wing arm of the ANC was for a strongly centralised, controlled and developmental state. Yet there was a recognised need for improved efficiency and productivity. He saw NPM as a way of clawing back power from the Reagonites and Thatcherites (or neo-liberals in opposition politics as he saw it). NPM was in effect, if implemented properly, giving back power to the state as a regulator and a social entrepreneur according to him. He saw NPM as a progressive response to the Reagonites and Thatcherites as well as public choice theorists. Tony Blair adopted NPM as a joined up state. In South Africa we too through clustering of related functions at cabinet level operate as a joined up state and this was NPM in action according to Fitzgerald and the other policy management experts (2015).

The CEOs also complained that although they have no financial control over the budgets but are held responsible. Fitzgerald (expert, 2015) has also pointed out the restrictive nature of the current PFMA in governing expenditure. The CEOs also believe that there is no current enabling legislative framework to delegate financial responsibility and autonomy to CEOs. This function tends to sit with the Provincial Head of Department (HoDs) and Provincial Member of the Executive (MECs). This was also a finding in the literature review and document analysis as presented in chapter 2 of this research. This hierarchy of control points to the importance of context and established way of practice in the public services generally and health services in particular since 1994. It's a reflection also of the apartheid era politically managed public service as well as the clientalist post-apartheid system.

Van Den Heever (expert interview, 2015) also raised the issue of poor budgeting practices that currently occurs. He believes that the current budgeting system is not strategic and does not link to any agreed performance indicators. The CEOs are the last to know in the entire process of budget determination according to him. The CEOs do get a budget letter at the beginning of the financial year but most CEOs do not sign it as they feel that they have no control over it and therefore do not want to be held responsible for it. There is also a lack of financial capacity in supporting the CEOs according to the experts. This was a recurring subtheme of this research. Most CEOs do not have the appropriate financial support in terms of level of appointments and capacity in their financial departments. These findings were also confirmed by the focus group discussion held with the senior hospital managers.

What came through consistently through this research is that one of the major challenges faced by CEOs of public hospitals is that they have no real financial control over their budgets but are held responsible for spending. The CEOs believed that under the current political climate financial delegations were not possible. They do get a letter stating that they are accountable for the provisional budget but most CEOs know that they will overspend. A CEO responded: "Because in the beginning you have insufficient budget". The budgets are always underfunded and because of the accrual based budgeting system that they use they are always carrying shortfalls into the following financial years.

Some solutions were proffered. Budgets should be zero based according to the one CEO. At present it is incremental in nature and does not take into account inflation nor salary increases. They do try and plan ahead and often have to defend their budgets and expenditure at regular meetings with head office. They "have budget meetings monthly and do report on trends" and "every month you will say that you are overspent".

However they also feel that a big problem is that they present their budget requests to junior finance staff at head office who often have no insights into budgeting at hospital level. So they don't understand the implications of the budgeting process and cannot act on the requests made by the CEOs. There is a general lack of support from finance staff at Head Office according to the CEOs. They present budget line items with predicted expenditures and some have Activity Based Costing presented to argue the case for more budgets but invariably they get a budget based on the previous year's expenditure. They do have "budget bilaterals" with head office during the financial year where they discuss budget issues but this often has no real impact on future budgeting. In fact this past year they were given "provisional budgets on quarterly predictions but to date have only received the first quarter". "In October of every year you could present an adjustment budget but this did not happen this year." The CEOs claimed that budgeting is now largely a "paper exercise"

In summary then this study provides support to the findings of the DBSA (2010) and those of Cameron (2009) and Awortwi (2006) in that inadequate budgetting processes affect the running of public hospitals adversely and this is compounded by a lack of professional financial management capacity. Van Den Heever (expert interview, 2015) also commented on inadequate budgeting systems and he sees the problem as much more systemic as just lack of involvement in budgeting exercise. Fitzgerald (expert interview, 2015) believes that the PFMA which intended to bring better financial management and control to the public sector in fact did the opposite. It hamstrung financial decision making by restricting spend to budget line items, calling any deviations from this as inappropriate and this often led to qualified audits by the Auditor General. All participants agreed that there is insufficient budget and a general lack of financial delegations and discretions given to CEOs. The CEOs complain that because there is this lack it is hard to hold the CEOs accountable on the failing

of the institutions. The financial accountability issue is at the heart of the PFMA (1999) and so too were the proposed 2006 delegations. Having the CEOs being financial accountable is also a recurring theme in all of the Ministerial Task Teams findings and recommendations as well as the findings of the DBSA (2010). As it stands the real budget holder according to the PFMA is at the provincial head office viz. the HOD.

4.3.3. Human Resources

Another major challenge that was raised both in the in-depth interviews as well as the focus group discussion was that of Human Resource Management issues. As far as staffing is concerned CEOs in the majority of provinces can replace staff that leave during a financial year but any new staff appointments have to be motivated for at head office (this even applies to new cleaners too in some cases). All new posts and unfunded vacant posts need to be approved by head office before filling them. There are no updated norms and standards as relates to human resources and they often use outdated organograms. This issue has been brought to the attention of head office numerous times. Another HR problem is a lack of middle management staff with appropriate expertise. Senior HR, Finance and Administrative support was a huge problem with the focus group discussants. However, lower level support staff was also in short supply and were often incorrectly graded, and were therefore difficult to retain. This affected operational management capacity and in particular in relation to supply chain management, clerical and administrative work, porters and cleaning staff somewhat adversely in the opinion of these CEOs.

One CEO who was concerned in particular about obstetrics and neonatology argued the need for advanced midwives. They often rely on agency staff, particularly on night duty, at huge expense to the hospital. This included the recruitment process which often had head office interference as this negated their ability to recruit appropriate staff. Permission was required from head office or the district office (in relation to district hospitals) to fill posts, professional posts, and in some provinces even to the level of cleaners. This often frustrates the CEOs as they are held accountable for the cleanliness of the hospital by the OHSC.

Another challenge that came up repeatedly was that staff structures were not updated and did not fit the current service package and this hamstrung CEOs in terms of getting appropriate staff. A CEO from a rural hospital said: “if I don’t have enough money to employ, then you cannot employ as you wish. The biggest challenge was scarcity of health professionals especially doctors and allied professionals”. (Interview 1). The lack of appropriate human resources, both in quality and quantity, was a major challenge faced by nearly all of the CEOs interviewed. Permission was often required from head office (or district head office) to fill posts, particularly professional posts. This was confirmed by the focus group discussion with senior hospital managers who complained of the tedious processes involved in filling posts especially specialist posts. This was borne out by the focus group discussions with the CEOs where upon elaboration they described their inability to appoint staff that have left during the year problematic as even as replacements (i.e. filling vacant funded posts). This frustrates the CEOs as they are also measured against the cleanliness of the hospital. Often budget locks were imposed by provinces late in the financial year and all the filling of vacancies gets frozen. A CEO made the following point in this regard: “I don’t have enough money to employ, then you cannot employ as you wish?” (Interview 6).

Some appointments take a long time and are often held up at head office level according to the CEOs. Health professionals were particularly scarce, a point repeatedly made, and if CEOs have the opportunity to fill these posts the head office often takes over many months to vet the filling of the post which by then the health professional applicant has lost interest in coming to the hospital. The CEOs repeatedly made the point that there are outdated organograms and no guidance as to what are the norms and standards of appropriate staffing levels for each type of hospital. Another CEO also alluded to lack of capacity as a particular challenge: “In terms of management support there is a challenge where you as the CEO of a hospital... don’t have a fully-fledged management team (to support you).” The experts point to what they see as incompetent bureaucrats that have been appointed throughout government departments. The senior hospital managers also point this out as a problem and that the lack of decision making, the lack of accountability and prevailing incompetence is a malaise affecting head office mainly. They believe this is what causes the

“trench warfare” mentality as referred to earlier by the experts that were interviewed. This was clarified by the participants as don’t be seen or heard, keep your head within the trenches, don’t do anything and you will survive another pay cheque each month.

One issue in HR was raised as a salient example by a manager that for him to fill a senior specialist post in surgery took well over a year because such a senior post has to be vetted by the provincial head office. This also contributes negatively on one’s risk management capacity according to this manager and head office seems unaware of these repercussions. There are some delegations to fill lower level posts such as that of medical officers, nurses and registrars.

Also the clinicians who are often joint appointments with universities in the academic complexes (where hospitals are the training platforms for medical schools) feel more loyal to the university than to the services (the services pays their salaries). These clinicians who are heads of their respective clinical units have their PMDSs done by the CEOs and the group said that this is inappropriate and undermines them. The one senior hospital manager felt very strongly that the clinicians should report directly to the senior hospital managers.

Another idiosyncratic management committee was the EXCO (Executive Committee) of the hospitals where the main component of this committee was the administrators who sit with the CEO and this is the highest decisions making body in the hospital. This committee determines allocation of resources, staffing levels, procurement processes and other core service related issues. The core business i.e. health care provision, is not addressed by this committee directly as there are very few representatives of the health care providers on this committee. There also appears that personalities play a big part in determining how people are managed. The focus group as a whole believe that the management structures need to be sorted out first before you hold people responsible and accountable. The key challenge as defined by the group is that there are no clear levels of responsibility and accountability because of the strange reporting structures and the functioning of the various committees.

Awortwi (2006) stresses the importance of having a well-qualified and professional civil service to implement NPM. None is more crucial than in the health sector particularly as it pertains to professional as well as support staff. This is a worldwide problem and particularly worse in developing countries. The CEOs argue the same in that they feel they are only as good as their team and if the team hasn't the appropriate staff in terms of capacity (qualifications and experience) than they are sure to fail. The DBSA findings also illustrate this as the CEOs in the DBSA study felt that another constraint to their performance was a lack of competence of direct reporting lines as well as that of support staff. Professionalising the bureaucracy has been an intention of the government for a long time according to the experts interviewed but this never materialised largely because of a lack of political will.

The policy management experts all concur that we have inappropriate bureaucrats in senior positions at all levels of government. This is so because of widespread patronage and nepotism. The ANC government deploy their faithful comrades into very senior positions and this affects the running of public service in nearly all spheres of government. However they all believe that it is worse in provincial structures and therefore impacts more on the health and education sectors in particular. Often budget locks were imposed by provinces late in the financial year and all the filling of vacancies gets frozen. A CEO in the focus group discussion made the following point in this regard: "I don't have enough money to employ, then you cannot employ as you wish?" What is clear is that the HRM function rests ultimately with politicians. They have the power to hire and fire. At provincial health level this power rests with the MEC.

4.3.4. Operational Management

The third biggest challenge is in relation to operational management according to the CEOs and senior hospital managers and this associated with the difficulty in managing finances as well were those relating to procurement practices and repairs and maintenance. The CEOs opined that this was mainly due to poor procurement practices generally in the province as head office often had the final say. Procurement was often under the discretion of

procurement officers and in Gauteng was largely controlled by the GSSC (Gauteng Shared Services Centre – a centralised provincial procurement office). The GSSC was a centralised structure in the Gauteng Province that oversaw all HR, Finance and Maintenance functions of all the education and health services rendered by the province. They proved to be inefficient and very expensive. Allegations of corruption against the GSSC left the province no option but to dismantle it and shift the functions it had back to the Provinces Health and Education Departments in particular. With that there has been a shift to discretionary expenditure of up to R500 000 that has been given to CEOs since 2014. This has its own challenges too because they CEOs require three vendor quotations before they can sign off the order. This becomes difficult when they need to repair something urgently such as a boiler that is malfunctioning and is negatively affecting the power supply to the hospitals. With frequent blackouts this often becomes a crisis and needs to be acted upon quite urgently according to the CEOs. The CEOs complain that within the current regulations they need three quotations and visits by the preferred providers who have to dismantle the boiler before giving the quotes and this becomes a longwinded exercise which can have dire consequences. With tenders, this being centralised, late payments are also a huge issue. The central office takes an inordinate length of time to pay vendors and some vendors stop supplying essentials such as food and drugs because they haven't been paid timeously. "I think the major challenges are making sure that you have resources, especially supplies that you need on a daily basis, your gloves, syringes, medicines and even making sure there is food" complained one CEO (Interview 9).

In terms of goods and services supplies are more often than not less than what CEOs apply for because it has been curtailed by the central or head office through which routine purchase orders go through. Hospitals frequently run out of basics such as syringes, needles, paper towels, gloves and food. The CEOs and the senior hospital managers believe that a combination of corruption and ineptitude is to blame for this. Even medical supplies have to come from a central depot and this poses huge challenges when hospitals run out of drugs in particular. However there has been some move to decentralise this function where hospitals can buy directly from suppliers, but this has its own challenges according to the senior hospital managers when linked to preferred providers. The senior hospital managers

find this preferred provider approach as extremely problematic when the providers cannot supply the contracted items as agreed in their initial awarding of tender. Eyles (expert interview, 2015) as mentioned before also finds this extremely problematic and easily open to corruption. The awarding of tenders at head office and the lack of transparency of this process is also questionable according to him.

Another CEO commented on goods and services saying: “we submit requests and you find yourself given smaller amounts than last year and you think adjustments will help you which never really do as a result you find yourself overspending.”(Interview 7). The accrual accounting system also exacerbates this in that over expenditure on essential goods and services are carried over in to the following financial year.

The focus group discussion with the senior hospital managers highlighted the issues of a lack of competence and inappropriate systems at operational level that exacerbates this problem. At a tertiary hospital the operational SCM work is left to a person with a Standard 8 (Grade 10) certificate, with no real prior experience in procurement and who deals with over 5000 items on a paper based filing and procurement system. The question has to be raised as to how did this appointment occur and why was nothing done to correct this? However this person reports to a Deputy Director and a Director who often contributes to the inflated bureaucracies that we often have at public hospital with no real accountability held by these positions. The senior hospital managers as well as the experts blame this poor performance in SCM on a lack competence as well as on a lack of accountability. There are no consequences for non-performers. A point repeatedly echoed by Van Den Heever and Eyles (expert interviews, 2015). This is a reflection on the failures of PMDSs and tools of NPM if not implemented properly according to Fitzgerald (expert interview, 2015).

Most provinces have embarked on embracing the private sector to deliver its supplies and part of its maintenance. The tedious bureaucratic nature of the way it awards its tenders and the lateness of payments lead to hugely inefficient service provision in these areas. This also opens the way for corruption to creep into these areas of concern according to the CEOs and the senior hospital managers. All the experts warn of the dangers of the current

awarding of tenders by government and its how it easily lends itself to corruption. Van Den Heever and Fitzgerald (expert interviews, 2015) both caution against outsourcing without the necessary governance and accountability structures. In Gauteng "Builders Warehouse" has been awarded the contract for repairs and maintenance and are supposed to provide a 24 hour callout service to public hospitals but rarely does so according to one senior hospital manager. This was a head office imposed preferred provider without any consultations with the hospitals.

4.3.5. Other Challenges

Other challenges that CEOs often faced were related to inappropriate patient referrals, organised labour disputes, lack of support staff capacity, inadequate information technology and communication systems, poor procurement and maintenance practices and health sector reform issues.

Inappropriate patients are those that come to hospital without referral notes and most central and tertiary hospitals have this as a major problem. Patients cross provincial borders or are inappropriately referred from other provinces and this leads to congestion and overflow at the receiving hospitals. Also there has been a huge increase in acute trauma cases across all public hospitals. The budgets given to hospitals do not take into consideration of this according to CEOs. This challenge of inappropriate referrals mainly affected tertiary and central hospitals in particular. These bigger and more specialised hospitals tended to see patients that should have been managed at a lower level such as Regional and District Hospital level. The reasons given by the CEOs is often due to inadequate services at these lower level hospitals, inappropriate referrals from these very same hospitals and private practitioners, or because of the perceived better reputation of these central or tertiary hospitals the patients vote with their feet. Also patients flow across provincial borders because of the unavailability of specialised care in some provinces. The Steve Biko Academic Hospital for example is both a Central and Tertiary hospital situated in Pretoria and is often inundated with patients from Limpopo and the North West Provinces. The CEO describes his problem as follows:

> The bigger challenge at Steve Biko is that we have a lot of inappropriate patients, inappropriate levels of care…people go to central hospitals because the care at district level is inappropriate.. there is a lot of demand from Limpopo and North West. (Interview 5).

The Steve Biko Academic Hospital has also seen a dramatic rise in acute trauma cases over the past few years. This has impacted negatively on the other wards (mainly medical as the overflow of patients is accommodated here) and the budgeting and human resources planning at provincial level has not taken this into account. Patient demand has increased dramatically over the past few years without the additional resources being made available according to most CEOs.

As far as relationships with organised labour are concerned most CEOs felt that it is important to have good relationships with the unions but this poses its own challenges. If CEOs don't have good relationships with unions this can undermine them when they take disciplinary actions against truant staff members. Dismissals are taken up by head office and because of union interference (head office is perceived to be sympathetic to organised labour by the CEOs) some staff are kept on suspension (whilst still being paid) for years. This means that the CEOs are unable to fill these posts as they are not vacant. These views were confirmed by the senior hospital managers and they felt that this was further exacerbated by the fact that the people at head office do not understand the nature of how hospitals are run and what challenges hospitals face.

Dismissals are often overturned by HODs and suspensions drag on for years. They often interfere in appointments as well. One CEO opined that: "I can mention of our organised labour - you should have a good relationship with them. If you don't they report to the head office and their side is always taken." (Interview 8). However there was evidence of some good working relations with organized labour. Another CEO said that when it comes to dismissals only the HOD can do that. He further elaborated upon its consequences as: " In my institution I found that people were stealing money, it was 2006, that even today are still

on (the staffing), some of them resign and go, what is this saying to other employees who are honest."(interview 9). However, according to some CEOs in the Western Cape Province there could be good working relationships with organised labour. Their cleaning services were apparently outsourced with the agreement of labour as the current staff was far too old to carry on working.

