THE VALUE OF SHARED CORPORATE SERVICES IN IMPROVING PATIENT CARE

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DECLARATION

I, hereby declare that the work that I present in this thesis is based on my own research, and that I have not submitted this thesis to any other institution of higher education in order to obtain an academic qualification.

____ 28 March 2009

Dr NIKIWE NOMAPELO NOMPOZOLO Date

DEDICATION

This work is dedicated to my late father Dr T. T. D. Hongo whose humility and passion for helping the sick and the disadvantaged always inspired me.

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ABSTRACT

This case study was undertaken from mid 2003 to December 2005. It investigates the influence of the Corporate Services Centre (CSC) on customer (patient) service quality in the East London Hospital Complex (ELHC). This approach was justified on the basis that even though most patients do not have enough knowledge of clinical practices in order to make an accurate assessment on their quality, the same patients would readily appreciate factors such as faster turnaround times, drug availability and cleanliness. The study focuses on both service providers and end users for a quality health service delivery by looking at the potential of the shared corporate services centre. This was done by identifying important areas for improvements, such as response times, waiting periods and other aspects of the various services.

The ELHC was formed from the merger of Frere and Cecilia Makiwane Hospitals, with a distance of 26km between the two institutions. The complex itself was in its infancy stages, having had to go through a process of re-engineering, rationalisation and standardisation of the two hospitals. The study seeks to answer the following key question: *What has been the contribution of the corporate service centres in relation to health care service quality?*

The study examines the impediments to the realization of full potential of the Corporate Services Centre (CSC) through expedited decision-making and improved turnaround times. The main functions of the CSC were Procurement and Asset Management; General Administration (including but not limited to Transport, Office equipment, Patient Administration, Office Support, and Professional Secretariat Support); Financial Management and Administration; and Human Resource Management and Human Resources Administration.

The study recommends that the CSC, to justify its existence, needs to consult with the clinicians and the patients to better understand what their needs and aspirations are. The study also emphasizes that the CSC is there purely to remove the administrative load and ease the processes and the biggest mistake is to make it an authority over the hospital, instead of being a support. Finally, it was realized that a lot of structural changes, business processes and organisational cultural changes are essential if one wants to create an impact through shared corporate services.

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CHAPTER ONE
INTRODUCTION

Significant transformation can be discerned in the post-apartheid South African health sector. The Department of Heath (DoH), for example, has been rolling out health services to all patients, as the end users, since 1994. The post-apartheid state is committed to addressing the weaknesses and gaps of the apartheid health sector. For example, the DoH provides free health services to under-5s. It has also been instrumental to the legalisation of the termination of pregnancy.

In the apartheid era, health research had indicated that an effective national Primary Health Care (PHC) system could significantly improve the health services and status only in the short term. However, basic public health conditions, such as adequate housing, safe water and sanitation, the location of health facilities, especially in the rural areas, would still be inappropriate. Such a holistic approach to PHC would require massive investment in infrastructure. The growing numbers of HIV/AIDS infected people in post-apartheid has borne testimony to the indicator suggested by apartheid health research.

Today, most PHC institutions have very high numbers of AIDS in-patients and HIV-infected outpatients. The workload of medical practitioners in PHCs has increased alarmingly. The exodus of medical practitioners to greener pastures, such as Great Britain, North America, Australia, New Zealand, and the Eastern bloc countries has exacerbated the situation. This is a key challenge in the health sector.

The state has attempted to address the challenge through the Batho Pele policy. This is a White Paper on transforming public service delivery (Department of Public Service and Administration (DPSA) in October, 1997). Batho Pele is a policy framework and implementation strategy for transforming public service delivery in all spheres of government. It focuses on improving service to the end user. It mandates service providers to identify important areas for improvements, such as response times, waiting periods and other aspects of the various services. Further to the call,

departments are tasked to develop a program for the improvement of service delivery and to publish standards for the services and monitor them. According to Batho Pele public provisioning is a legitimate expectation and not a privilege.

The lack of empirically based, pragmatic blueprints for the organization of the major public systems was addressed through the formation of shared services centres or corporate services centres.

1.1 THE CORPORATE SERVICE CENTRES

In December 2002, South African President Thabo Mbeki appointed the Department of Public Services and Administration together with the Public Service Commission (PSC) to investigate and intervene in the rendering of services in four departments in the Eastern Cape. The departments concerned were the DoH, Department of Education (DoE), the Department of Public Works and the Department of Social Development and Welfare. Mbeki was concerned about poor service delivery in these four departments in the Eastern Cape. This study focuses on the DoH.

Service delivery improvement was the central purpose of the Corporate Service Centres (CSCs) formation. The CSCs would draw down powers and functions from Head Office to CSCs and aim to increase service delivery to all institutions through expedited decision-making and improved turnaround times. The main functions of the CSCs were Procurement and Asset Management; General Administration (including but not limited to Transport, Office equipment, Patient Administration, Office Support, and Professional Secretariat Support); Financial Management and Administration; and Human Resource Management and Human Resources Administration.

Implementation at all levels was in line with these four functional streams and each site would have a CSC coordinator or project manager working with individual consultants on-site for each stream and external functional specialists for each stream

visiting all sites. This formed a matrix structure of implementation. The DoH itself had its own assignee to each stream, with a Project Manager.

Prior to the launching of any CSC site, having signed the MOU, Pytron[1] provided a detailed specification of solutions. The DoH management and Pytron compiled a blueprint, with details of the functional analysis of each unit within a stream; policies, procedures and process maps; functions and delegation of authority; change management; transaction processing flow and service standards. The blueprint was completed on February 18, 2004 with the training manuals and scorecard meant to follow. The blueprint entailed the envisaged situation. Going into sites, Pytron with its consultants would have to launch the CSC and audit the different streams against the functional analysis. This would culminate in gap analysis with regard to business processes, skills, equipment and the organizational structure. Recommendations would then follow, addressing the identified gaps with regard to policies, processes, maps, staffing and training and infrastructure requirements. Approval would be sought from the DoH through a site readiness report, detailing the structural and financial implications. Implementation would follow and then an exit signoff for handover.

The ELHC formed from the merger of Frere and Cecilia Makiwane Hospitals, with a distance of 26km between the two institutions, launched its CSC on February 26, 2004. The complex itself was in its infancy stages, having had to go through a process of re-engineering, rationalisation and standardisation of the two hospitals. The CSC launch preceded any work on site to secure a buy-in from all the stakeholders, more importantly, the community. CSC implementation had to be aligned to the Batho Pele Policy. Hence, consultation, information sharing, openness, transparency, and redress, being four of the eight principles of Batho Pele, meaning "People First", were being addressed by such launches involving the affected community.

[1] Pytron Information Holdings was the company that won the tender to implement the formation of the Corporate Service Centres for the Department of Health in the Eastern Cape.

1.2 PROBLEM STATEMENT

The study seeks to answer the following key question: *What has been the contribution of the corporate service centres in relation to health care service quality?*

To answer this question, the study aims at examining the successes and failures in the implementation of the CSC in the Eastern Cape DoH. The study evaluates the impact of the CSC formation on the quality of patient service in the ELHC. It measures the quality of service against the expected service standards as laid down by Pytron Information Holdings and the ELHC. Service quality includes access to services, relevance to need, equity, social acceptability, effectiveness, efficiency and economy (Maxwell, 1984, pp.1470-1).

1.3 SIGNIFICANCE OF THE STUDY

The outcomes from the research will be used as performance indicators for Pytron staff, the hospital complex and the DoH. It will be used to evaluate whether the investment was worthwhile or not. The latter is of particular interest to the hospitals. The study will stipulate preventative measures in other CSC sites. Putting greater focus on rendering value for money service might lead to a paradigm shift insofar as the mindset of the people regarding payment for public health services is concerned. This would affect revenue generation.

1.4 LIMITATIONS AND DELIMITATIONS

The study is about CSCs within the ELHC. It confines itself to the administration stream, looking at service delivery vis-à-vis patients. For the Batho Pele Policy, patients' satisfaction is crucial to the improvement of service delivery. It identifies measurable changes such as waiting periods for patient registration. The study investigates patients' experiences as service users.

The researcher sought the informed consent of interviewees. They were free to withdraw at any stage of the interview process. Confidentiality and privacy were ensured through anonymity and use of pseudonyms of the interviewees. Permission

was obtained from the authorities such as the chief executive officer and other senior managers of the hospital, the project director in Bisho, chairperson and project director of Pytron Information Holdings, consultants, medical records officer, hospital registration clerks as well as trade union representatives.

1.5 STRUCTURE OF THE REST OF THE STUDY

Chapter 2 reviews extant literature and looks at relevant broad areas of theory whereas *Chapter* 3 provides the research method and methodology. *Chapter* 4 presents the research findings. *Chapter* 5 then interprets the findings presented in the previous Chapter. Finally, *Chapter* 6 concludes the study and makes some recommendations.

CHAPTER TWO
LITERATURE REVIEW

The chapter looks at public health delivery models globally, in the region and in South Africa. Public health delivery models are state policies on performance and reform in the health sector. The chapter reviews literature on the concept of patient satisfaction, its definition and how it is measured and challenges confronting researchers.

South Africa is yet to develop a framework for health indicators agreeable to the majority of stakeholders. Even more telling, is the lack of a set of indicators for assessing the quality of practice management. Nevertheless, it is generally accepted amongst practitioners and in many publications and policy documents of the Department of Health (DoH) that the following six dimensions are key health indicators: infant and under-five mortality rates; life expectancy; crude birth and death rates; fertility rates; nutritional status; morbidity; and indicators of environmental health.

Globally, there are acceptable sets of health indicators that are helpful in understanding and interpreting summaries of global health statistics reported in professional journals and international publications (see, Larson and Mercer, 2004, for instance). According to the two authors, global health indicators can be divided into those that directly measure health phenomena (e.g., diseases, deaths, use of services) and indirect measures (e.g., social development, education and poverty indicators); these are also referred to as proximal and distal indicators respectively. On the basis of population statistics describing levels of education attained and access to safe water and sanitation, it is possible to categorize a country fairly accurately as having a population with a high, medium or low burden of disease.

Larson and Mercer (2004) also draw attention to the fact that global health indicators used in developing countries for the most part address morbidity, mortality and important precursors of both whereas in developed countries, a large proportion of the key health indicators reflect lifestyles and individual behaviour such as physical exercise, smoking, diet, or substance and alcohol abuse.

In spite of the acknowledged limitations of many health indicators and the reservations one might have about the accuracy of health statistics derived in developing countries, Larson and Mercer (2004) nonetheless do provide useful estimates of a population's state of health. Although the absolute estimates may lack accuracy, they constitute valuable heuristic measures by which to monitor change within a population over time. Another study that grapples with similar issues impacted on by the CSC is that of Boshoff and Gray (2004). Even though their study was on private hospitals, their objective of investigating whether superior service quality and superior transaction-specific customer satisfaction enhances loyalty as measured by purchasing intentions among patients is moot. Their research design allowed an assessment of the relative impact of individual dimensions of service quality and transaction-specific customer satisfaction on two dependent variables, namely loyalty (as measured by intentions to repurchase) and customer satisfaction, the latter measured as 'overall' or cumulative satisfaction. The results reveal that the service quality dimensions as intended by the CSC can impact positively on both loyalty and cumulative satisfaction.

2.1 SATISFACTION IN HEALTH CARE SERVICE DELIVERY

The challenges of organizing health service delivery in a manner that provides adequate quality and coverage of health care to the population against a background of economic recession and limited resources is not unique to South Africa. What this study calls for in response to these challenges is the use of research-informed evidence while implementing reforms in the health sector. Proposed policy thrusts must not be so incongruent with the evidence on the ground. Current drives including efforts to develop indicators of performance which assess and reward use of resources at the local level to improve coverage, utilization and quality seem not to have borne much fruit going by the number of complaints in the press and elsewhere regarding service delivery in South African hospitals. Similarly, other interventions such as the integration of service delivery at district level with more decentralized planning to make services better responsive to local needs as well as changes in basic and in service training strategies seem to have faired no better.

Health means different things to different thinkers across countries and times. Like most authors on the subject, Terris (1988) defines health as considerably more than the absence of disease: something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual. Similarly, Terris (1990) defined health as a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity. There has been shift in the approach to define health.

In the initial phases, health was seen as a state of the mind or attitude. Later on, the definition of health focussed mainly on the physical state. Eventually the consideration of external environment became pertinent to health definition. This led to the socialist approach, which identifies health as a basic human right and maintains that it is the responsibility of government. Moreover, WHO considers health as a basic human right. WHO views public health as the extent to which individuals or groups are able to satisfy needs, realise aspirations, change and cope with their environment (Terris 1988; 1990). During the last century, the definition of public health has been accepted in a broad social sense and as a universal right. Public health is a state obligation to protect and enhance people's health. Health departments and related government agencies carry out this obligation.

