

**Views and Perceptions of Healthcare Workers on the National Health Insurance at
Pietersburg -Mankweng Tertiary Hospital, Limpopo Province.**

by

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DECLARATION

I, Makwena Margaret Matsi, , hereby declare that the work on which this dissertation is based, is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree at this or any other university or tertiary education institution or examining body.

.....day of.....20.....

Matsi M.M

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TABLE OF CONTENTS

DECLARATION	ii
ACKNOWLEDGEMENTS	iii
LIST OF FIGURES	vii
LIST OF TABLES	viii
LIST OF APPENDICES	ix
LIST OF ACRONYMS	x
ABSTRACT.....	xi
CHAPTER 1	1
1. STUDY INTRODUCTION AND BACKGROUND	1
Problem statement	4
The aim and objective of the study.....	6
2. Summary	7
CHAPTER 2	7
2. LITERATURE REVIEW.....	7
2.1 Introduction	7
2.2 The need for the NHI.....	7
2.3 Community perceptions regarding the NHI	9
2.4 The influence of Health Care Workers on the NHI.....	12
2.5 The implications of the NHI.....	14
2.6 Factors influencing enrolment to the NHI.....	16
2.7 Summary.....	18
3. RESEARCH METHOD.....	19
3.1 Introduction	19
3.2 Research design	19
3.3 Study setting and site selection.....	20
3.4 Population and Sample	20
3.5 Sample size calculation, sampling procedure/ techniques	20
3.6 Data collection methods and procedure	21
3.7 Data analysis.....	22
3.8 Reliability and Validity	23

3.9 Bias	23
3.10 Ethical considerations.....	23
3.11 Summary.....	24
CHAPTER 4.....	25
4. PRESENTATION AND INTERPRETATION OF THE FINDINGS	25
4.1 Introduction	25
4.2 Response rate.....	25
4.3 Demographic characteristics of the respondents	25
4.4 Respondents knowledge of National Health Insurance scheme	27
4.5 Healthcare workers perceptions with regard to NHI.....	30
4.6 Summary.....	38
CHAPTER 5	39
5. DISCUSSIONS AND CONCLUSION.....	39
5.1 Introduction	39
5.2 Results and discussions	39
5.2.1 Demographic distribution.....	39
5.2.2 Knowledge of the NHI	40
5.2.3 Perceptions on the implementation of the NHI at the facility	42
5.2.4 Perceived general challenges during the implementation of the NHI.....	43
5.2.5 Perceptions on the key characteristics of the service delivery building blocks linked to NHI.....	44
5.3 Limitations	50
5.4 Conclusion.....	50
5.5 Recommendations	51
5.6 Summary	51
REFERENCE LIST	52
APPENDICES	60
APPENDIX (A): Participants Information Leaflet	60
APPENDIX-B: Informed Consent.....	62
APPENDIX(C-1):Request Letter to Conduct Research at Polokwane Tertiary Hospital	63
APPENDIX(C-2):Request Letter to Conduct Research at Mankweng Tertiary Hospital	65
APPENDIX (D): Letter to Request Permission to Pre-Test Questionnaire.....	67
APPENDIX (E): Data Collection Tool - Self Administered Questionnaire	69

APPENDICE F: MREC Certificate 80

APPENDIX G (1): Data Collection Permission Letter from Head of Department 82

APPENDIX G (2): Data Collection Permission Letter from Ethics Committee 83

APPENDIX G (3): Data Collection Permission Letter from Pietersburg Hospital 84

APPENDIX G (4): Data Collection Permission Letter from Mankweng Hospital 85

LIST OF FIGURES

FIGURE 4.1: RESPONDENTS' AGE DISTRIBUTION	25
FIGURE 4.2: RESPONDENTS' GENDER DISTRIBUTION	26
FIGURE 4.3: RESPONDENTS' DISTRIBUTION OF CATEGORIES	26
FIGURE 4.4: RESPONDENTS' DISTRIBUTION OF LEVEL OF EDUCATION.....	27
FIGURE 4.5: RESPONDENTS' KNOWLEDGE OF NATIONAL HEALTH INSURANCE SCHEME.....	28
FIGURE 4.6: CHALLENGES DURING THE IMPLEMENTATION OF NHI.....	31
FIGURE 4.7: REASON FOR GOOD, FAIR AND POOR QUALITY OF HEALTHCARE.....	33
FIGURE 4.8: MEASURES TO RESOLVE POOR QUALITY OF HEALTHCARE.....	34
FIGURE 4.9: BARRIERS TO CONTINUOUS HEALTHCARE SERVICES.....	35
FIGURE 4.10: MEASUREMENT TO IMPROVE CONTINUOUS HEALTHCARE SERVICES	35
FIGURE 4.11: BARRIERS FOR COMMUNITY ACCESSING HEALTHCARE SERVICES	36
FIGURE 4.12: MEASURE TO IMPROVE COMMUNITY ACCESS TO HEALTHCARE	37

LIST OF TABLES

TABLE 4.1: SOURCE OF INFORMATION ABOUT NHI	28
TABLE 4.2: ASSOCIATION BETWEEN KNOWLEDGE OF NHI AND SELECTED DEMOGRAPHICS	29
TABLE 4.3: IMPLEMENTATION AND POLICY OF THE NHI	30
TABLE 4.4: HEALTHCARE SERVICE OFFERED IN A FACILITY	32
TABLE 4.5: CONTINUITY OF HEALTH SERVICES	34
TABLE 4.6: ACCESS TO HEALTH SERVICES	35
TABLE 4.7: HEALTHCARE WORKERS ADHERENCE TO REQUIRED WAITING TIMES	37
TABLE 4.8: BARRIER AND MEASURE TO ADHERE TO WAITING TIMES	38

LIST OF APPENDICES

APPENDIX A: PARTICIPANTS INFORMATION LEAFLET

APPENDIX B: INFORMED CONSENT

APPENDIX C: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT
PIETERSBURG AND MANKWENG TERTIARY HOSPITAL

APPENDIX D: LETTER TO REQUEST PERMISSION TO PRE-TEST
QUESTIONNAIRE

APPENDIX E: SELF ADMINISTERED QUESTIONNAIRE

APPENDIX F: ETHICAL CLEARANCE CERTIFICATE

APPENDIX G: DATA COLLECTION PERMISSION LETTERS

LIST OF ACRONYMS

EMS	Emergency Medical Services
NHI	National Health Insurance
SWOT	Strengths, Weakness, Opportunities and Threats
HWs	Health Workers
WHO	World Health Organisation
UHC	Universal Health Coverage
IDA	International Development Association
NGO's	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
CBHI	Community Based Health Insurance
FGD's	Focus Group Discussions
GPs	General Practitioners
PHC	Primary Health Care
HPSP	Health and Population Sector Programme
OOP	Out -of pocket
GDP	Gross Domestic Product
SREC	School Research Ethical Committee
MREC	Medunsa Research Ethical Committee
CHPS	Community Based Health Planning and Services
HIV	Human Immuno-Deficiency Virus
AIDS	Acquired Immune Deficiency Virus
TQM	Total Quality Management
RCS	Rural Care Services
CD	Chronic Diseases

ABSTRACT

Background: Countries around the world are working towards achieving universal health coverage by means of Health Reforms, South Africa is also in the process of achieving this goal through the National Health Insurance (NHI) scheme. There are countries in the world including those in Africa that proved that employing this measure is possible to attain universal health coverage, though there may be challenges around Human, Material and Financial resources that needs to be addressed successfully. Challenges around poor access to health services are reported almost around the world including South Africa and health care workers are also implicated as a means to an end or an end themselves. Health care workers including Nurses, Doctors, Allied health personnel and emergency medical services personnel (EMS) are responsible for the implementation of the NHI therefore their views and perceptions regarding the NHI are very important in the study.