Information Technology and Communications is another huge challenge raised by the CEOs as well as the other participants. Computer networks that are in place are often slow and outdated and internet and emails work erratically. There are poor Health Information Systems generally in most hospitals and some are still paper based. The computer systems on patient management are often around 15 years old. There appears to be a government move to upgrade these according to most of the CEOs and senior hospital managers. There is also a lack of IT support within the hospitals. The literature argues the importance of having good information technology for NPM purposes as it drives efficiency in service delivery and in decision making (van Thiel and Leeuw, 2002). Fitzgerald (expert interview, 2015) believes that an effective and efficient e-government element is critical to any NPM reform process.

One of the senior hospital managers in the focus group who is "in charge"' of Maternal and Child Health (MCH) says that she never assessed health outcomes in these areas. The hospital as a whole did not measure health outcomes. But now with increasing levels of litigation the hospital is looking at mortality and causes of death. It is only now that the hospital is interested in outcome indicators. Causes of death were not recorded routinely. In fact according to the one hospital manager no mortality rates were ever recorded. There is also a very poor information system that does not support the collection of health outcome data. There are multiple sources of information and multiple information systems that do not talk to one another. For example the Medicom system that is currently used in most public hospitals is purely for patient administration and to order medicines. Clinical information is not collected electronically anywhere. One senior hospital manager lamented the fact that: "we have not cracked HIS in 21 years". In Gauteng in particular there are no integrated information systems and both the focus groups feel strongly that as long as there

is a lack of interest from leadership on the importance of information systems and that there may be perverse incentives as to what is used . They believe that we will never have an integrated system in the foreseeable future. Strangely though, according to the senior hospital managers, is that Gauteng Health has purchased the full SAPS system that can do this integrated HIS but the question remains as to why has this not been rolled out. It seems that each political head wants their own system according to some members of the group. So deaths continue to be recorded manually in the main.

According to the interviews and focus group discussions many CEOs come and go but the inefficient administrative system remains. Many people in the system know this and they often do not take the new CEOs seriously as they know that they won't last. According to the focus group each CEO should look at admissions, discharges and deaths daily, but they do not. There is also no forum where health outcomes are discussed. The meetings attended by the senior clinicians and senior management always centres on non-core issues such as parking, accommodation and security. Mortality and morbidity issues are rarely if ever raised at these meetings.

Some activities are also captured on the District Health Information System, electronic TB register and various other performance management indicators of the institution as a whole. They recently had inspections by the Office of Health Standards and Compliance and often received conflicting audits where the one CEO was scored a 55% but received the prize for the most improved hospital in the province from head office.

As regards the OHSC and its audit of SCM a lot still needs to be done according to most of the participants. The OHSC was supposed to assist in improving the quality of hospital services through its regular audits. The senior hospital managers believe that it measures inappropriate things. For example they measure TB cure rates and the use of hypertension and diabetic registers at regional and central hospitals whereas these services are found only at PHC clinics. A shocking example of inappropriate scoring was where a SCM department at one hospital got full marks based on the four criteria that the OHSC used but yet the SCM department is known to function atrociously in real life according to the senior

hospital managers. There is also a lack of transparency of the findings of these OHSC audits according to the focus group discussions and these are elaborated upon later. If The OHSC is conceptually being copied from the UK its findings should be made public according to the focus group.

One CEO believed that performance management functioned well in the private sector but for some reason it does not seem to work in the public sector and this could be due to reasons of “demotivation”, “attitude” to work or “the environment”. There is a monitoring system of the PMDS in the HR PERSAL system but the CEOs felt that “you just chase numbers” reporting whether you have done it or not.

Another challenge that came up in the interviews was a lack of support staff capacity both in number and in qualifications in carrying out the procurement and repairs and maintenance efficiently.. The CEOs complained that they are often required to have the necessary qualifications, competence and experience to fill their posts but the same was not required of support staff. Quoting a CEO: “In terms of management support, there is a challenge where you are a CEO of the hospital but you don’t have a fully-fledged management team that will support you.”(interview 12). This was also of particular concern in relation to finance and human resources officers, as well as supply chain managers. Even auxiliary services such as artisans were in short supply.

Another CEO elaborated as follows:

> ..when you take certain responsibilities they must go hand in hand with support staff so example human resources, finance, auxiliary services such as maintenance, we don’t have posts like artisan, when anything breaks you have to outsource because we don’t have knowledgeable people in the hospital. (Interview 9).

Communication is also a challenge and quite a few CEOs raised it as such. This was in relation to structures at head office. Communication was often top down with a barrage of memo’s and circulars coming from head office to the CEOs often with no consultation as to the feasibility or appropriateness of these. The lack of continuity in leadership was also an issue raised in the interviews as it affects continuity in communication adversely. Gauteng

for example and according to one CEO has had six CEOs and six HODs in the recent past. Each comes with their own agenda and changes things all the time. There are also many people in acting positions and these lead to bad communication between CEOs and head office because of all these changes. These issues lead to a lack of institutional memory and inefficiency according to the CEOs. Another issue that came up was a lack of head office and political support. It seems that if anything goes wrong at a hospital it is the CEO who is held accountable even if he or she has no direct influence or control. CEOs are often suspended by the MECs or HODs and this occurs when news of bad incidences at the hospital reach the press.

4.3.6. Delegations

Delegations were initially given in 2006 according to a CEO from Gauteng. These were signed off by the Head of Department (HOD) and the responsible Member of the Executive Committee (MEC). But according to one CEO in Gauteng they were removed gradually by 2010. Another CEO from Gauteng had this to say:

> ..the department policies – some do assist. There are some that actually nullify or dilute delegations that we do have, and the delegations have are the last one outdated 2006 documentation……. if the delegation says you allow post retirement appointments and a subsequent circular says that you cannot anymore you now need to apply to the HOD to reverse this. (Interview 5).

The Western Cape CEO said that: “policies rained upon them from head office”(Interview 4), but in the main were welcomed. A CEO from the Free State called delegations “yo yo delegations”(Interview 12), alluding to the frequency that they come and go and he referred to the policies as being good but often not implementable. These issues of delegation are discussed further below.

According to the research, inadequate and inappropriate delegations and departmental policies were a cause for concern, a view held by most participants. The last delegations

were given in 2006 in some provinces and these were signed off by the MEC, HOD and the CEOs. It covered HR, Finance and Supply Chain Management and CEOs were able to do much more in terms of managing their hospitals. But decision making in these areas was slowly reduced or removed over time. In Gauteng this was worsened with the centralisation of many Finance and HR functions in the Gauteng Shared Service Centre (GSSC) and this led to a rapid decline in service delivery and a rise in corruption. A CEO quoted an example relating to this: "We would pay R6500 for an advert in City Press (for a post) and pay R39000 to R40000 for the same advert through GSSC." The GSSC was put in place to save money but by 2009 it became apparent that it wasn't and has subsequently being dismantled with powers still remaining at central office level. This was due to a combination of political (MEC) and HOD intervention.

Some CEOs blamed the removal of delegations on the rapid turnover of MEC's and HOD's. "You need a stable provincial office for you to expect to be stable, if in six years you have six MECs and six HODs, almost one MEC and one HOD per year you can't expect stability in the department. Every time you have new plans and ideas, before they can be implemented they are removed" complained one CEO (Interview 8).

Policies too that were put in place after 2006 removed some delegations according to the CEOs. Current financial delegations allow CEOs to spend up to R500 000 for goods and services. However those that require tenders are administered by head office with no input from the CEOs at all. HR delegations allow for staffing replacement positions (vacant funded posts) in some provinces, but any new posts or posts lost through the last financial year have to be motivated for. Disciplinary action is not entirely delegated as appeals go to head office where they stay unresolved often for years. Operational management issues linked to tenders or public works are a huge problem too. The repairs of equipment and general maintenance of infrastructure takes a long time to do. These problems according to the participants suggest is due to a lack of clear communication channels between the hospitals and their respective head offices. It is further aggravated by a lack of insight and competence by the bureaucrats at head office level who do not understand the intricacies and responsibilities that go with running a hospital. There are a few policies that do assist in

managing the hospitals according to the CEOs as regards those that guide some discretion on finance, human resources and day to day operational management issues, but these varied across provinces. The senior hospital managers however opined that these can change yearly and this often sows confusion. A CEO summed up the challenges they faced as follows: “We have yo-yo delegations” referring to the frequency that they come and go or change(Interview 11).

There were some delegations given to CEOs recently (post 2009) but these were patchy and differentiated across the country. The CEOs complained about this differentiation and also mentioned that HR and Finance delegations need to link with the appropriate capacities within the hospital. One CEO said that: “If I have the delegation to do so… this is my budget and plans for the hospital and I should sign for it… and they should let me do it, .. I should be responsible if I fail..” (Interview 1).

Some CEOs felt that there was micro management from the Head Office. The CEOs complain that they don’t have the appropriate authority to be responsible and to have complete management control over their hospitals. Starting in 2010 some CEOs were given via departmental policy some control over their budgets, but on paper only, as mentioned before. They were often historical in nature and there was invariably overspend. The last delegations were given in the mid-2000s according to most CEOs and became outdated and superseded by new policies. A CEO who had procurement powers of up to R500 000 still has to get a signature from head office before money is spent. It appears that with most things financial: “you have to apply through the HOD”(Interview 2).

This can take ages, for example a tender for a new Radiology service at one big hospital was awarded in 2011 and is only being installed in 2014. Security tenders are administered by head office but the cost comes out of the hospital budget which often does not allow for this line item expense appropriately as they are not part of the adjudication process. Some CEOs have delegations of up to R50 000 and this is far too little according to them (district hospitals). The main concern of CEOs is that according to the Public Finance Management

Act (PFMA) they could be ultimately responsible even if they don't have the necessary power or control over finances and HR.

A few CEOs had some delegations that allowed for quick appointments. This came through new departmental policies that allowed for what is called walk-in interviews i.e. if you identify a health professional that is scarce you can interview directly without advertising. However in the main you had to follow DPSA policies around recruitment and affirmative action and some of these processes take a long time because of head office interference. This often led to the loss of prospective staff.

There were new HR delegations that were developed over five years ago according to some CEOs across a few provinces but the provinces did not follow through and implement these as yet. It seems that a major determinant of delegations according to most of the participants is political and it is often when a new MEC comes into power that delegations are curtailed, changed or removed. All CEOs continually argue for more HR and financial delegations in particular to be able to function. One CEO said: "I don't have a dentist but I have two dentists from outside the public service that have been waiting for the last three months to be appointed." (Interview 7). In some district hospitals the CEO can only appoint up to level six and the district office does the rest. Some CEOs find it: "difficult to appoint people that you wish". (Interview 1). The CEOs often have to get approval for certain posts from head office as elucidated by this same CEO: "For most professional nurses and doctors you have to get permission". (Interview 1). Another CEO elaborated similarly: "I can't advertise, I can't appoint, even issues of discipline are also centralized at district" (interview 7).

However, in the Western Cape there appears to be a greater level of delegations. CEOs are able to appoint medical officers, specialists and professional nurses up to the level of assistant directors. For director level upwards the provincial head office appoints. Also with finances the CEOs in the Western Cape have financial business units and the management teams are appropriately qualified and well-staffed. The procurement delegations are also up to R500 000. Tenders are however done through head office in the Western Cape.

As regards delegations and policies related to it the common themes reflected upon in the focus group was similar to that of the in-depth interviews. The last real delegations were in 2006. These have been slowly withdrawn and replaced with circulars that dictated how CEOs should work in relation to Finance and HR issues. Policies have also undermined most delegations, but some policies do assist. For example the CEOs have delegated authority to spend up to R500 000 currently as long as they have three quotations. Anything more than R500 000 needs to have head office approval. This means that CEOs can now renovate wards for example which used to cost over R200 000 in the past and was way over the previous R50 000 limits. However there are also new approaches to control expenditure and this has been recently introduced, a mechanism called "budget lock". "If you overspend on any line item it is budget locked, you are not allowed to shift money between line items".

The CEOs commented that there are some useful policies that are implemented at the hospital level such as human resources policies, information and record policies, risk management policies and supply chain management policies. The CEO from the Western Cape (a CEO that was part of the KwaZulu Natal group and had subsequently got employed in the Western Cape) in particular was happy with the policies as they created standardisation across the whole province: "In this particular province if you want to paint the walls of the offices it has to be a certain colour…you don't have to waste time to make small decisions because policy is driven by it."(Interview 4).

CEOs of district hospitals also agreed that some policies do assist but the administering of them has to be vetted by the district head office: "Whatever I request has to go through the Chief Director and the final approval is through our provincial district office".(Interview 7).

A different take on the issue of delegations was taken up by the experts interviewed. Delegations in themselves are not of concern to Prof van Den Heever (expert interview, 2015). In terms of institutional economics, according to him, was the issue of principal agent and whether they act in their private capacity or not and whether there were incentives or not. He felt that there were structural problems in dealing with the latter and delegations

dealt with autonomy but not with incentives. Money can still get stolen because of delegation. What is required is the ability to regulate public administration through accountability mechanisms.

Decentralisation (a main feature of NPM) according to Prof Van Den Heever (ibid) needs clear accountability mechanisms. There are four pillars to this accountability according to him. Firstly there needs to be explicit performance requirements. Secondly there has to be transparency and therefore reports on performance requirements must be made public. Thirdly there needs to be a supervisory structure that receives regular reports on performance and offers strategic direction and be able to act on it if things go wrong. The supervisory structure should have no conflict of interest and should be independent and represent the public's interest. Finally there should be penalties and rewards. These four pillars provide a coherent accountability framework which is largely absent in the public sector and especially so in hospital management. CEOs are currently not held accountable to hospital boards and hospital boards are not appropriately functioning according to Van Den Heever(ibid). However the CEOs feel that they are held accountable through performance management agreements (the PMDSs) and their short term contracts with head office.

4.3.7. Performance management

Performance management was implemented in 2002 and most people were not happy with it according to the CEOs. It had major gaps in its implementation according to the CEOs. There was a particular weakness in the verification process and the Bargaining Council questioned the role of moderators. It tends now to focus on incentives rather than how you performed. Directives are also lacking in terms of how you score and measure according to the CEOs. All CEOs do have performance management systems in place but they all agree that it does not really help with performance management at present. Performance Management contracts are signed at the beginning of the financial year between employer and employee and are reviewed at the end of the year. This is also supposed to happen quarterly but this is not always the case. Most CEOs find the three monthly appraisals problematic and these are very often not done or done very superficially. CEOs are assessed

by the Directors of Hospitals or Directors of Districts in the main. The CEOs in turn assess the staff reporting to them and this cascades down the organisational structure.

One CEO said: “It is subjective and everyone scores above average”,(Interview 2), and another CEO said that: “It has to be specific as to how you measure performance on the basis of one to five with three being normal… if you have done what you are expected to do you should get a three and not a five which is often demanded of you”.(Interview 6).

Some of the CEOs argue that although there are performance management policies in place compliance is problematic. One CEO made the following point: “All appraisals done by supervisors and managers of performance agreements are not genuine as they don’t focus on service delivery or health outcomes”(Interview 7).

Even after the performance appraisal is done by the supervisor or manager it has to be moderated. This is often problematic and arduous. The CEOs argue that the performance management needs to link to the specific job description and duties of the individual with clear outputs that are measurable. A CEO is quoted making the point: “ …some people don’t understand what to put in the contract and how to assess the individual against the performance indicators”.(interview 5).

Another CEO indicated its misuse as follows: “We have a problem when we look at scores and what people do, they do not follow a normal curve, it is a skewed curve to the right”. (Interview 9).

In terms of its intention the CEOs concur that it was supposed to hold people accountable, identify gaps in terms of their performance and offer training and development opportunities. But it tends to be used purely to get the cash bonus at the end of the year. Quoting a CEO who makes these points:

> ..it is not done properly at the level section because there is a need of capacity building around the performance management system and also to instill the sense of

> responsibility among managers, to ensure that when they do these evaluations it is in a professional and objective manner rather than just to give scores and points for the sake of the cash bonus. (Interview 12).

Another CEO described his situation as follows: “At the moment there is micromanagement from the head office. At the beginning of the year there is a performance agreement that you sign which is meaningless because they don’t allow you to do all these things”. (Interview 7).

Performance Management as an issue was also raised in the focus group with the CEOs. Although they did not understand it in the context of the NPM paradigm they concurred with the in-depth interviews in the way it was implemented and has its problems too according to the focus group discussions. It does not adequately manage underperformance. There are no disincentives. It is often done by supervisors who tend to score what the subordinate employee scores which invariably is higher than the expected three. There is a sense of entitlement for the bonus that goes with the higher scores (four and five). Three is the score you should get for doing your work as expected. CEOs are currently permanently employed and they do sign annual PMDS contracts and are supposed to be quarterly and annually assessed. The quarterly assessments are rarely done but they view them as important for developmental and monitoring purposes. The developmental needs of employees that are identified through the PMDS process should be met through the HR Training and Development Unit but this is rarely the case. So the CEOs question the usefulness of the PMDS as it is currently used. It also creates perverse incentives in that employees only focus on what they put in the PMDSs in the beginning of the year and tend to ignore their other duties.

Performance Management Systems have been implemented since 2002 but have their pros and cons in implementation according to the CEOs and the other research participants. The biggest problem according to the CEOs and the senior hospital managers is that underperformers are not managed and there are no disincentives. The inability to weed out non-performers is at the crux of the problem according to Eyles (expert interview, 2015).

There is a sense of entitlement (Eyles calls it a culture of entitlement) and most staff members see it as an opportunity to get a bonus according to the CEOs and the senior hospital managers. Most supervisors sign what the employee grades themselves without thoroughly interrogating it. Also the employees put in their performance measures indicators or outcomes in terms of what they know they can achieve in their jobs without putting in all the measurable deliverables in their job descriptions. This gaming of the PMDS is quite rife according to the CEOs and senior hospital managers. “It is subjective and everyone scores above average”, opined one CEO(Interview 6). The experts share this view but are much harsher in their judgement of the current PMDSs. It is not achieving what it set out to do, it is abused and should be discarded according to them.

