



An investigation into the management of public hospitals in South Africa:

Stressed institutions, disempowered management

Research Report
Commissioned by the Department of Public Service and
Administration

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Executive summary

Public hospitals:
Stressed institutions,
disempowered management

I. Introduction

NALEDI was commissioned by DPSA to conduct research into six regional hospitals and two tertiary hospitals spread over KwaZulu Natal, Gauteng and Northwest Province, in addition drawing on its in-depth research knowledge of Chris Hani Baragwanath Hospital (CHB).

II. Findings

1. Public hospitals are stressed institutions

Public hospitals generally are highly stressed institutions due to staff shortages, unmanageable workloads and management failures. The degree of stress varies between institutions, depending on degree of staff shortage and management dynamism. The nursing function exhibits such high levels of endemic stress due to short staffing that it may be regarded as a function in crisis.

2. Changing health environment

The public hospitals in this study have experienced substantially increased patient loads over the past decade because of rapidly growing urban populations and the associated diseases and traumas of poverty, because of the escalation of the HIV/AIDS pandemic, and because of the failure of the primary health care clinics and district hospitals to capture the patients who should not be attending secondary and tertiary institutions.

3. Interface between Provincial Head Office and hospital

The relationship between hospitals and provincial head offices is dysfunctional. The head offices in all three provinces have centralised control over strategic, operational and detailed processes but are unable to deliver on these. The interface between hospital and head offices is blurred and ambiguous. There is no clear locus of power and decision-making authority. Hospital managers are disempowered and cannot take full accountability for their institutions. The structural relationship between province and institution is a disincentive for managerial innovation.

4. Dysfunctional management structures

Hospital management structures are dysfunctional and fragmented, preventing the integrated management of operations, paralysing initiative and preventing accountability. The overall effect is pervasive disempowerment of managers, giving rise to a management culture in which administration of rules and regulations is more important than managing people and operations or solving problems. In some cases exceptional managers have improved hospital functioning, but the nature of their success tends to prove the general rule (see Section 9 below).

5. Weak management functions

Apart from dysfunctional structures, management functions remain weak simply because they are under-resourced in virtually all institutions. The result of weak management functions is that scarce human and financial resources are often managed in a wasteful and ineffective fashion.

6. Management skills

While there is undoubtedly a lack of management skills in the public hospitals, the primary problem is the disempowerment that arises from incoherent management structures. A comprehensive programme of change would have to address both structures and skills simultaneously.

7. Staff shortages

Staff shortages are a critical problem in most public hospitals, and are generated by underfunding as well as a national shortage of professional skills. Shortages of support workers such as cleaners and porters exacerbate the problem of scarce skills, as nurses and doctors have to perform unskilled but essential functions. Shortages of nurses in particular are generating a healthcare crisis in public hospitals and pose a threat to the long-term functioning of the public health sector.

8. Clinical/patient care outcomes

Clinicians and nurses in all but one of the hospitals studied state that staff shortages and management failures compromise patient care and have an impact on clinical outcomes. In many cases the result is increased morbidity rates, higher costs of intervention and longer hospital stays. In others it affects mortality rates.

9. Improvements and innovation

Where there is innovation and improvement it is dependent either on informally bending and breaking the regulations that govern the functioning of public hospitals, or on formal agreement to waive them. The future of innovation and improvement in public hospitals depends on a change to the regulatory framework and its details.

10. Conclusion

The high level of institutional stress in the public hospitals is caused by managerial disempowerment and the pressure of work overloads. In an environment of scarce financial and human resources it is all the more important to focus on a sustained investment in management capability so that these resources are managed in as effective away as possible. What is needed is the restructuring of the relationship between provincial head offices and public hospitals, the empowering of hospital management and enhancement of their capacity, as well as innovative strategies to increase staffing levels.

III. Recommendations

- 1. Provincial head offices should relinquish attempts to manage institutions and concentrate rather on policy, strategy and auditing of management performance.**
- 2. Hospital managers should be granted full authority, and be held fully accountable, for managing their hospitals without interference from head offices, according to agreed budget, business plan and performance.**
- 3. New hospital organisational structures should be based on clear operational units, for example the surgical department, establishing clear lines of authority and accountability and ending the fragmentation of the silo structures.**
- 4. Considerable investment in management capacity and systems is required in order to overcome current management paralysis.**
- 5. Implement a new staffing model based on increasing the numbers of less-skilled staff so that scarce skills can be deployed appropriately.**
- 6. Reopen nurses training colleges and reintegrate with hospitals.**
- 7. Establish a joint DPSA, DOH and DOF task team to implement these recommendations.**

Research report

I. Methodology

NALEDI was commissioned by DPSA in early November 2005 to research the functioning of public hospitals in South Africa, building on our experience in the Chris Hani Baragwanath Hospital (CHB) transformation project. Given that the research report had to be completed by the end of the first week in December, it was agreed that NALEDI would limit its investigation to eight tertiary (level 3) and regional (level 2) hospitals in three provinces.

We conducted on average four interviews in each institution (with the CEO, a senior clinician, nursing middle manager/s, and trade union shop stewards). While this provides a somewhat limited assessment of hospital functioning, it does nonetheless provide broad indicators. We used the intensive and in-depth analysis developed in our four-year-long research and participation in the CHB transformation project to guide our interviewing strategy and interpret the results.

The research methodology we have employed is essentially a qualitative methodology, which facilitates a more complex analysis of the relationship between cause and effect than quantitative methodologies and permits the 'experience from below' to be captured and explored. The research conducted at CHB consisted of a series of intensive interviews and focus groups with representatives of all occupational categories and management groupings within Chris Hani Baragwanath in order to identify problems and develop strategic proposals for transformation. These were conducted in 2002 and 2004. In addition, our research has consisted of a process of participant observation over the period of four years that NALEDI has been present at the institution as a transformation adviser.

II. Research findings

1. Public hospitals under stress

Our investigation indicates that public hospitals are highly stressed institutions due to staff shortages, unmanageable workloads and management failures. By 'stressed institution' we mean that institutional functioning is stressed (weak functioning, problems and breakdowns not addressed, dysfunctional management, lack of systems), staff are stressed (high workloads, stressed health, high levels of conflict, poor labour relations), and public health outcomes are poor (inadequate patient care, poor and inconsistent clinical outcomes, increased costs of poorly managed illness).

There is a significant variation in the level of stress and the way stress is managed from institution to institution. Our assessment of the degree of stress at different institutions must be regarded as tentative, given the time constraints and the limited number of interviews conducted at each institution. Nonetheless, certain patterns do emerge.

The primary factor in distinguishing levels of stress appears to be differentials in resource allocation and workload between institutions. A secondary factor is the varying strength of management at different institutions.