Purpose: The purpose of the study was to describe the views and perceptions of health care workers with regard to the roll-out of the NHI at Pietersburg-Mankweng tertiary hospital, Limpopo Province.

Materials and Methods: This was a cross sectional study conducted at Pietersburg and Mankweng tertiary Hospitals. Self-administered questionnaires were issued out to 255 health care workers in order to describe their views and perceptions with regard to the roll-out of the NHI at Pietersburg-Mankweng tertiary hospital, Limpopo Province. All statistical tests were conducted and based on a p-value < 0.05 , and considered statistically significant.

Results: A total of 255 healthcare workers participated in this study. A greater proportion (64%) of the respondents had knowledge of what the NHI is about: “Of these, only 37% have detailed information on how their facility is involved in its implementation”. Thirty nine percent of the respondents said that healthcare workers are prepared for the implementation of the NHI in their facility. The health care workers (43%) further said their facility is ready to provide some of the tertiary services when NHI is rolled-out, the findings were not statistically significant. Participants’ response regarding the perceived challenges during the implementation of the NHI in their institution illustrated that the most common challenges were administrative issues (30%), funding (21%) and personnel (11%). In relation to the key characteristics of health services delivery building blocks

(comprehensiveness, continuity, service access and patient waiting times) linked to the NHI, more than half of the participants (56%) said that the healthcare services are accessible to all people in need of them and sixty percent of the respondents reported that the institution adhere to the required waiting time.

The participants indicated that bad staff attitude, personnel factors such as shortage of staff, shortage of qualified staff, shortage of equipment and supplies, lack of insurance, lack of regular source of care, lack of finance, infrastructure and administrative factors as barriers towards adhering to the health services delivery building blocks characteristics. The measures to improve on barriers as identified by participants includes, hiring/training staff, positive staff attitude, good relationship between the community and health care providers, incorporate cultural differences, resolving infrastructural challenges, improving on availability of equipment and supplies, appropriate health system financing, improve health system coverage, increase health information sharing, reducing waiting times, improving on staff factor, improving on patient factors and improving on financial resources.

Conclusion: The findings in this study provides important information on health care workers views and perceptions on the NHI. Therefore as South Africa continues with the roll-out of the NHI through various phases it is important that health care workers are educated and engaged to ensure that the ideal of achieving universal health coverage through the NHI is realised.

CHAPTER 1

1. STUDY INTRODUCTION AND BACKGROUND

Health care is a worldwide phenomenon. It is therefore imperative for countries in need of reforms to benchmark with their world partners especially those who prove to be doing well in order to be successful. This is important because a lot is involved in the provision of comprehensive health services to communities. These encompass, the availability of material, human and financial resources. While material and financial resources may be available, their efficient use relies heavily on the human resources required within the health sector. The human resource component of the health sector is required at various levels of the government to ensure that the moneys, infrastructure and supplies are utilised to reach the community in a satisfactory manner. Strategies are employed to ensure that the services are rendered efficiently and this includes requesting and/or utilising the inputs of those involved or affected in service delivery. Healthcare workers are one such group from whom inputs are requested. Their involvement usually enhances ownership of the decision made. Inputs can be made through public participation. This denotes an ‘open, accountable process through which individuals and groups within selected communities can exchange views and influence decision making (Buccus, 2008). Health system reforms are some of the huge projects of a country aimed at addressing the health care needs of its people and hence when new systems are to be put in place the recipients and providers must be involved at every stage of development. In South Africa, the Civil Society Participate in Policy Making such as the National Health Insurance (NHI) at various levels of the government and this is entrenched in the country’s constitution of 1996. Section 59 (1) of that Constitution, indicates that the National Assembly must facilitate public involvement in the legislative and other processes of the Assembly and its Committees. Section 70b also states that the National Council of Provinces may: make rules and orders concerning its business, with due regard to representative and participatory democracy, accountability, transparency and public involvement. Section 115(a) also indicates that a provincial legislature or any of its committees may: receive petitions, representations or submissions from any interested person and institutions (Buccus, 2008).

When policies are amended or new ones are developed such as the Health Reforms or NHI, all stake holders' needs to be consulted and their input be taken into account such as the views and perceptions of Healthcare workers at facilities. It is said that community engagement in health is worthwhile for various reasons: (1) to determine local needs and aspirations, (2) to promote health and to reduce inequalities, (3) to improve service design and quality care; and (4) to strengthen local accountability. Furthermore, it is indicated that the process of community engagement or public participation process engages various ways and these include testifying at hearings, taking part in public opinion surveys and serving on advisory organs. In addition, direct action, including peaceful and violent protests, constitutes powerful forms of civil society participation in governance and engagement in the policy processes across the analytically differentiated phases of the policy process.

Some studies on Community engagement in the introduction and implementation of the National Health Insurance in South Africa, have shown some disparities involved in the process of consultation between the rich and poor regarding the NHI policy (Setswe and Monash, 2012). It is said people from the rich neighbourhoods are shown to have a number of alternative ways to use for community engagement. These include community meeting, petitioning the local councillor, minister or even Parliament, writing letters in local and national newspapers. They may also use technology such as emails and social networking mechanisms such as Face book, twitter or developing a blog to state their opinions (Setswe and Monash, 2012). On the other hand, the deprived rural and squatter neighbourhoods were found to be wanting due to lack of resources, coordination and cohesion capabilities than their better-off neighbours (Setswe and Monash, 2012). This implies that if the poor were not reached during the consultation process their views will not be fairly represented. Setswe and Monash (2012) further highlights some of the organisations used to represent the views of the poor such as the Black Sash and the Oxfam-Monash teams working with rural and peri-urban communities to inform them about the NHI and obtain their views on its implementation, particularly in their own communities Therefore it is important also to note that health care workers are part of the broader society. Hence their views might be well or poorly represented depending on the neighbourhoods they belong to.