Overall, the CEOs, senior hospital managers and the experts questioned the performance management system’s current usefulness. CEOs also described other ways in which their performances should be measured which relates to hospital indicators such as bed occupancy rates, cure rates (TB hospitals), caesarian section rates, average length of stay and so on. This lack of alignment of institutional performance indicators with that of the staff’s PMDSs was also an unresolved issue raised by the experts. Another CEO confirmed this opinion by saying that: “All supervisors and managers of performance management agree that these (measurement indicators) are not genuine as they don’t focus on service delivery or health outcomes” (Interview 9). There have been recent audits by The Office of Health Standards and Compliance (OHSC) and this may be another mechanism to assess performance of the institution as a whole which should reflect the performance of staff ultimately. However the audits tend to focus on input and process measures mainly at present. The senior hospital manager’s feel that the OHSC can assist in holding health services accountable but at present they use inappropriate indicators and their findings are not transparent. A point also raised by Van Den Heever (expert interview, 2015) who criticises the current worth of the OHSC.

The PMDSs as it is currently designed appears to refer to generic outcomes that are easily manipulated according to the CEOs. Most people know how to game the performance management system according to Van Den Heever (ibid). The measurements that should be

used must add value and focus on outputs and outcomes (results based management). Fitzgerald (expert interview, 2015) expressed a similar opinion on how bonuses are determined in the City of Johannesburg where inappropriate indicators are used and the senior managers get huge bonuses in spite of the fact that citizens are not getting appropriate services. The senior hospital managers confer with Eyles (expert interview, 2015) view that we have a sense of entitlement in the public services at present and that everyone gets a four score. Staffs feel that they are entitled to a cash reward each year and the senior hospital managers believe that this status quo will remain as no-one really challenges it.

Performance contracts are critical to achieving the NPM agenda of improving efficiency and holding public servants accountable (De Lancer Julnes, 2006). However, the current performance management system leaves a lot to be desired as its implementation does not meet its objectives. It creates the performance paradox as sometimes good performance is not always rewarded according to the CEOs, experts and senior hospital managers. It also leads to perverse incentives as the employee selects the indicators that they know they can perform well in (van Thiel and Leeuw, 2002). The linkage of individual performance contracts to the performance of the institution as a whole is also not clear. However some CEOs believed that with the introduction of the National Core Standards one might be able to improve the application of performance management in hospitals in particular, however this does not address the issue of quality of care.

As far as NPM was concerned Prof Van Den Heever (expert interview, 2015) agreed that decentralisation and performance agreements can be part of the discussion but we need to question the gains. It talks to autonomy and there are gains or benefits from having a degree of autonomy but he stresses that one still needs strong accountability. He believed that one can have multiple indicators for accountability. However, he felt that NPM was generated in Pretoria which is far from the coal face and hence did not work effectively in the public sector. He felt that command and control is still government's default structure. He wanted more voice and more transparency linked to accountability frameworks and questioned how public opinion influences authority with this current model. He felt quite

strongly that the NPM discussion does not deal with design intricacies. Choice refers to internal market mechanisms. The moment information is made available to the public people will choose. Choice and accountability requires objective measurement. However at present people cannot choose. You cannot link choice with incentives currently.

Prof van Den Heever (expert interview, 2015) emphasised that the solution was to address the governance issue. According to him we need to appoint boards that are independent and who can appoint CEOs and fire them if they don't perform. The UK has appointed boards or governance structures that hold CEOs accountable. Ideally he believes that we should have a democratic governance structure such as the New Zealand model. This places incentive pressures on the executive. Health care has become too expensive and this is a worldwide phenomenon. The main focus is to improve productivity and not cut budgets. However he felt that ideal governance structures are still very far away as far as South Africa were concerned. He suggested that we can have a staged or phased approach to a stronger accountability model that is independent from government. He suggested that fundamental to the effective functioning of independence governance structures is access to appropriate systematic information. This access to information coming from hospitals is currently not available according to all three experts. They recommended that the rationalisation of health information systems should also be done systematically.

As far as performance management is concerned all the experts concedes that it is not a new idea. It is trending and monitoring and evaluation is even trending more. They are perhaps the "dying kicks of the Weberian horse" according to Fitzgerald (expert interview, 2015). People in public management doubt the value of performance management today according to Fitzgerald. In 2002, Mayor Amos Masondo established a performance monitoring set up in the City of Johannesburg. It is now statutory. Fitzgerald chairs this committee, and has 12 years' experience with this, but feels deeply concerned about it. Executives score well on their balanced score card. This is because they all have five year contracts and maximise rather than optimise their services. He feels ambivalent about the measures for executive's performance. As they do not do their whole jobs, they do not do new things and they do not innovate: "performance management is not anything other than

a last century tool to incentivise managers". He also believes it is an adversarial system and does not build teams. Professor Fitzgerald (ibid) had an experience with this when he was Deputy Vice Chancellor at the University of the Witwatersrand. The Council wanted to introduce performance management systems with bonuses for senior management at the University. The managers rejected it outright. Professor Fitzgerald regarded the performance bonuses as an insult. He says that he cannot understand how one can incentivise if a person was supposed to do their job properly. He believes that what is currently being used in government is outdated and is certainly not NPM.

Prof Van Den Heever (expert interview, 2015) made mention of the Taylor Commission of Inquiry (2002) that recommended back then the establishment of independent hospital boards that can hire and fire hospital CEOs. At the moment CEOs are political appointments and he believes feels CEOs "will fail without fail" because of this. He compared this to the Tamminy Hall experience in New York in the 1930s where under a Democratic Party led government people were appointed because of their political connections. Servicers deteriorated until they professionalised the services and delinked it from political influence. He firmly believes that health outcomes will not improve if this issue of political appointments is not sorted out. This will be further exacerbated if there are no incentives and no accountability mechanisms. He also believed that the Minister of Health with all his good intention has no real power over the provinces and that the DBSA recommendations to the Minister did not provide for a coherent or structural solution and this as implemented will likely degrade over time. MECs want access to decision making power and thereby access to financial decision making, tenders and patronage (promoting friends). Politicians who appointed CEOs perpetuate the current failings in the system. An appropriate regulatory framework can deal with this to a degree. However we have seen a degradation of health services over the last decade despite the huge increase in expenditure according to Van Den Heever (ibid). He also complained that the public service, besides being inefficient, was extremely bloated. In 1994 we had one Director General (DG), two Deputies (DDGs) and a few Chief Directors (CDs) that ran Health and Welfare at national level. We now have one DG for Health, with six DDGs and many more CDs. Despite this, there has

been no change in efficiency or outputs since this change according to Van Den Heever (ibid).

Prof Van den Heever (ibid) further commented on indicators (performance or management indicators) that should be part of the reporting requirements of the CEOs and their hospitals. These have to be relevant and most importantly available for public scrutiny (transparency). He criticised the recently established Office for Health Standards and Compliance (OHSC) as being a fake accountability mechanism. If judged against the four pillars that he believes are fundamental to an accountability framework it fails miserably according to him. The OHSC measures mainly inputs and processes. There is an absence of transparency as their findings are not made public. He pointed out that there is no requirement of hospital CEOs or health managers in general to generate mortality rates (as a health outcome indicator). This would make a material difference as to how you hold CEOs accountable according to him. He suggested that one needs a few value based indicators that feeds into the accountability framework. This view was supported by most of the research participants.

4.4. Health Sector Reform in South Africa

NPM was at a high water mark and was trending globally when democratic government took over in 1994 according to Fitzgerald (expert interview, 2015). NPM influenced the political spectrum in South Africa and was not a right wing ideology. He distinguished the influence of public choice theorists, which influenced Thatcher and Reagan, from that of his understanding of NPM, which had left of centre roots (especially as espoused in New Zealand at the time). According to Professor Fitzgerald (ibid) New Zealand was considering contracting out health services and did not consider this as privatisation but allowing for more efficient control and regulation by government. It had contracted over 90% of General Practitioners, and so incorporated them into the public system, and obliged to government pricing and regulation. This was socialism in action according to Fitzgerald.

During his work in government Professor Fitzgerald(ibid) was aware of the ANC's attempts to elevate the status and rank of hospital managers in an attempt to have them have more authority and be able to make decisions. This never materialised in his stay at government. This issue came back cyclically according to him. He commented on the then Minister of Public Services Geraldine Fraser-Moleketi's views that NPM gives you a toolbox and one can use as appropriate (rather than buy into its ideology), a point also repeatedly made in Chapter 2. He felt strongly that politicians can through regulation rather than command and control achieve service objectives. NPM asks government to be a facilitator. He opined that hospital mangers had to be elevated in terms of status and rank so that they have the requisite authority to make the necessary decisions. They need their own budgets and "must be able to repair windows" if they want to. However the middle just bloated at head office level so that the heads of hospitals that was at Director Level during his tenure at government were under layers of Weberian bureaucracy. Hospitals were supposed to be strategic business units, but nothing like this ever happened. The norms and standards that were set and the culture of the public service gobbled it up. CEOs have subsequently been elevated in rank and salary and status but cannot do their jobs properly according to him. This is further exacerbated by bloated head offices which have a trench warfare mentality according to Eyles (expert interview, 2015) and this inaction is entrenched in most of the health departments contributing to the overall poor service delivery. NPM was trying to address this in that it gives you a vast array of tools and says "use as appropriate" and it is not an ideological debate but one of efficiency according to Fitzgerald (ibid).

Prof Fitzgerald was a Director General at national government level post 1994 and used NPM principles and tools to re-organise the Weather Bureau, which has international significance, into an agency that is now much more efficient according to him. He felt that he needed to protect the bureau from layers of bureaucracy. Professor Fitzgerald felt that this was a left wing approach as government had the ultimate oversight through regulation. He also believed that Geraldine Fraser-Moleketi did not like NPM initially because NPM can have a non-nuanced interpretation in that it gives powers to the executive and seems to take it away from politicians. He felt strongly that political control would still be there but "through regulations rather than command and control". He believed that we have very

expensive cell phone rates and internet bandwidth charges because of this command and control mentality. NPM has other tools where government can be a facilitator to solve problems. Politicians were too caught up with the privatisation versus centralised debate. NPM is a post-modern approach and now employs e-government and informational nodes of management. He believes that at present we don't talk about NPM but we can still see many good examples of it, for example, the King Shaka (a.k.a the Albert Nkosi Luthuli hospital) in KwaZulu Natal, where the management is run by the private sector.

According to these research findings the CEOs were generally unaware of the NPM paradigm and its impact on public sector reform and health sector reform in South Africa in particular. They were aware of some of the tools of NPM such as delegations, accountability, performance management and governance but saw that in terms of general PSR in South Africa. They also knew of some policies or legislation that directly affects the way they run their hospitals such as the Policy on the Management of Hospitals. They were also unaware of the NPM paradigm and its place in the White Paper for the Transformation of the Public Service or even its implications in the White Paper on National Health Insurance (South Africa, 2015). All that they knew was that hospitals were categorised in a particular way and that determined what services you are supposed to render and the role of the OHSC. Some were aware that there was draft legislation on the functioning of hospital boards and at central hospital level but this was still in its draft stages.

The CEOs were acutely aware of the implications of the PFMA and its possible ramifications on their ability to account for the expenditure of their respective hospitals but felt hamstrung to control their own finances. The PFMA and subsequent regulations allows for financial delegations to be given to the CEOs by the HOD or his designate but they feel that HODs and MECs are reluctant to do this appropriately. Fitzpatrick (ibid) also believes that the PFMA as it currently is severely restricts the HODs ability to incur expense strategically rather than creating the flexibility to being creative with one's budgets. Perhaps this is why the research shows that the HODs and MECs are reluctant to decentralise financial management fully. There are some piecemeal delegations that allow CEOs to for instance to purchase goods and services up to in some instances to a total of R500 000 but with strong

head office oversight and a poor payment history. The senior hospital managers also describe the procurement processes as tedious and often run by incompetent staffs that are rarely held accountable for their poor SCM systems. This flies in the face of the intended PSR and HSR initiatives in South Africa. This is also not in accordance with the principles of NPM principles and talks to the fluctuating government stance on the use of NPM principles in HSR over the past two decades according to the experts.

In terms of HR Awortwi (2006) on his critique of NPM reforms in developing countries made the point that for NPM to be implemented their needs to be adequate numbers of well qualified and professional civil servants in the system. The WHO recommendations also highlight this issue, of having competent staff, as critical to the building clocks of a health system (WHO, 2001). The CEOs complained about the inability and restrictions placed upon them by head office compromising their ability to appoint staff. The appointment of health professionals took a long time and this affected service delivery quite severely. They were also particularly concerned of not having appropriately qualified management staff in finance, human resources and supply chain management in particular. “You are as good as your team” was a perfect pronouncement on this issue by one CEO. These views were shared by the senior hospital managers and they blame it on a lack of understanding of those in authority at provincial head offices as to what HR requirements the current HSR asks for.

However, according to the experts and as emphasised before, delegations can only be made effective if there are appropriate accountability frameworks in place. Their suggestion is that hospital boards should be given this responsibility and must hold the CEOs and senior hospital management to account on their ability to manage their budgets, their staff and ultimately the health outcomes of their patients. This is in line of the NPM paradigm of let the managers manage but hold them accountable to the public (through appropriate governance structures). The draft legislation in this regard as it relates to central hospital (South Africa, 2015) will lead to a huge contestation between the provinces and the national department. Constitutionally the provinces are responsible for health care delivery and the setting up central hospitals as currently envisaged is that it should become a national

government responsibility. I believe that we are still a very long way from implementing this and many CEOs and senior hospital managers are unaware of its implications.

The MEC has the ultimate responsibility for human resource management issues but subsequent amendments to the PSA allows for delegations to be given to managers lower down the system. New MECs often do not delegate and I know of senior health professional appointments and even staff applications for study leave being held up by MECs. This political control manifests itself throughout our government where Ministers and MECs fire, move and suspend senior executives as and when they deem necessary. The ultimate HR function rests with politicians and this is also very evident in health. Again this lack of delegation stems from a lack of trust and flies in the face of NPM reform.

As far as broad public sector financial reforms were concerned the CEOs knew about the implications of the PFMA and the PSA (South Africa, 2012). They did not seem to be aware of the immediate implications of the National Health Insurance on their work. They have been exposed to some work of the OHSC and were more concerned in meeting the requirements of this office in terms of core standards (South Africa, 2011). This is a major cause of concern for me as the CEOs and their senior hospital managers' lack of engagement with the national processes on NHI will leave them and their hospitals ill prepared for the coming changes. In my opinion the NHI will have a great impact on the current public hospital services and issues of contracting hospitals to deliver on the NHI will be a crucial part of the coming debates.

4.5. Recommendations to government

Most CEOs were happy and committed to their jobs. But they acknowledge that there is always room for improvement and skills need to be enhanced. They wanted to be able to act independently, able to fill posts, procure and maintain their services and infrastructure with sufficient budget. More than anything they say is that "the tools of the trade are needed", and "finance, HR, goods and services that are adequate". (Interview 12).

The one CEO opined that CEOs need realistic budgets, which are activity based, and that CEOs should sign performance agreements that are related to explicit deliverables. Another CEO expressed his opinion as follows: “if there can be genuine delegations that allow managers to express themselves…if you fail (you sic!) will have to accept it yourself”. (Interview 1).

A CEO stressed the importance of having a supportive team around the CEO and he is quoted as saying: “You have a budget of over half a billion and you have a finance manager sitting at level seven or eight it doesn’t make sense”. (Interview 2). Another CEO from a different province said, in terms of delegations and advice to government:

> My first one will be the issue of delegations, which they must give us the power to run the hospital and include that if I want to buy something which I think is important I should be allowed to…and as CEO I should be able to appoint, we lose doctors because we wait for appointment letters from head office. (Interview 8)

CEOs also wanted to appoint their own executive teams that are adequately qualified and competent. CEOs also expressed the need for more support from the central or head office particularly in relation to HR, infrastructure maintenance and equipment. The CEOs also emphasised that: “You must have an enabling environment”. (Interview 2).

As far as our government’s attitude to NPM is concerned Fitzgerald (expert interview, 2015) felt that initially government was in tune with global trends (immediately post 1994). Joined up government is a manifestation of NPM. There are some current initiatives that according to him are NPM in nature such as the establishment of the Gauteng City Region (GCR) which is a strategic alliance of government partners in a joined up manner. The GCR works to some extent as he believes it is not joined up optimally. We are still occupied with the developmental state dogma. He felt that he was committed to it initially and we had good case studies, such as Malaysia and the Asian Tigers, but we went nowhere with it. Government was interested in other things. 10 years later Trevor Manuel started talking of the developmental state again. Prof Fitzgerald (ibid) believes that we have moved on: “we

have missed that train". He believes that the developmental state is a nostalgic idea where all government departments should be aligned. But Fitzgerald (ibid) does not see this happening. Provinces continue to function and will not relinquish their powers. You cannot have strong national, provincial and local governments. ANC technocrats tried to get rid of provinces but regional interests were so established that the idea was scuttled. So a centrally driven approach is not feasible in South Africa at present. He suggests that we should ask questions about using NPM going forward. Twinning for example is an NPM idea. We currently have twinning between some public hospitals and some French hospitals. The point that Fitzgerald felt that had to be made was to use resources available to you and others, create different kinds of relationships and that are more entrepreneurial, should use NPM with "a light touch" was Prof Fitzgerald's recommendations going forward. Governments understanding and implementation of the developmental state is outdated and a 20th Century trend. "We need an Intelligent State" (which has more NPM features such as e-government) according to Professor Fitzgerald (ibid). His view is that NPM is still relevant today but we need to create different kinds of relationships. The new paradigm in the 21st Century which builds upon NPM (and all the other earlier layers of change in public management) is called Public Value according to him. We should ask how the public sector adds value to the services they deliver. He made reference to the work of Bennington in this regard.