Various factors have prompted the state to develop public health policies and programmes. A healthy workforce is vital for the productivity and economic development of a country. Thus, many countries introduced public health as a social reform in support of economic development. In the United Kingdom, public health services originated from the shocking revelation that a large proportion of young men were unfit to fight in the Second World War 1939-45. In other cases, with increased population movement, governments became concerned with avoiding the threat of infectious diseases from outside the country.

This evolution of public health services required efficient budgeting and cost management. The demand was for making public health decisions based on a cost-benefit analysis. As Pestieau (2009) argues, the health officer, like any public servant, should learn which line of work yields the most for the sum expended. Despite the

state's public health obligation Harvey (2001) notes that public health is a collective responsibility, a partnership between the state and the population served (p. 72). This requires open communication channels between government and citizens and structures and opportunities for public participation in public health issues.

All health systems face challenges. These include demographic changes, increased population mobility, rising costs of new therapeutic techniques and increased public demands and expectations. Each country experiences varying degrees of health within its population. Health service provisioning varies for different geographical areas. For example, it is difficult to provide identical facilities in rural and urban areas. There are inequalities in provisioning among different social groups. Even within homogenous groups, there are variations in the utilisation of services (Pestieau, 2009).

In addition, broader environmental factors such as housing, employment and behavioural factors such as alcohol use and sexual promiscuity also contribute to the health status of a population (Terris, 1988; Pestieau, 2009). The preference of traditionally technical models over more recent social models of care does not always provide optimal health benefits. In social models, emphasis is on the patient's voice on how best they can be served.

Factors like these influence and guide governments in their choice of health care delivery models and the apportionment of their often-limited resources. To safeguard the mandate within the definition of public health, global institutions like WHO, FAO and the World Bank oversee health practises. These global institutions are involved in monitoring, pacesetting and acting as watchdogs to ensure the restoration of human dignity with the delivery of health services.

These and other governmental and non-governmental bodies regularly adopt a number of conventions and agreement, which in turn act as global policy levers. The adopted policies are often implemented at different levels of the health delivery system. Therefore, certain conventions and international agreements justify public health action.

All health systems operate within a framework enshrined by the national laws of their countries. The State assumes the role of either being a regulator for the arrangements for patients to receive healthcare, the contributor to healthcare financing or the guardian to ensure that the correct balance of resources leads to optimum health. It is upon that country's ability to utilise efficiently the structures to initiate broad policies that maximize the population's health. Health commissioning should take care of improvement in health status, risk reduction and the services necessary to achieve these improvements and the monitoring of the achievement of the tasks identified (Larson and Mercer 2004).

Various attempts have been made to improve the efficiency and effectiveness of health delivery. These include the introduction of charters for waiting times and reduction of travel times by bringing services closer or locating services in individual practises or locations rather than concentrating them in a few large centres (Kickbusch 2001).

Lang and Caraher (1997) feel that considerable education within the public health world is necessary to avoid local complacency and to align the public with what is right. This creates a need for a strong patient – provider interface to filter through global health perspectives.

In 1991, the DoH in England published a Patient's Charter that provided a policy for high levels of quality health care based on its values. It illustrates the rights of patients and the standards they should expect to receive from the NHS. This laid the foundation for the kind of service standards that the CSC was intended to implement at the ELHC, such as transparency and patient recourse in the case of failure to deliver. The publicity associated with the charter aimed at consciously reducing waiting times and response times for hospital treatment. In 1994, performance tables on hospitals and ambulance services on a number of standards were published for comparison.

The United Kingdom funds its health delivery system through taxation. The services are generally free. Cost control is achieved by charging individuals' nominal levies for prescribed drugs, eye tests and dental treatment.

Running parallel services to the private health sector, the NHS structure in England as of 1995 to date is described here. In this model, contracts between the purchasers and the providers are locally negotiated. Purchasers allocate the budget from the NHS executive to purchase services for patients.

Health authorities, general practitioners, and fund holders (GPFs) coexist operating on a needs and activity basis, respectively. The former allocation uses a weighted capitation formula determined by the size of the population. The latter is related to the type(s) of services offered by the fund holder's scheme and the usage thereof. Of note is the separation of the purchaser and the provider functions and responsibilities within the NHS. This ensures better focus on public health issues by the health authorities as opposed to worrying over managerial issues of health care institutions. This enables the health authorities to reach independent views on the health needs of the public without regard for direct financial gain. These views feed into the creation of targets through which the performance of the health authorities is judged.

GPF's are a concept that started in 1991. A registered group of practitioners secures a budget to provide a limited list of resources for their patients, especially for speciality services and investigations. The guaranteed payment influences preferential shorter waiting times for procedures or specialist consultations. The challenge is for the GPF to manage savings properly, if any. Purchasers are NHS trusts, also formed in 1991, with more than 400 in existence in England. A board of directors together with a non-executive chairperson, elected by the SOS, manage the trusts. Trusts manage acute hospitals, community health centres and services, ambulance services, mental health and learning disabilities. To the core, they manage all NHS services and are responsible to either the health authorities or GPF as purchasers for delivering the agreed standards of service as providers, with cost activity and quality.

Trusts enjoy greater autonomy in management as compared to hospitals directly managed by health authorities; this is especially evident in the flexibility with the hiring and firing of staff. Trusts are at the same level as our hospital complex CSC's but differ in patient intake and funding channels. However, they are always within the public eye and have to adhere to a certain accountability framework that includes breaking even, generating 6% return on assets and staying within an external financing limit. Ham (2005 p. 248) acknowledges the incentives government has in place, as rewards, for hospitals attracting more patients as a "money following patient" scheme to ensure quality service.

General practitioners (GP), as independent contractors within the NHS, provide primary healthcare services to patients. Contracts are negotiated at a national level but delivery monitored locally by the health authority. There are about 1900 patients per practitioner and the tendency is more towards group practises working alongside nurses and other healthcare workers. Reimbursement by the health authority is via Capitation method for patients on GP's lists. Quality is still entrenched with incentive bonuses for reaching targets for preventative medicine. In addition, the government partially pays for the premises and staff used by the practitioners.

In terms of service, the practitioner is the first port of call for the patient; access to specialists is through referral from the GP. Creating high patient satisfaction means that patients are at liberty to choose their GP and vice versa. This is conducive to high quality service and adherence to service standards as it is an aspiration for one to be the doctor of choice and has created a trend of the family doctor service.

2.2 THE POLITICS OF PUBLIC HEALTH

Since the first democratic elections in 1994, the South African state has focussed on the lifestyle of its people as a way of improving the health of the nation. Past challenges, like access, equity and the quality of service in affected communities, have as a result been the primary focus. South Africa has a model of PHC with clinics as the first port of call. Services offered at PHC level include immunisation, communicable and endemic disease prevention, maternity care, family planning,

screening of children, child healthcare, health promotion, counselling services, chronic diseases, rehabilitation, oral health services, accident and emergency services (Burger, 2005).

Professional nurses and not doctors usually attend to patients at these primary health care institutions. Any cases needing treatment beyond the scope of the clinic are referred to a hospital for a higher level of treatment. To maintain a balance between the demands of health care and the supply of resources, the approach used is to rapidly respond to urgent medical conditions and ration access to other services through waiting lists. Those unprepared to wait for services then go through the private sector facilities if they can afford it. These are private hospitals or private wings in NHS hospitals.

Scholars and practitioners alike now agree that it is possible to define good health care management practice across a set of domains such as infrastructure, staff, information, finance, quality and safety and so on. As MacKinnon (2004) states, there is simple arithmetic to the rising costs of health care, just as there exists a formula to undertake national income accounting. Most observers agree that it is very unlikely that a resource-restrained country like South Africa would be able to afford free health care services for all hence the need to emphasize co-production syst At present, not enough effort is being put on the ground to improve information management systems especially in the district hospitals, which still rely largely on hand-written and type-written paper-based filling systems. It was revealing during the fieldwork that none of the hospital administrators mentioned the lack of information management systems as a serious problem. Hospital administrators in all the hospitals visited expressed concerns about staffing shortages and emergency department waiting times and quality but were unable to link this in part to the dilapidated state of information technology.

Issues of good governance are currently in the forefront of both public and corporate governance. Health care is no exception. Being a pillar of good governance, improved accountability is often called for as an element in improving health system performance. As Brinkerhoff (2004) argues, the concept of better accountability may seem straightforward on the surface. However, it contains a high

degree of complexity. He thus advocates rigorous conceptual and analytical clarity if accountability is to be more than an empty buzzword. He elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance and political, or democratic.

The kind of analytic framework proposed above for mapping accountability would thus help identify linkages among health sector actors and interrogate capacity to demand and supply information as well as exercise oversight and sanctions. Brinkerhoff (2004) characterizes three accountability purposes, namely, reducing abuse, assuring compliance with procedures and standards, and improving performance. This is motivated by the fact that accountability does help to generate a system-wide perspective on health sector reform as well as help identify connections among individual improvement interventions, and thus reveal gaps requiring policy attention. The overall impact would be to enhance system performance, improve service delivery and contribute to sound policymaking.

2.3 SOUTH AFRICA'S HEALTH CARE DELIVERY MODEL

Attempts at outsourcing support services to inject competitiveness or publishing comparative data on performance of hospitals and strengthening of management of health services are options worth considering. In 1983, the Griffith's report suggested that every health authority and hospital appoint a chief executive for managerial leadership and promote improvements in efficiency and quality of service. It put emphasis on the inclusion of doctors and other health care professionals in management.

Notably, the South African approach has been one of recruiting largely administrative personnel with no medical background for hospital management positions. In 1999, South Africa launched its Patient Charter outlining the rights of patients and a complaints mechanism, "should patients not be satisfied with the quality of care they received" (Tshabalala, 2004, p.7). These programmes aimed at improving the quality of hospital services. In addition to the Charter of Patients' Rights procedures when dealing with complaints and suggestions, a service package

with norms and standards for district hospitals and possibly later for regional hospitals were developed.

Information sharing on best practice is another method of strengthening primary care provision. The DoH provides overall guidance in the form of an annual executive letter outlining expected baseline requirements and objectives. These include waiting time targets, control of drugs expenditure, health of the Nation targets, patient charter standards and implementation of information technology strategies. The guidance identifies national priorities for the following three to five years.

In July 2004, Health Minister Dr. Manto Tshabalala-Msimang released a handbook on Strategic priorities for the NHS 2004-2009 (Burger, 2005). Amongst the listed objectives in the strategic priorities is the restoration of human dignity through the rendering of quality services. The strategic priorities document outlines the intention to develop a uniform patient information system (PIS) to enable retrieval of patient records wherever they present themselves for medical attention. This would improve efficiencies in patient registration and the reliability of patient history information.

Rahman and Barsky (2003) argue essentially that data collected routinely within the NHS do not enable an assessment to be made of the impact of service delivery on outcomes for patients and populations. South Africa performs regular client satisfaction surveys through the Hospital Management and Quality Improvement Grant (Tshabalala, 2004, p.7). It is a challenge for hospitals in South Africa, notwithstanding the different models of public health delivery, to find suitable indicators for performance tables derived from standards that are set as either service standards or patient charters.

A similar model to that of the United Kingdom is one where health is primarily the responsibility of provincial governments within their own departments of health and where the national government is only involved with subsidising funding (Terris, 1988). This is the case in Canada.

Hospital administration is a very strong profession, with a shift from purely medical personnel to more formally trained administrators. Provincial governments largely finance the hospitals, with limited funding also coming from the national government. Hospitals have an annual budget allowing administrators flexibility in spending. Coaffee and Johston (2005) cite the difficulties experienced in coordinating efforts of the different hospitals due to their autonomy. He mentions the trend that developed towards the amalgamation of all hospitals in a city and the creation of a common management board. These were the early beginnings of CSCs.

The South African National government is primarily responsible for funding and policy formulation. Provincial governments see to the delivery of health services and control the quality of health services and facilities (Burger, 2005). The amalgamation mentioned above also manifested itself in the formation of hospital complexes formed from joining the operations of hospitals within the same cities, this being the case with the location of my study, the ELHC.

Since the promulgation of the Canada Health Act (1984, see Terris, 1988), there is no user charge for the entire population in Canada for any medically necessary or essential hospital care, and the government pays for physicians' services. Many scholars such as Coaffee and Johnston (2005) as well as Hay (2001), however, warn that many free services enacted by public health authorities are set for withdrawal eventually due to the impending cessation of government funding as public coffers keep shrinking. South Africans have to pay a nominal fee for health services at public health institutions.