Despite the need for a transparent process of consultation regarding health system reforms such as the NHI, it is important also to determine whether the systems in operation are

addressing the health needs of society as a whole. These will assist in the consultation process of the proposed new policies or the NHI because the evaluation processes such as the SWOT (Strengths, Weakness, Opportunities and Threats) analysis of old policies may indicate the necessity for new ones. Shisana (2011) shows that various health reforms in South Africa did not meet the health needs of the entire society and this is indicated by the number of documented reforms that the country implemented or suggested. These include the health system through colonialism and Apartheid. The systems were characterised by fragmentation within the public health sector and between the public and private sectors and the following are highlights from the past reforms according to (Shisana, 2011):

1. At an early stage, health facilities were racially segregated and curative and preventive services were separated when Public Health Amendment Act of 1897 was implemented.
2. The 1919 Health Act gave responsibility for hospital curative care to four provinces and preventive and promotive health care to the local authorities.
3. The Gluckman Commission (1942–44) was an attempt to redirect the health system. At the heart of this vision was a chain of community health centres, which were forerunners of community-based primary health care. Gluckman became Minister of Health in 1945, but the Nationalist Party assumed power in 1948, before the Gluckman recommendations had been implemented, and they were subsequently rejected.
4. The apartheid system further entrenched fragmentation of health care when the Bantustans were created, each with its own health department. The Bantustans and their government departments acted separately from each other, like quasi-independent powers, with control carefully manipulated by Pretoria. By the end of the apartheid era, there were 14 separate health departments in South Africa and health services were focused on the hospital sector, and primary level services were underdeveloped.
5. Post 1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and it continues to perpetuate inequalities in the current health system.

With regard to the NHI, perceptions were sought from the society at large. These included health care workers at operational level who usually advocate for such reforms with the

aim of improving the health of the community. Studies in South Africa, Shisana et al (2006); McIntyre (2010); Evans and Shisana (2012) have shown differences in opinions about the National Health Insurance (NHI). The perceptions of society at large about the NHI indicate that there is a generally positive response by most groups in support of the NHI. However, on the envisaged benefits, other individuals in society are of the opinion that there must be a thorough debate by all stake holders about the NHI before its implementation based on the failures from the previous reforms (Shisana et al, 2006; McIntyre, 2010; Evans and Shisana, 2012).

Health care workers are one component of such reforms and are part of the community. A number of studies indicate that the community at large have different perspectives/perceptions that impact on health reforms during its introduction or implementation and these perspectives/perceptions are in relation to issues such as: (1) communication of the objectives and the rationale for the reform aimed at keeping staff motivated e.g. Franco et al (2002) showed that workers are motivated when their goal is congruent to that of the reform with respect to training and impact on performance. (2) the need to overcome factors influencing utilisation of health services such as individuals, material resources, availability of free public health services and social resources need to be addressed. (3) the impact of health care insurance/reform on particular groups of health care workers e.g. nurses and doctors on career development indicate that opportunities are limited and achievements are not adequately rewarded (4) addressing factors that influence employment decisions, retention of health human resources linked to financial factors, human resource management, and occupational and macro-environmental issues such as stress and workloads (Franco et al, 2002; Lipinge et al, 2006; Bakeera et al, 2009; Rupert, 2010; George et al, 2013) .

From these studies it seems there are health services systemic issues that impact negatively or positively on universal access to health care e.g. availability of staff and material resources.

Problem statement

The South African health sector like in other countries such as Brazil (Brazilian Unified Health System) and currently United States of America (Obama Care officially called the Patient Protection and Affordable Care Act) has undergone some reforms with the aim of promoting access to health care (Patient Protection and Affordable Care Act Health-

Related Portions of the Health Care and Education Reconciliation Act, 2010 and Gragnolati et al, 2013). The developments pre-democracy with regard to health reforms in South Africa started with the recommendation in 1928 by the Commission on Old Age Pensions and National Insurance. This was followed in 1935 by the Committee of Enquiry into National Health Insurance which was replaced by the 1942-1944 National Health Services Commission. The last one was the tax-funded national health system of the 1980s (McIntyre, 2010).

By 1994, at the dawn of democracy, South Africa had put in place the current two-tiered system which is still failing to embrace the principles of equity and access and these resulted in the introduction of the NHI. The output of the two-tiered system is indicated by the disparities of the quality of health care services received in the private and public health care. A health system reform and the idea of mandatory health insurance have been on the table since the 1930's in South Africa (Collie Committee of Enquiry, 1936). The possibility of introducing mandatory health insurance was re-raised by progressive academics in the early 1990s and was formally incorporated into the African National Congress's National Health Plan (African National Congress, 1994; McIntyre and Gilson, 2002; McIntyre et al, 2008).

The Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa (2002) proposed that a comprehensive package of services be covered and that South Africa move ultimately toward a NHI system that integrates the public sector and private medical schemes within the context of a universal contributory system (Taylor, 2002; McIntyre et al, 2008; McIntyre and van den Heever, 2007). Currently the private sector provides the best quality service compared to the public sector which provides health care services to 84% of the population in South Africa with its chronic shortage of health human resources, supplies, equipment, and facilities (Department of Health, 2011). These differences in service delivery have an impact on all South African including the health care workers, George et al (2013) in a study conducted in South Africa on factors influencing health-worker employment decisions, indicated that, Health Workers (HWs) in the public sector reported the poorest working conditions, as indicated by self-reports on stress, workloads, levels of remuneration, standard of work premises, level of human resources and frequency of in-service training.

The aim and objective of the study

Based on these current challenges within the South African health sector; the aim of the study was to assess the views and perceptions of health care workers regarding the NHI in the South African health system at Pietersburg-Mankweng tertiary Hospital complex in the Limpopo Province.

The study objective was therefore to describe the views and perceptions of health care workers with regard to the roll-out of the NHI at Pietersburg-Mankweng tertiary hospital, Limpopo Province.

South Africa with its goal of ensuring universal coverage to health care through the NHI is one "Big" change that the country is currently focusing on. According to the NHI policy paper by the Department of Health, the NHI is said to be an innovative system of health care financing with far reaching consequences on the health of South Africa. The aim of the NHI is to improve service provision by promoting equity and efficiency for South Africans to have access to affordable, quality health care regardless of their socio-economic status (Department of Health, 2011). The NHI is being rolled-out in three phases, starting with preparing central hospitals to provide specialised services to all citizens, under the control of central government (Health 24, 2015). Ten pilot districts were identified in 2012 in eight provinces in South Africa and this comprise of, OR Tambo (Eastern Cape), Gert Sibande (Mpumalanga), Vhembe (Limpopo), Pixley ka Seme (Northern Cape), Eden (Western Cape), Dr K Kaunda (North West), Thabo Mofutsanyane (Free State) and Tshwane (Gauteng) (South African Communications and Information System, 2015). In 2013, Progress has been reported from pilot districts, covering improvements in quality, hospital reforms, primary health care (PHC) re-engineering, infrastructure, human resources for health, district management, referral systems, and cooperation with private doctors at district level (Parliamentary monitoring group, 2013). On the 11 December 2015 the White Paper on National Health Insurance was formally enshrined in the constitution of the country (National Health Act, 2003). This means that the NHI is a reality which all South Africans are faced with, including the healthcare workers. To ensure thorough implementation of this law it is essential that the physical, psychological and social environment where the health reform occurs to be thoroughly prepared such as in the case of the NHI. Hence consultations with the providers of care being the key stake holders is crucial in order to assess their views and perceptions and somehow fit the similarities and the differences into the system thus fostering the realisation of these major health care goals.