Public value is a new post Weberian paradigm but has elements of NPM in it according to the experts. It still retains the issue of incentives, partnerships and accountability. Performance Management and Monitoring and Evaluation are therefore still in vogue in government according to the experts. They believe that the New Development Plan (NDP) has NPM elements in it. However with the move to public value the aggressive approach to NPM has smoothed out. These are global movements taking place in this regard. Advanced democracies do not use NPM rhetoric. Our government understands this but does not want to admit it according to the experts. Fitzgerald (ibid) says "government can only go so far. The private sector is driving our economy. Government has to say that they want this all seeing democracy and has to build it." However he believes that as government we are in a limbo somewhat and we are moving to a semi-entrepreneurial state by default.

A critical recurring underlying sub- theme is a lack of leadership or lack of a continuity of leadership where institutional memory is often lost. One CEO also argued the case for continuity in leadership and is worthwhile repeating the quote to make the point:

> "You need a stable provincial office for you to expect to be stable, if in six years you have six MECs and six HODs, that's one MEC and one HOD per year you can't expect stability in the department. Every time you have new plans and ideas, before they can be implemented they are removed. (interview 5).

It was also pointed out (again) that it was only in the Western Cape that they had the same HOD for over ten years and every other province has changed their HOD numerous times.

> "People with institutional memory are gone; management by constancy is an issue". (Interview 8).

Criticism of the use of consultants when there are crises also came up: "..after three periods it is all over and we get KPMG in.. if we had good management we could have written the (policy sic!) documents ourselves". (Interview 5). The Gauteng Health Department at the time of doing this research was under administration and so were five departments in Limpopo and this was of concern to the CEOs. The Premier in Gauteng had appointed Price Waterhouse Coopers and other consultants to intervene until March 2015. The CEOs in the affected province expressed concern that soon everything will be under their control viz. HR, procurement, finance, security, communication and infrastructure.

The CEO of a psychiatric hospital advises that psychiatric hospitals are different from other hospitals and that the Ministers and other politicians approach to them should be different as there is: "no one-size fits all". (Interview 8). He further states that: "there are too many legal issues….many cases are taken to court….either they have to prove that they are mentally sound…" (Interview 8), and "the CEO should be involved with other stakeholders which include the community, the police, the department of justice, etc….. his job also has

political oversight but if he wants to transfer a patient to another province it is not him or the psychiatrist that decides but the HOD and the MEC".(Interview 8).

One CEO that was on the verge of retiring from his hospital said:

> for me it was a nice experience, after being a CEO I need to contribute something for that area. I am busy finalising a book that I am writing: ' Better Management of Public Hospitals', and that book entails a lot of experiences…and how I was implementing to improve a particular hospital.(Interview 12).

Inadequate funding on the whole was another issue that needed to be brought to government's attention. One CEO said that if he compares his hospital to others that have fewer beds that he is surprised that they get the same budget as his. Also the budget grows on average about five-percent a year so there is no real growth as this is often below inflation and this pushes him to take money from goods and services to be able to pay employees.

> Our budgets are growing at a rate of 5% so there is no real growth. In the last three years …..the needs have been increasing and most of the money goes towards paying salaries and benefits. They will be complaining that the hospitals are dirty, when people retire we can't replace them. …..the government must relook at budgeting…it must be zero based budgeting but currently it is not. (Interview 7).

A CEO from a rural hospital had a particular challenge in attracting and retaining staff and in particular health professionals. He suggests that government must put in place schemes such as bursaries to attract rural students to the professions so that once they qualify they will return to these areas. In summary the one CEO said: "two principles that I believe will sort out our problems..(we) should be ..given the necessary delegations and the money and people should be employed on a contract basis maybe five years renewable". (Interview 10).

Recommendations on further training were also made and the importance of the appointment of appropriate staff and the current nepotism that prevails:

> they appointed a chief operating officer here and it was a disaster and this person was promoted to the next post (CEO) in another hospital and it was again disastrous, and she was then asked to resign. She was not able to do her job, but she left two hospitals behind that have to get up… The corruption that goes on everywhere is because of this. (Interview 3).

An important piece of advice was to clamp down on corruption and control absenteeism. Another important recommendation was to re-evaluate the organograms and start getting improved and more appropriate organograms in terms of the norms of the facility. Infrastructure too was a huge challenge and CEOs often don't have an on-site handyman to assist with maintenance. They are too reliant on Public Works for infrastructure maintenance and development. The CEOs would like sufficient budget and delegations to allow them to deal with infrastructure needs independent of public works. One CEO elaborated upon these points as follows:

> The first thing will be the budget and on HR and evaluating and review of the current organogram… getting a proper organogram is essential in terms of the norms of the facility because that is the basis. If I can get that organogram that is really serving a purpose for the institution that will be a beginning….. We still do not have a handy man and we still have to deal with public works and the department of infrastructure and development, sometimes this is a huge problem .(Interview 6).

Another issue that nearly all the particpants felt needed to be addressed by government was that of hospital boards and their governance roles. They were often ceremonially appointed with no real powers. They needed to represent community interests and be properly trained and supported. This is seen as critical by the experts. The issue of governance and appropriate accountability mechanisms is of paramount importance if we

want to hold CEOs and hospitals as a whole accountable to the public they serve especially according to Van Den Heever (expert interview, 2015).

I concur with the CEOs overall advice to government which was that the CEOs were prepared to take responsibility in managing their hospitals effectively if given the appropriate delegations with the systemic support that goes with this. They wanted appropriate budgets, appropriate human resources and appropriate support for all their operational management functions. With this they felt that tailor made performance management agreements that dealt with clearly defined outcomes and results could be signed by the CEOs and that it should also take into account each CEOs unique challenges. Also the necessary governance structures should be placed so as to hold the CEOs and their senior management accountable. These views were supported by the experts and the senior hospital managers. The experts were sceptical as to whether these proposals would be implemented in the short term but was optimistic that they could probably phased in over time. The lack of political will and the nature of the current political power issues (e.g. tension between provincial and national governments) led to unnecessary and often negative consequences in the current running of the health services. However, a broader question that has to be answered is whether there is value in implementing these NPM reforms in the health sector and in particular in relationship to public hospital management in the current political climate? My suggestion on reflecting on the findings of this research, is that NPM reforms should not be indiscriminately adopted in the public sector and less so in the health sector and consideration be now given to Public Value as an added dimension to viewing public services going forward.

CHAPTER 5: NPM, HEALTH SECTOR REFORM AND CEOs IN THE PUBLIC HEALTH SECTOR IN SOUTH AFRICA

5.1. Introduction

This chapter integrates the literature review, the document analysis and the results from the quantitative and qualitative research in the context of international and local public sector reforms seen through the lens of NPM. The CEOs interviewed in the study do not operate in a vacuum. Their ability to function is also related to the degree that the South African government embraced NPM principles and tools in its reform of its administration and as regards health sector reform. This chapter also contextualise the CEOs and the other participant's views as described in the previous chapter within the ongoing public sector and health sector reforms that were undertaken by the South African government and in particular it's National Health Department since 1994. In South Africa post 1994 efforts to re-invent the post-apartheid state happened at the same as international shifts in the contemplation of what and how should the ideal workings of the public sector occur according to Chipkin and Lipetz (2012). Osborne and Gaeblers book, "Reinventing Government" (1992), became the reference public service reform text in the South African public sector context according to Fitzgerald (expert interview, 2015). Osborne and Gaebler argued the case that the state could still play a critical role in the economy and society provided it changed its view on the old bureaucratic model to applying a selection of new and more efficient tools which include private management practices that have been developed and tested in the business world (viz. NPM managerialism). The South African government partially adopted this NPM approach in its public sector reforms post 1994 (Cameron, 2009) and this is discussed next.

The New Public Management (NPM) practices and tools is what the ANC led government wanted to use without buying into its ideology according to Cameron (2009) and Fitzgerald (expert interview, 2015). The ANC believed that this new public administration style could be disassociated from its neo-liberal roots to serve a more democratic developmental agenda consistent with its Reconstruction and Development Policy (RDP) (ANC, 1994). The

attraction to an efficiency-driven public management agenda aligned itself with this thinking. Within some ANC think tanks the NPM argument resonated very strongly (Fitzgerald, expert interview, 2015). It ensured a way of keeping the leadership role for the state while aiming to avoid waste, inefficiency and corruption according to Cameron (2009). For the purposes of this reflection the main point to be elaborated upon is that from the late 1990s restructuring and transforming the public sector in South Africa borrowed largely from the NPM paradigm. Fitzgerald (ibid) supports this view but distinguishes the NPM paradigm from its neo-liberal roots and argues that one can use the NPM principles and tools without associating it with right wing or neo-liberal ideologies. He argues that the latter are more strongly influenced by public choice theory than is NPM as the ANC understands it. This research indicates that from a policy point of view that in fact the ANC led government did adopt the tools of NPM managerialism such as decentralisation, performance management, contract appointments, and accountability mechanisms but failed largely in its implementation. This as the research indicates is in the main due to the context that influenced the ability of CEOs of public hospitals to manage effectively. This is explored further in the next section thorough the lens of NPM.

5.2. New Public Management

The research as to what extent has the South African public service and in particular its health sector been influenced by the New Public Management (NPM) reforms from 1994 to date is first discussed. The adoption of the Department of Public Services of the WPTPS embraced the NPM principles of decentralisation and rightsizing; which means in essence the reducing of the size of the public sector; corporatisation in the form of changing public service departments into independent units or agencies; the formulation of the Senior Management System (SMS); the use of a performance contract system for heads of departments; the adoption of a flexible human resources system; and the introduction of performance management systems for all public servants; as measures to improve public service delivery (Cameron, 2009). Hood (1991) posits that NPM is a convergence of two different streams of thought. The one stream was business-like managerialism borrowed largely from the private sector. The other stream was based on New Institutional Economics

(NIE) which is informed largely by public choice theory, as well as transaction cost and principal agent theory. As informed by the research and opinions of the experts the ANC government primarily adopted the managerialism stream which are really private sector tools that attempts to improve the functioning, efficiency and effectiveness of the public sector. The NIE stream looks to privatisation and the creation of markets as its main mechanism to influence and improve the way the public sector delivers services. This is an important distinction and is clarified by the research.

The United Nations (2005) stated that most of the embracing of NPM principles could be attributed to the ongoing attention that organisations such as the Organisation for Economic Co-operation and Development (OECD), the World Bank and the International Monetary Fund (IMF) paid to it. Pollitt and Bouckaert (2005) argue that the extent to which NPM has superceded traditional bureaucratic public administration can be debated. There is also a growing view that NPM is perhaps inappropriate for developing countries (Manning, 2001; United Nations, 2005). However, international economic influences have been an important part of the picture that informed public administrative reforms according to Cameron (2009). Some of the general reasons for public sector reforms internationally are to contain public sector expenditure, improve the bureaucratic burden and redesign social policies that have become unaffordable (Pollitt and Bouckaert, 2004). This research indicates that we are not ready for wholesale NPM reforms in the public health sector and in particular as regards public hospital management. However South Africa was influenced somewhat by international trends and this is discussed next.

Bardill (2000) posits that public sector reforms in South Africa was shaped by the increasing globalisation, the lack of success of centralised state-dominated development strategies, the deepening economic crisis in the developing world and the influence of IMF/World Bank structural adjustment programmes. This led to a reassessment of the role and functions of the state by the ANC government. The Reconstruction and Development Programme (RDP) was one of the most important policy initiatives of the ANC led government post 1994 (ANC, 1994). It was according to Cameron (2009) a comprehensive, coherent, socio-economic programme which aimed to bring together development, reconstruction, redistribution and

reconciliation into a one national programme. It was a brave new vision for the fundamental transformation of South African society (RDP White Paper, 1994). The RDP was aimed to be a social democratic vision of a new South Africa, with an emphasis on the rights for the poor. However, due to tight fiscal constraints imposed by the previous regime onto the new government financial austerity measures were put in place. This led to the subsequent adoption of government's macroeconomic strategy: Growth, Employment and Redistribution (GEAR), in 1996 committed itself to more conservative and orthodox fiscal policies (Seekings and Nattran, 2006). Hirsch (2005) believes that GEAR was an economic strategy aimed mainly at reducing government budget deficit, albeit in the context of a broader developmental strategy. This led to a reduction in all national budgets in real terms (including health) and led to a state of paralysis as far its transformation agenda was concerned which included a slowing down of the adoption of NPM tools in the public sector.

Hirsch commented that although the government did not entirely abandon the RDP, public sector investment under GEAR remained low during this period of financial consolidation. The adoption of GEAR in 1996 according to Bardill (2006) led to some NPM public sector reforms being carried out in a more rigid budget driven paradigm with an emphasis on cost-cutting, rightsizing and private sector partnerships. Seekings and Nattran (2006) argue that only two of the four aspects of GEAR had been subsequently implemented, namely the reduced budget deficit and trade liberalisation. The other two, labour market reforms and privatisation were partially implemented. This according to Cameron (2009) weakened the implementation of NPM reform in South Africa. This patchy implementation of NPM is also seen in the health sector. The appointment of HODs on contracts, the implementation of performance management systems, the outsourcing of certain services, public-private partnerships, the tender process and the intention to decentralise was part of the public sector reform and in particular health sector reform agenda since 1994. Whether there have been some successes with PSR and HSR or not in terms of NPM is now debated.

South Africa was isolated during the apartheid era and was unaware of international developments in public administration according to Thornhill (2008). After 1994 it was quite evident as to what had to be done. There had to be a major transformation of the public

service towards a more democratic one which put customers (citizens) first (Fraser-Moleketi and Saloojee, 2008). In the early 1990s NPM was in its prime internationally and its principles had a great deal of appeal for the ANC led government according to Fitzgerald. The White Paper on the Transformation of the Public Service (WPTPS, 1997) was developed as the ANC governments' policy framework for the transformation of the public service and most of its recommendations were according to international best practice in public administration, namely through the adoption of NPM managerialism principles. The subsequent Presidential Review Commission of Inquiry on the Transformation and Reform in the Public Service (PRC, 1998) was set up to review the public service. The Commission had international advisors according to Cameron (2009) and Fitzgerald (expert, 2015) who were steeped in NPM thinking and made wide ranging recommendations which were implemented by government without often thinking through their ramifications (South Africa, 1998).

While the government did not lose its developmental and constitutional roles and responsibilities, most authors agree that NPM reforms were influential during this period of reform. Miller (2005) argues that much of the reform in South Africa paralleled those reforms in other countries such as United Kingdom (UK) and the USA. The Director-General for Public Service and Administration Richard Levin (2004) believes that public sector reform has been shaped by the tenets of NPM, which had a major focus on decentralisation of management and in particular that of human resources management. There were a range of reforms processes that influenced the shaping of the public sector. Geraldine Fraser Moleketi repeatedly argued that the ANC led government wanted to borrow the tools of NPM but not buy into its neo-liberal ideology (Fraser-Moleketi, 2010), a point also made by Cameron (2009) and Fitzgerald (expert interview, 2015). This led to some NPM tools being adopted in the general public sector reforms such as mentioned before viz. contract appointments, performance management systems, contracting out certain services, tender awarding to private service providers, public-private partnerships, and some move to decentralisation. This according to the research has unfortunately not materialised sufficiently and is borne out by the experts' opinions in this regard. In terms of decentralisation, the CEOs that participated in this study argue that delegations given in

2006 were slowly removed over the subsequent years and one CEO referred to them as "yo-yo delegations" as they would come and go depending on the MEC and HOD at the time. This element of decentralisation, namely delegations, had a political imperative that was pushed by most of the Ministers of Health over the last few decades but rarely sufficiently materialised. This was largely due to the influence, often resistance, of the MECs in the provinces and the political power they had over these processes according to the participants in this research. The participants in this research also felt strongly that there was none if any move to decentralisation during the last decade of health sector reform. Decentralisation was a ministry of health's priority, which had numerous task teams and inter-ministerial committees trying to advance it for over the last 20 odd years, but failed to have been affected because of a whole range of reasons. The main reason according to this research was a lack of political will and support particularly from the provinces. Decentralisation is one of the first steps to implementation of NPM PSR reforms and is briefly scrutinised below in terms of the findings of the research.

5.3. Decentralisation

One of the main characteristics of NPM is the dismantling of many central control mechanisms and passing them on to lower tears of the public service (Polidano, 1999). In NPM language, decentralisation is the means to enable line managers' greater managerial authority and responsibility. Hood (1991) aptly describes this aspect as hands on professional management i.e. let the managers manage. Also, devolving human resources and financial management functions to managers is another important component of NPM. The Public Service Amendment Act of 1997 (South Africa, 1997) made the Minister for Public Services and Administration responsible for policy on functions of the public service, conditions of service, scales of salaries and wages, allowances of class, rank and grades, employment policy, its organisational structure, transfer of functions, post establishment, creating, grading and abolition of posts and appointments, and promotions and transfers (Ncholo, 2000).

A further amendment to the PSA in 1998 led to provincial departments reflecting the structures of their related national departments. Thus the members of the executive councils (MECs) in these newly created provincial departments now had the managerial authority to organise their departments and hire and fire their employees as they feel fit (Adair and Albertyn, 2000). This quasi-federal constitution meant that there was decentralisation down to sub-national actors such as provinces. Cameron (2009) commented that it was important to note that these executive powers were decentralised down to the level of politicians and not to managers, although provisions were made for further delegations to managers. This was according to Cameron (2009) inconsistent with international best practice, which rather than saying "let the managers manage" which is one of the central tenets of NPM, was more of a situation of "let politicians manage" (Hood, 1991, p. 3). This criticism of having the politicians' manage is also made by the experts that were interviewed. They also blame the politicians for inept bureaucratic appointments on nepotism, patronage and inappropriate ANC cadre deployment.