Academic personnel like physicians in public health institutions in Canada bill the government on a fee-for-service above a base salary, subject to income ceilings (Pestieau, 2009). In South Africa, all hospital physicians are subject to a basic salary determined by a set salary scale. Physicians are motivated by punctuality in bookings and appointments of patients. Otherwise, there are no incentives for them to see large numbers of patients. In South Africa, patients are at liberty to choose their own physician. Physicians are not aware who their patients are for any particular day because they are walk-in patients. The above situation can create duplication of

services paralleled with increased costs and lack of accountability on the part of the physicians.

Uniform patient information systems (PIS) are a cornerstone to effective patient administration. The present system of information exchange in health care is predominantly the "paper record" and all of the sustaining processes related to access and retrieval are paper based (Mercer, 2001). There are many advantages. This includes the fact that previous medical records are available for medical personnel. In addition, it curtails duplication of services with investigations and hospital hopping. It also helps in tracking of patients wherever they present for family updates and prevention of medical hazards (Tshabalala-Msimang, 2004). Lastly, it facilitates easy verification of hospital visits for complaints handling and legal processes.

Access to such information is beneficial to other disciplines outside the health department. For example, registration of births and deaths with the Home Affairs Department is one likely department. The Social Development Department with its disability grant approval and management is yet another. Coalition of information and analysis of patterns with hospital visits would also prove beneficial for medical research purposes, allowing for indicators of imminent hazards, for control purposes.

Patient information is however, privileged information. Thus, any information system needs gate-keeping mechanisms to allow only authorised users to specific information. Well-developed information systems are crucial to provide timely, accurate and comprehensive information about health status, costs, quality, utilization, workload, outcomes and satisfaction (Carol, 1996). Countries advanced with technology further extend the usage of computers with improved quality health care through patterns that manifest from monitoring key indices with patients' illnesses. They rely on computer charts for guidance with their choice of treatment (Rosser & Kleiner, 1995, pp.27-36). These writers reinforce the principle that quality improvement actions rely on data collection, and hence the need for patient information systems.

Proudlove and Boaden (2005) show how collecting, integrating and organizing patient flow information is vital for proper planning and the avoidance of bottlenecks (p. 245). They show the "potential for information systems to support the management and improvement of in-patient flows in National Health Service hospitals" (p.245). The trend is for organizations to make less use of operational data at the individual patient level to plan. As Pestieau (2009) argues, the lack of an operations manager say in public hospitals, as would be found in other types of service organizations, is by itself a potential source for loss of quality. In a manufacturing concern, a production manager would play this key role.

Thus, information systems can be used to integrate to-come-in-lists and operational flow information even with the outpatient departments of the hospital. Such integration of information would also alleviate the stress of tracking patients within the hospital by relatives following them. "It is necessary to recognise that the components of the patient journey form a system, the effective management of which requires integration." (Proudlove and Boaden, 2005, p. 248)

Similar to private hospital operations, waiting times can be measured, monitored, and analysed in public hospitals. Effective management of these indices would lead to better experiences for patients visiting public hospitals. The importance of this is evidenced by the existence of organizations like the Modernization Agency in England, which helps hospitals in improving patient flow with their programmes (Proudlove and Boaden, 2005, p.246).

Rosser and Kleiner (1995) found that a lack of regular inspections by special project teams other than the employees themselves does not improve quality. They see the inclusion or invitation of these teams as a means to develop new and effective tools for interacting with the community to come closer to preferred methods of care (pp.27-36). Their involvement also ensures that whatever standards are set, the service is not just delivered to fulfil the minimum standard, but that the standards are used as continuous benchmarks to attain continuous quality improvement.

The role of information systems is justifiable for any quality improvement due to the demand in quality improvement for constant data collection. The challenge is for all institutions to be ready with information systems at all points to allow for the proper collection, monitoring and implementation of acceptable service standards. There is a need for a shift from using computers only for office administration, to include the entire patient-journey, indicating exactly when and where the patient is at a point in time.

Computer systems do not monitor the cost of quality. Rosser and Kleiner (1995) illustrate that quality failure has, besides the human cost, an actual cost that needs to be captured in terms of labour time and materials. These costs can be integrated into cost accounting to improve management efficiencies.

At district level, District Health Information Systems (DHIS) are already operational with an emphasis on capturing vital information flow from the health centres and public hospitals. Dongwoon Han and Heejin Lee (2003) relate the formation of the Korean DHIS to various issues, which can be summarised as systemic data collection to gather meaningful statistics for planning and health intervention programmes by the local health authorities (pp.278-285).

The approach to the DHIS, as opposed to a hospital information system, focuses on the broader community drawing out patterns from various patient illnesses from different sites rather than focussing on efficiencies of patient admission and registration within one institution.

Financial goals do not motivate state institutions. Perhaps because they are subsidised, most do not feel any pressure to create a competitive edge. The Batho Pele initiative started to draw the focus towards patient service by focussing on redressing the past inequities. It is however questionable as to whether the Batho Pele principles are filtering down to provincial and district level.

In South Africa, the post apartheid government has shown commitment to patients' rights and concerns by drawing up papers like Batho Pele in 1997 that covered all

public service recipients, including patients. Despite this commitment, much remains to be done about the actual choice a patient has for health care within the public sector.

Patients relying on state institutions usually have to accept the location and type of service they can get. "Consumer evaluation studies can be seen as providing feedback on a service within which consumers often have little influence, or any realistic choice but to remain even if dissatisfied" (Batchelor et al, 1994 citing Mc Iver and Carr-Hill, 1989).

The WPTPS of 1997 and the Patients' Rights Charter have been compelling guides for health delivery institutions towards creating choices and restoring human dignity to patients in rendering health services. The South African Constitution Act No. 108 of 1996 proposes human dignity to be at the foundation and at the fore in rendering quality health services.

As Mbovane (2004) observes, the 2000 District Hospital Service Package of Norms and Standards of South Africa require each hospital to conduct a patient satisfaction survey at least once a year in order to measure the satisfaction level of service users. This modifies service to best suit the needs and circumstances of the target community.

Further to the above, recent baseline patient satisfaction studies have been done in Eastern Cape hospitals using surveys. The quality health care assurance unit spearheaded the surveys and outsourced some areas, whilst monitoring progress. These annual surveys aim at monitoring whether programme implementation for quality improvement has a positive impact for the patients as consumers. One would view this as an effort by government to gauge its efficiency and to see if their service does match the requirements of the patients (Batchelor et al., 1994, p.22).

What the government through the quality health care assurance unit has done so far are baseline surveys. Hospitals will also conduct annual surveys on their own. The

quality health care assurance unit conducted baseline surveys for all hospitals in batches, the first two being done in 2004 and 2005.

The quality health care assurance unit had to develop survey guidelines to ensure uniformity in the surveys for all the hospitals. Boshoff and Gray (2004) provides an interesting basis for the development of such a survey tool. The proposed dimensions to be interrogated in the survey include such tangibles as; responsiveness, assurance, empathy, access and general satisfaction. The data is then to be analysed using the District Health Information system (DHIS) under the guidance of the Hospital Information System Project (HISP).

The findings of the first batch survey done by the ECDoH in 2004 could be summarised as problems of tangibles in most hospitals but overall general satisfaction was mostly high (Mbovane 2004). In particular, with the ELHC, Frere hospital performed better at the in-hospital front whilst CMH performed better on the outpatient front. Administrative staff at outpatient seemed more helpful at CMH in comparison to their FH counterparts. Toilets were dirty in both hospitals.

The findings of the second batch survey show varied results for the different dimensions. There was no uniformity in the outcomes. This illustrated that each institution was unique and that management had to tailor any quality improvement plan according to its needs. Results showed that patients perceived varying degrees of weakness and strengths at the institutions.

Forming a Shared Services Centre or Corporate Service Centre is fast becoming a popular choice for achieving economies of scale, greater efficiency and focussing on organizational goals. The formation of shared services can be viewed as either a "medium-term coping mechanism or as a long-term feature of sustainable" government or organizations.

Forming shared services centres, commonly known as corporate services centres has been a strategy used in both the public and private sector of business. A Shared Services Centre consolidates business units, eradicating duplication of services over

the same geographical areas and gives clarity around powers and functions. Shared services affect the capacity to deliver services and aims at bringing relief on any internal capacity issues. Movement towards the sharing of services also should give any organization a chance to address the quality of staff they have.

A shared services centre allows for the consolidation of administrative or support functions like human resources, finance, information technology and procurement. The administrative or support functions from different departments come into a single stand-alone entity (Shared Services Discussion Document, 2007, p.5) with the objective of rendering services more efficiently and effectively.

What resonates from the above definition is that the services are not merely centralised into an existing department or structure, but a new separate and independent organisation results with the support functions being its core business. This implies the outsourcing of shared services. This means that these services are rendered in a professional manner. Service level agreements (SLAs) are then put in place between the departments and the SSC.

The SSCs have the departments as their only clients. They are responsible for ensuring cost reduction, streamlining of services and astute professionalism, benchmarking with pre-intervention levels of service. This concept affords the shrinkage of many back-offices to one back-office and the standardising of support equipment. Most importantly, it allows departments to focus on their core business in the delivery of services.

Within the health industry, the objective in forming SSCs is to deliver economies of scale, enable expertise and overheads to be shared, encourage innovation and allow providers to concentrate on their core business which is health care (McGuinness, 2006). It is envisaged with the formation of SSCs to transform ordinary organizations into high performance organizations. This is accomplished by focussing resources on core and high impact deliverables rather than behind the scenes administration. This shortens process maps as it eradicates duplication of services and reduces costs.

The focus with the SSC intervention is on end-user satisfaction. Through professionalism that comes with the SSC, government departments become "citizen-centred, out-come oriented and accountable" (Shared Services Discussion Document, 2007, p.6). This intervention is described as a turnaround strategy or innovation to cope with capacity shortages affecting service delivery. Thus, it requires change management to absorb and minimise any negative effects during the transition phase.

It is also imperative to harness new organisational cultures from the very onset to avoid slipping back into old and bad tendencies that brought about this intervention. Today's Human Resources Shared Service leaders must have the ability to deliver immediate, high quality performance at the outset and continuously improve performance moving forward (see, Carol, 1996).

Maxwell (2006) thinks culture change is very different and perceived as more difficult in the public sector than the private sector. She thinks it is paramount to identify and manage these differences to ensure successful SSC implementation and operation. One needs to assess which behavioural changes need to take place and alter behavioural patterns for both the SSC and its customers.

Leaders have to ensure that their staff embrace and feel comfortable with the changes. Carol (1996) argues that it is essential to keep up with and proactively respond to the changing needs of the organisation and to deliver on the promises made during the business case and implementation phases.

A question that comes to mind is whether it is wise to continue with the same heads of department inherited from the old structure. The old saying that 'old habits die-hard' does not augur well for the future where the same heads are retained, or transferred within the new structure. It would make sense to revitalise this intervention with fresh blood.

Prior to the formation of a CSC or SSC, a functional audit is conducted. This entails assessing levels of service delivery, which may be benchmarked with other departments or counterparts from other countries. These are confirmed by

comparing these results with surveys from customers benefiting from the services. A skills audit, infrastructural capacity and transferability of posts also form part of the functional audit. The above then informs the department on what support functions to transfer. Also with districts, one would decide on transferable functions, their destination and amalgamation decisions. The decision of who to collaborate with follows from examining which services to share. Establishing the partnership mindset is very critical to the success of the CSC (Carol, 1996**)**. No one partner is bigger than the other. All need to ensure independent control and accountability.

2.4 SERVICE QUALITY

The word quality has different meanings to different people. The Oxford English dictionary defines quality as a degree of excellence in whatever is being graded or quality as a special feature or characteristic that is special. The former definition of quality as a degree covers the elusive and abstract aspect of quality pertaining to service, as when service is being rendered the recipient is consuming the service whilst receiving it, rendering it intangible (Parasuraman, Zeithaml and Berry, 1988). However, the latter ascription of this Oxford dictionary definition of quality, as a special feature, demonstrates that there is room for associated tangibles to influence the definition of service quality.

Without particularly focussing on a single issue, Olshavsky (1985) is cited to have viewed quality as an overall evaluation of any product or service, similar to an attitude (Parasuraman, Zeithaml and Berry, 1988, p.15). Taner and Antony (2006) also view quality as a judgemental concept, citing Taylor and Cronin (1994) who outlines the basis of such judgement as values, perception and attitudes (p. 2). Consolidating the above statements, Zeithaml (1987) is cited to have defined perceived quality as "the consumer's judgement about an entity's overall excellence or superiority" (Parasuraman et al., 1988).