Differentials in resource allocation are captured in the table at the end of this document. It should be noted that tertiary hospitals are expected to be more highly resourced than regional hospitals, as level 3 patients require more intensive and specialist clinical interventions.¹

It is noteworthy that the differences in resource allocation between the two tertiary institutions capture the continuation of apartheid differentials: CHB is a formerly black hospital, while Hospital B is a formerly white institution. All the other hospitals studied were formerly black institutions, so we are unable to comment further on the persistence of apartheid inequities in budgeting. It is also noteworthy that the Gauteng hospitals generally have the lowest level of resources. The hospitals in North West Province have a somewhat greater level of resources, while the KwaZulu Natal hospitals in our study have access to significantly greater resources than do those of the other two provinces.

The most stressed hospitals are those with the lowest resources per bed (CHB, Hospitals C, D, G and H). The least stressed hospitals are those with greater resources per bed, as well as with long traditions as high-quality hospitals which provides them with a kind of 'social capital' (Tertiary Hospital B, Hospital E; it should also be noted that the latter hospital is undergoing a process of bed reduction which has reduced workloads). Hospital F, while relatively well resourced, exhibits medium levels of stress because of increasing numbers of patients and management weaknesses. The North West hospitals, while somewhat better resourced than the Gauteng ones, are nonetheless highly stressed institutions. Of the highly stressed and least resourced institutions, CHB is in crisis (i.e., it is in a process of institutional decline that can only be reversed through sustained and far-reaching intervention), Hospital D is highly stressed and possibly verging on crisis, and Hospital C is highly stressed but showing managerial improvement in some areas.

The differences between hospitals with relatively similar levels of resources can be attributed to the management factor – the varying capacity and depth of management between institutions, as well as the more intangible element of 'social capital' referred to above. Thus Hospitals C and H are somewhat less stressed than Hospitals D and G because of a relatively dynamic and experienced management team. In other words, where there are resource constraints *the capacity to manage scarce resources (human and*

¹ Cost per patient day was calculated at R984 at regional hospitals and R1637 at tertiary hospitals in 2003/4 (www.hst.org.za).

financial) effectively is of critical importance. The recommendations of this report therefore focus on investing in and building this crucial capacity.

Our research indicates that *hospital stress is concentrated in its most acute form in the nursing function.* Nursing is the foundation of clinical and patient care, especially in the South African setting where nurses have a wide scope of practice, and it bears the brunt of increased patient-loads, staff shortages and management failures. High levels of stress in nursing undoubtedly impact on clinical outcomes and patient care as well as on staff morale, recruitment and personal health. Indeed, the extremely high levels of stress in nursing across the majority of public hospitals amounts to a crisis in this function. It is a crisis both of immediate functioning as well as the long-term reproduction of nursing numbers and skills in the public sector.

2. Changing health environment

Much of the increasing stress faced by the public hospitals studied here may be attributed to the changing health environment in which they operate. Firstly, rapid processes of urbanisation have dramatically increased the population served by these urban hospitals. Much of the newly arrived population lives in informal settlements subject to the health hazards of poverty – a high incidence of trauma and disease. Apartheid isolated many of these problems in the bantustans. Democracy has exposed the cities to their pressures, was simultaneously giving skilled professionals access to job opportunities internationally.

Secondly, the HIV/AIDS pandemic has greatly increased the pressures on hospitals. Greater numbers of patients, higher acuity levels and complications, and slower recovery rates all impact on limited resources. High mortality rates take an emotional toll on doctors and nurses. The head of the internal medicine department at one of the hospitals reported an average of 150 HIV/AIDS associated deaths per month, and commented that doctors are choosing to specialise in other areas as a result: ‘No-one seems to take it as a disaster. But it is like three bus loads crashing and wiping out the passengers *every month*. That would be a huge disaster reported in all newspapers.’

Thirdly, respondents in all of the hospitals commented that the system of referrals from primary health care clinics fails to screen out patients who should not be arriving at level 2 or level 3 hospitals. On the one hand many patients simply bypass clinics or district hospitals and go directly to higher-level hospitals; on the other, clinics are referring patients who should be diagnosed and treated at the clinics or level-1 hospitals. These failures contribute directly to the pressures in the hospitals studied here. It is beyond the scope of this study to assess the reasons for such failure.

3. Interface between Provincial Head Office and hospital

Hospital management at hospitals across the three provinces reported extreme frustration at the dysfunctional relationship between hospitals and provincial head offices. The head offices in the three provinces (indeed, in all provinces as far as we can ascertain) has centralised control over strategic, operational and detailed issues. At the same time, the interface between hospitals and head offices is blurred and ambiguous, and control is exercised in an authoritarian and bureaucratic manner. Head offices provide no induction, support or mentoring for new or struggling CEOs.

Centralisation is somewhat greater in Gauteng and North West province than KwaZulu Natal. KwaZulu Natal has delegated greater disciplinary powers to hospital management who have the power to dismiss. In contrast, hospital managers in the other two

provinces can only recommend dismissal to head office. Furthermore, Gauteng has centralised financial, HR and procurement functions and processes in the Gauteng Shared Services Centre (GSSC), further disempowering hospital management.

Hospital managers describe the GSSC as ‘a failure’. Procurement often results in inappropriate or poor quality materials and equipment, which on occasion has to be discarded, as well as lengthy delays and lack of information. HR processes such as advertising, recruitment, salary payment etc suffer from innumerable delays, and data is error prone. One HR manager who had himself been deployed to the GSSC and then redeployed to his hospital described the GSSC as ‘a nightmare’ which requires considerable additional ‘paper shuffling’ at hospitals in order to accomplish anything, and commented that it is extremely difficult to face employees and explain the mistakes and delays made elsewhere. *Hospital managers' lack of control undermines management accountability.*

Despite these differences, the degree of centralisation and consequent disempowering of hospital managers is similar in the three provinces, as the two quotes on these pages, one from a CEO in KwaZulu Natal and one from a CEO in Gauteng, demonstrate. Another CEO commented: ‘I want real decision-making powers. Currently I make a decision, it is

First hospital manager

‘Head office doesn't have the necessary competence to do their tasks. They are scared to give any direction. Senior people are insecure, they avoid making decisions. They don't know what's happening on the ground. We battle to retain staff, especially clinicians, who become irritable with procurement procedures and tedious motivations required by head office, and the long delays. There is also much wrong with the way CEOs are currently selected and appointed. There needs to be a formal orientation programme followed by a mentoring period. Head office should provide an enabling environment for good budgeting but that is not what happens. Here we spend up to nine months drawing up our budget and motivation before presenting it to head office. Then they just reject it and give us what they have decided. Then when the end of the financial year approaches, there's a big rush to spend money. We are punished both ways: if we overspend and if we underspend. I am very ready for devolution. More powers is precisely what is required, especially for HR and Finance.’

queried, then denied. We want head office to have confidence in us. Head office should play a supportive role and be visible to us.'