2. Summary

In this chapter the introduction and background of the study was discussed. The problem statement that led to the development of the study aim and objectives was discussed as well.

CHAPTER 2

2. LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to provide a background to the study by explaining what other researchers reported on matters related to this study and hence its relevance. This chapter is divided into six sections that include identifying the need for the NHI, community perceptions regarding the NHI, the influence of Health Care Workers on the NHI, the influence of Health Care Workers on the NHI, the implications of the NHI and Factors influencing enrolment to the NHI.

2.2 The need for the NHI

The World Health Organisation (WHO) is one of the world bodies that aims to protect the health of people throughout the world through a number of programmes such as the Universal Health Coverage partnerships. The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them and this requires: a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; a sufficient capacity of well-trained, motivated health workers (WHO 2015). In realising the goal of Universal Health Coverage (UHC), WHO has partnered with organisations such as the World Bank which shares another view of the UHC that of being smart investment and a measure of protecting human rights. This view is based on experiences of guaranteed health coverage resulting from advanced economies in countries such as Europe, Canada and Japan where their populations have for decades, decreased their out-of-pocket expenses (World Bank Group,2015). It is reported that some countries are now following suite such as Brazil, Russia, India, China and South Africa and they represent nearly half the world's population and it is further said that in Africa, Rwanda invested in a universal

health coverage system after the 1994 genocide and recently close to 80 percent of Rwandans are insured and life expectancy has more than doubled (World Bank Group, 2015 and WHO 2015).

It is evident that various countries 'desire for the NHI is to protect the human right to health care by ensuring universal access to health care services to its population and this also impact on the health care workers as the health service providers. In ensuring universal health coverage the World Bank through the International Development Association (IDA) has fulfilled a number of strategies, amongst them there are those that affect health workers in developing countries (World Bank Group, 2015). For example it is said during the past decade (2003-2013), IDA has:

Trained more than 2.6 million health personnel, Ensured that more than 29 million births were attended by skilled health personnel Constructed, renovated, and/or equipped more than 10,000 health facilities (World Bank Group, 2015). It is further said that through the services rendered by health care workers IDA has Immunized nearly 600 million children, Provided more than 194 million pregnant women with antenatal care during a visit to a health care provider, ensured that more than 210 million pregnant/lactating women, adolescent girls, and/or children under age five were reached by basic nutrition services, purchased and/or distributed more than 149 million long-lasting, insecticide-treated malaria bed nets, purchased and/or distributed more than 386 million condoms and etc. (World Bank Group, 2015).

It is shown that some of the rationale of the NHI it is its intention to decrease the gap relating to social disparities in health by removing financial barriers, the need is also based on benefits such as pooling of resources, risk protection against cost of illness and convenience and the guaranteed availability of coverage (Evans and Shisana, 2012; Patient Protection and Affordable Care Act Health-Related Portions of the Health Care and Education Reconciliation Act, 2010; Rupert, 2010 and Jehu-Appiah et al, 2011).It is also said that Health insurance is currently being considered as a mechanism for promoting progress to universal health coverage (UHC) in many African countries because the concept of health insurance is relatively new in Africa and it is hardly well understood and it again remains unclear how it will function in countries where the majority of the population work outside the formal sector (World Bank, 2015).

In terms of country specific developments, it is documented that the World Bank Group helped in Brazil to strengthen the health surveillance system and expanded access to and improved the effectiveness of health, water, and sanitation services for especially vulnerable groups, including indigenous peoples. As a result, 74% of the indigenous population was immunized by 2010 and malaria-related deaths declined by 60%. Furthermore in Rwanda, World Bank Group support has led to an increase in health insurance enrolment from 7% to more than 70% of the population; a 50% increase in utilization of health services by poor children; a 63% increase in the use of insecticide-treated mosquito nets; a doubling of use of family planning services; a 62% decrease in malaria incidence; and a 30% decrease in child mortality (World Bank, 2015). Again in Vietnam, as of 2013, 68% of the population was covered by fully subsidized health insurance. Though nationwide coverage for the “near-poor” (those living within 130% of the poverty threshold) is estimated at 30%, with Bank Group support, coverage for this group in the central north region reached 64% as of 2013 (World Bank, 2015).

2.3 Community perceptions regarding the NHI

Studies show that in the process of Health Sector reforms the people affected, that is, recipients and providers of health services raise various perspectives. They are either in support or against the reform and their perceptions are also based on individual or group differences and experiences. For example, some community members would prefer that there must be health coverage for all achieved either by raising or reducing taxes, the disadvantaged groups being mostly in support of the idea of raising taxes (Shisana et al, 2006). The issue of participation and involvement in health reforms is highlighted in the studies conducted in South Africa and Western Pennsylvania , where it is said that health reforms requires active public participation and involvement. Participation and involvement should be either in governance or through debates and is seen as an important aspect in the process of policy formulation such as the NHI, the inclusion of all stakeholders (public servants including health care workers, Non-Governmental Organisations (NGO’s), private sector) in order to identify and pursue health system reforms that will ensure universal access is highlighted (McIntyre, 2010; Rupert, 2010 and Harris et al, 2011). Furthermore it is said in another study that the principles and implementation of the NHI have been inadequately communicated to the public and, as a result, there may be another public outcry, more or less similar to that on e-tolling, when implementation begins (Sekhejane, 2013).

The acceptability of the NHI also highlighted in the community's views in relation to the community knowledge and understanding of the reform. For example in the conclusion of the study conducted in Kenya it has been reported that as Kenya continues to prepare for UHC, it is important that communities are educated and engaged to ensure that the National Health Insurance Scheme (NHIS) is acceptable to the population it serves and this is because the results showed that the level of awareness of health insurance schemes was high even though there was limited knowledge of how health insurance functions as well as understanding of key concepts related to income and risk cross-subsidization (Mulupi et al, 2013). The results also under the theme of knowledge, awareness and understanding of health insurance shows that the majority of individuals (77%) who did not belong to any form of health insurance reported that they were aware of at least one community based health insurance (CBHI) operating within the community. Of these, 55.7% reported that they were aware of the procedures required to join a CBHI while the results from focus group discussions (FGDs) showed mixed patterns regarding awareness and understanding of health insurance where most FGDs' participants expressed lack of awareness of health insurance and attributed this to limited efforts to promote CBHIs, Others felt that being a rural setting people hardly travelled to urban areas where such information was readily available and therefore knew very little about health insurance in general and its role in health care payments (Mulupi et al, 2013). Furthermore it was reported that those who were likely to have a good understanding of health insurance were people in formal employment because it was mandatory for them to be members of the NHIF and/or CBHIs (Mulupi et al, 2013).

Findings of the study in Kenya have some similarities with the study conducted in South Africa where it has been shown there were some disparities involved in the process of consultation between the rich and poor where people from the rich neighbourhoods were shown to have a number of alternative ways to use for community engagement such as community meeting, petitioning the local councillor, minister or even Parliament, writing letters in local and national newspapers, and using technology such as emails and social networking mechanisms such as Face book, twitter or developing a blog to state their opinions on the NHI. On the other hand the deprived rural and squatter neighbourhoods were found to be wanting due to lack of resources, coordination and cohesion capabilities that their better-off neighbours have (Setswe and Monash, 2012).