Philip and Hazlett (1997) define service quality as "the ability of the organization to meet or exceed customer expectations". McAlexander and Kaldenberg suggest that

service quality is the "provision of appropriate and technically sound care that produces the anticipated effect."

The general understanding from the works of the above researchers, qualified by Taner and Antony (2006), is that service quality is un-storable because it has no tangible output. However, it is the researcher's opinion that the service encounter makes the service quality storable. The fact that customers are able to relate to perceptions of each aspect of the service, constructs an overall quality level that will always be vivid in their minds and will influence future use of the service provider.

McAlexander and Kaldenberg (1994) suggested that a patients' perspective of service quality is influenced by not only central issues of technical care, but also peripheral and non-core issues like physical facilities, administration personnel and information leaflets and channels (pp.34-39). This relates very well to the associated tangibles discussed in the first paragraph of this subsection.

Within a hospital setting or any healthcare organization, quality can be conceptualised in different ways. Firstly, clinical quality that relates to the clinical processes, procedures and diagnostic methods and criteria (Zifko-Baliga, Krampf and Robert, 1997). Secondly, perceived quality is a conceptual framework that is commonly used by patients to judge quality service. The outcomes from the two frameworks above are usually different. That is patient's evaluations are different from those of the physicians (McAlexander and Kaldenberg 1994) largely due to different levels of education.

A third conceptual framework would be the economic or finance-driven quality (see, for instance, Brinkerhoff, 2002). It can be taken for granted that clinical quality is associated with morbidity, mortality and infection rates. In this thesis, it is the actual service experience that is refered to as patient-driven quality, with typical complaints of long waiting times, unfriendly staff and staff with bad attitudes.

Carol (1996) refers to the same concepts discussed above as management quality (efficiency), professional quality (need) and patient quality (wants). Thus, there is a

strong link between perceptions of service quality and patient satisfaction and these impact on patient loyalty and compliance with treatment (McAlexander & Kaldenberg, 1994). The question remains whether loyalty is an issue for public sector hospitals.

In earlier years, the conceptualisation of quality in the hospital situation focused only on two streams, clinical quality and perceived quality (Zifko-Baliga, Krampf and Robert, 1997, p.1). The former covers an area of expertise and is thus, largely, unknown territory for the patients to judge. Monitoring and evaluation does not fall under any particular directorate, but under the Chief Executive Officer's (CEO) office. Quality assurance includes Clinical assurance and Customer care. With the implementation of the CSC, service level agreements (SLA's) had to be put in place to ensure proper support of clinical services as the core function.

External review of the clinical services also takes place regularly through accreditation by the Council of Health Services Accreditation of Southern Africa (COHSASA). This non-governmental and non-profit organization has set standards and is in the business of grading hospitals. The Health Professions Council of South Africa (HPCSA) and the national DoH recognise it.

Zifko-Baliga, Krampf and Robert (1997) earlier employed a slightly different framework to explain quality. They divide service into three pillars, namely; structure, process and outcome. The structure dealt with the tangibles associated with the physical environment. Process was more the interactive part of the service rendered by the personnel. Outcomes were perceptions of the patients in terms of recovery, accuracy and reliability of the service.

The perspective from which the quality of a service is measured can constitute either an objective quality or perceived quality (Parasuraman et al, 1988). Objective quality involves a special feature or quantifiable or mechanistic measures to justify the quality assessment. Service standards and any other key performance indicators could be used as tools to measure objective quality. Subjective quality emits different responses from different individuals and is relative to prevailing circumstances at the

time when service is delivered. Customer surveys sift through the perceptions of subjective quality to get an overall and average judgement and attitude to the service experience.

What seems to surface is that the definitions, management and control of service quality within the healthcare industry have been shifted from being a professional concern to being a managerial concern. Many scholars (see, for instance, Brinkerhoff, 2002; Laing and Hogerzeil, 2001), Recognise the need for administrative and managerial support with the rendering of appropriate medical care by professionals. Prior to these developments, the technical knowledge of medical and nursing professionals had been considered sufficient for assuring quality and safety for the health care provided to the citizen.

The shift in mindset has justified the concept of creating corporate service centres as administrative units supporting clinical functions. One could then summarize the above by reiterating that health professionals are not the sole custodians of quality health care delivery. It is the joint responsibility of health care providers, financiers, politicians and the patients as consumers.

2.4.1 DRIVERS OF QUALITY IMPROVEMENT

Quality improvement is driven by a number of factors including profit and market share gain, and patient safety with error-free service. Continuing quality improvement soon becomes a learning curve for discovering system failures from a manager's perspective.

Gronroos (1984) identified service quality as a range of resources and activities. He further realised that an integrated model of service quality stemming from the above range, informed by the perceptions of the consumers, would be useful in guiding management in their decision-making (Taner and Antony, p.2, 2006). Management therefore needs to set standards in a manner informed by the priority needs of the patient community they serve (Che Rose et al., 2004). The challenge lies in how far healthcare providers know and understand their customers, the customer factor. Thus, diversity in patient profiles poses a great challenge.

Taner and Antony (2006) state that a better understanding of how consumers evaluate the quality of health care will help administrators and service providers in determining and improving weaker aspects of their health care delivery system. They feel the outcome of the service and the process of service delivery influence customer service quality evaluation. Thus, examination of the processes undertaken for service delivery and an evaluation of the results are the cornerstone of effective service level management.

The customer factor surfaces from a customer-centred paradigm where institutions are being managed as businesses intent on return on investment. Thus, customer retention and loyalty are paramount. The customer is king and differentiation in service is the key. Boshoff and Gray (2004) see the customer factor as the foundation of organizational strategies of service, quality and reliability management.

The quality of service not only depends on the performance of the service provider, but also the performance of the consumer (Philip and Hazlett, 1997). This actually allows perceptions of different individuals to be influenced differently. Perceptions of service quality will differ within the same organization due to the different ways in which patients present themselves and have different expectations. The challenge then is how we standardise the measurement of service quality with different individual sets of attributes coming into play.

Taner and Antony refer to Taylor and Cronin, who, ten years later confirmed the importance of the role of patients' information when defining the quality of an organisation. They felt that core to the definition of quality were the perceptions and attitudes of the patients as consumers. They regarded the patients as experts in judging quality (Taner & Antoni, p.2, 2006).

Gronroos' understanding was highlighted much later by the development of a conceptual model of service quality with various non-core determinants by Parasuraman Zeithaml and Berry (1988, p.13). Parasuraman based her constructs of quality on different dimensions of similar attributes grouped together as tangibles,

reliability, responsiveness, assurance and empathy (1990). These originated from a 22-item instrument used for assessing customer perceptions of service quality called Servqual.

Servqual is an instrument Len Berry and his team developed to measure quality levels through measuring customer satisfaction (Moore, 1996). This developed from the identification and measurement of the gap between expectations and what is perceived to be the level of service received. Servqual now measures five consolidated attributes as opposed to the ten generic attributes they started with.

Servqual as a tool came under criticism from a number of researchers. Boshoff and Gray (2004) have developed a more applicable tool. Boshoff and Gray (2004) felt that there was undue significance attached to the consumer's service expectations while omitting what was important and core to that service. This implies the use of more direct measurements of the service, like the service standards.

Boshoff and Gray (2004) make it easy to notice whenever a gap score can be an indication of quality. Parasuraman, Zeithaml and Berry regard service quality as an attitude that "results from a comparison between a consumer's service expectations and perceptions of the performance they have received" (cited in McAlexander and Kaldenberg, 1994).

However, fourteen to sixteen years later, researchers like Taner and Antony still validate Servqual as a reliable standard instrument for measuring functional service quality in a hospital environment (2006, p.1). For this particular study, the researcher used a modified form of Servqual.

2.4.2 EXPECTATIONS

Taner and Antony (2006) highlight two levels of expectation as the desired and adequate (p. 5). They cite Zeithaml as having named the gap between the two levels, the "zone of tolerance" of the consumers of that service (1993). However they are quick to identify that health consumers are not accepting of mediocre services, as

they are always in need of critical action. Due to the value attached to health, as an asset for good life, this zone of tolerance appears to be insignificant compared to other services.

Perceptions as a basis of judgement are influenced by the expectations the recipient of the service has (Parasuraman, Zeithaml & Berry, 1988). The gap between the expectations and the perceptions usually constructs the quality levels on a scale of how the received service approximates the expected service.

In my understanding, expectations are dependent on what education customers have about the service they are about to experience. Che Rose et al. (2004) emphasised the need for patient education to assist them to cope with their conditions of illness. This they believed would lead to better satisfied customers and a more positive overall perception of the quality of service.

In today's socio-economic climate, each organisation faces the challenge of meeting rising expectations from better-informed customers. Taner and Antony argue that patients have a general lack of expertise with clinical services offered to them (2006, pp.1-10). This led me to shift the focus in this study from clinical quality to what patients perceive as quality. Management is challenged to facilitate patient education by developing and publishing service standards that are used to monitor performance (Zairi et al, 1999, p. 299). These standards usually indicate milestones in service delivery.

It must be remembered that Swartz and Brown drew attention to the fact that patients' service perceptions are mostly different from physicians' perceptions as service providers (McAlexander & Kaldenberg, 1994, pp.1-2). There is a universal cultural belief that the doer forgets and the receiver does not forget. This confirms the lasting picture of service levels received by the customer.

Service quality results from organisational variables including leadership, psychological climate, the climate for service and contextual performance (Laing and Hogerzeil, 2001). It is therefore critical that leadership strives to create a culture of

quality service within the organisation and that this be complemented with appropriate training on service quality.

This remains a challenge in state institutions despite several initiatives like the Batho Pele White paper. The question is whether management's message of service quality improvement actually penetrates down to the lowest level of employee. In addition, it is imperative that future research is used to identify, develop or modify a tool to measure not only performance of staff but to also measure the drive to create a competitive edge within public institutions.

Zairi et al (1999) confirm the link of quality levels to overall effective organisational performance (p. 298). However, the focus of my study is on the impact on existing quality levels of the changes that were implemented. Comparing the two, the researcher considers quality as a "global judgement, or attitude, relating to the superiority of the service" (Parasuraman, 1988, p.16).

It is recommended that in order to maintain and improve the quality of health care services, administrators should utilize feedback through patient perceptions of care surveys, besides relying on clinical and economic criteria (Taner & Antony, 2006, p.1). Sewell cautioned that, "Serious deficiencies are likely to occur if there is any attempt to achieve quality without a full understanding of the requirements and expectations of customers" (cited in Che Rose et al., 2004, p.146).

Traditional cultures coupled with structural and functional deficiencies pose a threat to quality improvement for any organization. It is highly imperative that a climate of trust should exist between managers and healthcare professionals.

2.5 THE LINK BETWEEN QUALITY AND SATISFACTION

Quality relates closely to satisfaction. McAlexander and Kaldenberg state that service quality has a significant effect on patient satisfaction (1994, p. 1). The patient derives satisfaction from post-experience evaluation of a service, as explained by Bolton and

Drew (cited in Taner & Antony, 2006, p.2). Satisfaction is achieved when the performance of the service exceeds customer expectations (Parasuraman et al., 1985). However, the relationship between satisfaction and quality is not a simple linear relationship, but an exponential one. This emanates from the fact that satisfaction describes a single transaction as opposed to the overall adjudication encompassed in a quality assessment (Parasuraman et al., 1985).

The researcher hopes to draw patterns from the satisfaction levels of various specific transactions. The voice of the patient as the final consumer is an important input in the evaluation of the level of quality for services rendered (Zifko-Baliga, Krampf and Robert, 1997, p. 1). Evason and Whittington (1997) seem to think patient satisfaction studies are mostly done as window dressing, without real concrete consequential change or improvements. However, patient satisfaction studies are much desired by professional and clinical staff as a guide to improving patient happiness which in turn is associated with compliance to treatment that ensures recovery and health gain (pp.7-19).

In line with the afore-said moral responsibility of state-funded hospitals, the above writers highlight the right of citizens to comment on and be involved in the planning and development of health care policy. This is presently a serious concern with the community regarding the envisaged service transformation process (STP) that the Eastern Cape DoH wants to embark on.

Patients and health service providers assess the delivery of service differently in terms of perspectives, knowledge and need. Tucker (2002) cites the importance of and the need to investigate patient preferences and expectations as a way of trying to understand what patients regard as valued service. She believes it is important to understand what is valued by patients to know where and how service changes can be made.

Generally, satisfaction goes along with contentment or a pleasant feeling with receiving what a person wants or needs. In this way, patients evaluate distinct

dimensions of healthcare (Tucker, 2002) guided by values attached to the different aspects of health care experiences from the past.