Analysis of the delegation documents pertaining to Gauteng reveals that there is no meaningful delegation of financial powers. Hospitals have no authority to set up and maintain the necessary financial functionality to support their operations. Likewise, only trivial HR accountabilities have been devolved to hospital management, and the latter is unable to provide the necessary human resource support for an effective hospital. Procurement too remains in all essentials a centrally managed process.

Provincial head offices operate on the assumption that they are able to manage the hospitals under their control as if they were simply administrative wings of their departments. However, this is quite clearly a mistaken assumption. Hospital managers describe continual management failures on the part of head offices: failure to respond to proposals, failure to make decisions, making decisions and drafting regulations that are disruptive and impose failure on hospitals, convening workshops and developing strategies that are meaningless to hard pressed managers. Hospital management's authority to improve operational processes and efficiency is undermined by centralised control over crucial operational systems, by centrally determined rules and by operational interference.

Ambiguous interface

It is extremely unclear where head office control ends and institutional discretion begins. Thus hospital management claims there is very little delegation of powers, whereas provincial officials claim that there is extensive delegation.

In our experience the web of delegations and regulations creates a vast field of ambiguity where many managers are uncertain what their powers and responsibilities are and which decisions have been made by province and which by other managers in the institution. Incompetent managers make use of this ambiguity to conceal their own incompetence. As a result, the prevailing culture is to assume that most decisions have been made by province head offices and that it is best to accept the status quo rather than innovate.

Second hospital manager

'Province just does not manage. I was appointed here as Acting CEO. I had no experience, no training, but the next thing I am getting demands for quarterly reports! I complained to other more experienced managers about not getting any help out of head office. They just said, "Welcome to the club!" I keep getting circulars or notices which are out of date. When we raise problems the district manager just notes it, saying it will be attended to. Nothing happens. Or we are asked to put our problem in writing, and if we do that nothing happens either.'

At the same time, head office bombards management with demands for information and meetings, and for management to implement new guidelines and systems. This drains management time and energy especially when there is very little in the way of functional support systems in any discipline at operational level. On the other hand, communications from head office are often slow and impose difficult deadlines on management, contributing to the culture of firefighting rather than focusing on longer term strategic issues.

Authoritarian control, managerial subservience

There is a tendency for provincial officials to adopt an authoritarian attitude towards senior managers in the hospital and treat them as junior employees. The lack of any insulation between hospital and head office means that hospital management are dependent on provincial officials for the development of their careers. Hospital managers therefore fear to rock the boat, innovate and take risks, or contradict provincial officials. The consequence is that provincial officials and political heads get to hear

what hospital managers believe they want to hear, rather than a frank account of what is happening in the institution and on the ground. This contributes to the failure to understand and solve delivery breakdowns.

New HR planner disrupts functioning at hospital

Head office in Gauteng controls the staff establishment of hospitals in minute detail, preventing the flexible management of recruitment, employment and promotions in order to deal with locally specific problems and needs. For example, in December 2004 a new staff planner was introduced across Gauteng. This had a negative impact at CHB, as the new staff planner assumed 1500 beds (the projected number for the new CHB after the migration of beds to three new district hospitals still to be built) rather than the current 2800 beds. As of the beginning of 2005, management was expected to run a 2800 bed institution with a staff establishment appropriate for a 1500 bed institution. Management immediately submitted an interim HR planner in order to bridge the gap until the institution is downsized. By mid-year head office had acknowledged its error and requested a redrafted interim HR planner, which again was submitted as a matter of urgency. There has to date still been no response to this, and the hospital continues to run with grossly inadequate staffing levels. The disjunction between those with authority to make decisions and those tasked with running the institution undermines accountability for decisions (or failure to make decisions).

The net effect of these dysfunctionalities is that there is no clear locus of power and decision-making authority. Hospital managers are disempowered and cannot take full accountability for the successes and failures of their institution. The structural relationship between province and institution is a disincentive for managerial innovation and responsibility, and rewards subservience, over-sensitivity to rules and a lack of focus on problem-solving. It is also clear that even if it were desirable for head office to exercise this degree of control, in many cases it lacks the capacity or competency to do so. The sorry saga of the new HR planner described above is a case in point. Lengthy

delays and poor decisions in turn encourage passivity and lack of initiative on the part of hospital managers.

The dysfunctional interface between provincial departments and hospital management suggests the need for a fundamental rethink of their respective roles and accountabilities.

4. Dysfunctional management structures

Hospital management structures are dysfunctional and fragmented, preventing the integrated management of operations, paralysing initiative and preventing accountability. The overall effect is pervasive disempowerment of managers and an experience of managerial vacuum on the part of staff.

The silo structure of management

The management structure of all the hospitals in our sample is essentially the same, fragmented into parallel and separate silos of managerial authority. Thus nurses are managed within a nursing silo, doctors are managed within a silo of clinicians, and support workers are managed by a web of separate silos for cleaners, clerks, porters, etc.

The senior managers in the institutions themselves have extremely wide spheres of responsibility with little authority to make decisions or implement them. Thus for example, a clinical department such as paediatrics is headed by a chief clinician who has no control over the nurses or support workers in the paediatric department. At the level of senior management, a senior clinical executive (superintendent) has responsibility for the paediatric (and other) departments, but little substantial authority over it because authority is exercised within each of the silos (doctors, nurses, support workers). As a result, the clinical executive has to attempt to negotiate with all parties. On certain issues the chief clinician will agree to a decision made by the clinical executive, but on other issues will appeal to the clinical director.

This means that what should be managed as an integrated operational unit (for example a ward, a clinical department) is instead managed in a fragmented fashion with no clear accountabilities. In this situation all actors are disempowered, and oscillate between diplomacy, persuasion, negotiation, angry confrontation, complaint and withdrawal. In the process few problems are definitively resolved, with adverse implications for patient care.

This kind of disempowerment and lack of accountability was present in most institutions we investigated, although to varying degrees. At all but one institution clinicians and nurses play no significant role in determining budget, or monitoring and controlling costs (for the exception, see Section 9 below). *In other words, those with responsibility for using resources have no accountability for the budget which allocates resources, while those responsible for the budget have no accountability for the activities that the budget must support.*

This generates structural conflict between professional staff and managers. At CHB clinical heads of department have no idea what their budgets are and costs are not disaggregated within the institution. At Tertiary Hospital B, which is comparatively better resourced, the chief clinician interviewed for this study commented that he has no direct involvement in the budget, that a management information system for tracking expenditure against budget doesn't exist, that there is always a crisis towards the end of the year as management attempts to cut costs and reduce budget overran, and that in any case budgets are unrealistic. At none of the regional hospitals were clinical heads involved in budget processes, beyond motivating for major equipment expenditure.