The study from Kenya also reported on communities' perceptions on the proposed national health insurance scheme and their preferred designs where the majority of household survey respondents (93.0%) supported the implementation of a compulsory national health insurance scheme for Kenyans (Mulupi et al, 2013). The government was the most preferred revenue -collecting and purchasing organization (51.8%) for such a scheme, while 32% preferred an autonomous purchasing agency, with some control from the government. Private purchasing institutions were hardly preferred (11.7%). The General Practitioners in south Africa also raised their perceptions regarding the NHI where understanding and costing of NHI was researched and the results showed that their differing thoughts about the NHI, it has been reported that the General Practitioners (GPs) were mostly ambivalent about NHI, with 47% taking a neutral stance; 21.5% supported it and 32.5% did not and this was because the GP's were uncomfortable with the lack of clarity and control of risks with NHI. It is said some cynicism was mostly related to the specific NHI capitation proposal, of solo GPs, 24.2% rated their own understanding of capitation as very poor to poor whereas 75.8% rated their understanding as fair to very good (Moosa, 2012 and Mulupi et al, 2013).

Komape (2013) also reported on community perception in the FGD's study that examined perceptions about health care delivery along various dimensions and this included service quality, responsiveness, patient satisfaction, staffing, and cleanliness of facilities. The result of the focus groups under the theme - "Beauty and the beast: the private-public split" shows that during the initial part of each focus group , across all groups, participants started off with strong views that private was "good" and public was "bad". In this theme, negative statements were initially and almost-automatically expressed about public hospitals and positive ones about private hospitals. Komape (2013) further reported that about 95% of the respondents indicated that the health insurance was a good and a reliable means for replacing the cash and carry system or financing of health care if managed properly. The respondents also indicated that the health insurance improved access and cost effectiveness of health services as one of them in the FGD's said "Health care and treatment has become easily and readily available especially if one is insured thereby making financing easy". Some participants also highlighted some of the benefits of the national health insurance schemes in terms of long term developments in the health sector such as building of infrastructure, buying equipment and enhancement of human capital, improved focus on preventive health care (Komape, 2013).

2.4 The influence of Health Care Workers on the NHI

Health care workers as the providers of health services were shown to have an influence on recipient decision to access health services. The decision to use or not to use health care facilities was based on characters displayed by health care workers in their attitude (good/bad), the use of bad language and also poor facilities in which they work. In making the choice to use public or private health care, the study by WHO showed that 2.8% of participants would rather use the private sector due to the bad attitude of health care workers in the public sector (Juma and Manongi, 2009 and WHO, 2012). Gadallah et al (2010) however indicates that the attitude of health care workers when there are work problems in reformed Primary Health Care (PHC) units/centres is satisfactory as compared to those in non-reformed PHC units/centres and this of course is related to the NHI. In a study conducted in South Africa amongst PHC Nurses at Johannesburg Metropolitan district D2, the results show that the nurses are positive towards the NHI. Nurses are positive and ready to support the implementation of the project but proper buy-ins, stakeholder engagement and proper planning needs to be in place in order for the successful implementation of the project.

Numerous studies have been conducted in South Africa amongst health care workers, mostly general practitioners where there are mixed responses in terms of supporting the implementation of the NHI, some do not at all support the NHI because it is viewed to be detrimental, some states that they will support it due to envisaged personal benefits and to achieve the social goal of universal coverage for quality health care in South Africa, as well as a commitment to open engagement and debate, (Amandla, 2009; Ramjee and McLeod, 2010 and Surrender et al, 2015).

The conclusion of a study conducted in South Africa amongst health care experts shows some of the views that influence the success of the NHI in relation to the concept of equity where it is said the true viability of the NHI scheme will be tested by the government's ability to improve the delivery of medical services to the general public. The fulfilment of its promise may remove a fundamental difference between the poor and rich people of South Africa. Furthermore some experts raised important equity issues around the NHI which is seen to transform South Africa that is currently one of the most unequal societies in the world. Reynolds said a decent health system can promote equality and the NHI could

also help to stem costs for everyone, as regulation of healthcare costs in both the private and public sector is envisioned in the plan. van Niekerk cited in Amado et al (2012), the director and professor of social policy at the Institute of Social and Economic Research at Rhodes University also highlighted some of the areas of concern that south Africa need to address for NHI to progress well such as Private-sector healthcare costs which are not regulated and the save for medicines, and costs which have increased by 120 percent in the past decade. Some experts further said that they believe that South Africa should look to countries such as Rwanda that have been successful in bettering health outcomes with simple interventions as a model for the NHI and to realise such interventions there is a need for strong public participation, government transparency and a renewed focus on training health professionals (Amado et al, 2012).

Rigoli and Dussault (2003) in the results of the systemic review indicate intermediary factors influencing the effects of reforms and responses of Human Resource which of course influence the success of projects such as the NHI. They include focusing on human resources in the strategic planning and implementation of the reform process because their reaction has an impact on the process, involving workers in the design and implementation of the reform by training them on how to follow new procedures, encouraging participation of workers' representatives such as professional associations or unions, ensuring coherence between the institutional culture and values, the objectives of the reform instruments, and the tools and timetable of the implementation process to facilitates the commitment of workers to the reform process, adapting managerial or financial tools to the proposed changes (Rigoli and Dussault, 2003).

Some of the factors that impact on health care worker's influence on the NHI includes shortage of heavy workloads, poor compensation packages, low quality of work life, and poor leadership, human resources for health, fragmented, outdated and Static curricula, skill-mix imbalances, mal-distribution in terms of skills and 'brain drain' have been reported as the barrier to scale-up health systems and health specific interventions, (Mosadeghrad, 2014 and Senkubuge et al, 2014). An example cited in a study conducted on Health workers and their professional bodies states that "The continuing dissatisfaction (Nearly one half of the health workers (45%) reported difficulties fulfilling their duties, especially doctors, women, and younger workers. They cited inadequate supplies and

infrastructure, bad behaviour of patients, and administrative problems of health workers may have undermined the effectiveness of the HPSP (Cockcroft et al, 2011). As a measure to deal with the difficulties mentioned, the researchers said it is presenting the views of the public and service users to health managers helped to focus discussions about quality of services and it is important to involve health workers in health services reforms (Cockcroft et al, 2011).

The studies conducted at George Mukhari Hospital in South Africa and Nigeria also indicate that knowledge about the NHI has potential impact on the implementation on the NHI were it is said more than half 54.45% of the healthcare workers did not know that membership to NHI would be compulsory, while 63.33% believed that NHI will not provide adequate cover compared to current medical schemes. Regarding the main objectives of NIH, 54.58% of the healthcare workers were knowledgeable whereas 44.26% were unaware of the proposed socio-economic benefits of NHI. Overall, 55% of the healthcare workers supported the implementation of NHI. The study revealed that healthcare workers had inadequate knowledge about the proposed NHI, but overwhelmingly supported its introduction, (Bezuidenhout and Matlala, 2014 and Dutta and Hongoro, 2013).