The main reason post 1994 for not adopting or fully embracing NPM principles and particular its essential element of decentralisation according to Cameron (2009) and Fitzgerald (expert interview, 2015) was that the ANC government did not trust the white bureaucrats of the old regime. These were still the majority of the staffing in the higher levels of public administration, a legacy of the past regime agreed to in the negotiations that led to a Government of National Unity post 1994. Executive politicians were required to change the higher echelons of the bureaucracy according to the ANC led government post 1994. Subsequently new Public Service Regulations were introduced on the 1st July 1999. They were to replace the detailed human resources provisions contained in the old Public Service Staff Code. These new regulations according to Cameron (2009) were intended to transform the staffing structure of the public sector and promote the decentralisation of human resources power to lower levels of management (South Africa, 2001). However what must be borne in mind and emanating from the research that staffing, especially at senior levels, were largely political appointees (as confirmed by Van Den Heever and Eyles, expert interviews, 2015). This research, within this political context, attempts to unpack the degree to which decentralisation and delegations occurred in practice. One view as expressed by

the previous DG of the PSA is that decentralisation has been a failure (Levin, 2004). Levin argued that decentralisation has not really empowered managers with the necessary resources to use these delegations effectively. Van Den Heever and Fitzgerald (expert interviews, 2015) argue that politicians also did not really want to decentralise. According to the experts when politicians did appoint people in senior positions these were often done through patronage and nepotism than by expertise in the field. This created often bloated bureaucracies that were largely inefficient but with strong political oversight. This according to the research contributed to the lack of decentralisation and delegations and this is confirmed by the interviews with the CEOs and senior hospital managers.

The CEOs and senior hospital managers argued that they cannot manage their hospitals effectively within the current situation largely because of inadequate delegations and poor head office support. This was in their opinion due to a generally inefficient bureaucracy that impacted negatively on finance, human resources and operational management in the main. The issue of appropriate governance structures for hospital boards, as raised by numerous ministerial tasked teams and described in the earlier chapters, were also never properly addressed until now according to the research. The Policy on the Management of Hospitals (2012) indicates an intention to create independent and much more functional hospital boards. There is also draft legislation on the development and implementation of new governance structures for central hospitals or group of central hospitals that appears to address this (South Africa, 2015). In this draft piece of legislation the establishment of the hospital board and its control over and management of central hospital are elaborated upon. The hospital board (executive board) will appoint the CEOs and set the strategic direction of the hospital. It will hold the management of the hospital accountable in terms of performance agreements. This appears to be going in the right direction as far as delegations and accountability of CEOs are concerned but there will be contestation with the provinces as the central hospitals will have to become a national health function to achieve this and the Western Cape, governed by the Democratic Alliance, has made their opposition on this this quite clear according to this research.

While some policies for decentralisation have been put in place, there have been limited decentralisation and delegations in practice according to the experts interviewed. Also more importantly there has been a consistent lack of accountability frameworks put in place where decentralisation has occurred. In 2008 the DPSA requested all national and provincial departments to provide it with a list of delegations of powers and duties in terms of the PSA and Public Service Regulations. Seventy three out of 151 departments responded: a third of the respondents had limited delegations from EAs to HODs, 39% had average delegations, 18% had above average delegations and 19% had extensive delegations (DPSA, 2008).

These findings show that most departments are still not decentralised, with only 37% (18% above average and 19% extensive delegations) of HODs having a reasonable degree of delegations according to the report. In addition the data reveals that a trend was emerging where departments which were performing well were more likely to have delegated a fair proportion of powers and duties to HODs (DPSA, 2008). These findings therefore indicated that most managers have not been given sufficient powers to manage even at HOD level and most of the powers rest with the Executive Authorities (the MECs). This has been confirmed by the CEOs and experts that were interviewed in this study who argued that how can you hold managers accountable for service delivery if they have not been given sufficient authority to manage? As pointed out before CEOs wanted more delegations and the systemic support that goes with it. One Director General, according to the DPSA report (2008) said that the institutional parameters are not there for managers to manage. Another issue was that Ministers and MECs sometimes bypassed DGs or HODs and to manage other managers lower in the hierarchy. This has also been argued in the interviews with the CEOs and senior hospital managers where there is a nationwide experience of CEOs being removed or moved (redeployed) after political intervention. All CEOs and senior hospital managers complained without exception as to a lack of decentralisation particularly as it relates to human resources management (the ultimate power rests with the politicians, the MECs for Health in the provinces). Some CEOs and senior hospital managers complained that they have to get head office permission to hire new staff and even sometimes at the level of a new cleaner. Experts view this problem as political. The politicians don't want to relinquish power. The expert's views are that politicians fail to see that they can become

facilitators through the use of NPM tools in that they can control via regulations. The politicians fear the loss of power according to this research, or perhaps they do not want to relinquish the power they have as they don't trust the bureaucrats that they employ.

The conclusions of my research resonate with the discussion above and this is summarised as follows. The CEOs are very frustrated at the position they find themselves in. Their main challenge in enabling them to manage is not having the appropriate delegations for financial management, human resources deployment, operational management and eventually influencing health outcomes positively. However this decentralisation has to be within an appropriate accountability framework according to the expert interviews. Accountability cannot be held by CEOs if they are not given the appropriate powers and authority. The experts highlight the issue of a lack accountability in the public sector generally particularly around the financial implications of problem such as corruption and inefficiency. Political interference is according to this research the major contributor to the problem. The relevance of the research is that it examines the problems that CEOs face in managing South African public hospitals, explains them, compares them and validates them in relation to NPM theories and international viewpoints. The research indicates that at best only a few tools of NPM were adopted and these often patchy or incomplete (Cameron, 2009). It furthermore explicates the view of a selection of CEOs, experts in public management and senior hospital managers and their views on how to solve the managerial problems faced because of a lack of decentralisation (which includes governance)and allows them the opportunity to offer solutions. Another huge challenge identified by most of the participants was financial public service reforms and this is discussed next.

5.4. Financial Public Service Reforms

Finances are generally more regulated than human resources because of their macroeconomic implications, most notably the impact of government expenditure on the budget deficit. One of the NPM tools is to decentralise financial management to lower levels of governments or agencies and put in the appropriate accountability frameworks and structures. Tenders and the procurement processes have been problematic according to this

research. There is therefore a particular concern that procurement policies are not open and transparent. The PFMA has also influenced politics-administration relationships in that it has sometimes led to conflicting lines of authority according to Cameron (2009). The DG or HOD has clear responsibility and accountability for financial management, while the executive politicians are ultimately responsible for human resources management. The PFMA made the DG or HOD responsible for the financial resources of his or her department as the accounting officer. It provides for a wide range of functions and responsibilities, including implementing internal audit systems, efficient use of departmental resources, effective systems for controlling financial resources in departments, management of liabilities and ensuring the safeguarding and maintenance of assets, and undertaking disciplinary action against public servants who contravene the Act (Miller, 2005). This has been problematic in the public sector in general and in particular for CEOs of public hospitals in South Africa according to this research.

The Public Finance Management Act (PFMA) (1999) introduced financial reforms and three year planned programme budgeting (DPSA, 2004). This Act introduced a performance based approach where the concentration was shifted from inputs and rules to outputs and responsibilities. The objective included giving greater responsibilities to officials but at the same time holding them more accountable. It also allowed for the modernising of the system of financial management in the public sector. However, Fitzgerald (expert interview, 2015), believes that the PFMA is too restrictive and that it does not empower managers to make discretionary financial decisions. However, if anything there has been a move towards centralisation according to him. This view is supported by Cameron (2009) as well. This again is borne out by the interviews with the senior hospital managers as well as the other experts. CEOs are given a budget letter in the beginning of the financial year, often with insufficient funds, to operate their hospitals but all the payments are centralised with tons of red tape to negotiate through. Line items are kept rigid and there is no space to make discretionary expenses, a real problem in allowing managers to prioritise expenditure, a point also made by all the experts (2015). Procurement is a huge problem that was emphasised by the senior hospital managers during the focus group discussions. They believe that they have the inappropriate staff in charge of SCM and there is no real

accountability held by staff doing procurement. They believe that these staff members in procurement are incompetent and inefficient but because of blurred reporting lines they are not held accountable for non-performance. This is the place that corruption creeps in according to this research. This view is supported by the experts who believe that there are no mechanisms within the public sector to weed out non performers and procurement in particular is prone to corruption. In conclusion therefore, despite the best intentions of the PFMA i.e. to hold HODs and DGs accountable, it does not facilitate a process for sufficient delegations lower down the line management and therefore inadequate decentralisation. However it allows for corruption creep within existing functions and it cannot manage this adequately within the current bureaucratic structures. In theory CEOs are held accountable for huge budgets, anywhere between R400 Million to R2 Billion rand, but they are not privy to its determination nor its actual spend. Van Den Heever (expert interview, 2015) argues that current budgeting systems are archaic and inappropriate. The current legislation (viz. the PFMA) does not support the implementation of NPM reforms. The research indicates that hospitals should determine their own budgets and be held accountable for its expenditure, and most importantly, this within the appropriate governance frameworks.

5.5. Health Sector Reforms in South Africa

The CEOs and senior hospital managers' views on current health sector reform in South Africa were largely informed by their own experiences. They in fact knew nothing about the NPM paradigm and its influence on current public sector reform. A brief account of the sequence of the current health sector reforms post 2007 as informed by the literature review and document analysis is described next. It was most recently refined at the National Conference of the ANC held in Polokwane in 2007 and was informed by all the previous ANC policies that go back as far as the Freedom Charter of 1958. The ANC government was aware of the growing concerns of the poor performance of its health sector (Schaay, Sanders, Kruger, 2011). According to these authors the sequence of events was as follows. Firstly a Health Sector Roadmap was determined and this provided a diagnostic view of the key problems facing the health sector. It was commissioned by the ANCs National Executive Committee's (NEC) Sub-Committee on Education and Health in 2008 and coordinated by the

Development Bank of South Africa (DBSA). The Roadmap report and other consultations led to the Health Minister's 10 Point Plan which intended to guide government health policy for the next few years. It also identified opportunities for coordinated public and private health sector efforts in order "to improve access to affordable, quality health care in South Africa" (Rispel, 2010, p. 1). The 10 Point Plan informed the National Department of Health's Strategic Plan 2010/11-2012/13. Two important points of the 10 Point Plan need to be highlighted here as they are of particular relevance to the functioning of public hospitals. The one point was no. 3. Health Service Quality Improvement, and point no. 4. Strengthening health care system management. This clearly indicates that the ruling party identified these two issues as important in improving health care delivery in South Africa and this also informed the development of the purpose of this research, albeit only focussing on CEOs and public hospital management.

On the basis of the 10 point plan and the establishment of a Performance Monitoring and Evaluation Department in the Office of the Presidency and the release by the National Planning Ministry of the Medium Term Strategic Framework (MTSF) 2009-2014 a performance agreement between the President and the Minister of Health was signed in October 2010. This is articulated as the Negotiated Service Delivery Agreement (NSDA) (signed between the Minister of Health and the President) for the Health Sector. This was based on the government's vision to better the life of all South Africans (A Better Life for Al)and in particular to attain Outcome 2: A Long and Healthy Life for all South Africans. For the health sector there were four strategic outputs identified which the health sector must achieve.

Output 1: Increasing life expectancy

Output 2: Decreasing Maternal and Child Mortality

Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

Output 4: Strengthening the health system.

With the setting of the NSDA and with reference to output 4, a significant number of health sector reforms were planned to be undertaken. In 2011 the Minister released a green paper

on the National Health Insurance (South Africa, 2011) as his first major piece of legislation under his headship. A further White Paper on the NHI was released in December 2015 (South Africa, 2015). This proposed NHI is a plan for a financing mechanism for the health system that will pool mandatory contributions and public sector finance to purchase services from accredited public and private sector providers. The main aim of the NHI is achieving universal health coverage for all South Africans. In its first five years of being rolled out, the key focus is to strengthen the health system through: "Improved management of health facilities and districts; Quality Improvement; Infrastructure Development; improved medical devices and equipment purchases; Human Resources planning, development and management; and Information management and systems support" (South Africa, 2015). The establishment of the NHI fund is intended to be a government-owned entity that is publicly administered.

Research was commissioned to inform the NHI process and Schaay, et al (2011) reviewed how to improve the running of the services by assessing hospital autonomy issues. Also in recognition of the need to improve quality of care as per the 10 point plan the Ministry of Health implemented a number of quality assurance and quality improvement programmes according to Schaay, et al (2011). These included the setting up of National Core Standards for Health Establishments in South Africa (South Africa, 2011). The core standards consist of seven domains. The first three relate to the core business of the health system: delivering quality health care to users or patients. These are: Patient Rights, Clinical Governance and Care, and Clinical Support Services. The remaining four domains are essentially the support systems that ensure that the core business is developed and these are: Public Health, Leadership and Corporate Governance, Operational Management, and Facilities and Infrastructure. The Office for Health Standards and Compliance (OHSC) has already audited health facilities including hospitals and are piloting auditing tools according to the CEOs.

As part of the plan to improve health systems management a Healthcare Management Project, initiated by the Ministry of Health and facilitated by the Development Bank of South Africa, was carried out to assess the competency of public hospital CEOs and district managers and was reported upon earlier in this research (DBSA, 2010). According to the

DBSA (2010) the way of determining the competence of hospital CEOs would have been to review individual and institutional performance data and compare these. The DBSA could not find reliable individual performance data and given the number of factors that contribute to the overall institutional performance, it was impossible according to them to make any firm conclusions about individual performance based on this data. Thus they developed their own health management competency framework, scorecard and assessment battery which was used to assess each CEO. The key components of the scorecard were: qualifications, experience and assessed competencies. The findings of the DBSA study concurred somewhat with this research in terms of qualifications and experience. However it did not objectively assess performance and fails to get any viewpoints from the CEOs or health manager's perspective on what their opinion of the management challenges there are. This is also the view of Van Den Heever (expert interview, 2015) who criticised the DBSA process as being unscientific and inappropriate. He felt that objective measures of performance were not used. He also criticises the DBSA research on not answering the question as to how the CEOs were appointed in the first place and secondly what are the hospital senior managers views on how do the CEOs perform (for example a 360 degree assessment was not performed). Most importantly according to him was the issue of how CEOs and senior health service managers are held to account is ignored. He was especially concerned as to what sort of independent democratic governance structures were to be put in place to hold CEOs and their senior management accountable.

The DBSAs findings however, incomplete as it was, informed the current Policy on Hospital Management. Its main failing in my opinion and confirmed by the experts is that it was not informed by the CEOs lived experiences and challenges in running a public hospital. This research argues the case that CEOs of public hospitals face many challenges in their day to day work. This has largely stemmed from the fact that they do not have the necessary delegations and support to do their work properly. A lack of political will and a lack of enabling policies and accountability frameworks are the key limiting factors according to the CEOs, senior hospital managers and experts in public management that I interviewed. This is not reflected in the DBSA findings at all. Other limiting factors that these participants

identified are inadequate human resources (lack of health professional staff and lack of support staff), inadequate financial resources and inappropriate information technology. The experts believe also that as long as we don't provide appropriate accountability frameworks and hold senior managers to account delegations in themselves may not lead to efficiency. Van Den Heever (ibid) in particular emphasised the case repeatedly that we need the appropriate governance structures in place before delegations are given to CEOs. Also, Fitzgerald (expert interview, 2015) does argue that decentralisation is still an important aspect of managerialism thinking but is concerned that government is still ambivalent about implementing it and the rationale behind this is that politicians feel that they will relinquish power if they do so.

Conclusion

CEOs of public hospitals in South Africa operate within a particular political climate that determines the way they function. All PSR and HSR are largely determined by the political context according to this research. The government wanted to adopt the tools of NPM but not buy into its ideology. It also got huge resistance from the provincial executives (MECs of Health in particular) in trying to decentralise and delegate financial and human resource in particular to line managers such as CEOs of hospitals. This led to an inefficient public sector in general and health in particular as regards the management effectiveness of hospitals. The use of the NPM paradigm and its usefulness within the South African has to be questioned according to this research particular in the light of the politics at play.

According to the literature review, document analysis and the qualitative research South Africa is not ready to buy into the entire NPM paradigm at this point in time. This is because we do not have the relevant expertise nor capacity (particularly in finance, human resources and supply chain management), nor the appropriate information systems (lack of e-government) to make appropriate and timeous decisions. There is also a glaring lack of appropriate accountability frameworks (such as democratic governance structures) in the public sector in general and in public health care in particular. Most importantly, and this research concludes this, is that the political context invariably determines whether we move

towards this managerialism framework or not. There has been a reluctance from politicians (MECs in the province) to relinquish power and move to more centralisation (Cameron, 2009). This view was shared by the all three experts interviewed in this research. International experience and in particular the African experience according to Awortwi (2006) and Vyas-Doorgepersadh (2011) also makes this point.

Some commentators, such as Hutton (1996), point to fundamental weaknesses in the NPM ideology implementation and as a contributor to relative economic decline where these NPM principles are implemented. As far as the health sector reforms are concerned the qualitative research indicates that CEOs want to manage effectively with the appropriate decentralisation mechanisms in place that will allow for clear cut delegations and accountability mechanisms put in place. What is needed is a re-evaluation of what NPM tools can be used to improve the efficiency and effectiveness of the public hospital system in the current South African context if any. According to Fitzgerald (expert interview, 2015) we have in fact moved beyond NPM per say and should reconsider the new public management paradigm of what are public goods, does the public have choice and the importance of public value. I have not deliberated upon the Public Value approach as espoused by Bennington (2005) as the South African public sector has not embraced its principles. I definitely believe, and as informed by this research, that we should now include it in the discourse of current public sector reform.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. Introduction

This chapter interrogates the research question and links it to the research findings that have been interpreted through the lens of NPM and in the context of current health sector and public sector reform in South Africa. The purpose of the study was to explore the views of CEOs in public hospitals in South Africa as regards the managerial challenges they face and what possible solutions there are in improving these. Their views were complimented by in-depth discussion with public management experts (a view from the top) and a focus group discussion of senior hospital managers (a view from the bottom). This research shows that there are systemic restrictions on the ability of CEOs of public hospitals to perform. The voices of CEOs in public hospitals have not generally been heard. Their views, opinions and recommendations on how to better manage public hospitals have not been articulated before. This research provides critical information that is informed and expressed by the practitioners themselves. Further depth in terms of understanding the research question was gleaned through the interviews of experts in public management and the focus group discussion with senior hospital managers. The triangulation of all these findings with the literature review and document analysis is presented in this concluding chapter. Recommendations for consideration are also presented here.