In the wards themselves, nursing managers complain that, although they have responsibility for effective ward functioning, they have little control over support staff in the wards (cleaners, clerks, porters), as they are supervised by supervisors within separate silos of authority. On the other hand, nurses tend to defend their silo against interference from doctors or managers. (See box)

Where institutional stress is somewhat lower, and managerial capacity is somewhat higher, there is more space for doctors, nurses, managers and support staff to negotiate and accommodate the fragmentation of work organisation. Where institutional stress is high, the fragmented silo structures generate the fault lines along which high levels of conflict and managerial failure are manifested.

Fragmented management in the wards

- “We are blamed for all the non nursing things that don't get done - but we don't have the power to ensure that they get done. It's not fair.” (Nurse)
- “The main snag is the other categories - their refrain is, I don't fall under a nurse.” (Nurse)
- “It is very difficult to work with people who are managed from far away. I don't know their job.” (Nurse)
- “Requisitions are done by the sisters. Clerks are not allowed to order anything. We could do a lot of requisitions.” -Ward clerk
- ‘The nurses have an attitude, they say you interfere too much’ (CEO)
- ‘The bridge between clinicians and nurses has broken down irrevocably’ (Chief clinician)

Culture of bureaucracy and incompetence

Since there is no well structured locus of authority and control, managers are not accountable for any particular clinical or operational outcomes. The result is that managers in one section of an institution, for instance HR or nursing management, will make decisions according to their understanding of rules and procedures and the requirements of their own department, and ignore (or be ignorant of) the disruptive impact on other departments. For example, clinicians and other medical professionals often state that HR shows no interest in filling posts, and mentioned several cases where potential employees were lost due to lengthy delays and lack of communication. One commented, ‘It is always us driving and them slowing things down.’

The inefficiency of cutting costs

CPN 1: We are instructed to organize overtime on the same day when we need it. This is very difficult and time consuming. Off-duty nurses are already committed elsewhere by then, and even if we can locate them, we cannot persuade them to rush back to work.

CPN 2: I start the day looking for extra staff. Every time I need to make a call out of the hospital, I have to phone switchboard. It is very laborious.

CPN 3: Ward -x- was out of control on Monday morning. Nurses refused to go into the ward because of the situation there.

CPN 4: We had a recent case where the shortage caused a patient who needed turning to get bedsores. This led to complications and then the patient's death. That's an example of the consequence as it affects patients.

In a second example, nursing management issued several instructions that made it significantly more difficult for nurses to run the wards, all ostensibly with the aim of reducing costs. The actual impact, though, was to increase inefficiency as well as direct costs. Thus overtime work was prohibited, so increasing the dependency on agency nurses. Agency nurses were only permitted to be called in on an on-the-day basis, making it impossible to plan ahead, and increasing the workload of already overstretched chief professional nurses. New nursing staff could only be recruited at entry-level, thus discouraging the appointment of experienced staff and ensuring that

the wards were permanently understaffed. A discussion with In-Charge Chief Professional Nurses illustrates the impact on nurses and health care (see box).²

At the same time as administrative and managerial departments generate more problems in the wards, real immediate problems in the wards remain unresolved by administrative departments. Thus nurses complained about the many beds with broken wheels in their wards, and that although they had submitted requests for repairs through the normal procedures, nothing had happened for several months. When this problem was eventually investigated by a senior manager he found out that the contractor who had been appointed to repair beds had gone out of business, and no one had seen fit to find a new contractor. *Managers and professionals in the wards had no power to solve this problem, while those who did have the power had no accountability for outcomes in the wards.*

It is our experience that disempowered and unaccountable management structures gives rise to a specific management culture in the public hospitals. *The administration of rules and regulations has become more important than managing people and operations or solving problems and ensuring decent service delivery.* We have found a culture of 'management by memo'. Managers believe their task has been completed once they have communicated a change of rules or procedures by means of memorandum. They will express genuine surprise when asked whether they have actually visited the wards or other work sites to discuss with staff what the impact of the new rules is on their work.

² *Chris Hani Baragwanath Hospital: Situation Analysis*, Report by the CHB Transformation Task Team (1 September 2004: 9)

As often as not, such decisions are disruptive because the managers concerned have no understanding of the workplace.

Clinical processes displaced by bureaucratic processes

The specific disempowerment of clinicians displaces the clinical process from being the central concern in public hospitals, and replaces it with bureaucratic, managerial or financial concerns. Clinical outcomes necessarily suffer as a consequence, and there are high levels of demoralisation amongst nurses and clinicians. This, together with the paralysis of management and absence of clear structures of authority and accountability, generates a permanent state of frustration and conflict within occupational categories, between occupational categories, within management, and between staff and management.

A general view that clinicians do not make good managers has come to predominate in the public service. In our experience this generalisation lacks any foundation. We found clinical heads to be extremely concerned about all aspects of healthcare, including the organisation of nursing, the movement of patients, organisation of support services, the use of resources and budgets, and with clear and often innovative ideas about the effective functioning of their departments.

The clinical work process entails high levels of skill and complexity which it is difficult for non-clinical managers to fully understand and therefore manage effectively. The current fragmented organisational structure disempowers both clinicians and managers, and prevents either from working effectively. *Management and clinical processes need to be integrated if hospitals are to be more effectively run both with respect to optimal resource utilisation and optimal clinical results.*

5. Weak management functions

Apart from dysfunctional structures, management functions remain weak simply because they are under-resourced in virtually all institutions.

A clinical head in one of the highly stressed regional hospitals commented that management was highly motivated, but very understaffed: 'Those in senior positions are obliged to do hands-on work all the time instead of being free to manage.' He himself had no clerical support and had to type minutes, and his office is too small for him to meet anyone there. At CHB managers comment that the institution is characterised by 'permanent crisis management', and clinicians comment that managers 'range across the hospital fighting fires and plugging gaps' instead of managing clinical departments and taking accountability for operational effectiveness. At institutions where management is better resourced and levels of stress are lower, management is able to ensure smoother operations and in some cases adopt a more proactive approach to improving effectiveness, although with quite limited results.

The result of weak management functions is that scarce human and financial resources are often managed in a wasteful and ineffective fashion.

HR management

The HR function in public hospitals is essentially a personnel function for administering payroll, leave, recruitment, etc. It lacks the strategic or proactive capacity to manage human resource development, labour relations, improve the disciplinary regime, etc. The institutions have no skills development plans or employment equity plans. The result of

Discipline

“There are no disciplinary measures from top to bottom. If a nurse steals the clothes of a patient there will be no disciplinary action, they will give a lecture on how to conduct ourselves. But the culprit is known. Are we not supposed to be disciplined? Where is this discipline? A known habitual loafer is never disciplined.” - (Enrolled Nurse Auxiliary)

these HR failures is far-reaching, affecting morale, discipline and labour relations.