2.5 The implications of the NHI

Studies show variety of benefits brought about by health system reforms or NHI and these benefits are also effected on health care workers at micro and macro-economic level. These includes promotion of worker motivation once the transition process is passed, improvement of the financial status of facilities for rendering universally accessible services, reduction in mortality rate and an increase in life expectancy (Franco et al, 2006 and Dalinjong and Laar, 2012). On the contrary improving on universal access is also linked to service abuse, while poor access to health care is associated to factors such as difficulty in affording health care services due to the system used, unsatisfactory services, inconvenience timing of premium payments, being healthy and lack of confidence in the scheme, transport constraints, inadequate supplies e.g. drugs (Bixby, 2004; Shisana et al, 2006; Jehu-Appiah et al, 2011 and WHO, 2012).

In a study conducted in Ghana on the financial protection effect of Ghana National Health Insurance Scheme the study confirm the positive financial protection effect of health

insurance where it is said the effect was found to be stronger among the poor group than among general population (Nguyen et al, 2011). The benefits are seen to help mostly the low income countries who are considering a similar policy to expand social health insurance such as the NHI. The results of the study again shows a clear and consistent pattern that emerged across all measures where it is said having NHIS significantly reduced the probability of catastrophic OOP (Out -of pocket) payment on health services. The estimated reduction ranges from 0.5 percentage point (for expenditure of at least 20 percent of non-food expenditure) to 1 percentage point (for expenditure of at least 5 percent of income). In relative terms, a reduction of 1 percentage point would be 67 percent compared with the mean of the insured and 36 percent compared with the mean of the uninsured. Consistent with the finding on OOP expenditure, males have been shown to have a significantly lower incidence of catastrophic payment than females (Nguyen et al, 2011).

South Africa also forecasted the NHI benefits based on themes of Macroeconomic, productivity, health. It is said there are three sources of broad-based benefits to the society and economy that can be roughly estimated as offsetting the additional costs of NHI. These are in three categories: macroeconomic multiplier benefits of NHI (5% for each rand spent); labour productivity benefits (20% in the medium-term); and improvements in morbidity and mortality rates (up to 184 000 reduced premature deaths per year and 20% additional healthy days per person) (Amandla, 2009). For example under productivity benefits it has been reported that the health system affects the productivity of labour in the production process therefore the introduction of an NHI system must improve the efficiency of the health sector and increase the quality of the health service if it is to have long run effects on the growth rate of the economy (Amandla, 2009). It is further said to calculate health benefits associated with lower morbidity and mortality rates, consider the top ten diseases responsible for registered deaths in South Africa. To estimate the potential decline in premature deaths once NHI is established and hence health care is made universal, it makes sense to compare the benefits of rationalizing health financing in South Africa with countries that have already adopted a single-payer NHI system and which also spend between 7.7% and 9.7% of their Gross National Income on health care: Australia, Canada, Denmark, Norway and Sweden (all of which have extensive private health care provision, publicly financed). These countries cannot be easily compared given the very different socio-economic characteristics [and lack of a high AIDS (Acquired Immune-

deficiency virus) rate], but avoidable mortality and Disability-Adjusted Life Year estimates that show the vast differences in outcomes given the similar health/GDP (Gross Domestic Product) ratios in the two types of systems, (Amandla, 2009).

2.6 Factors influencing enrolment to the NHI

Studies shows positive and negative factors influencing communities to enrol for the NHI. There are various reasons cited amongst them includes knowledge, awareness and attitude and factors such as age, gender, employment and others. For example the results of a study conducted in Ghana on What Factors Influence Enrolment? Respondents aged from 22 to 56 the study showed that a positive relationship with health insurance membership enrolment was associated with being young, educated and amongst male being the breadwinners of their family (Ebenezer and Chiaraah, 2014).

Another study conducted in South Africa highlights the barriers to enrolment to the national health insurance and they included insufficient information, unaffordability of payments and perceived administrative complexity (Govender et al, 2013). Again in a study conducted in Nigeria on understanding client satisfaction with a health insurance the results indicated a high satisfaction rate with the health insurance scheme was observed (42.1%). Marital status ($p < .05$), general knowledge ($p < .001$) and awareness of contributions ($p < .05$) positively influenced clients' satisfaction. Length of employment, salary income, hospital visits and duration of enrolment slightly influenced satisfaction (Mohammed et al, 2011).

Again various studies have reported numerous challenges impacting on the success of the NHI were it is said long waiting times, unavailable medicines, rude staff, unaffordable price of the service, high labour costs and low managerial capacity, Shortage exists of both lower-level health facilities as well as equipment, low training of physicians relative to the country's needs, shortage of midwives also exists, low recruitment remains with ageing, retention challenges especially in rural and remote areas and in the norther regions, low quality of care and HWs' competencies and productivity, low motivation, heavy workloads, poor compensation packages, poor leadership, lack of a quality-oriented culture, poor relationships between community and health staff, confidentiality and the gender of health workers, long distance to health facility, cost of transport and cultural practices, weak outreach programmes, bad scheduling of health programmes and poor

communication (Escobar et al, 2010; Ramjee and McLeod, 2010; Halwindi, 2013; Karima, 2013; Mutale et al, 2013; Mosadeghrad, 2014 and Eide et al,2015).

Positive factors have been also identified in studies that address the health system challenges in order to improve the user's need for health services during a particular reform and consequently improve workers' motivation. It is said interventions should include a strategy for partnering with the community by providing employment and training of local people to implement the intervention, training and support for staff, adequately staffing, transparent delegation of tasks, responsibilities and the roles, impact apply system wide approaches during evaluation, positive workplace culture through strong leadership, with the presence of champions and change agents, cultural awareness training must be included, reasonable workloads and provision of adequate living conditions for remote staff should, a dedicated referral coordinator in the referral processes, providers should receive guidance on how to communicate with their patients, including patients in monitoring their progress and speaking with patients in lay language is important (Gibson et al,2015 and Mutale et al, 2013).

Furthermore it has been reported that adequate number of high skilled and experienced employees must be employed continuously, discourage ineffective recruitment, encourage monitoring of doctors and staff, and ensure that performance and practice standards are met to enhance service quality provision. Again it has been concluded that public health sectors should improve the level of adoption of technology and willingness to invest and advance in modern technology in order to facilitate service assessment, improve process and communication which are essential for effective and efficient service quality in public health sector, effective allocation of financial resources in public health sector in order to promote other functions that contribute to service delivery, reduce the bureaucracy in financial management and offer funds for purchase of high quality health equipment and employing of more competent staff who could offer (Wanjau, 2012).

In a study conducted at Senegal where it is said that majority of respondents perceived that the 5S program (5S stands for five Japanese words, Seiri, Seiton, Seisou, Seiketsu, and Shitsuke, which broadly refer to maintaining cleanliness for the improvement of healthcare services) brought on changes in each of the following areas: 1) visible or physical areas of the health centre (all respondents said 'Yes'), 2) (Yes=19; No=1; Don't know=1), 3) their own daily routines (all respondents said 'Yes'), and 4) the work of other health centre staff members (Yes=17, No=2, Don't know=2) (Kanamori et al, 2015).