The quantitative study outcomes showed that of the 30 CEOs who completed and returned the questionnaire all had some form of higher education, and a reasonable amount of experience(average was 7.7 years and DBSA recommends 6 years). The majority were African (87%) and male (53%). The most important point that the CEOs emphasised was that in the current circumstances they were bureaucratically hamstrung and unable to manage effectively (86%). This is a worrying figure and does not appear anywhere in local literature, policy or research. It is patently absent in the DBSA (2010) research commissioned by the NDoH in assessing the competence and requirements for CEOs in public hospitals in South Africa. Most CEOs felt that they had insufficient delegations for managing their finances,

staffing and quality of care. The majority felt that they needed more delegations for finances (90%) and for staffing (100%).

These findings concurred with those of the in-depth interviews of the CEOs and of three experts in policy and management and the focus group discussions with the CEOs and with senior hospital managers. Most of the CEOs explained that the main impediments and challenges facing them were systemic and lack of clear policy direction. In their opinion some legislative constraints (such as the PFMA and PSA) were also placed on the scope of their financial, human resources, performance and operational management capabilities. These powers for all intent and purposes were held at provincial head offices (at MEC and HOD level). It was not only a matter of decentralisation and the devolving of delegations but of ensuring that there were effective processes on the ground in terms of adequate staffing (professional and support), support systems such as HIS and most importantly appropriate head office support. They urgently wanted clear and appropriate delegations and were prepared to take the consequent responsibility and accountability. The experts felt that delegations in themselves will not address the managerial challenges. What are needed more importantly are democratic accountability frameworks. In particular they believe it is important to have appropriate governance structures to be put in place first before delegations are given. This governance structure should have no conflicts of interest and should be able to hold the CEOs and senior management to account on predetermined deliverables. The research also stresses that relevant monitoring and measurement processes are to be put in place which has to hold the CEOs and senior hospital management account to these democratic governance structures. The process of measurement and accountability also has to be transparent. The latter i.e. being transparent, in effect being the main measure of public accountability. However, this research shows that this is unlikely to occur because of the politics at play i.e. the political context will ultimately determine if decentralisation will ever take place.

This idea of using NPM tools such as decentralisation with both the appropriate delegations and accountability mechanisms are critical in enabling institutions such as public hospitals to manage themselves better. There is currently draft legislation enabling the establishment of

hospital boards with accountability mechanisms for CEOs but only covers central hospitals contingent on these hospitals becoming national responsibilities (South Africa, 2015). However this is unlikely to be implemented in the short term as it first requires that the NDoH take over the running of central hospitals and this research shows that many provinces are resistant to this (arguing that the delivery of hospital services are their constitutionally charged duty of province). The CEOs and the senior hospital managers were also unhappy with the current performance management systems that were in place. They were all prepared to sign performance contracts if given the necessary powers and resources and to be held appropriately accountable. The CEOs currently don't sign the budget letters given to them and their performance contracts are generic with no real incentives or disincentives for CEOs. The CEOs were also concerned that the current performance measurement system as being far from adequate. I agree with the views of the experts in public management to dismiss the current PMDSs as inappropriate and in fact suggest that it should probably be discarded in its present application. The CEOs too highlighted the fact that there was no alignment between their performance management systems and that of the institutions ability to perform particularly in the light of the work of the Office of Health Standards and Compliance (OHSC). Of concern was that there was little obvious structural preparation taking place aside from meeting OHSC requirements for the implementation of the ambitious NHI (National Health Insurance) that the Minister of Health has embarked upon. The research findings are also critical of the functioning of the OHSC. The current OHSC audit mainly looks at input and process indicators and does not hold CEOs to account. The main criticism of the OHSC audits is that they will not be made public (i.e. a lack of transparency) according to Van Den Heever (expert interview, 2015).

This is an important consideration in that the NHS in the United Kingdom (UK) publishes league tables for hospitals according to Eyles (expert interview, 2015) and should be considered as part of public accountability requirements. This in the light of the current health sector reforms in South Africa where the proposed NHI borrows a lot of its ideas from the UK NHS. The senior hospital managers also see some of the OHSC audit indicators as inappropriate for hospitals. There has also been a clear lack of involvement of CEOs and senior hospital managers in the preparation for the NHI. This is a critical oversight by the

Minister in my opinion in that the bulk of health expenditure occurs through hospitals. Furthermore, with the move towards the NHI, decentralisation of public hospitals was going to be a possibility notwithstanding some opposition to it. The NHI is looking towards a model based largely on the United Kingdom's experience of establishing independent trusts (or boards) to oversee the running of hospitals in a decentralised manner. In relation to this the implications of the White Paper on the NHI (South Africa, 2015) which was released after this research was done are discussed next.

6.2. Implications for Implementation of the National Health Insurance

Since the launch of the Green Paper on the National Health Insurance in August 2011 (South Africa, 2011) there has been substantial progress according to Matsoso and Fryatt in terms of health sector reform, hospital management and performance standards setting and evaluation (2013). Part of this progress according to these authors is related to hospital management reforms. Regulations on the designation of the various types of hospitals and on policy and governance were released for public comment on the 2nd March 2012 (South Africa, 2012). The regulations gave clarity on the categorisation into district (small, medium and large), regional, tertiary, central and special (such as psychiatric and tuberculosis hospitals), and the services that should be provided in each. This regulation also broadly defined the roles and responsibilities of Chief Executive Officers (CEOs) and this a key step according to Matsoso and Fryatt (2013) in ensuring the appointment of appropriately competent hospital managers paving the way for the decentralisation of management. However, the findings of this research indicate that there are already appropriate CEOs that have been appointed in the main and that there are often political and systemic factors that constrain their performance. Most importantly this research indicates that there has been little if any decentralisation to public hospitals taking place.

The subsequent White Paper on the National Health Insurance was released on the 10th December 2015 (South Africa, 2015). Pertinent points related to this research are briefly discussed here.

The White Paper builds on the Green Paper of 2011 in that it articulates a more detailed plan as to how the NHI will be rolled out and what the financing options are. Its main focus is to provide universal health coverage to all South Africans in an affordable manner. Of interest to this research is that it talks more clearly to a purchaser provider split. It talks to the accreditation of health service providers, private and public, as well as elaborating on provider-payment at hospital level. The NHI fund will be the single purchaser of personal health services for the population The NHI Fund will contract directly with accredited public and private facilities at the relevant level of care. It identifies the problems as raised in this research that public hospitals are paid through inappropriate budgeting mechanisms. The policy suggest a move towards a case-mix activity adjusted payment system (such as Diagnostic-Related Groups or DRGs) to hospitals irrespective of whether the hospital is public or private. There is also a move to greater management autonomy by establishing governance structures such as hospital boards across all levels of hospital categories. It talks to an establishment of a National Health Information Repository and Data System. The White Paper is quite ambitious in what it wants to achieve in quite a short space of time. It does however address some of the concerns raised by this research in that it argues for better governance structures. But whether these will be independent and able to hold CEOs accountable is not that clear. Also the CEOs roles will have to dramatically change. As can be seen from this research CEOs are largely unprepared for this new role as envisaged by the NHI. This in my opinion is because of their lack of involvement with the discussions of the implications of the NHI. They need to be much more involved with the Ministerial teams that have been created to address the various aspects of the NHI and in particular its implications for public hospitals as these changes are planned to be phased in over the next five years.

A major concern as informed by this research is regarding the planned structure of the NHI in that we do not have the appropriate technical support staff, both at purchaser and provider level, to provide the necessary information available for timeous decisions as this model currently demands. All the CEOs, the public management experts and senior hospital managers complained of this lack of professional competent support staff and inefficient, outdated information systems. A professional bureaucracy is critical to any PSR which uses

NPM principles according to Awortwi (2006).This in particular as it relates to financial management that is required for such a complex purchaser-provider split.

The OHSC will have to be much more involved in ensuring quality of care and appropriate costing and charging of services at all levels of care rather than focussing on input and process measures as it currently does. Our current HIS is and has always been the Achilles heel of our entire public health system and is particular poor in our public hospitals as demonstrated by this research. We will have to have detailed information as to the unit costs at the various levels of care and this will have to be risk adjusted. This requires skills that are really in short supply in South Africa. Another concern as regards this White Paper on the NHI is that it has copied quite a bit of its structure and principles from the experiences of the current NHS of the United Kingdom without testing its feasibility in our context. There has been no clear demonstration of whether the UK NHS has become more efficient since it moved to the purchase provider split model under the Thatcher government (and her interpretation of NPM largely driven by public choice theory and private sector involvement) and which is now continued to be tampered with (and continued to be dismantled in my opinion) by the current Conservative government.(Hood and Dixon, 2015).

As mentioned before the NHI policy (2011) and the recent White Paper (2015) talks to changing the way the management of hospitals will take place due to the separation of purchaser and provider functions and is of particular importance to the future functioning of public hospital managers. I am certain that with the current crop of CEOs, competent as they are in my opinion, may require the appropriate training and support to do this effectively. According to the NHI policy complex institutions such as hospitals need highly skilled and empowered senior managers to ensure the provision of efficient and high quality services. The NDoH has prepared draft guidance within the regulations for the strengthening of hospital boards in the public health sector. In addition, the NDoH plans to take over the management of central hospitals. Work in this regard has already started with three hospitals in Gauteng viz. The Charlotte Maxeke Johannesburg Academic Hospital, the George Mukhari Academic Hospital and the Steve Biko Academic Hospital.

These hospitals render highly specialised services (tertiary and quaternary) on a national basis and are a platform for the training of health workers and for carrying out research. They also function as referral units for the other hospitals and employ highly trained staff. Initial work has focussed on the establishment of functional business units that will define the costing of services, revenue generation, collection and retention as a first step in strengthening their information and administration systems. Also, a case-based hospital payment system (based on Diagnostic Related Groups) is being piloted in several hospitals including Umtata (Eastern Cape), Universitas (Free State), and Inkosi Albert Luthuli (KwaZulu-Natal) (Matsoso and Fryatt, 2013). However this research indicates that most of the CEOs and senior hospital managers of public hospitals are unaware of the implications of these NHI initiatives on the future functioning and financing of their hospitals. In fact the CEOs and senior hospital managers have not been invited to any discussion of the NHI to date.

A notable achievement of the NHI process was the advertisement of senior manager posts and the appointment of new health facility managers in 2013 and 2014. Whether this has strengthened the health system capacity is uncertain. This followed the report from the DBSA (2010) on the assessment and capacities of senior health managers in 2010. There has also been re-imbursement reform with many CEO posts re-graded and then advertised. 102 of the 118 new CEO positions have been filled (i.e. 86%). A decision has also been taken by the NDoH that in future all senior health service managers will need to have undergone specialist training and be accredited by the newly established South African Leadership and Management Academy. The improvement of administration and management is high on the NDoH agenda. But what is missing is that all these initiatives appear to be top down and are not informed by the CEOs experiences on the ground (i.e. not bottom up). Also and more importantly appropriate accountability mechanisms (in particular democratic governance structures) have still not been put in place.

None of the current initiatives seem to address the concerns raised by the CEOs and the senior hospital managers in this study. This is largely due to the fact that the CEOs have not been engaged in policies that affect them. All the recent policies are driven by the Minister

and the NDoH and are too prescriptive according to this research with no real engagement of important stakeholders including the CEOs. This also interferes with the autonomy of the provinces which have constitutional implications according to the experts. The Western Cape in particularly, run by the opposition party (the Democratic Alliance) has largely ignored the Minister of Health's policy in implementation. This will be another area of contestation as regards the NHI going forward. According to this research all that appears to have happened as regards public hospital reform during the study period is that the government shuffle the chess pieces around, namely CEOs, and is clearly not addressing system, process or policy issues that improve the way they function. The CEOs, senior hospital managers and the experts interviewed raised the issue of the serious lack of adequate budgets and inappropriate budgeting systems. The current NDoH plan is to look at cost centres as part of the creation of functional business units but that is long term and does not address the immediate problem of a lack of financial information systems capacity in most public hospitals that can inform current budgeting processes appropriately. There is some commitment to improving infrastructure and the setting aside of moneys for this but inexplicably there is no mention of any improvement in the provision of medical equipment, drugs and other supplies. The latter is mainly due to the current poor financial management and inefficient payment systems. Suppliers are not paid in time, a perennial problem affecting nearly all government departments that result in public hospitals running out of essentials such as medicine and equipment as well as food for patients.

The CEOs and senior hospital managers have repeatedly stressed the importance of appropriate human resources both in capacity and quantity. There is in contrast not a mention of appropriate staffing structures in any document released by NDoH in the capacitation of facilities and in particular hospitals. The severe lack of health professionals is a chronic problem that will probably worsen in the future and the lack of support staff such as porters and cleaners is becoming a crisis in some hospitals. However, as mentioned before there has been a draft document on the development and implementation of new governance structures for central hospitals or group of central hospitals (South Africa, 2015). Albeit in draft form it goes some way to address issue of accountability structures for central hospitals. It gives much more responsibilities to hospital boards and sets up

mechanisms to hold CEOs of central hospitals accountable to these new governance structures. Whether this will ever materialise remains to be seen?

This approach according to the experts interviewed should be rolled out to all public hospitals. However the CEOs and the senior hospital managers were in the main unaware of the implications of this draft legislation. The White Paper on the NHI elaborates much more on having governance structures across all levels of care and suggests it be phased in. If these governance structures are democratic, independent and can hold CEOs accountable on the performance of the institutions than this may well work in the long run. This research indicates that these will probably be political appointments reporting directly to vested political interests. The CEOs will be given new performance criteria and hopefully it will include being measured against health outcomes as well as financial management as was requested by CEOs in this research. Much more work needs to be done on what exact measurements will CEOs be judged against and how will these measurements be done, by whom and most importantly how will the CEOs be held publicly accountable for their performance.

The Office for Health Standards and Compliance (OHSC) was established in 2013 according to legislation (South Africa, 2013). The overarching objectives of the office are to protect and promote the health and safety of the users of health services. However it uses institutional performance measurement tools. Its functioning will have to now align with the White Paper on the NHI in that it will now be the key accreditation body for both private and public sector services and will probably have to be the quality assurance and efficiency monitoring body. At this stage it is still very far from being able to do any of these competently according to the research. However, improvement in the quality of services through ensuring compliance with standards will remain the responsibility of health service providers. Since the promulgation of the legislation and the establishment of the OHSC there has been an audit of 3880 public sector health facilities (including clinics, community health centres, district, regional, specialised and tertiary hospitals) in all nine provinces using specialised performance measurement tools for certification purposes (Health System Trust, 2013). The main criticism levelled at the performance measurement indicators is that

they are largely input and process indicators and not output or outcome indicators, often not appropriate for public hospitals, and that the findings are not made public i.e. the process is not transparent. It is at present an inappropriate audit system for the NHI, a view supported by both the experts and the senior hospital managers interviewed in this research.

This research confirms the points made by Bateman (2011) and Harrison (2010) that CEOs of hospitals face huge challenges in managing their hospitals and in particular their enforced inability to make decisions. These authors attribute this to a lack of delegations, poor performance management systems and unclear lines of responsibility and accountability. The research found that a lack of enabling legislation, a lack of clear accountability frameworks and the lack of political will at provincial level to be the key factors in retarding this process of decentralisation.

Kettl (2000) describes six core characteristics of NPM and these are improved productivity, marketisation, service orientation, decentralisation, appropriate policy, and accountability. If measured against these our policies appear appropriate but the lack of will in supporting its implementation is where it fails. From my discussions with the research participants if we had to just focus on improved productivity, appropriate decentralisation and establishing proper accountability structures we will go a long way in improving the quality of service we provide as well as improve the efficiency of public hospitals. There is a not the political will to decentralise functions because politicians don't want to lose power if these institutions becoming autonomous. This research argues that the political interests can still retain the power by having the appropriate regulations in place, a view strongly supported by Fitzgerald and the other experts (2015). There are also inappropriate policies and ill-defined responsibilities given to the CEOs of public hospitals. There is generally a lack of support from provincial head offices as far as central, tertiary, regional and specialised hospitals are concerned and provincial district offices as far as district hospitals are concerned. These are important issues that have to be addressed at the highest levels of government. However, it seems with the current Minister of Health we may have the opportunity to turn the corner in improving hospital performance in areas of governance and responsibility through the

NHI White Paper even though clear implementation policies in this regard have still not been made public.

Using another measure the WHO (2007: p2) defined six building blocks critical for an effective health system and these are:

> A good health system which delivers effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed with a minimum waste of resources; a well performing health workforce that operates in ways which are responsive, fair and efficient to achieve the best health outcomes possible; a well- functioning health information system; a well- functioning health system; a good financing system and good leadership and governance.

Using these building blocks and viewing the hospital as a microcosm of the health system, the public hospitals and the CEOs perform poorly as well. Our current health system does not deliver effective and safe health care. We have an unacceptably high Infant Mortality Rate (IMPR) and Maternal Mortality Rate (MMR) compared to countries that are similarly developed as us. We have inappropriate and understaffed health services. We have archaic health information systems and poor leadership and governance. In relation to the latter, and as mentioned before, we generally do not have governance structures that can hold officials accountable throughout the public sector. Power often rests with politicians and they meddle in service delivery rather than focussing on policy development and establishing regulatory frameworks (which should be their main function according to the experts). Interestingly the WHO does not use an NPM paradigm to inform its policy. It looks at the generic functioning of a good public health system and what is required to build it. This raises the question that we do not have to view the functioning of the health services nor that of the public hospitals only through an NPM lens but we can use other lenses such as the WHO building blocks framework. The White Paper largely ignores the recommendations of the WHO according to this research (although it makes a brief mention of them). But we can still use its principles while we phase in the NHI and as I pointed out before that if we just aim to improve productivity we can probably achieve just as much

gains as will be possible by re-engineering the entire system, a view I share with Van Den Heever (expert interview, 2015).