Discipline appears to be a problem that most public hospitals, particularly in relation to support workers, but also amongst nurses

and doctors. The fragmentation of authority structures, lack of accountability and intimidation, and the disempowerment effect of head office control of discipline all contribute to this problem. Lack of discipline has a generally corrosive effect on work ethic and morale.

Labour relations is also highly conflictual at a several of the hospitals that we visited, particularly with unions representing support workers. Indeed, nurses at two hospitals described the ‘disruptive’ growth in the power of trade unions as one of the two most significant features of postapartheid reality in their hospitals (short-staffing was the other).

The primary reason for both of these HR problems is the absence of a strategic HR function with the capacity to proactively establish a new post apartheid disciplinary regime appropriate for a constitutional democracy. The old apartheid disciplinary regime crumbled in the face of worker militancy and the democratic breakthrough of the early 1990s, and has not been replaced with a mutually embraced new workplace order, particularly for non-professional staff who tend to feel excluded.

HR failure is also linked to the broader *low morale* and frustration of staff who feel they are not valued and have little prospect for improving their skills or advancing their careers.

It appears to us that neither provincial health departments, nor the National Department of Health, nor the Department of Public Service and Administration, have a progressive concept of HR strategy which focuses on the proactive management of people and relationships. Instead, the sole emphasis appears to be on the administration of centrally

designed procedures and regulations that govern employees. So for example the centrally developed Performance Management System is administratively complex and relies for implementation on under-capacitated personnel administrators to support over-stretched managers. The result is staff demoralisation and disputes rather than enhanced performance. The critical need is to establish enhanced HR capacity at hospital level. The new HR strategic framework developed by the National Department of Health does not address this need. Until it is addressed, human resources will continue to be managed ineffectively.

Financial management

Likewise, financial departments are generally grossly under-resourced and lack the capacity to draw up or monitor budgets, control costs or expenditure, or monitor shrinkage and waste. Budgets bear little relation to operational reality, and there is consensus that budgets are ‘meaningless’ as they are based on historical budgets rather than being zero base budgets based on actual operational activity and realities.

In several of the hospitals management is working towards disaggregating costs and allocating them to operational units, most often wards and/or pharmacy. Although this is described as working towards ‘cost centres’, this is not truly the case since the fragmented management structures prevent the allocation of accountability for controlling costs. Moreover, most managements acknowledge that cost allocation and recording is still extremely weak and partial, particularly because information systems and the IT systems required to support them are so weak or even nonexistent. In most cases, financial systems are manual rather than digital, which makes real-time cost control and financial management impossible.

Only in one hospital had the extremely dynamic manager, who was in addition willing to bully and defy head office officials, managed to establish a working budget and cost centre based system (see Section 9). In another hospital that did manage to painstakingly devise an activity-based budget, this was simply rejected by head office and replaced with a lower budget without any negotiation over the implication for budgeted activities. This would hardly encourage managers to persist with the efforts of relating budget to real activity!

All of these limitations make cost controls, financial targets, accountability and budgeting close to impossible.

Data and information

Weak management systems, fragmentation and lack of capacity means that data collection of all sorts – financial, clinical, HR – is nonexistent or suspect, which in turn

means that effective management is impossible. As with other aspects, the situation varies considerably between hospitals and even between clinical departments. This is especially the case as effective quality auditing requires a combination of different sources of data that are generated in different staff silos.

Thus for example clinical outcomes depend on ratios between mortality figures (clinicians and nurses), various morbidity indices such as wound sepsis rates, bedsores rates, complications and incidents (clinicians and nurses), and patient admission numbers and length-of-stay figures (administration departments). In less stressed hospitals clinicians may collect accurate data on clinical indices such as mortality rates, and correlate these with broad administrative data such as admission numbers, but in most cases the capacity and human resources to integrate the data consistently are lacking. In addition, data collection itself is highly suspect, particularly from administration and nursing because of the workloads and stress of these functions (see box).

Workload prevents data collection

We ask the group of three chief professional nurses whether they are able to keep accurate records. They look at each other carefully. This is an extremely sensitive point for nurses who are legally and professionally obliged to keep good records. Then they all burst out together: 'Records are not up-to-date! We do not have time to take vital data, change dressings, keep records of incidents and mortality & morbidity conferences. We know 'what's not written is not done'. We are trying our best, but it is so difficult.'

At the same hospital a manager worked overtime in casualty. He recalled some 30 patients coming in, but the following day he noticed that nursing records only recorded 10 patients. They had been too busy to record the missing 20. The CEO commented that they put a lot of effort into trying to reconcile data, but when in doubt simply use the data on the IT system, because that is what head office has access to.

Thus, even where *data* is collected, the transformation of this into reliable management *information* does not or cannot take place.

6. Management skills

Lack of management capacity is often conflated in our national discourse with a lack of management skills. In our view this is misleading. While there is undoubtedly a lack of management skills at many hospitals, the primary problem is the disempowerment that arises from incoherent management structures, a lack of any clear

locus of managerial authority and a lack of management resources.

Simply improving skills would have no impact on the managerial crisis unless the problem of managerial structure and accountability is also addressed. As a group of hospital managers commented at National Conference of CEOs convened to discuss a new Masters programme in hospital management: 'You can have all the degrees you like, but it will not help you manage without adequate delegations, staff and infrastructure.' Conversely, once the problem of structure, authority and accountability is resolved, an effective programme of upgrading skills can be implemented.

There are a number of talented managers with initiative and good ideas who are currently thwarted by dysfunctional structures and their resulting disempowerment. If given the opportunity to work within functional structures they would rapidly learn new skills and take the initiative to solve big problems.

Having said this, skills weakness remains an important problem. Several CEOs referred to the lack of induction and support programmes for hospital managers. This is also a problem affecting heads of HR and finance departments.

The problem is exacerbated by the lack of stability at senior management level. In one hospital the CEO has been in an acting position for a year, simultaneously continuing to operate in his permanent job as a head office official. In another, the nursing manager had been acting CEO for a year, simultaneously continuing to run nursing – and continuing to earn the salary of a nursing manager! Even two of the more long standing regional hospital CEOs complained about delays in formalising their contracts. This kind of situation suggests that provincial head offices do not take the office of CEO that seriously.