2.7 Summary

In this chapter we have discussed the literature review by explaining what other researchers reported on matters related to this study and hence its relevance. The discussions were based on the six sections identified and they included identifying the need for the NHI, community perceptions regarding the NHI, the influence of Health Care Workers on the NHI, the influence of Health Care Workers on the NHI, the implications of the NHI and Factors influencing enrolment to the NHI.

CHAPTER 3

3. RESEARCH METHOD

3.1 Introduction

The purpose of this chapter is to explain the quantitative method used in answering the research objective. In this chapter the research design, study setting, study sample, data collection method, data analysis and ethical issues will be discussed.

3.2 Research design

A cross-sectional descriptive quantitative research design was employed because of the nature of the study which aimed at deriving to a conclusion across the wide population. Quantitative research aims at conducting a systematic scientific investigation of data and their relationships. Measuring is key in quantitative research because it shows the relationship between data and observation. The overall structure for a quantitative design is based in the scientific method. It uses deductive reasoning, where the researcher forms a hypothesis, collects data in an investigation of the problem, and then uses the data from the investigation, after analysis is made and conclusions are shared, to prove the hypotheses not false or false. The basic procedure in a quantitative design involves the following steps:

1. Make your observations about something that is unknown, unexplained, or new and Investigate current theory surrounding your problem or issue.
2. Hypothesize an explanation for those observations.
3. Make a prediction of outcomes based on your hypotheses and formulate a plan to test your prediction.
4. Collect and process your data.
5. If your prediction was correct, go to step.
6. If not, the hypothesis has been proven false.
7. Return to step 2 to form a new hypothesis based on your new knowledge.
8. Verify your findings.
9. Make your final conclusions.
10. Present your findings in an appropriate form for your audience.

There are different types of quantitative research designs and in this research the Cross sectional descriptive study was used to collect data (Shuttleworth, 2015).

A cross sectional study takes a snapshot of a population at a certain time, allowing conclusions about phenomena across a wide population to be drawn. Therefore descriptive cross sectional research seeks to describe the current status of an identified variable/ phenomena in a population at a certain time (Shuttleworth, 2015).

In this study the cross sectional descriptive study allowed the researcher to research on the subset of the entire population in this case health care workers from two tertiary institutions (Polokwane and Mankweng hospitals) within four sections, that is, Nursing, Clinical, Allied Health and Emergency Medical service at a single point in time. This design also allowed for comparison of their views and perceptions on the NHI.

3.3 Study setting and site selection

Pietersburg-Mankweng Tertiary Hospital complex which is under Polokwane municipality at the Capricorn district, Limpopo province. The complex has a bed capacity of 1210 (National Health Act, No 61 of 2003, Regulation, 2011: 655).

3.4 Population and Sample

Target population include all health care workers from Nursing, Clinical, Allied Health and Emergency Medical service working at Pietersburg-Mankweng Tertiary Hospital complex, in Limpopo province. The estimated population of the study included 2312 employees. The health care workers researched were sampled using proportionate stratified random sampling technique. The sample comprised of 255 health care workers at Pietersburg-Mankweng from Nursing, Clinical, Allied Health and Emergency Medical service.

3.5 Sample size calculation, sampling procedure/ techniques

The sampling frame comprised of Pietersburg-Mankweng Tertiary Hospital complex health care workers within the updated human resource workforce profile report. This is relevant because it had an indication of correct figures of staffing of each section within the facility within the specified period. Proportionate stratified random samples of health care workers was done according to the various sections of the human resource workforce profile. Based on the most recent numbers in the workforce profile per stratum, that is for

February 2014. Stratum 1- Nursing personnel =1473, stratum 2- Clinical personnel=404, stratum 3- Allied health personnel=311, stratum 4- Emergency medical services personnel=124. The study sample size at 95% confidence was 330 health care workers. To close the gap for incomplete responses or non-responses on questionnaires, 10% of health care workers was added, which brought the total sample size to 363. Sample size proportions per stratum were as follows: Nursing personnel = 231, Clinical personnel = 63, Allied health personnel = 49 and Emergency medical services = 19. Convenience sampling was used where health care workers who reported on duty were given questionnaires.

3.6 Data collection methods and procedure

The Self-administered questionnaire was selected. This type of questionnaire is either in paper or electronic form, which a respondent completes on his/her own. A questionnaire is a survey method that utilizes a standardized set of questions, which allow respondents' answers to be systematically compared and/or contrasted. Questionnaires must be designed carefully, as to ensure clarity. Self-administered questionnaires enable researchers to reach a large number of potential respondents in a variety of locations. Questions may be designed to measure dichotomous responses (e.g. yes/no or true/false), interval responses (i.e. the Likert scale), or semantic differential responses (e.g. 'never', 'sometimes', or 'always').

The self-administered questionnaire can be exploratory in nature and serve as a starting point for other methodologies. Questionnaires can include an option for participants to indicate if they would like to participate in a follow-up interview, which allows the researcher the opportunity to further explore the research question by collecting qualitative data. The advantages of this method of data collection are that they can be distributed to a large number of people at a relatively low cost, which increases the odds for a greater number of respondents, Lowers the costs than interviewing, Reduces interviewer bias, and ensures that “Social desirability” answers may be less of an issue (Medanth, 2015).

In this study Self-administered questionnaires were used to collect data on health care workers from Nursing, Clinical, Allied Health and Emergency Medical service. The respondents completed the questionnaire on their own using simple English languages without help from the researcher or assistant. This was guided by the literacy level/ qualifications of study respondents. A self-administered questionnaire comprised of two sections, that is, section A with seven (7) questions concerning the background of

respondents and section B with twenty two (22) questions concerning respondents' views and perceptions on NHI.

The questionnaires were distributed to the respondents in their sections by the researcher. The respondents were informed that by completing the questionnaires it means they gave consent to participate in the study. This was done to ensure that the participants' responses cannot be linked to their identity thus assuring their anonymity. The respondents were given a period of one to two weeks to complete them. Completed questionnaires were collected in the boxes provided to the managers of the four disciplines immediately thereafter. The completed questionnaires were coded according to the each stratum for data analysis e.g. the code of NMH meant - Nursing Mankweng Hospital and EMSP meant Emergency Medical Services Pietersburg Hospital. The questionnaire was adapted from Eiselen, et al (2005) and Allin, et al (2007) and adjusted. For the closed-ended questions on background, the participants were required to tick in the appropriate rating or response of the seven questions. For the closed-ended questions on participants' perspective about the NHI, the respondents were required to tick in the appropriate response as rated with numbers or otherwise specify the response in the space provided. The purpose of the study being to determine the views and perceptions of healthcare workers on the NHI and need for consent in ensuring confidentiality and autonomy were explained to the potential respondents on the questionnaires.