Tucker (2002) describes satisfaction as an attitude. Largely known to us is the fact that satisfaction always follows action. Therefore, satisfaction is an attitude formed following an evaluation of the service experience but based on predetermined expectations. Batchelor et al. (1994, citing Carr-Hill) describe satisfaction as a relative measure influenced by previous experiences. Satisfaction is studied to gear the managerial mindset towards the consumer. It opens up avenues for communication between the consumer and the service provider (Batchelor et al., 1994, pp.22-30).

Personal feelings of equity or sharing and the rendering of service also moderate patient satisfaction (Tucker citing Alford, 1998). This is because being involved imparts satisfaction through having knowledge of the processes. Even as the service confirms or disconfirms desires or outcomes the consumer is considerably less disappointed with negatives because they are aware and have been involved with everything that could possibly be done.

Individual preferences (cited by Klein, 1997) surface as moderators that influence the evaluation of a service (Tucker, 2002). This was realised when patients appreciate diversion from the norm in service to cater for their different situations, that is, specifically tailored or customised service. Satisfaction levels are also influenced by dimensions like access, communication, outcomes and quality (Tucker, 2002). To unpack the dimensions mentioned above, a few examples follow: Access – availability, waiting times, convenience and accessibility allowing a greater number of patient-physician contacts.

Communication refers to the interaction that grants patients' information about the service they are about to experience and for them to be listened to in a responsive manner. The positive relationship between quality and satisfaction is quite evident, as is the fact that they are multi-dimensional (Tucker & Adams, 2001, pp.271-272). An area for future research remains identifying which one predicts the other, as there are conflicting thoughts from different writers. Tucker and Adams (2001, p.273, citing

Cleary and McNeil); Jun et al. (1998); Koehler et al. (1992) and McAlexander et al., (1994) all suggest that there is inconclusive evidence as to the predictive direction of the relationship between quality and satisfaction. However, Tucker (2002, citing Oliver) did later attest that quality predicts consumer satisfaction (p.52).

Due to a lack of technical competence and medical knowledge, patients evaluate quality and satisfaction at the level of the care they receive (Tucker and Adams, 2001, p.273). Tucker and Adams define caring as the thoughtfulness bestowed by health care givers in their interaction with patients (2001, p.278). Thus, patients' assessment of quality differs largely from clinically based assessment outcomes. Nevertheless, the differences amongst individuals influence both quality and satisfaction judgements.

Interestingly, Batchelor et al. (1994) identified the coexistence of gratitude and dissatisfaction with certain patients. She aligns this with patients' fears of victimisation should they expose their dissatisfaction. This type of situation further limits the options that patients have for service.

Satisfaction needs to be assessed and monitored continuously to extract the current actual performance of the service provided (Johnson, et al., 2005, p.603). Johnson (2005) sees satisfaction as an indicator of past, present and future performance of an organization. Its continuous assessment reveals whether service is still relevant, competitive and of good value.

Patient satisfaction studies cannot override the need for proper consultation prior to any investment institutions want to embark upon. Imposed services usually do not encourage consumers to seek redress (Batchelor et al., 1994, p.23) when things go wrong. In addition, a paternalistic role by the service provider results in the consumer becoming passive.

Keeping all the above dimensions constant, individuals on their own still differ with their evaluations (Tucker, 2002, p.49, citing Haslam et al.) due to different demographics and situational, environmental and psychosocial factors. Cultural

beliefs and orientations also influence the evaluation (Tucker 2002, citing Carr-Hill and Cothern and Collins).

Thus, we can classify the moderators of patient satisfaction as patient specific (including age, marital status, education, and gender and health status) and provider specific (including access to the service and communication). Tucker (p. 59, 2002) suggests that the provider specific moderators are more dominant and significant in influencing patient satisfaction. Tucker (2002) argues, "Although significant, patients' characteristics are clearly subordinate to patients' evaluations of health system characteristics in the determination of satisfaction" (Tucker, 2002, p. 61). The patient specific variables, that is, patient characteristics, however, allow for variance in satisfaction levels.

Not mentioned in existing literature, is a third category that is dependant on both the customer factors and provider factors. This is a patient-provider combination, including moderators like outcomes. The outcomes involve weighing how early a condition is brought for medical attention, the seriousness and the service the professional team could deliver. However, patients remain satisfied when they feel that all that was possible has been done. Batchelor suggests that patients can only make judgements of satisfaction when they have enough knowledge of the service and the expected standards (1994, p.25). Receiving the anticipated care will enhance satisfaction levels.

This means that while segmentation of marketing initiatives can be phased in to cater for patient specific moderators, the combination category will always be there and being outcomes related, will have an emotional drive harnessing it. It is thus, for me, imperative that an organization develops a good reputation that will supersede any doubt relating to these outcomes. This is a service that patients would like trusting. Tucker supports this by saying "Any organizational efforts that improve patients' evaluations of access, communication, outcomes and quality have a potentially far greater affect on satisfaction than segmenting initiatives."

The main driver of customer satisfaction is customer retention. In general, industry offers good and bad customers (Johnson et al., 2005 citing Jones and Sasser (1995)). The rationale would be for any organization to retain the good ones and divest the bad customers. However, health providers cannot exercise both options. They are bound by the Hippocratic Oath to receive and to retain patients for as long as the required service is within their scope of work.

Sourcing referrals from satisfied customers serves as a driver in competitive industries. This is usually by word of mouth and leads to successful and self-sustaining organizations. Different frameworks or terms of reference exist with satisfaction studies. These are overall satisfaction, satisfaction with attributes and relative satisfaction (Johnson et al. 2005, p.601). Overall satisfaction involves a global judgement of the service, as is the case with quality evaluation. It is seen as an aggregate or cumulative assessment of satisfaction.

Satisfaction with attributes highlights those special attributes that are very pleasing in receiving the service. These perhaps mitigate in making the service to be bearable instead of a complete disaster. Given a choice, these are the only sections of the service that the consumer would rather receive at that institution. They are perhaps what make the consumer come back for the service.

With relative satisfaction, "Customer experiences not only with the focal organization but also with other firms may influence satisfaction ratings" (Johnson et al., 2005). That means that customer's experiences with similar or competing organizations may influence customer satisfaction. Like quality, satisfaction is multidimensional. Batchelor et al. (1994, cite Dornan and the Health Policy Advisory Unit) mention, amongst others, a few dimensions like access, cost, humaneness, overall quality, informativeness, physical facilities, competence, outcomes and continuity of care. Quality in this research was assessed as cumulative retrospective assessment of satisfaction.

2.6 CONCLUSION

Future research could perhaps be to ascertain linkages and relationships between ethics, quality and satisfaction. Of interest would be to know whether being always morally right as an innate attribute is perceived as quality to enhance satisfaction. Patient satisfaction studies in the United Kingdom date back to the 1950's (Batchelor et al., 1994, p.22). Emphasis was on establishing the patient's choice in health care. The government's involvement in ensuring quality service was shown by the drawing of the white paper, "Working for Patients" in London in the late 80's to address "patient sovereignty and the accountability of providers" (Batchelor et al., 1994, p.22).

State institutions have to maintain a high moral ground and "have a moral responsibility to be fully accountable for the efficient use of public resources." Che Rose et al., (2004, citing Sarji). Philip and Hazlett (1997) argue that a "profession's concern for the quality of its service constitutes the heart of its responsibility to the public."

In public hospitals, patients do not have much choice with choosing a health service provider due to limited financial resources and the limited number of provider institutions available or accessible to them. This results in despondency with patients and silent customers who do not complain. However, the physician-patient relationship is affected by service quality in terms of compliance and adherence to treatment regimes (McAlexander & Kaldenberg, 1994). Thus, quality of service is an antecedent or prerequisite to customer satisfaction, which in turn influences patient retention or being the provider of choice.

CHAPTER 3
RESEARCH METHODOLOGY

This chapter discusses the research methodology. The research used a constructivist approach extracting meanings from patients' experiences and perceptions of hospital patient administration services. This was achieved with open-ended interviews with long-standing patients. These were followed by exit questionnaires, the tool adapted from Servqual. I also observed patient administration services. These multiple sources of evidence led to an interpretive analysis of the data.

3.1 RESEARCH GOAL

The research goal was to establish patients' experiences and perceptions of improvement, if any, in the quality of service rendered to patients since the implementation of the CSC. Recognising the limitations of patient knowledge of clinical assessment and medical treatment, I focussed only on patient administration services. The way and the speed with which these services are offered can have a therapeutic effect on an ill patient.

The research participants had been patients at the hospital prior to February 2004, when the CSC was launched. That was when service changes were implemented. By the time of the study, administration services were meant to be functioning according to the SLA's. The study therefore covers the post implementation period of the CSC, to 2007.

3.2 RESEARCH PARADIGM

First, the purpose was to describe and understand the participants' experience and perceptions of administration service changes brought about by the establishment of a CSC in the ELHC. Second, I sought evidence of actual outcomes of the establishment of the CSC.

According to Winegardener (1998), interpretive research manifests an interest in understanding how people make sense of their world and the experiences they have in the world. An interpretive paradigm assumes a relativist ontology. My aim was to illicit participants' multiple realities based on their specific experiences of hospital administration services (Denzin and Lincoln, 1994, p.110). "Multiple, apprehendable, and sometimes conflicting social realities that are products of human intellects" can be constructed by the researcher (Denzin and Lincoln, 1994, p.111). This placed me, as the researcher and primary data collection "instrument," centre-stage as I subjectively constructed interpretations as the investigation proceeded. This aspect of my research assumed a relativist epistemology.

Second, my interest in establishing evidence of real change located that aspect of my research within a post-positivist paradigm, with a critical realist ontology (Denzin and Lincoln, 1994, p. 109). According to Denzin and Lincoln (1994, p.110), a post-positivist epistemology places the researcher in the position of striving after objectivity with the intention of understanding objective reality as closely as possible.

3.3 METHOD

A single case study was utilised. Gall et al. (1966) wrote that the epistemology of most case studies is interpretive. I sought to illicit participants' social constructions of shared meanings (Winegardener, 1998). Batchelor (2001) suggested that the most popular areas for patient satisfaction studies are the outpatient, accident and emergency and in-patient departments (p.42). This research was limited to the outpatient department only. The research was conducted in the natural setting of the participants. Winegardener (1998, p.8) concurs with Babbie and Mouton (2001) about the use of multi-method data collection tools for qualitative case studies.

3.4 DATA COLLECTION

An interpretive study was decided upon to capture the patients' insider perspective of hospital administration service. This allowed the participants to describe in detail and me to probe in-depth to understand their experiences and perceptions. Van der Mescht (2003, p. 46) believes that qualitative data is most appropriate for an interpretive study. I have therefore generated my data primarily from interviews and observation. The Servqual questionnaire supplemented my primary data collection tools.

A number of different data collection methods were applied because "no single source of information could be trusted to provide a comprehensive perspective" (Winegardener, 1998: p.8). This is referred to as triangulation. Patton (1990) also endorsed triangulation to validate and crosscheck findings. The interviews preceded both the observations and the questionnaires. I conducted semi-structured interviews, with a set of guiding questions to ensure that no pertinent issues were left out. Interviews lasted on average 90 minutes.

The study used a purposive selection of interview participants. I could only interview participants who had used the hospital services prior to the implementation of the CSC and they had to be still using the services at the time of the research. The study excluded children under eighteen. Participants were selected through identifying the date of their first service from the hospital. In certain instances, pharmacy staff assisted with identifying qualifying participants.

I conducted the interviews at the respondents' homes to ensure their maximum convenience and comfort levels. This afforded us quiet and privacy. Three interviews were conducted with each participant, spaced over a week to allow for recollection, review and refinement.

The first interview was done with the patient sitting alone. I managed to focus the participants on PAS only. From this first interview, I noted a few issues that were not included in the interview. This helped inform subsequent interviews.

With the second and third interviews, the spouse joined in. The intention was for spouses to remind participants of any information they had forgotten. They also gave participants a sense of security. The spouses had also been to the hospital during the specified periods, either as escorts for the participants or as patients themselves. These circumstances led to impromptu focus group types of interviews, where each one wanted to voice their own experience and opinion. All these interviews were recorded in the presence of an observer who was my aide.

Staff interviews were also conducted, with certain key staff members. These interviews were informed by data from the patient interviews, observations and questionnaires. The data from the patient interviews, mentioned above, were not directly divulged but did influence my questions and probing. This was to ensure that the staff did not assume a defensive stance.

Instead, I adopted a "problem-solving" approach, revealing indirectly some of the findings that had surfaced in the patient interviews, observation and questionnaires . The idea was not to blame anybody but rather to help identify better practices. All these interviews were conducted on the work premises of the staff members concerned.