7. Staff shortages

Staff shortages have an impact on all the public hospitals we visited (except possibly for Hospital E, where the number of beds was being substantially reduced). The most hard hit categories are nursing, pharmacy and other specialist professionals. Nurses consistently complained of stress, exhaustion and low morale as a result of the heavy workload they have to bear. (see box) A DENOSA representative summed up the experience of virtually all the nurses we interviewed: ‘The absenteeism profile is high. Nurses are worked out, stressed out, sick.’ As we pointed out above, the nursing function

Nurses describe their workload
‘We always have to rush: we wash, we medicate, we move on. You miss some things. You cannot listen to the patient. You cannot be broad and implement things that would improve health care and staff morale. You cannot apply your knowledge and improve the unit. We also have to do inventory, push patients to other departments, clean floors, take a trolley to fetch food and dish it up, all because there is a shortage of support staff. You have to do it for the patient, nutrition is part of nursing care. We also have to do the doctor's duties while we wait for him. People resign, die, retire, and they cannot be replaced. The pressure leads to absenteeism, as nurses we become demotivated and no longer have empathy. It affects the patients. You cannot have tea, you cannot eat. At the end you suffer. You become sick. It also affects our families, we come home so irritable and so tired, and we earn peanuts!’ – Chief Professional Nurses

is the backbone of the public hospital. The unmanageable workload, staff shortages, lack of support workers and management failures combine to place this function in a general crisis. While there is a national shortage of nurses, the crisis situation in the hospitals makes it even more difficult to recruit new nursing staff. Turnover and attrition of new recruits is high, and newly trained nurses tend to leave for private hospitals where the workload is more manageable.

The reduction of the state's

commitment to training new nurses, and the closure and downscaling of many nursing colleges, has contributed to the crisis of this function. Not only has this policy contributed to the national shortage of nurses, but it has aggravated the crisis in the wards. The old system whereby nursing colleges were integrated into the functioning of hospitals meant that there was a steady stream of student nurses contributing 'hands' to everyday nursing of patients. Nurses who recall the old system frequently commented that the closure of colleges has had a 'disastrous impact in the wards'.

Nurses too expressed anxiety about the future of their profession. Their heavy workload and what they see as a general loss of respect by the public and the hospital community for the nursing profession, makes it difficult to attract a new generation of trainees. Nurses expressed quite forcefully their view that conditions for their profession have declined with the advent of democracy (see box).

Staff shortages do not only affect nurses. Shortages of support workers like cleaners, porters, clerks and messengers all undermine effective functioning of the hospitals. It appears that these less-skilled functions have been regarded as less important by government authorities under pressure to reduce staff numbers and staff costs, and that these posts were significantly reduced in the staff establishment of many hospitals in the late 1990s. In hospitals where the staff establishment does have unfilled support worker posts these are in some cases underfunded, and in other cases seemingly cannot be filled because of the constraints of Resolution 7. However, the essential role that support staff plays in many hospital activities means that this is a false saving, impacting adversely on the utilisation of scarce and expensive professionals. Thus one hospital manager commented that the absence of porters leads to the cancellation of operations, and at most hospitals it is clear that staff cannot work at full efficiency because more skilled

Nursing in decline

- 'The biggest change since democracy is a shortage of staff.'
- 'We really wonder, how does the government value the nurses of this country? Nurses are not happy, they are not treated as professionals.'
- 'The way they treat us! We work like slaves, in the future there will be no nurses. The young ones are leaving. The government doesn't know anything about us and how we are working – it really hurts us.'

personnel are forced to do routine and unskilled tasks due to these shortages.

For example, the shortage of nurses means that doctors have to assist each other handling patients or doing basic tasks; the shortage of nursing auxiliaries means that professional nurses have to do more routine tasks; the shortage of ward attendants mean nurses have to make tea; the shortage of porters means nurses have to collect

medicines from the pharmacy; clerical shortages means professionals have excessive administrative loads; and managers are continually firefighting, and unable to focus on strategic tasks; for example, pharmacy managers find themselves packing shelves instead of managing. As one clinician put it, 'Everyone is doing the work of categories below them', which is a wasteful use of scarce skills.

Many hospitals also experienced a shortage of doctors. This is particularly acute outside the main metropolitan areas like Durban and Johannesburg. Thus the hospitals in North West Province experience an acute shortage of specialist and experienced clinicians, and even a hospital only some 50 kilometres outside Johannesburg described similar problems. While we did not interview Allied Medical professionals at other hospitals, the figures for CHB below may be taken as indicative, as acute shortages exist in these professions.

It is difficult to quantify staff shortages at the different hospitals because little systematic work has been done to establish what a realistic staff establishment should be for each hospital, and the Health Department has avoided committing itself to specific staff-patient or staff-bed ratios. Thus one is dependent on old staff establishment figures which can only be taken as broadly indicative as they do not reflect shifts in service loads over time, or on new staff establishment figures which have been arbitrarily arrived at.

For example, according to the historic staff establishment, Chris Hani Baragwanath has an overall staff shortage of 32%, with individual categories as follows³:

- 36% shortage of nursing staff
- 73% shortage of pharmacists
- 45% shortage of allied health
- 46% shortage of managers/ administrators
- 30% shortage of support staff
- the institution is finding it increasingly difficult to recruit junior doctors.

By far the majority of the vacant posts in the staff establishment were *unfunded* because of financial constraints. The institution found it difficult to fill the *funded* vacant posts because of difficult working conditions at the hospital. The extreme pressure and great workloads in turn meant that professionals and nursing staff were reluctant to apply for jobs at the institution, and that there was a high rate of attrition. The radiology department had felt the impact of declining numbers of radiographers, down from 80 a decade ago to 55 now, when the increasing workload indicated an optimal staff level of 110. Service and morale inevitably suffered. Pharmacists experienced the same problem, and estimated a 50% annual turnover.

According to the new staff establishment drawn up by head office, however, the staff shortage is only 13%. According to management proposals, nursing in the surgical department is understaffed by 32%, and according to an expert analysis based on a more systematic application of internationally accepted ratios based on a patient acuity levels, understaffing may be as high as 42%.

In the wards staff have to cope with a daily crisis, as staff shortages mean shuffling staff from ward to ward, or calling in agency staff, to ensure that at least a bare minimum of service can be rendered. Increasing patient numbers and increasing acuity levels are exacerbated by the nursing shortage, and the fact that young nurses leave the institution

³ This section is drawn from Transformation Task Team (2004: 8-10) (see footnote 2).

as soon as possible. The impact on their mental and physical health is acute, and one measure of this is absenteeism and sick leave.

At CHB we found In-Charge Sisters and matrons paying ‘thank you’ money from their own pockets to ward attendants and official ‘volunteers’ to clear heavy bags of waste from the wards, because the ward attendants were so understaffed, and to cleaners who put in extra effort.

8. Clinical/patient care outcomes

As noted above, quantitative data on clinical outcomes such as mortality rates, wound sepsis and bed sore rates, patient recovery rates and so on are frequently unreliable, difficult to access or non-existent. We therefore have to rely on the more qualitative and subjective views of those intimately involved in clinical processes, that is, clinicians and nurses.