The WHO approach confirms my opinion as informed by this research in that the problem is not only with the CEOs, it exists within the context and processes that they have to function within. There is a huge waste of resources in both time and money when decision making is centralised. This is further exacerbated by an inadequate workforce that includes support staff. There are insufficient financial and human resources delegations to CEOs. Furthermore, the current health information systems that should support timeous and appropriate decision making are not integrated and largely dysfunctional, the budgeting and financing systems currently used are inappropriate and often unworkable, the supply chain management systems are in a crisis and there is a lack of good political leadership and democratic governance generally. The NHI White Paper also acknowledges this but does not give clear cut strategies to improve these.

The debate about the value of implementing NPM has to be revisited. The theoretical framework argues the case for public choice as one of the main theories informing NPM. Public choice is a branch of modern economics that assumes that public firms are inefficient, and, therefore, their role should be diminished (Bruntetto, Y, and Farr-Wharton, R., 2005). Moreover, they argue that public sector organisations that cannot be privatised (such as public hospitals) should adopt private sector management tools because they are more efficient and effective. However this has been questioned. I argue against the use of public choice theory as when you are sick (and poor) you do not have much choice in determining where you are going to get health care from. Inevitably it's the most accessible public health service to you that determines where you go and this applies to the majority of South Africans (who are largely poor). Fitzgerald (expert interview, 2015) also believes that we don't need to use the public choice theory to inform our use of NPM. He argues that there could be efficiency gains if NPM tools are used appropriately. This is in line with the managerialism approach to NPM where efficiency and effectiveness can be improved by using some private sector management mechanism but not necessarily privatisation. According to Rainey (1991, p. 131) the present day beliefs about " private sector superiority

... have driven a massive amount of political and administrative activity and a substantial body of scholarly writing [yet] no one really know which assumptions are valid". Hence there is also an emerging debate questioning the real impact of NPM. The post NPM paradigm is inclusive of a public value dimension and this is what now should be explored going forward. The current public sector reform and health sector reform in South Africa has lagged behind international trends in public management that have already embraced the public value paradigm as espoused by Bennington (2005) and Moore (1995). From the research it appears that we have to move beyond the NPM paradigm and begin to consider that as we develop a more accountable public service we need to look at what the public values and how do public services add value to the public.

6.3 The main findings of this research

The main finding of this research is that CEOs of public hospitals in South Africa are appropriately qualified and do have the appropriate experience to do their work well. This is contrary to the view of government, the DBSA and authors such as Awortwi (2006) in this regard. They are, however, are unable to function effectively because they have not been given the appropriate delegations to manage their finances, human resources and operational management requirements optimally. This in the view of CEOs and senior hospital managers is due to a lack of appropriate finances, delegations to make financial, human resource and operational management decisions and poor support from their respective head offices. There is also a lack of appropriate professional staff (from finances, human resources to health professionals) and effective accountability frameworks that is seen as key requirements for the implementation of NPM in developing countries (Awortwi, 2006 and Cameron, 2009). There is a need to carefully delineate the responsibilities of the public hospital CEOs with a clear performance contracts that are carefully matched to the delegations that they are given. The experts in public management advise that we also need the appropriate leadership and democratic governance structures to support the CEOs in their work. I believe that the CEOs who participated in this study provide important insight as to why they cannot perform optimally. This is critical information that should be taken to the highest tiers of decision making in the provinces and the national department of health

so that their voices can be heard and that appropriate action to remedy the situation be taken. To me the most important contribution of this research is that to understand managerial challenges that are being faced in the delivery of public services generally and by public hospitals in particular is that of the 'context'. In South Africa it is largely the political context that determines this.

The value of adopting the NPM principles and practices also has to be questioned particularly within the South African public health sector context. Although the underlying ideas that drive the global public management revolution may appear elegant i.e. give managers more flexibility, let (or make) them manage, hold them accountable for results, incorporate more market testing and private sector management techniques and so on. However, what is missing in the discourse are certain troubling elements of current government sector reform in South Africa. In particular the relationship between public managers and elected officials, the connections between managers' performance and government budgets, and governments leverage over the private sector. The reluctance of politicians to decentralise is a recurring theme. Also the lack of appropriate governance structures is critical if we need to have appropriate accountability frameworks and these are yet to be established. Politicians according to the experts are reluctant to establish democratic governance structures in the main because they believe that they will lose power and control. Political meddling is probably the biggest challenge facing public managers in South Africa today. Whether the NHI White Paper will be implemented as planned in a phased approach to deal with these challenges may well be thwarted by political agendas at provincial level as is the current case of resistance of central hospitals to being made a national competency. So understanding the context is critical to the implementation of any policies in health sector reform and this is often largely ignored.

In questioning if NPM is appropriate for Africa, Vyas-Doorgapersad (2011) in his review of its implementation in Africa has found this varied with varying degrees of success. Decentralisation and downsizing has largely been a failure according to this author. Contracting out and corporatisation has been successful in some countries in Africa. However the author argues that the application of NPM tools has to be context specific.

According to this research it is the political context that largely determines if NPM tools can be effectively used.

Some of the other new techniques that have been adopted in some parts of Africa include performance management systems (Botswana, South Africa, Uganda); pay and grading reform (Ghana, Mozambique, Guinea and Tanzania), operational and management control systems (South Africa, Ghana, Nigeria and Mauritius), total quality management and information and communication technologies in service delivery in many African countries. (Vyas Doorgapersad, 2011). These again have some successes but mostly have not been sustained. Larbi (1999) argues that the new public management approach may not be a panacea for the problems of public sector management particularly in crisis states, but a careful and selective adaptation of some elements to certain sectors may be beneficial.

Therefore, in terms of this research and those mentioned above NPM principles tools should not be adopted as a blanket solution to deal with inefficient health systems. Specific NPM tools relevant to the South African context should be piloted before adopted as national policy. Some scepticism has to be maintained as we don't have the human resources capacity (lack of professional bureaucracies) nor the information system infrastructure (e-government) within the current public health sector to take on NPM wholeheartedly. NPM principles include the need for accountability and this governance principle of how to hold public institutions to account to the public is not being addressed adequately by government and less so in the health sector. The issue of governance and accountability within the prevailing political context is probably the most important issue that has to be addressed, even as regards the NHI, before we can see any real improvement in public service delivery and in particular public hospital management in South Africa. Consideration should also be given to the public value paradigm as we move away from the individual (public choice) to the involvement of the public in the future delivery of public health services.

6.4. Recommendations

The CEOs made interesting recommendations when asked what advice they would give to government to assist them in performing better in their jobs. They first qualified what they had to say by insisting that overall they are happy and committed to their work. They wanted to be able to act independently, able to fill posts, procure and maintain their services and infrastructure with sufficient budget. More than anything they say, what is needed are the appropriate "tools of the trade" and "finances, HR, goods and services that are adequate". They need realistic budgets, which are activity based, and they are willing to sign performance agreements that are related to explicit deliverables.

The international recommendations on improving leadership and management in health services, resonates with what the CEOs want. The WHO also elaborated further upon this in its series on "Making Health Systems Work", in its Working Paper No. 10 (2007) called "Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and Management in Low-Income Countries. 29 January – 1 February 2007, Accra, Ghana (WHO, 2007)" where it makes special mention in its proposed framework on the following as regards managers in the health services:

> Ensuring adequate numbers and deployment of managers throughout the health system; ensuring managers have appropriate competencies (knowledge, skills, attitudes and behaviours); the existence of a functional critical support system (to manage money, staff, information, supplies, etc.) and; creating an enabling working environment (w.r.t. roles and responsibilities, organisational context and rules, supervision and incentives, relationship with other actors).

In terms of creating an enabling environment the WHO framework requires clarification of: the degree of autonomy; clear definition and communication; clarity of roles and responsibilities; a clear fit between roles and structures; existence of national standards; rules and procedures and so on. The report highlights and emphasises the importance of delegation of authority (over staff, budgets, etc.) as a particular challenge in the working

environment in the health sector and this resonates with this research's main findings and recognises this as an international problem (WHO, 2007). What is important to note is that these recommendations are for traditional public health service bureaucracies and is independent of any NPM framework? So it also raises the point made before and that is that NPM tools are not the only solutions to move to more efficient health service delivery.

The issue of competence of CEOs of public hospitals in South Africa has always been a vexing one for government. The DBSA report (2011), states that the obvious way of determining the competence of hospital CEOs and district managers would be to review individual and institutional performance data and compare these. Unfortunately reliable individual performance data was not available and given the number of factors contributing to overall institutional performance it was impossible to come to firm conclusions in their research. Thus based on their empirical research the DBSA study developed a health management competency framework, scorecard and assessment battery with which hospital CEOs and district managers were assessed. Their research hypothesised that the ideal profile of a hospital /district manager would comprise: health and business qualifications, and extensive experience within the public health system. This research findings do well when measured against these two criteria and I would hasten to say that in fact most hospitals in the public sector have appropriately qualified and experienced CEOs. The NDoH and DBSA had a predetermined idea that the CEOs were incompetent largely because they believed that they were ill qualified and inexperienced without any objective evidence in my opinion.

The questions that I have regarding the DBSA study are that albeit interesting findings it does not deal with underlying contextual and structural issues that make CEOs underperform, a point also made by Van Den Heever (expert interview, 2015). Firstly it assumes that CEOs are functioning in an ideal world and secondly that their measurement tools are valid and reliable. The details of the tools are never clearly explained anywhere in the report, which is not in the public domain. The report did inform however the new policy on hospital management and subsequent re-advertising and re-employment of new CEOs across many hospitals and at a higher grade. Another interesting finding of the DBSA work

was that when hospital CEOs and district managers were asked about delegations, that in terms of preferred delegations the hospital CEOs indicated a strong preference for HR delegations out of a choice of HR, Finance and Supply Chain Management delegations; whereas district managers expressed a preference for financial delegations. The CEOs in this study wanted both delegations and the concomitant accountability. But the biggest obstacle I found through this research was one of a political reluctance to do so.

This research agrees with the DBSAs overall recommendations which required a range of differentiated interventions for hospital and district managers. These interventions according to the DBSA could include but are not limited to: training and development; mentorship and coaching; correct recruitment and succession planning. This will be even more critical as the NHI is rolled out to public hospitals and districts. The DBSA also confirms the findings of this research are that manager competence is only one amongst many systemic and institutional factors to consider but does not elaborate on these.

It is certain from reading the international literature, experiences in Africa and South Africa and the findings of this study that recommendations to government need to be clear and strongly put. The new policy on the management of hospitals is not adequate in addressing the needs that are articulated by the CEOs in this research. It provides some framework but not sufficient detail. There needs to be a clear decision on the adoption of appropriate NPM principles and tools such as decentralisation, relevant performance management systems and the appropriate adoption of selected private sector mechanisms in order to achieve improved efficiency and productivity. Africa and South Africa have adopted aspects of NPM piecemeal according to Oluwu and Wunsch (2004) and Cameron (2009). The political context of countries in Africa is probably the key determinant as to whether its implementation will be successful or not. NPM emphasises results rather than input and processes. This can be supported by current audit mechanisms such as the core standard requirements of the OHSC which are intentionally developmental in improving the institutional capacity to function optimally. However the indicators that are measured by the OHSC are mainly input and process driven. We need performance indicators that are

output and outcome based and that links institutional performance to that of the managers and ultimately the CEOs of public hospitals.

There is an urgent need for clear policy on delegations that give CEOs appropriate control over the financial, human resources and operational management of their hospitals. This also urgently requires enabling legislation. The CEOs need appropriate budgets, human resources, health information systems and the necessary support from provincial head office to do their work efficiently. Key to their performance is having the appropriate professional and support staff to enable them to carry out their responsibilities. However, I believe and a view shared by the experts, that within the South African context the main way to hold services accountable is through the establishment of appropriate democratic governance structures first. This issue of governance and accountability is partially addressed by the draft legislation that was just released for public comment (South Africa, 2015) but falls short of holding CEOs accountable for health outcomes. It may also take a long time to implement according to the research. There may be individual training requirements for some CEOs but they should be specific to the CEO and not generic for all CEOs. There may be a need to professionalise health service management and the public service more generally (Awortwi, 2006). This is an important NPM requirement which we have not achieved in the public health sector as yet. The CEOs need to be prepared for the NHI and the requirements of the OHSC and training and support may be required here. Finally, an appropriate performance management system for CEOs needs to be put in place where the CEOs are held to account for budget, human resources, operational management and as mentioned before, health outcomes.

Internationally there is insufficient evidence that NPM Hospitals are more efficient than traditionally managed ones. (Alonso, Clifton and Diaz-Fuentes, 2013). According to these authors what did matter may be the management itself and not the management model. Ferlie, Pettigrew, Ashburner and Fitzgerald (1996) document a whole series of NPM structural changes which were implemented in the 1980's and 1990's in the UK as part of an NPM study. One of the most important examples that they elaborate upon was the establishment of the internal market or quasi-market in the UK's National Health Services

(NHS). What was interesting to note was that these authors concluded that this was a series of reforms within the NHS which had failed. This began with the abandonment of Regional Hospital Boards (too local), and their replacement by a three tier – Regional/ Area/ District – health authority structure (more national co-ordination) which was subsequently altered by the deletion of Area Health Authorities (too many tiers), the reduction in the overall number of Regional Health Authorities (to establish a national executive), the subsequent abolition of District structures in favour of Hospital Trusts (which were to be more responsive to patients), the abandonment of Regional Health Authorities, and the replacement of Hospital Trusts by Foundation Hospitals (which were to be even more responsive to patient needs). (Webster, 1998). More recently Hood and Dixon (2015) published the findings of a 30 year review of NPM as implemented in the United Kingdom. Their main findings are that the United Kingdom does not have a government that works better and costs less. In fact, the government works slightly worse with respect to fairness and costs a bit more than before!

CEOs, experts in public management and senior hospital managers interviewed in this research study overwhelmingly believe that the crises in South Africa's hospitals can be overcome by appointing suitably qualified and experienced staff to support the CEOs, arming the CEOs with the required tools and powers to enable them to address the challenges of the job and setting up structures that will hold them accountable to the public.

The CEOs through their collective voices as amplified by this research urgently require the government to ensure the adoption and implementation of Dr Motsoaledi's 10 point plan. This requires eliminating the systemic blockages indicated in this research and currently extant, addressing the lack of proper delegations, through redrafted clear policy, as well as the serious legislative constraints facing CEOs of hospitals. Eliminating the politics and political gatekeepers at provincial level, by closer adherence to the recommendations geared to empower CEOs and managers, as well as to be able to hold them to account, is the solution. Finally the government needs to question its commitment to the NPM paradigm and if so does it adopt elements of it which it finds useful. The feasibility of NHI structures as informed by the NPM paradigm in particular as regards purchaser-provider splits need to be tested within the South African context before it is widely implemented.

My final recommendations to government as regards public health services is that consideration be given to embracing the public value paradigm in its future planning and deliberations. In my opinion the public value approach argues for much more public accountability than the NPM paradigm ever did.

6.5. Directions for future research

This study contributes to the debates and critiques around decentralisation and the required autonomy of management in public hospitals. It gives insights into the challenges faced by CEOs of public hospitals in South Africa. However, more research needs to be done in areas such as:

Developing theories on how public institutions such as hospitals function in South Africa, in relation to new governance structures and appropriate accountability frameworks in particular,

Conduct comparative studies with other public institutions that face similar challenges as regards lack of decentralisation and lack of enabling legislation,

Examine the changing organisational cultures of public institutions since 1994 and how it informed health sector reform,

Explore the impact of the NHI on the future functioning of public hospitals and the roles of CEOs in the future dispensation through the lens of NPM.

Question the validity of NPM in today's public sector environment in South Africa considering global trends towards an emphasis on public value as the new discourse of public management.

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Annexure 1: Chief Executive Officers of Public Hospitals Questionnaire Survey

Please fill in the required information and place a tick or a cross in your answer?

General Information: Study ID Code: …….. HOSPITAL Tick: (District), (Regional), (Tertiary), (Central). Province: ……Years working: …… Demographics: Age in years…… Sex……. Race…….. Educational Qualifications……			
Question	Yes	No	Don't Know
1. Are you familiar with Departmental policies that govern the way you manage?			
2. Are there Performance Management Systems for CEOs in public hospitals in place in your province?			
3. Are there management delegation guidelines for CEOs in place in your province?			
4. What are CEOs in your province measured against?	Yes	No	Don't Know
• Budget			
• Staffing			
• Quality of Care			
• Health Outcomes of patients			
5. In your opinion are you able to manage your hospital effectively in the current circumstances?			
6. In your opinion do you have sufficient delegations to manage your hospital effectively in respect of:	Yes	No	Don't Know
• Budget			
• Staffing			
7. In your opinion are there areas of your performance as CEO that can be improved with respect to:	Yes	No	Don't
• Budget			
• Staffing			
• Quality of Care			

General Information: Study ID Code: …….. HOSPITAL Tick: (District), (Regional), (Tertiary), (Central). Province: ……Years working: …… Demographics: Age in years…… Sex……. Race…….. Educational Qualifications……			
Question	Yes	No	Don't Know
• Health Outcomes of patients			
8. What in your opinion are the main criteria for assessing CEOs performance in the public sector?	Yes	No	Don't Know
• Budget control and/or			
• Health Outcomes of patients			

Annexure 2: Information Sheet (Questionnaire only)

Information Sheet for Informed Consent: Questionnaire Survey

Chief Executive Officers and Public Hospital Management in South Africa.

Hello. My name is Shan Naidoo and I am doing my PhD with the Graduate School of Public and Development Management, based at the University of the Witwatersrand. I am doing a study to understand the management challenges facing CEOs of public hospitals in South Africa. I am inviting you to participate in this study, which is a survey using a self administered questionnaire, because I believe that you can provide important insights into the challenges facing CEOs of public hospitals in South Africa?