From the outset, the purpose of the research was fully explained to the respondents and they were reassured that their identity as sources of data would not be revealed. The respondents were also encouraged to compare the pre- and post-CSC implementation periods as much as possible.

3.4.1 PARTICIPANT OBSERVATION

Over a period of three days, participant observation was done at different points in the hospital. These were patient registration, clinic reception and the pharmacy waiting room. In addition, visibility of signs inside and outside the patient registration area was examined. I also looked out for any notices regarding service standards and the patient rights charter.

These were done in a non-obtrusive manner. Except for a short conversation when a patient sat next to me, I never communicated with any patients. Sitting quietly on a bench, I took notes of what was observed, at the same time listening and watching. Observations afforded me first hand information as opposed to reported behaviour.

This was also an opportunity to validate and crosscheck data already collected in interviews. After each day, observation notes were compared with data from the interviews.

3.4.2 QUESTIONNAIRES

Exit questionnaires to patients were administered at the hospital premises. I had to limit the length taking into consideration the amount of time these patients had already spent at the hospital. The questionnaire asked for perceptions of the quality of service received after experiencing it and patients' levels of satisfaction. Most scholars agree that customers use the same general criteria to judge whatever type of service they receive. Hence, the Servqual questionnaire was adopted. Servqual is a multi-item scale developed to assess customer perceptions of service quality in service and retail businesses (Parasuraman et al., 1988).

Pharmacy staff helped identify suitable candidates. They were moved away from the queue of patients waiting for their medicine to a nearby table. The questionnaires were compiled in English. Depending on the level of English literacy of the respondent, fieldworkers assisted respondents with their questionnaire completion.

3.5 DATA ANALYSIS

By integrating the data from my different sources, I hoped to see patterns and webs of significance that related to my research goal.

The interviews were played repeatedly on an audiotape. A summary was made of all the data. Issues were identified, labelled and, where appropriate, clustered together and renamed as themes.

Each dimension of the five constructs was looked at categorically. Comparisons were made between the different age groups and different sexes. Results from the different days were also compared to determine whether there were any patterns among age groups, sex and days of visits.

3.6 RESEARCH QUALITY

Effective triangulation using different methods of data collection ensured a connection between the experiences of participants recorded through different data gathering sources.

To maintain a high level of quality data systematic probing in the interviews led to thick descriptions (Remenyi 1999, p.28; Babbie & Mouton 2001, p.272) that enhanced the rigour of the study (Van der Mescht, 2002, p.49). I have made liberal use of the participants' voices in my data chapter. In addition, interviews allowed for excitement, anger, disappointment and other emotions to show fully, as these were conducted in the patients' residences.

My introduction to the participants as a medical practitioner seemed to instil a sense of trust that allowed for a free flow of information. However, I guarded against creating any expectations that the research would solve patients' problems.

Recording the interviews, with as little note taking as possible, enhanced the free flow of information as there was more eye contact, less attention to my note paper

and there were no interruptions. The questionnaire as an exit exercise, with the patient service experience still fresh in their minds, enhanced patients' keenness to participate.

I recorded in a journal the trail of events in my data gathering as they unfolded. The interviews were all recorded and my notes were filed for future reference. The names and addresses of the interviewees were not divulged, but are in the data file. In addition, my observation notes and the questionnaires were filed.

Finally, I was actively involved at all levels of data collection. Even with questionnaires that were not completed with me present, I always went together with the team to ensure that all settings were conducive to quality data collection and population sampling.

Proper conduct was displayed with seeking permission from the ECDoH to conduct the research in one of its facilities, the ELHC. The researcher still wrote to the institutions' Chief Executive Officer (CEO) requesting permission despite the grant from the head office. The researcher introduced herself formally to the hospital's superintendent and alerted her of the start date.

Throughout data collection, all the field workers wore nametags for identification. Etiquette was observed with the pharmacy staff that was at times assisting the fieldworkers and with the participants at all times. No false impressions were given to the participants regarding the nature of the study or the outcomes it would yield.

The participants' wishes to remain anonymous were respected with the data analysis presentation. The actual age of the participants was not probed, but rather the age group was just established.

3.7 RESEARCH ETHICS

Proper conduct was displayed by seeking permission from the ECDoH to conduct the research at one of its facilities, the ELHC. I also wrote to the ELHC's Chief

Executive Officer (CEO) requesting permission to conduct the research. I introduced myself formally to the hospital's superintendent and alerted her to the starting date of the research.

Throughout data collection, all the field workers wore nametags for identification. Etiquette was observed with the pharmacy staff who assisted the fieldworkers and with the participants. No false impressions were given to the participants regarding the nature of the study or the outcomes it could yield. The participants' wishes to remain anonymous were respected. Their actual age was not asked for, but rather their age group.

3.8 CONCLUSION

The tools used for data collection could be used in other hospital settings or for internal purposes by the pilot hospital itself. The results could also be transferred to effect corrective changes in other similar hospital settings (Trochim, 2002: p.1).

CHAPTER FOUR
PRESENTATION OF RESEARCH FINDINGS

The CSC formation and implementation came to being amidst many complaints about services rendered by public hospitals. The CSC moved to a plush head office close to the East London beachfront.

Despite the move, the CSC administration left behind a huge contingency of support staff at the hospital. These staff members had a duty to support the delivery of clinical services at the hospital and were still under the management of the CSC. Restructuring resulted in the creation of new posts in the CSC structure and transfers of personnel but it was the same people doing their old jobs.

With the formation of the CSC, their mandate was to improve services to ensure quality. To this end, as the CSC took autonomy, service level agreements (SLA) were supposed to be in place as a commitment from both the CSC and Facilities Directorate to the Clinical Services Directorate regarding turnaround times for delivery of support services. Service standards were also supposed to be drawn up and displayed for public users' awareness.

These raised hopes. There were plans for staff training in customer care and software courses. Patient records were organized and archiving of backlogs done. Each staff category was to be clearly identified with uniforms. The buildings' signage was to be improved. A customer care department was set up and staffed within the CSC structure in readiness for operations.

The CSC involved other departments besides administration, namely, finance, procurement and human resources. As discussed in the first and second chapters, the research focussed on the patient administration services because this is the one with greater contact and impact on the patient as the end user of hospital services. The findings from various data collection techniques follow.

4.1 OVERALL GENERAL DISSATISFACTION

Generally, all the participants in the research were satisfied with the results they got from the clinical service at the ELHC. They all had issues with certain aspects of the service, but felt that in most instances, they left the hospital feeling much better than when they arrived.

"Whenever he goes to hospital, with either tightness of the chest, gout, cardiac problems or asthma, he comes back a lot relieved," said the second interviewee. What was glaring was that the general satisfaction was mainly with the clinical service they received and not the administration service.

All the participants agreed on the inconsistency in the quality of the non-clinical service. This was the case with both the speed and the level of service. They all agreed that it depended on who attended to you on your arrival. The general feeling was that different staff would treat you differently at different times. This meant that you could never be certain about what to expect during any visit to the hospital.

This showed a lack of a service culture among the hospital staff. The hospital staff is not adequately trained to offer a consistent level of service. Additionally, this could also mask a morale problem that requires future investigation.

The participants were certain that this was the right hospital to be in as compared to the other hospitals Interviewee three attributed this to the constant availability of good medicine. This confidence is also manifested in the fight these participants are prepared to engage in to ensure admission at this hospital. Interviewee two relates an incident when he was turned away from admission after treatment; he laments being told that the hospital does not admit people of his age (eighty-four years) and that as a priority the beds were reserved for young people. His children however insisted on his admission due to the confidence in the hospital services and knowing that they could not get better services anywhere else.

This general feeling led me to probe into the hospital's patient service. Participants were urged to restrict their discussion to patient administration services but they could not help mentioning clinical services at times.

4.2 THE TANGIBLES

Patients agreed that the hospital was clean. They however showed concern at the state of the building in certain areas. Interviewee three commented, "We were born with the buildings in existence already, the buildings are old and certain areas need renovation". Comparing this hospital to private hospitals, he observed, "Unlike private hospitals, this hospital does not get renovated regularly".

The equipment at the hospital did not look impressive to the participants who felt they were old. Interviewee three professed that there was a lot of junk material ("ubugoxo") lying around, with most of these not functional. It is the feeling that there is also a shortage of equipment, especially computers.

Asked whether the shortage and state of the equipment was felt to affect service, the response was in the affirmative. Participants felt that only one machine working might delay service. However, they were certain of being attended to by the end of the day.

4.3 COMMUNICATING CSC IMPLEMENTATION

Regarding the CSC, its objectives and implementation, none of the participants seemed to have even a vague idea about it. They had never heard of the programme and were battling to understand what it all meant. What some of the participants knew about was the rationalization of the FH and CMH with the formation of the ELHC. However, they could not understand why they were at times not accepted for consultation at the other hospital if they had a card from the partnering hospital. "Why was I chased away then from CMH, if these two hospitals are the same?" was the concern of Interviewee one. Her concern was primarily that, not only was she turned away; she was not even assessed and given provisional treatment.

The question to probe further was whether the formation of the complex and the rationalization process was in the best interests of the patients and the community it served. Also surfacing were doubts whether the patients, as stakeholders, were informed of these changes before they were implemented. I wondered whether their input was considered valuable or whether it was a matter of those in management knowing what was good for them.

It surfaces from the discussion with interviewee three's wife that, due to its proximity, they would have loved to be attended to at CMH, but are not keen because of constant shortages of medicine. From this, it seems the services being offered at the two components of the ELHC are not consistent with each other. Is this by design or default?

4.4 INFORMATION ON SERVICES

It is evident that, very little, if any, communication exists between the hospital and patients regarding the services offered. No patient forums are ever held to broker any offerings or changes in offerings. None of the participants attest to receiving a clear message of expected services as they arrive at the hospital, nor during their patient administration journey. This leads to the patients not being able to estimate how much time they are likely to spend at the hospital. The implication is that if you visit the hospital, you have to dedicate the whole day for the visit.

"We never know what is to happen. We just wait for the folder", says Interviewee one. Interviewee two feels they only know what to expect due to the length of time they have used the service. Interviewee three confirms this, citing that they only had problems with their first visits, otherwise they got used to the service and the way it is delivered.

As a result, the patients have no choice other than accepting whatever service comes their way. How can they tell then, if something goes wrong with the service they get? This left me pondering whether ignorance delays service delivery in urgent cases.

4.5 SERVICE STANDARDS

4.5.1 COMMUNITY INVOLVEMENT

None of the patients were aware of any community involvement in planning sessions by the hospital management. The participants believed that even the changes already implemented were not communicated to the community. Changes were only noted as patients visit the hospital.

It is questionable whether there exists any formal community structure to handle such issues, except for political structures. I was embarrassed to learn that on some days the patients were informed that only students operated the clinics. The patients were given an option to leave if they felt uncomfortable with this.

4.5.2 FLEXIBILITY OF SERVICES

The concern here is the ability of the service to favour patients as the users. The question to ask was if there was adaptability of services to suit patients' needs. The service was considered flexible if it allowed changing appointment dates. "They do adjust the dates and treatment schedule if you inform them. They get cross if you don't communicate", attested Interviewee three. However, there seemed to be a problem whenever patients wanted consultations before the appointment date. This led participants, like Interviewee one, to go to other institutions, like Medicross.

This affected continuity of care. Usually, not all the patient information is transferred to the patient's records at ELHC. The risk posed here, is the alteration of the treatment regime without proper communication and planning with the regular attending physician. Removal of a winning treatment regime or alternatively, drug cross resistance, can render certain key drugs less effective.

Flexibility with folders does not exist at all. Participants are prohibited from keeping their folders with them, much against their will. This is compounded by the fact that all patient records are on paper. A problem arises whenever a patient folder is lost. A

patient's history is completely lost. An interview session with Dr. Macingwane led to revelations about the success of running a paperless hospital as witnessed by a management task team on their visit to Chief Albert Luthuli hospital in KwaZulu Natal province.

A sad discovery is the non-accommodation of patients if they have to leave the queue to answer calls of nature. "One cannot even go to the toilet. If your name is called whilst you are away, you get shouted at and told that you will get your medicines the next day because your folder gets to the back of the queue", related Interviewee 1.

The other issue that surfaced was the fact that your folder gets to the pharmacy after a long period if you have to move with it for all the investigations, like X-rays, Blood tests and others. With most of these investigations the results are only obtainable after a few days and are thus only needed back in the file in time for the next consultation. The risk of missing a day's dose of medicine if the pharmacy closes before the patient's folder is attended to creates a delay in treatment and pain relief for patients.