Clinicians and nurses in all but one of the hospitals we studied state that staff shortages and management failures compromise patient care. While professionals are generally reluctant to acknowledge that this entails avoidable mortality incidents, clinicians at CHB were more forthright: ‘Everything is done in a rush, and staff are left exhausted, with resulting reduction in quality of care and avoidable morbidity and mortality.’

More generally, nurses and clinicians note that excessive workloads have the following impacts:

- inexperienced or underqualified staff taking responsibility beyond their scope of practice, for example an enrolled nurse running a ward or monitoring patients on ventilators and therefore missing vital signs of deterioration in the conditions of a patient;
- increased cases of patient complications, ensuing in more intensive nursing, greater pharmaceutical costs and greater length of stay;
- more readmissions because patients are discharged before they are fully recovered;
- greater risk of infection because of poor infection control, sometimes due to workload and sometimes to management failures such as absence of proper procedures or lack of washing liquid, failure to maintain plumbing, electrical and other infrastructure, etc;
- poor patient recovery because of lack of essential drug stocks;
- lengthy delays before treatment, increasing the risk of morbidity and mortality.

In short, the pathology with which patients present cannot be addressed in a reasonable fashion due to a system in which management fails to support the nursing and clinical processes required.

Another, often overlooked, factor contributing to poor health outcomes for patients attending public hospitals is the decay in the public health and hygiene status of the

hospitals. Failure to clean, disinfect and maintain toilets (both public and in the wards), failure to maintain reticulated sewerage, failure of disinfection of wards and secondary areas of reticulation, broken floor coverage, rusted bedside lockers and drip stands all contribute to public health failure.

The comments of two clinical heads in regional hospitals are instructive. Both were clearly dynamic leaders who had spearheaded improvements in their respective clinical departments. One had been appointed head of department for two years, and commented that 'preventable deaths have been reduced from a period when mortality was a daily matter', for example with deaths of 80-90% of diabetes cases now reduced below the accepted average of 5%. Nonetheless, he rates the health service provided by his department as '60% of what it should be, up from 40% in the 1990s'. The second

Clinical care: nurses talk

- We do not give quality patient care. Now I am alone in the ward, it means I am unable to prevent certain things happening. The result is complications, wound sepsis, longer hospital stays. With the correct level of staffing we could get a 60% improvement in patient care.
- We have had cases of wound sepsis because we had nothing to wash our hands with. You get cross infection, you have to use more antibiotics, the patient has to stay longer in hospital.
- Shortages definitely affect patient care. You have an enrolled nurse in ICU, she does not fully understand, she does not notice ventilator problems until it alarms and the patient is in crisis. You are supposed to be transfusing a patient but to delay because you receiving another patient from theatre who also needs blood, and so you get complications.

clinician had only been appointed head of department for a few months, but observed that morbidity and mortality rates were down from 45-50 per month to 1-3 per month. It can be assumed that many other clinical departments continue to languish with unacceptably poor levels of healthcare, as did theirs prior to their interventions.

While many staff show outstanding commitment to working under difficult conditions, and there are clearly pockets of high-quality healthcare, the high levels of stress in most public hospitals cannot but impact on morbidity and mortality outcomes. Healthcare failures, such as lost patients or outbreaks of infection and infant deaths due to the breakdown of infection control procedures, will continue to occur under these

conditions.

9. Improvement and innovation

Despite the stressed nature of the institutions we investigated, we did come across several cases of sustained attempts to improve hospital functioning, as well as cases of innovation. It is worth reflecting on the conditions which have made such improvement or innovation possible. We reflect here on four cases: the CHB transformation project; a clinical networking of level 1, level 2 and level 3 hospitals; and two examples of management attempts to improve functioning in regional hospitals.

Chris Hani Baragwanath transformation project

This project aims to pilot integrated management structures, enhanced management capacity and empowerment in the Surgical Division (700 beds) at this hospital with the aim of improving clinical care and resource utilisation. This consists of a systematic attempt to reconfigure the head office/institution interface, devolve significant powers to local management, break the silo system and integrate nursing, systems, financial and clinical management under the leadership of the chief clinician, and identify clear chains of accountability and command. It also aims to address staff shortages, improve discipline, establish team working and put in place worker participation processes. The project has been under way since early 2005, and is fully supported by management, labour, and head office.

Critical factors for the successful implementation of this innovation, in what is the most highly stressed hospital we have encountered, have been: political support from Labour and from the MEC for Health, and the availability of external resources in terms of high-level expertise in order to supplement low levels of management capacity.

Since this project constitutes a new way of working, it challenges many of the traditional bureaucratic practices and constraints identified in this research report. These continue to exert an ongoing constraining affect and even threaten to paralyse critical aspects of the project. Nonetheless, important learning is taking place which should have a wide applicability.

Networking of level 1, 2, and 3 beds

The chief clinician heading one of the clinical departments at the second tertiary institution investigated for the study, has put in place an innovative strategy for shifting the level 1 & level 2 patients who inevitably (because of failures in the referral systems) end up in tertiary beds by networking with a nearby district hospital and a nearby regional hospital. He allocates part of his budget to expanding the number of (considerably cheaper) level 1 and 2 beds in these institutions, freeing up level 3 beds at his own institution. Clinicians from his own department are involved in clinical work and clinical supervision in the other two institutions, participating in the ward rounds, etc. They also work closely with the nurses and clinicians in the two institutions, empowering them to make important decisions concerning levels of healthcare and referral. This project entails an efficient use of scarce human and financial resources, and allows for a much more effective management of healthcare needs of different levels of patients.

This has been possible because of good relations between an innovative clinician and a hospital CEO who had been given a mandate to innovate and who was prepared to 'bend

the rules and regulations' to make things happen. The existence of considerable 'social capital' assets at the institution has also been a help. Coordination across the three institutions depends on the ability of the chief clinician to conduct multiple negotiations with three different CEOs. The logical next step would be to put in place a coordinated management structure for the three institutions, but this would require innovation at the level of the provincial bureaucracy.

Unfortunately, frustration at the constraints of centralisation (as detailed in this report) have led to the resignation of the CEO.

Two cases of sustained management improvement in regional hospitals

In two of the regional hospitals we investigated, we came across CEOs who had managed to implement sustained improvements in hospital functioning. In both cases the CEOs had successfully improved financial management and were able to move towards more realistic budgeting processes. They had also significantly improved the relationship between managers and clinicians by improving the ability of managers to respond to the needs of the clinicians. In the second of these two hospitals real cost centring had been introduced into the wards, and the unit manager we interviewed was impressive in describing how she takes responsibility for managing the budget, planning expenditure and monitoring costs. The clinical head of department interviewed at this institution had greater knowledge and awareness of his budget and costs, but did not directly manage the budget.