What is the purpose of our study?

The study will look at how CEOs view their management effectiveness and what are the constraints that impede effective management of hospitals and what are the possible solutions. I will look at how important management decisions are made. In other words, I am exploring management challenges in selected hospitals in South Africa: and in particular management effectiveness in the delivery of hospital services and decision-making to provide such services. As part of this overall study, I am interested in the views of CEOs in particular. You are one of 60 CEOs that have been randomly selected by me and all your inputs for this self- administered questionnaire will be kept confidential.

Why have you been invited to take part?

You have been invited to take part because of your involvement in the MPH Hospital Management programme at the School of Public Health and that as a CEO of a public hospital with substantial experience I believe that you will provide insightful views on the management challenges facing CEOs of public hospitals in South Africa.

What procedures are involved?

I will ask you to answer a questionnaire (that will be e-mailed or faxed to you) that briefly explores your views on management effectiveness, what does this mean to you, and management delegations and performance management, are they sufficient or not?

Do you have to answer this questionnaire?

No. You can refuse to answer this questionnaire. Even if you agree, you can change your mind at any time. Your non-participation or withdrawal from this study will not prejudice you in any way.

What are the risks of taking part in this questionnaire?

You may worry that I am testing you on how much you know about management effectiveness. This is not the case. Rather, I hope to identify those areas where management responsibilities, delegations and its current effectiveness may have to be clarified, or even changed.

What are the benefits?

There are no direct benefits to participants. It is possible that taking part in the study will assist us in informing the authorities as to what the challenges facing CEOs of public hospitals are and what can be done to improve them. The study has three components which are made up of the following:

1. A questionnaire survey of 60 CEOs randomly drawn from the MPH class list so that I have few CEOs each from Gauteng, Limpopo, Free State, Northern Cape and Mpumalanga Province (to have a quantitative understanding of the management challenges and delegations that you have). This informed consent information sheet is for your participation in this aspect of the study.
2. An in-depth interview of 12 CEOs drawn from the 60 who participated in the questionnaire survey and who have agreed to participate in a more in-depth interview (which will address the qualitative aspect of the study). You may indicate now if you wish to participate in this aspect of the study which will be done later.
3. A focus group discussion with four CEOs involved in the in-depth interviews and who have agreed to participate in the focus group discussion (and to explore qualitatively

how they view the challenges facing them). You may also indicate your interest now to as to whether you would like to participate in this aspect of the study. In the long run, we also hope that recommendations for improved guidelines will make for clearer direction on this issue.

What will happen to the data and how will confidentiality be maintained?

All data will be kept confidential. Only grouped data will be reported upon so identification of individuals viewpoints will not be able to be done. Your name and other identifying details will not be stored together with any data. The questionnaire data will be stored safely, that is, in a locked cabinet, and electronic records will be password protected. The data will be kept in storage in de-identified form and not destroyed.

What will happen to the results?

Results will be included in:

- My PhD
- Academic publications in open access journals; and
- Conference presentations
- Report back to all the participants (- you will be able to see the results and a summary report)

What do you need to do?

If you agree to participate, we will need you to sign the informed consent form below and return the self- administered questionnaire to me. The questionnaire will take about 15 to 30 minutes. If you need to discuss any questions you may have about the study please contact me. This may be in person or over the phone or by email. You may also want to indicate your willingness to participate in the two follow-up studies (the in-depth interviews and focus group discussions) and you can do so by placing the X in the appropriate box in the declaration form attached.

Will participants be paid?

Persons who take part in the questionnaire survey will not be paid.

Was this study ethically approved?

This study proposal was approved by the HREC (the Human Research Ethics Committee: Non-Medical) of the University of the Witwatersrand.

Who can I contact if I have questions?

For questions related to the study, please contact me Shan Naidoo at 011 717 2614 or email me at shan.naidoo@wits.ac.za

Please fill this written consent document and the questionnaire survey and fax it to me at 011 717 2084 or scan and e-mail it to me at shan.naidoo@wits.ac.za

DECLARATION from CEOs (CONFIDENTIAL)

Consent to take part

I, _____ _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

	Insert X
The questionnaire survey on management effectiveness and delegations of CEOs in public hospitals?	
If invited I agree to participate in the in-depth interviews to follow the survey?	
If invited I agree to participate in the focus group discussion?	

I understand that I can withdraw from the study at any time.

SIGNATURE OF PARTICIPANT: _____

Code: _____

DATE: _____

Annexure 3: Information Sheet (Interviews)

Information Sheet for Informed Consent: Interview Survey

Chief Executive Officers and Public Hospital Management in South Africa.

Hello. My name is Shan Naidoo and I am doing my PhD with the Graduate School of Public and Development Management, based at the University of the Witwatersrand. You may remember that I had sought your permission earlier when I sent you a self- administered questionnaire where you agreed to participate in subsequent research. However as informed consent is a continuous process I wish to reaffirm your participation in my proposed research as well as inform you what the study is about.

What is the purpose of our study?

The study will look at how CEOs view their management effectiveness and what are the constraints that impede effective management of hospitals and what are the possible solutions. As part of this overall study, I am interested in the views of CEOs in particular. You are one of 12 CEOs that have been purposively selected by me and that has agreed to be interviewed. All your inputs for this interview will be kept confidential.

Why have you been invited to take part?

You have been invited to take part because of your involvement in the MPH Hospital Management programme at the School of Public Health and that as a CEO of a public hospital with substantial experience I believe that you will provide insightful views on the management challenges facing CEOs of public hospitals in South Africa.

What procedures are involved?

I will ask you to answer a few in-depth questions that explore your views on management effectiveness at your hospital, performance management, challenges in management at your hospital, management delegations, are they sufficient or not, and how to manage better if given the opportunity.

Do you have to answer this questionnaire?

No. You can refuse to be interviewed. Even if you agree, you can change your mind at any time. You will not be prejudiced in any way if you do not participate.

What are the risks of taking part in these interviews?

There are no risks in you taking part in this survey. All information will be kept confidential and only thematic analysis of your opinions will be done together with the inputs of the other CEOs being interviewed. Your interviews will be kept in de-identified form by me.

What are the benefits?

There are no direct benefits to participants. It is possible that taking part in the study will assist us in informing the authorities as to what the challenges facing CEOs of public hospitals are and what can be done to improve them.

What will happen to the data and how will confidentiality be maintained?

All data will be kept confidential. Only grouped data will be reported upon so identification of individuals viewpoints will not be able to be done. Your name and other identifying details will not be stored together with any data. The interview data will be stored safely, that is, in a locked cabinet, and electronic records will be password protected. All the data will be kept securely by myself.

What will happen to the results?

As mentioned before the results will be included in my PhD; academic publications; conference presentations and a report back to all the participants (you will be able to see the results and a summary report)

What do you need to do?

If you agree to participate, we will need you to sign the informed consent form below and return it to me. You are free to call me to discuss any questions you may have about the study with me. The interview will be done by myself at a time and place convenient to you and may take about one to two hours. Because the interviews will be taped I will ask for your permission separately for audio taping in another form.

Will participants be paid?

Persons who take part in the in-depth interviews will not be paid.

Was this study ethically approved?

This study proposal was approved by the Human Research Ethics Committee (Non-Medical) at the University of the Witwatersrand before it was implemented.

Who can I contact if I have questions?

For questions related to the study, please contact me Shan Naidoo at 011 717 2614 or email me at shan.naidoo@wits.ac.za

Annexure 5: Interview guide for CEOs

Study Title: Chief Executive Officers and Public Hospital Management in South Africa.

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1. What are the major challenges that you face as a CEO of a public hospital?
   Prompt on: Finance; Human Resources; Operational management issues; and other?

2. Do you have departmental policies and procedures that govern how you manage?
   Prompt on: What are they about (get a copy)? Do they assist or hinder you?

3. Are Performance Management Systems in place at the hospital?
   Prompt on: Who do they apply to (get a copy)? If they apply to you what are its implications? Do they assist or hinder you? Do they measure quality of care?

4. Ask what are your delegated authorities? In respect of: Budget; Human Resources, Procurement and Supplies; Operational management and any other?

5. What recommendations would you like to make to government that will enable you to manage your hospital better?
   Probe in relation to current government policies such as PFMA, NHI and policies on hospital management?

Annexure 6: Consent for audio taping

(Template for in-depth interviews and focus group discussions)

Consent for Audio Taping

I hereby confirm that I have been informed by the researcher, Shan Naidoo, about the nature, conduct, benefits and risks of the study. I have also received, read and understood the written participant sheet.

I understand that I can decide whether or not the interview/ focus group discussions will be tape recorded and that there will be no prejudicial consequences for me if I do not want the interview to be recorded. I understand that if the interview/focus group discussion is tape-recorded that the tape will be safely stored for five years after the interview has been transcribed, and then destroyed. I understand that I can ask the person interviewing me to stop tape recording, and to stop the participating altogether, at any time.

I hereby give my written consent to be tape recorded.

Participant

_____ _____

Print Name Signature Date

Annexure 7: Focus Group discussion guide

Study Title: Chief Executive Officers and Public Hospital Management in South Africa.

After each probing question, reflect on the in-depth interview findings and assess if there is consensus or if a new argument is developing?

1. What are the major challenges that you all face as a CEO of a public hospital?
   Prompt on Finance; Human Resources; Operational management issues

2. Do you have departmental policies, delegations (new) and procedures that determine how you work? Reflect on NPM principles? What are they about (clarify)? Do they assist or hinder you (clarify)?

3. Are Performance Management Systems in place at the hospital?
   Who do they apply to (clarify)?
   If they apply to you what are its implications?
   Do they assist or hinder you?
   Do they measure quality of care?

4. What is happening in the current public service (Public Service Regulations) and National Health (Insurance) Scenario that may affect the way you manage hospitals?

5. What recommendations would you like to make to government that will enable you to manage your hospital better? Probe in relation to current government policies such as PFMA, NHI and policies on hospital management?

Annexure 8: Informed Consent for In-depth Interviews

DECLARATION (CONFIDENTIAL)

Consent to take part

I, _____ _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

	Insert X
I agree to participate in the in-depth interviews to follow the survey?	
If invited I agree to participate in the focus group discussion?	

I understand that I can withdraw from the study at any time.

SIGNATURE OF PARTICIPANT: _____

Code: _____

DATE: _____

Annexure 9: Information Sheet (Expert Interviews)

Information Sheet for Informed Consent: Interview Survey

Re: Chief Executive Officers and Public Hospital Management in South Africa.

Hello. My name is Shan Naidoo and I am doing my PhD with the Graduate School of Public and Development Management, based at the University of the Witwatersrand. I wish to reaffirm your participation in my proposed research as well as inform you what the study is about.

What is the purpose of our study?

The study will look at how CEOs view their management effectiveness and what are the constraints that impede effective management of hospitals and what are the possible solutions. As part of this overall study, I am interested in the views of experts in this area particular. You are one of 3 experts that have been purposively selected by me and that has agreed to be interviewed. All your inputs for this interview will be reported upon.

Why have you been invited to take part?

As an expert in the space of governance, public services and perhaps NPM I believe that you will provide insightful views on the management challenges facing CEOs of public hospitals in South Africa.

What procedures are involved?

I will ask you to answer a few in-depth questions that explore your views on policy and administrative context of current public sector reform and health sector reform. I am also interested in your views on CEOs management effectiveness public hospitals, the value of performance management, challenges in management delegations, are they sufficient or not, and how to manage better.

Do you have to answer this questionnaire?

No. You can refuse to be interviewed. Even if you agree, you can change your mind at any time. You will not be prejudiced in any way if you do not participate.

What are the risks of taking part in these interviews?

There are some risks in you taking part in this survey. All information will be made public and you will be identified in the research. Also, thematic analysis of your opinions will be

done together with the inputs of the other experts being interviewed. Your interviews will be captured by audiotaping it.

What are the benefits?

There are no direct benefits to participants. It is possible that taking part in the study will assist us in informing the authorities as to what the challenges facing CEOs of public hospitals are and what can be done to improve them.

What will happen to the data and how will confidentiality be maintained?

All original data will be kept confidential. Only pertinent data will be reported upon. Your name and other identifying details will not be stored together with any data. The interview data will be stored safely, that is, in a locked cabinet, and electronic records will be password protected. All the data will be kept securely by myself.

What will happen to the results?

As mentioned before the results will be included in my PhD; academic publications; conference presentations and a report back to all the participants (you will be able to see the results and a summary report)

What do you need to do?

If you agree to participate, we will need you to sign the informed consent form below and return it to me. You are free to call me to discuss any questions you may have about the study with me. The interview will be done by myself at a time and place convenient to you and may take about one to two hours. Because the interviews will be taped I will ask for your permission separately for audio taping.

Will participants be paid?

Persons who take part in the in-depth interviews will not be paid.

Was this study ethically approved?

This study proposal was approved by the Human Research Ethics Committee (Non-Medical) at the University of the Witwatersrand before it was implemented.

Who can I contact if I have questions?

For questions related to the study, please contact me Shan Naidoo at 011 717 2614 or email me at shan.naidoo@wits.ac.za

Annexure 10: DECLARATION by CEOs (CONFIDENTIAL)

Consent to take part

I, _____ _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

	Insert X
I agree to participate in the focus group discussion?	

I understand that I can withdraw from the study at any time.

SIGNATURE OF PARTICIPANT: _____

Code: _____

DATE: _____

Annexure 11: DECLARATION by Experts (CONFIDENTIAL)

Consent to take part

I, _____ _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

	Insert X
I agree to participate in the expert interview?	
If invited I agree to have my interview audiotaped	

Signature……Date……20……

Annexure 12: Interview guide for experts:

1. We have a situation where hospitals don't function because CEOs are held responsible for all the outcomes in their hospital, yet have no authority, can't initiate anything, in the two key areas of Finance and HR.

2. How did we get here, from the original ideals for govt decentralisation and autonomy, in 1994?

3. What was govt.s intention as regards NPM and where are we now, and why?

4. Power is still centralised? Probe on political interference?

5. Why has it taken so long to delegate? Probe – is it governments intention?

Annexure 13: Interview guide for senior hospital manager's focus group:

1. CEOs of public hospitals that I have interviewed have said that the main challenges facing them are finance, human resources, and operational management and communication systems. They say that the main reason is the lack of delegations. What are your opinions in this regard?

2. Can you comment on this – there can be no delegations without accountability – probe on current or proposed accountability structures if any?

3. What is govt.s intention as regards NHI and public hospitals, and why?

4. Power is still centralised? Probe on political interference if any?

5. Why has it taken so long to delegate? Probe – is it governments intention?

Annexure 14: DECLARATION by senior hospital managers (CONFIDENTIAL)

Consent to take part

I, _____ _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

	Insert X
I agree to participate in the expert interview?	
If invited I agree to have my interview audiotaped	

Signature……Date……20……

Annexure 15: Information Sheet (Focus group discussion with senior hospital managers)

Re: Chief Executive Officers and Public Hospital Management in South Africa

Hello. My name is Shan Naidoo and I am doing my PhD with the Graduate School of Public and Development Management, based at the University of the Witwatersrand. I am inviting you to participate again in this study, which is the focus group discussion of selected senior hospital managers and their views on the challenges CEOs face in the management of public hospitals.

What is the purpose of our study?

This part of the study will look at how senior hospital managers as a collective view their management effectiveness and what are the constraints that impede effective management of hospitals and what are the possible solutions. As part of this overall study, I am interested in your views within a group situation in particular. You are one of four senior hospital managers that have been puropsefully selected by me and that has agreed to be part of this process where we interrogate opinions as a group and perhaps get some group consensus going forward.

Why have you been invited to take part?

As a senior hospital manager of a public hospital you have substantial experience that I believe will provide insightful views on the management challenges facing CEOs of public hospitals in South Africa.

What procedures are involved?

I will ask you as a part of a group of senior hospital managers to answer a few questions that explores your group views on management effectiveness at your hospital, performance management, challenges in management at your hospital, management delegations, and how to manage better if given the opportunity.

Do you have to participate in the focus group discussion?

No. You can refuse to be part of the focus group discussions. Even if you agree, you can change your mind at any time. You will not be prejudiced in any way for non-participation.

What are the risks of taking part in the focus group discussion?

I hope to identify those challenges faced by you as a group of senior hospital managers, your current performance management systems and do these impede or assist you in carrying out your jobs as well as your management delegations and its current effectiveness. I also want to have a sense of your collective view of these challenges and how they may be remedied. The only risk is that in a focus group discussion we cannot guarantee confidentiality, but all of the data will be presented anonymously in my report.

What are the benefits?

There are no direct benefits to participants. It is possible that taking part in the study will assist us in informing the authorities as to what the challenges facing CEOs and senior hospital managers of public hospitals are and what can be done to improve them from your perspectives?

What will happen to the data and how will confidentiality be maintained?

I cannot guarantee the confidentiality of focus group discussion as you all know one another. However, all the data that I collect will be kept confidential. Only grouped data will be reported upon so identification of individuals viewpoints will not be able to be done. Your name and other identifying details will not be stored together with any data. The focus group data will be stored safely, that is, in a locked cabinet, and electronic records as well as audio taping will be safely protected.

What will happen to the results?

As indicated before the results will be included in my PhD, academic publications conference presentations and a report back to all the participants (you will be able to see the results and a summary report).

What do you need to do?

If you agree to participate, you will need to sign the informed consent form below and return it to me. You may want to discuss any questions you may have about the study with me. The facilitation of the focus group discussions will be done by myself at a time and place convenient to you and may take about one to two hours.

Will participants be paid?

Persons who take part in the focus group discussions will not be paid. However your travel and accommodation costs will be covered by the study.

Was this study ethically approved?

This study proposal was approved by the Human Research Ethics Committee (Non-Medical) at the University of the Witwatersrand before it was implemented.

Who can I contact if I have questions?

For questions related to the study, please contact me Shan Naidoo at 011 717 2614 or email me at shan.naidoo@wits.ac.za