4.5.3 COMPLAINTS MECHANISM

There is no awareness of any complaints handling mechanism by the participants. Interviewee 3 remembers seeing a small suggestion box in the waiting area of the outpatient reception lounge and mentions that they "have never seen anyone using this" and wonder if people are generally alert to this facility. "No channels are known to us, to whom or where, we only know to go to nurse", alluded Interviewee three. Interviewee two, was unaware of the method, the right person and mode of addressing complaints, and was sceptical of the manner of complaints handling.

A sense of fear is apparent. Interviewee one revealed that she did not feel good about reporting people because they need the jobs and are uneducated. They identify themselves with the socio-economic conditions of the hospital employees.

4.5.4 ATTITUDES

This is a very therapeutic tool for patients going through any hospital service. Mostly, patients are feeling low due to illness and their dependency on medication and therefore feel their lives are in other human beings' hands. Any reassurance, measure of comfort and courteousness always allays their anxieties. Participants sometimes get anxious on separation from the escorts who brought them. The escorts are equally worried due to such separation. As a practitioner, I quite understand the need to remove escorts during an examination or treatment. However, the escort needs to be properly addressed, made to feel comfortable and continually informed of progress.

Interviewee one related an incident where a wife was allowed with only her husband into the examination section. She remembers having to "kick a row", wanting to know what was to happen. Interviewee 2 had a similar experience, where security personnel would not allow the patient's daughter past a certain point. What infuriated the daughter was the fact that there were no porter services offered for her distressed parent and that he had to walk on his own without assistance. His condition would render him unable to recall his medical history well enough; "He could hardly stand on his feet. How would you expect him to answer all questions, especially his past medical history? Who was going to know what's happening with him that side?"

Few patients feel comforted and reassured before the doctors attend to them. Interviewee three felt that the only thing that made you feel better was the medication, not the staff. He mentioned that one just has to be tolerant, "Staff is not helping you to feel better. The talk is not very kind, but I am happy with the treatment."

4.5.5 RESPONSIVENESS

Conflicting responses surfaced from this area of research. Interviewee two's daughter mentioned that the condition of her father was always considered, as he would

always be attended to and treated, with his folder following, whenever he had an asthma attack.

However, there is a lack of responsiveness in the reception area. This is where patients have to wait to get their folders, to register their visit at the hospital. Interviewee three once witnessed a patient who collapsed and was left on a bench. The nurse in charge of sorting patients' details at reception was sometimes not in sight. My observations confirmed this.

4.5.6 HELPFULNESS

I was surprised to find that patients were scared of seeking help from, or asking, hospital staff for information concerning their treatment, directions of where to go next and what service to expect next and by when. Patients rather go out of their way to help each other.

Nurses were rated as the most helpful with full cognisance of how busy they always were. Other staff members, especially the cleaning staff, appeared to be less helpful. It was alleged that this category of staff lacked etiquette in dealing with patients. Interviewee three complained that the staff, "Never stop and answer patients, they are always busy".

Interviewee two asserted that generally people were scared and often asked other patients to speak on their behalf. This apparently stems from witnessing how other patients are treated. This is elaborated on in the next section.

4.5.7 DIRECTIONS

The directions offered through signage were considered unhelpful. This created a problem for elderly patients. Signs do not necessarily assist them. Interviewee one remarked that she "never noticed any signs." She always knows she is at the ground floor once she sees the yellow paint on the floor. To get to the first floor where her clinic is located, she will ask someone in the lift to assist her. Patients who have been

visiting the hospital for many years generally navigate their way easily because they know the hospital layout

Interviewee two's daughter claimed that elderly people need assistance from young people to get around the hospital. She was of the opinion that old people cannot go by themselves. She implied that the signs were not communicative and quoted just big words, "OPD, First floor."

The fear discussed in the previous section was largely reflected in this area. Even young escorts at times preferred calling their own homes to try to find directions instead of asking for assistance from the staff at the hospital. Interviewee two remarked, "Patients rely on each other". They were scared of being scorned by staff members. Both Interviewee two and three found that patients were prepared to accompany the patient needing help to where they wanted to go.

4.5.8 EFFICIENCY AND EFFECTIVENESS

Visiting the hospital was a time consuming exercise for patients because of the large numbers seen at the hospital on a daily basis. In addition, the rule of "First come, first served" was the norm, the exception being urgent or critical care patients. Patients were unhappy with certain areas that seemed to delay them much longer than expected.

The waiting period, as patients try to retrieve their folders in order to register their visit, is in most instances perceived to be very long. Patients were happy when eventually they got attention, but complained about waiting for too long. Interviewee one estimated the waiting period to be two hours. This was compounded by the noise in the area. And even when numbers were issued on arrival at the service window, their sequence was not followed in retrieving one's folder.

Interviewee two has been admitted to the hospital on a number of occasions. He occasionally had problems getting his folder. It was through his intervention, by tracing details of previous visits, that got him his folder. "I went to look in the ward and found it lying next to the window", he related. His daughter tells of a white box

they had to sort through to get the folder, after a relative working at the hospital suggested the folder could still be in it. The folders were still in transit to the filing room.

A lack of communication by staff members leaves patients wandering around. This appears to be due to an uncaring attitude and lack of empathy. Patients are not informed of the process flow and estimated waiting periods. They are also not given clear instructions of where they have to proceed to and what to expect from the next service point.

This is the most frustrating waiting area for almost every participant. Interviewee one feels that every patient should take along something to eat during visits to the dispensary. Patients felt this poor service began about two years ago. They claimed that the pensioners who used to work at the dispensary operated more efficiently and were more time conscious. They wonder whether the CSC changes have negatively affected the pharmacy's operations.

A number of causal factors were mentioned. "They now take the folders in big batches and take long to release them. Then they continue to take more on top of the unfinished first batch," observed Interviewee two. Another factor is that all the dispensary staff take lunch at the same time. The dispensary is then closed. The patients fail to understand why the staff cannot take lunch breaks in shifts. Some felt that the dispensary was short-staffed anyway. On the other hand, others thought that the dispensary used to perform better with more or less the same number of personnel.

Patients did not understand the sequencing of folders. The first one in is not guaranteed to be the first one out. Interviewee two felt there was no discretion for wheel-chair cases. The worst situation is when the waiting area is full without even a bench to sit on. The fact that patients were not made aware of any changes, to allow them to adjust, made them dissatisfied. They found it unacceptable to wait three hours to get their medicine.

Patients reach the dispensary coming from different service areas of the hospital. This is the exit point and where they will leave their folders. There was a bottleneck here as the dispensary was not aware of who was coming and when. They were unaware of the intake for the day.

Compounding this problem was the fact that the dispensary closes its doors at half past four in the afternoon, and only operates during the week. The emergency pharmacy only caters for the casualty section. Patients tend to compare the dispensary services at FH with those at CMH. They felt that despite the same lunch break disruption, CMH was much quicker with dispensing. The problem was that FH always has all the "good medicines" in comparison with CMH.

4.6 CONCLUSION

Due to study limitations, this research focuses on patients' perceptions of patient services at CMH only. The vision and mission of the hospital are not well integrated in the organisation culture or structure. The hospital is not seen as a place of business but as a place of work.

Nurses were rated as the most helpful category of staff. Some patients felt white nurses were more caring that black nurses. Similarly, older nurses were rated to be more caring than younger nurses. Thus, there were perceived inconsistencies in staff attitudes and in the levels of service received by patients.

CHAPTER FIVE
INTERPRETATION OF RESEARCH FINDINGS

A huge quality gap in the levels of service delivery exists between the clinical and the non-clinical components of the hospital service. The literature shows that patients are unable to comment on clinical excellence in hospital service. This is because they are non-professionals in a highly specialised field. However, they do recognise an improvement in their health status and the availability of good medicines that are given to them as prescribed by medical practitioners.

The patients in my study generally left the hospital feeling much better. They have strong feelings that they will not get good clinical service anywhere else. Hence, they are prepared to fight for their admission at this hospital despite any non-clinical service flaws they might experience in the process.

Patients have an option of choosing medical care from either public or private sector hospitals. What usually dictates their choice is their socio-economic status. If there is a family member who is in formal employment they can normally afford to have medical aid benefits. Medical aid members and beneficiaries usually opt for private hospitals, not for the clinical service, but rather for the non-clinical service they receive.

The levels of clinical standards were satisfactory to these patients. It was rather the process of getting to be attended to that affected them the most. McAlexander and Kaldenberg (1994) indicate that quality is influenced not only by the central issue of clinical care, but also by peripheral and non-core issues like physical facilities, administration personnel and information (pp.34-39).

This chapter discusses what emerged from the themes in the previous chapter. The discussion is informed by the literature review. Discussion is done under the headings facilities and equipment, communication, attitudes and time frames. The next section discusses the findings on the facilities and equipment as perceived by the patients.

5.1 FACILITIES AND EQUIPMENT

The literature review revealed that the management and control of service quality within the healthcare industry has shifted from being a professional concern to being a managerial concern. The nature of the facilities and the state of the equipment is not the core business of the clinician. Nevertheless, Laing and Hogerzeil (2001) identified a need to create a link between clinical and administrative support. They showed the much needed role of administrative and managerial support in the rendering of appropriate medical care by professionals. This way of thinking may behind the creation of CSC's.

Therefore, a healthy link between a clinical section and administrative support is critical for the benefit of the patient. Communication of patient care information provides such a link because of its shared patient focus. The core business of a hospital remains that of offering a cure for sick patients. This focus must be at the forefront of managerial and administrative service. Hence, the term administrative support is widely used. It is not clinical support for the administration!

Zifko-Baliga, Krampf and Robert, (1997) offered a model for service quality. They refer to structure, process and outcome. Structure dealt with the physical environment such as facilites and equipment and maintenance (Parasuraman et al, 1988). The patients in my study approved of the level of cleanliness but were dissatisfied with the maintenance of the buildings. The buildings are old and poorly maintained. They are able to compare this to what they see in modern private hospitals. However, the focus in private hospitals is not on frills in service but rather on creating a competitive advantage in the quality of service delivery (Raduan et al., 2004). This is the forte of private hospitals in attracting patients. This ensures the retention of their patient base.

Due to the lack of a financial drive or a focus on the bottom line, the conditions of public hospitals are not attractive to patients. Furthermore, due to socio-economic

conditions, including poverty, public hospitals already have large numbers of patients and do not need to look attractive to attract new patients. Finally, public hospitals operate on a subsidised budget. In an impoverished environment free service is a major attraction.

Patients also commented on the lack of reasonably new equipment and the shortage of computers. This effects process flows and delays patients (Zifko-Baliga, Krampf and Robert, 1997). Any delay in rendering service is a delay in patient relief and can, at times, be life threatening.

In 2004, the National Minister of Health emphasised the need for a uniform patient information system in order to, amongst other objectives, shorten the process of patient registration. The findings show how far away the hospital is from being able to speedily and effectively track patients.

Proudlove and Boaden, 2005) found that patient waiting times and indeed the whole patient experience could be improved by using information technology to improve patient flows. I will elaborate on this when I discuss time frames in 5.4.

The literature review showed that health professionals are not the sole custodians of quality health care delivery but that it is a joint responsibility of health care providers, financers, politicians and the patients as consumers. This needs effective communication channels among these stakeholders.

5.3 COMMUNICATION

The Patient's Right Charter states that "Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health" as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996).

What surfaced from the data was a lack of a hospital community structure representative of the community it is serving. Communicating issues of health

delivery with the patient community is necessary as they are stakeholders. Issues to be discussed would include matters affecting the delivery of services like times, location, costs, and the addition and removal of services. This could happen through an organized community structure and would precede an intervention strategy or business process engineering. Alternatively, a survey could be performed to determine the feeling of the majority of community members, before a change was introduced.

Besides community-wide communication and consultation, communication is needed with patients within the hospital. Proudlove and Boaden (2005:245) discussed the potential of information systems to support the management and improvement of patient flows in National Health Service hospitals. From the foregoing, we thus see the need for an operations manager in hospitals, that would include communications, as would be found in other types of service organizations.

This type of communication generally employs the use of posters, brochures and newspaper adverts. Feedback is not necessarily deemed to be essential, as what is communicated is simply information.

My research shows that a lack of information communication is evident throughout a patient's administration journey. Firstly, they are not aware of the existence of the CSC and what it stands for. Secondly, they do not know what to expect when they visit the hospital, what process their consultation will follow and how long it will take. They are not aware of any patient or community forums that discuss hospital issues. The Charter of the Public and Private Health Sectors of the Republic of South Africa, in its fundamental principles, provides for patients' right to information and the avoidance of misleading information.

The lack of road mapping of a hospital visit in terms of verbal communication, process flow charts and signage is a source of unnecessary delays for patients in getting to points of service. Such process flows should be simple and transparent.