In both these cases the CEOs were dynamic and innovative people who had managed to establish strong management teams. The first had been in place for 10 years, the second for three. The latter was a particularly strong leader with wide government experience and networks, and he had no qualms in confronting provincial officials and breaking the rules where necessary: as he put it, 'rules are not more important than delivery'. Thus he put in his own financial software and found the expertise locally to make it work, rather than relying on provincial officials. He also described a method for increasing his decision-making ability and circumventing head office constraints: he would write a letter to the relevant official, outlining the reasons for his decision and stating that he assumed he could go ahead and implement unless he was instructed otherwise within two weeks. Invariably there would be no response and he would go ahead.

In these two hospitals strong, confident and innovative managers were able to significantly improve functioning. Nonetheless, institutional stress remains high because of staff shortages and because of the ongoing frustration and disempowerment caused by centralisation. These indicate the limits of improvement within the current functioning of provincial departments. Improvement relies on exceptional managers who have had to engage in protracted battles to carve out areas of discretion and control. Neither of them constitute examples of systematic restructuring of relations and the distribution of power, as is the case at Chris Hani Baragwanath Hospital.

Conclusion

In all of the cases discussed here, innovation and improvement has been dependent either on informally bending and breaking the regulations that govern the functioning of public hospitals, or on agreement to waive the application of these regulations. The informal method is not a viable way forward, as it relies on exceptional individuals and can easily be reversed. *The future of innovation and improvement in public hospitals depends on a substantial change to the regulatory framework and its details.*

10. Conclusion

The high level of institutional stress in the public hospitals is the product of two distinct pressures coming from opposite directions. On the one hand there is the managerial paralysis and disempowerment which follows from the lack of a clear locus of managerial authority and accountability at all levels, which is in turn the outcome of excessive centralisation, dysfunctional management structures and understaffed managerial functions. On the other hand, there is the pressure of work overload, physical and psychological stress, inefficiency and clinical failures caused by understaffing. When managerial paralysis and inefficiency is combined with the daily operational crisis of excessive workload, the result is ongoing institutional stress and compromised healthcare outcomes.

Long-term erosion of the public service ethos, and consequent decline of the public health sector is likely, as the older generation of public service professionals retire or give up in despair, and the younger generation is so overwhelmed by workloads that they opt for the private sector.

These issues are not addressed by the hospital revitalisation programme, which is designed to improve the *hardware* of infrastructure and equipment. Important as this is, it is the *software* of people and systems which are crucial for improving hospital performance.

The evidence suggests that neither tinkering with regulations and delegations, nor establishing new training programmes for hospital managers, would be adequate to significantly improve the functioning of our public hospitals. Substantial structural reform is necessary if the long-term decline of public hospitals is to be avoided.

What is needed is a far-reaching restructuring of the relationship between provincial head offices and public hospitals, and a substantial empowering of institutional management and enhancement of their capacity, as well as innovative strategies to improve staffing levels. In an environment of scarce financial and human resources it is

all the more important to focus on a sustained investment in management capability so that these resources are managed in as effective away as possible. Our recommendations are designed to achieve that.

III. Recommendations

1. Interface between provincial head offices and hospitals

The relationship between head offices and hospitals should be fundamentally restructured, with a clear and unambiguous interface between the two. The role of head offices should be to develop broad strategy and policy, provide funding based on budgets drawn up at hospital level, and audit the hospitals' performance in relation to clinical, patient care and financial targets and indicators. Head offices should relinquish their attempts to manage hospitals, but should hold management fully accountable for effectively managing them. Head offices should also establish hospital management support units specifically to support hospital managers and ensure that proper induction, mentoring and training takes place.

2. Increased authority and accountability for hospital management, with the interface between provincial head offices and hospitals based on the following:

- Autonomy of management (executive powers) to manage their hospitals without interference from central office, according to the budget and business plan and performance targets (e.g. patient recovery rates, clinical outcomes, patient load, waiting times/lists etc.) agreed between head office and institution.
- Overall health policy and health plans for the province would provide the framework for the business plan and would be established in consultation with all institutions and stakeholders.
- Proper governance structures need to be established to oversee management delivery, probably residing in a strengthened hospital board with a clearly defined oversight role. This would also create the necessary insulation between institution management and head office.

3. Develop and implement a new organisational structure based on clear operational units (for example, a surgical department, an internal medicine department, an obstetrics, gynaecology & paediatric department), with the aim of driving clear lines of authority, accountability and empowerment down within the organisation and ending the fragmentation of the silo structures.

Each unit should be resourced with the necessary nursing, financial, HR and systems management to ensure optimal efficiency, clinical outcomes and cost centring, and have the authority to manage all clinical and support processes that affect the division, and to be accountable for clinical, financial and other outcomes. The scale of this would vary depending on the scale of the relevant unit. For example, a surgical division with 400 or 500 beds in a tertiary institution is a much larger-scale operation than a surgical department with 100 beds in a regional hospital. Each unit should be headed by the relevant head clinician to ensure the centrality of clinical processes (nursing and medical), and to ensure that these processes in turn integrate budgeting and cost control processes.

4. Increasing management resources and improving skills.

Considerable investment in management capacity and systems is required in order to overcome current management paralysis. This is essential if the public hospitals are to become effective managers of scarce human and financial resources. Transfer of skills must be an ongoing dimension of this work, partly through on-the-job mentoring and partly through off-site training programmes. External expertise may be a requirement. The chief focus should be on HR, systems and IT, which is where the most serious managerial breakdowns occur, as well as on nursing management.

5. Implement a new staffing model.

There is a national shortage of professional nurses, and their work overload is increased by the under-employment of support staff. Institutions need to develop a new work organisation in the wards based on task-based nursing which requires a smaller number of Professional Nurses to supervise the tasks of less skilled nurses (Enrolled Nurses and Enrolled Nursing Assistants), as well as expanding the responsibilities of support workers in order to relieve nurses of unnecessary clerical, routine and cleaning functions. The first step towards this is to immediately fill all support worker posts to relieve some of the pressure on professional nurses.

6. Reopen nurses training colleges

It is essential to increase the output of the nurses training programme. The easiest way to do this would be to reopen and expand the capacity of the nursing colleges that were closed in the 1990s. The old nursing training programme had numerous advantages. Firstly, the colleges were integrated with hospital functioning and were therefore able to offer intensive practical training, while at the same time meeting the needs for additional

nursing staff in the wards. Secondly, they drew their students from the local community in the area of each hospital, and in many cases the students went on to become permanent and long-service staff in their local hospitals. This created a stable local source of nurses. Once nurses leave their locality to train, they are unlikely to return.

7. Establish a joint DPSA, DOH and DOF task team to implement these recommendations.

The task team should develop a phased strategy for implementing the above, starting with an engagement with sites of innovation (particularly the Chris Hani Baragwanath Transformation Pilot, which is the most systematic attempt to transform hospital functioning) in order to draw the necessary lessons from accumulated learning on the ground.

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