The hospital with its staff is seen by the patients as a rigid bureaucratic institution with a service layout that serves the staff and not the community. Examples of this are the alteration of appointment dates and the keeping of patient records. Another example is the lack of a proper complaints handling system that is communicated and clearly visible to patients. Patients are fearful to even investigate what recourse they can take.

5.4 COMFORT

I was interested in patient references to the sense of comfort they receive from staff before the clinical encounter. Some patients reported they felt reassured, that staff showed empathy and were responsive and helpful. However, they did feel that the staff displayed a lack of empathy in their use of hospital jargon that was unfamiliar to most patients.

Another concern that surfaced was the separation anxiety experienced by patients when they were separated from an accompanying family member. This practice is governed by hospital policies. There are defined areas where or points beyond which only patients are allowed. This policy is not explained to patients and their escorts. This causes them to feel a sense of helplessness, especially for the escorts who sometimes feel their presence can improve the situation for the sick patient.

Patients expressed concern about the manner in which they are addressed by non-clinical staff. They are sometimes rude and intimidating. This attitude creates a sense of fear among patients. They are relieved when they get to see the doctor.

Many problems surround the registration process, before patients get their patient records. There is no prioritization of their condition, as a result of which more urgent cases experience undue delays. Some patients noted that the responsiveness experienced in the outpatient reception area as they queue to get their folders is far inferior to that experienced at casualty. It is known that casualty staff are well trained to handle emergencies. There is also a predominance of professional staff in the

casualty area. They do however see an improvement in service once they move on to be attended to by nurses.

There is a screening nurse in the outpatients' waiting area. According to the hospital management her task is to prioritise more urgent cases and to see that there are no undue delays. My observation was that of a lady who randomly went to patients. This resulted in some being overlooked. She had no sense of urgency and was more concerned with who arrived first. She was also often absent.

I have already discussed in 5.3 how a lack of signage in terms of process flows and service points created delays, frustration and even fear among patients. In summary, there is a lack of a service culture among non-clinical staff. There is no evidence of a shared mission and vision among them or in the hospital as a whole. There is no evidence of cooperation or communication among the different hospital units, especially between non-clinical and clinical staff. This is detrimental to patients' sense of happiness and satisfaction.

5.5 CONCLUSION

It is evident that the issues that surfaced are support service issues. The patients are fully satisfied with the clinical service they receive. The CSC was formed to improve support service delivery but it doesn't seem to be making any impact. In the final chapter that follows I make recommendations in this regard.

CHAPTER SIX: CONCLUSION

The aim of the study was to establish patients' perceptions of the quality of patient service in the ELHC. Patients visiting the hospital were used as participants. The methods used for acquiring information to answer my research question were interviews, questionnaires and observation. In this chapter, I overview my findings, identify areas for future research where gaps in knowledge exist and make recommendations.

6.1 LEVELS OF SERVICE

There is a gap in the levels of service quality between the clinical and non-clinical sectors of the hospital. The clinical staff is bound by professional ethics and the Hippocratic Oath to deliver the best service they can. There are no complaints with the clinical service. However, my findings reveal the need for a code of ethics governing the behaviour of the administrative staff in the hospital. This could enhance the possibility of sensitive patient handling and provide easy recourse in cases of improper conduct. The Health Charter states the intention to continuously train health personnel on patients' rights and the Batho Pele principles (Health Charter, p. 30).

The patient charter and service standards could assist to inform patients of what to expect when visiting the hospital, in terms of the information they should receive, and time frames for service. But these do not specify how administrators should behave when dealing with sick patients and their families. Ethics and codes of behaviour should not be confused with the precepts of patient care. Patient care would be revealed in the way staff comfort patients while providing quality care.

6.2 GENERAL MAINTENANCE

The focus with maintenance in public institutions is mainly on functionality rather than aesthetics. However, even the level of functionality is at times compromised with outdated or faulty equipment. This is invariably related to budgetary constraints.

In the hospital, the number of patients does not translate into profit. This removes any incentive to create an attractive environment in the hospital or to update equipment.

It would be interesting research to investigate revenue collection in public hospitals and how the generated revenue is ploughed back into managing the system. From a facilities management point of view, creating and streamlining projects, intensifying revenue collection targets and ring fencing those funds for continuous improvement would keep the facilities updated.

Operating on a fee-for-service basis and reverting to a classification system for patients with government paying the hospital on a capitation basis for services rendered would provide an incentive to attract more patients to increase income generation. As long as hospitals fail to operate as businesses, operating rather as charity institutions, they are bound to lack the drive to improve their service. The patients' Rights Charter currently allows for free emergency assistance regardless of the ability to pay. The challenge then is how to maintain a high level of service quality with a free service.

6.3 COMMUNICATION

The findings reveal a lack of communication, both with the patient community and with the passing on of information to patients. The hospital public relations office falls far short in its service. This is one of the crucial benefits that was supposed to have been introduced by the CSC.

It is imperative that the hospital have a proper communications department, which handles community consultation and information sharing with patients. There should be provision for patient feedback that is analysed and passed on to management for purposes of strategic planning, monitoring and evaluation. It is also critical that hospital management should show how patient feedback adds value to patient service.

Also imperative is the formation of community patient forums, representative of the community. What needs addressing and research as a matter of priority is the referral system to the hospital, including its area. In the meantime, management could start inviting the public to forums through the paper and broadcast media to consult on intervention programmes.

6.4 ATTITUDES

Patients are very sensitive to the manner in which they are received and treated, as they are emotionally fragile. The hospital complex needs to create an organizational culture of urgency, responsiveness, helpfulness and kindness in dealing with patients. This can be achieved through patient care training and instilling a recognition of the patient as a customer. In addition, it is essential that patients not be left alone without professional staff at any service point. This applies to all areas, including registration.

Improvement in process flows is essential for firstly, reducing bottlenecks and delays in getting patients through registration and secondly, for allowing patients to know the sequence of events in the service process. This could be facilitated by having clearly visible posters of the process flows on the walls at all service desks.

Management information systems can also facilitate the management of these process flows in that different units within the same institution could be linked (Proudlove & Boaden 2005, p.245). This would make it possible to track each patient and to estimate when to expect them at any service point. This could be particularly helpful for the pharmacy as they would be able to pre-pack medicines before the patient physically reaches the pharmacy.

Delays can also be reduced by giving sub-units in the hospital, such as clinics, a certain degree of autonomy in preparing for patients. This could be achieved by allowing clinics to see patients by appointment. Clinics that see patients on an appointment could then prepare for them before their arrival. That would include collecting their folders the day before and billing their own patients with an

integrated information system. With such a system in place, there would be no reason why patients who get to the hospital early in the morning should have to endure long waits.

6.5 TIME

The importance of an integrated information system in easing flows and reducing delays for patients has already been emphasised above. Delays could also be reduced by repositioning the file room so that it is close to the registration desks. This would lessen the wait for the retrieval of files. In addition, making the waiting area more inviting with, for example, comfortable furniture, magazines and a television set could assist in distracting patients and making their wait more bearable.

It is essential that the pharmacy employ more personnel so that it can be open until the last patient leaves. A dedicated service for people with disabilities is essential. Again, making patients more comfortable during their wait could be helpful. The pharmacy wait could also be reduced if the pharmacy knew before patients arrived what prescriptions were to be prepared.

6.6 CONCLUSION

The CSC, to justify its continued existence, needs to consult with clinicians, administrative staff and patients to better understand what their needs and aspirations are. The CSC exists to ease the administrative load of hospital staff and to facilitate patient processes. It is a mistake to place it in authority over the hospital. It was created to serve and support the hospital. Hopefully, this study will provide an impetus and some direction for this to happen.

While a number of structural changes have been introduced in the civil service, in line with the practices of the New Public Management (NPM), cultural and attitudinal changes are yet to be effected appreciably in the public sector to change the attitudes of civil servants to make them welcoming to service users. Overall, equity in health care remains theoretical rather than practical and the social goals of reform have not been achieved nor properly articulated.

The other remaining policy thrusts could broadly be divided into two strategies; decentralization and the incorporation of technology in governmental processes. In both movements, the main issues of concern remain the reduction of disease burden, the provision of drugs, provision of facilities and equipment and the participation of key stakeholders in service delivery. One recurring challenge though, as Ryan (1999) shows is the fact that rational approaches to public administration are inherently value-laden, emphasizing norms such as institutional integrity, representation or efficiency. It would appear as if no deliberate attempts have been made to find ways of incorporating the concept of social capital into these reform efforts.

Ever-growing public expectations, especially with the advent of the HIV/Aids scourge, are creating uncontrollable cost pressures. On the other hand, the government is faced with a mass exodus of doctors seeking greener pastures elsewhere. The system needs more money and personnel now, and a great deal more in the future. Raising money through general taxation is no longer a viable option. New attempts at devolving power and responsibility to these sub-local structures should be more responsive to local conditions rather than be directed by national policy. Because of the complexities of factional balancing in these settings, it is important to adopt, in the words of Coaffee and Johnston (2005), a 'pragmatic localism' in dealing with issues of decentralization locally. There is a need to design ways of transferring national programs and funding to districts and to further devolve these programs' responsibilities to local governments. Because of the capacity problems envisaged, collaboration among interdependent national and local governments would still need to be advanced.

The overarching purpose of the decentralization and devolution processes should be to open new opportunities of community-based involvement in policy and decision-making at various local levels. In summary, decentralization offers a number of challenges especially in terms of capacity regarding such issues as accountability and financial reporting. As Hay (2001) demonstrates in the case of Australia, these disparities can be explained by differences in the principal-agent relationships involved. The principal-agent relationships themselves vary because of divergences in

the nature of the activities carried out by the various organizations and their varying levels of importance.

To broaden the above discussion to public provisioning generally, it is important to highlight here the fact that, regarding the incorporation of technology into governmental processes, good governance tries to promote an agenda of citizen-centric and accountable government. Technology, especially that which promotes innovation in governmental processes, should be encouraged. Innovations are needed to make bureaucratic processes more relevant, encourage participation in decision-making, and improve service delivery generally.

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APPENDICES

QUESTIONS FOR PATIENTS:

1. **How long have you been visiting this hospital for consultations?**
2. **Are you satisfied with the health services in this hospital?**
3. **Do you get appropriate information regarding the services you need?**
4. **Has the hospital ever involved in any decision regarding the management of the hospital?**
5. **What kind of choices are you able to make regarding the services you receive in this hospital?**
6. **Whenever you had any questions about hospital services, did the organization answer these questions adequately?**
7. **How can you make your concerns known to the hospital management?**
8. **Do you have any suggestions for improving services?**
9. **Are you aware of any change(s) that have taken place with the hospital administration structure since 2004?**
   IF ANY- Do you think they were good or bad changes?
10. **How would you describe your day at the hospital?**

SERVICE PROVIDERS' QUESTIONNAIRE

Field Worker Name:

Date:

Respondent's details:

Gender: **Male** ☐ **Female** ☐

Age group:	**18 – 35yrs**	☐	**Race:**	**African**	☐
	36 –49yrs	☐		**Coloured**	☐
	50 –59yrs	☐		**White**	☐
	60yrs +	☐		**Asian**	☐
				Other	☐

This questionnaire is designed to ascertain what your perceptions are about the quality of service of the patient administration services. Your cooperation is highly appreciated.

Your identity will remain anonymous.

Please answer all questions

1. TANGIBLES

YES

NO

1. The hospital is clean.
2. The hospital is in a good condition.
3. The toilets are clean.
4. It is easy to identify staff with their dress code.
5. There are visible signs to guide you everywhere.
6. The equipment used for admission looks quite modern.

2. RESPONSIVENESS

7. The staff is always willing to assist.
8. The staff is keen to ascertain your immediate needs.
9. The staff always informs you of how long your wait will be.
10. The staff always assists you immediately.
11. I did not wait a long time to get my folder.

3. RELIABILITY

12. I am always seen within reasonable time for my appointments.
13. I have never seen an error with my patient records.
14. I never have to queue twice or go back for the same service.
15. The speed of service is the same at all times.
16. All staff offer you the same level of service.

4. ASSURANCE

17. The staff is always very pleasant and polite.

18. The information the staff gives you is always accurate.

19. I feel safe in the hospital premises.

20. My privacy was respected by all the staff.
21. The staff always seem to know what they are doing.

5. EMPATHY

22. It is easy to locate any section in the hospital.

23. The staff is very helpful when you have a problem.

24. The staff always listens and make you understand.

25. It is easy for me to change my appointments.

26. The service I get at the hospital is value for money.

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27. If you had a choice would you come to this hospital and why?

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____

____

28. What do you commend most about the patient administration service?

____

____

29. What would you like to see improved in the patient administration service and how?

____

____

____

____

THANK YOU FOR YOUR VALUED INPUT.