3.7 Data analysis

After receiving data from the field, the researcher checked the questionnaires for completeness. Information from questionnaires was captured on excel spreadsheet, data was cleaned, coded and then imported into Stata for analysis. Descriptive statistics of the demographic characteristics and the key variables was presented in absolute frequencies in the form of raw numbers, relative frequencies and percentages. Location, dispersive and shape statistics was analysed in the form of range, mean, mode, standard deviation and graphs. Chi Square test was used to test where there could exist some association between variables. The level of significance of all statistical tests was set at P-value of 0.05 in relation to the hypothesis of the study. To determine the differences in variables the researcher used the fisher's exact test.

3.8 Reliability and Validity

3.8.1 Reliability

To ensure internal reliability, the researcher ensured stability of the tool by determining whether the questionnaire gives similar results or not, and these was ensured by pre-testing the tool on a sample of 15 health care workers at Warmbaths Hospital. These also helped to improve the repeatability of the research tool.

3.8.2 Validity

Face and content validity was ensured by pre-testing the tool on health care workers at Warmbaths Hospital in Limpopo in order to determine whether the research design will be relevant and interesting to them and also to determine whether it is covering most of the areas that NHI addresses. Construct validity was ensured by adapting the questionnaire to what other researchers have studied in similar studies on health care workers' perspective with regard to health reforms. Instrument validity was conducted by pre-testing the self-administered questionnaire on health care workers at Warmbaths Hospital.

3.9 Bias

Assessment bias was eliminated by using the correct methods to select participants where only health care workers from Nursing, Clinical, Allied and Emergency medical services participants will be sampled. Procedural bias was eliminated by giving participants a period of one to two weeks to complete the questionnaires in order to avoid unnecessary pressure and also to stress the element of honesty. Measurement bias was dealt with by issuing anonymous questionnaires. The researcher also avoided reporting bias by ensuring that the results of the study are captured correctly and completely based on the responses given by participants in the questionnaires.

3.10 Ethical considerations

The researcher asked permission from the management of the Limpopo Department of Health and Pietersburg-Mankweng tertiary Hospital complex to conduct the study. The researcher also introduced self to the participants (Name, identity cards, name of university and course) and informed participants that they will be partaking in a study on the views of Health Care Workers regarding the National Health Insurance and also that the data collection process will take approximately two months. The researcher informed the

management and participants that a permission has been granted to conduct the study by SREC and MREC (MRECJ/169/2014: PG).

The researcher also informed the participants about the title, aim, objectives, and questionnaire and also explained about how the study will contribute to existing knowledge and its anticipated benefits to society and academic knowledge. The researcher gave information on how the data was to be collected that is, by using self-administered questionnaires. Participants were assured of confidentiality because each one of them was not asked to give consent regarding their participation, they were also informed that their involvement in the study is voluntary and if they decide to refuse to participate before the study begins, or wish to withdraw in the process of the study, they can do this without any prejudice. The participants were also told that they may continue to skip any questions that may make them feel uncomfortable without any penalty, and assured them that their withdrawal will have no effect on the compensation used to recruit participants.

Other ethical considerations viewed as important for the success of the study are:

Openness and integrity –The researcher was open and honest about the details of the study by giving participants information leaflets, responding to their queries and behaved in a professional manner at all times.

Protection from harm – The researcher minimized the risks of any harm, either physical or psychological, arising from any participant, researcher, and institution, funding body or other person, by ensuring confidentiality, privacy during the research process and also allowed participants to fill the questionnaire in their work environment.

Confidentiality - The researcher informed participants that the information that they provide will be kept confidential unless there are legal reporting requirements and that the results of the study will be used or published with their identity withheld. The questionnaires were stored in a safe lockable place.

3.11 Summary

In this chapter the quantitative method used in answering the research objective was explain. Furthermore the research design, study setting, study sample, data collection method, data analysis and ethical issues were also discussed.

CHAPTER 4

4. PRESENTATION AND INTERPRETATION OF THE FINDINGS

4.1 Introduction

In the previous chapter, the study design, settings, study population, sample size and sampling technique, data collection and data analysis are outlined. In this chapter, the response rate, demographic characteristics and in depth results addressing the objective of the study are presented and interpreted.

4.2 Response rate

Three hundred and sixty three (363) questionnaires were distributed to nurses, doctors, allied and EMS personnel. Only 255 were returned, giving a response rate of 70%. All 255 questionnaires were analysed for demographics and the study objective.

4.3 Demographic characteristics of the respondents

A total of 255 healthcare workers participated in this study. Large proportions (29%) of the respondents were in the age group 30-39 years, followed by those aged (20%) 40-49 years (Figure 4.1). Twenty two per cent of the participants did not indicate their age.

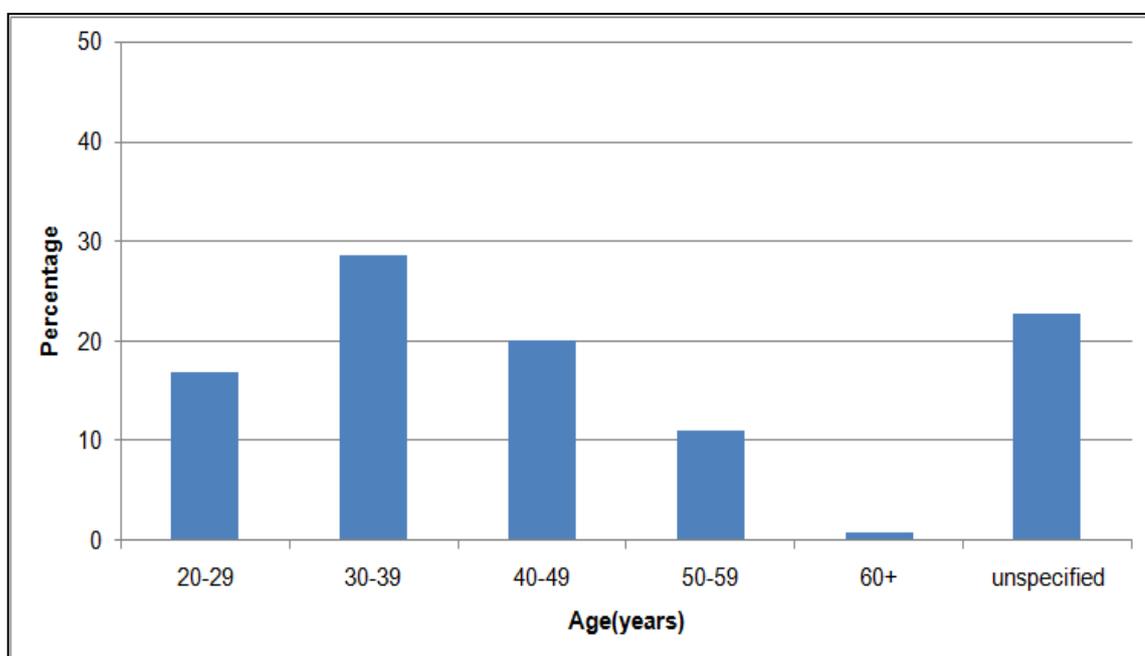


Figure 4.1: Respondents' age distribution

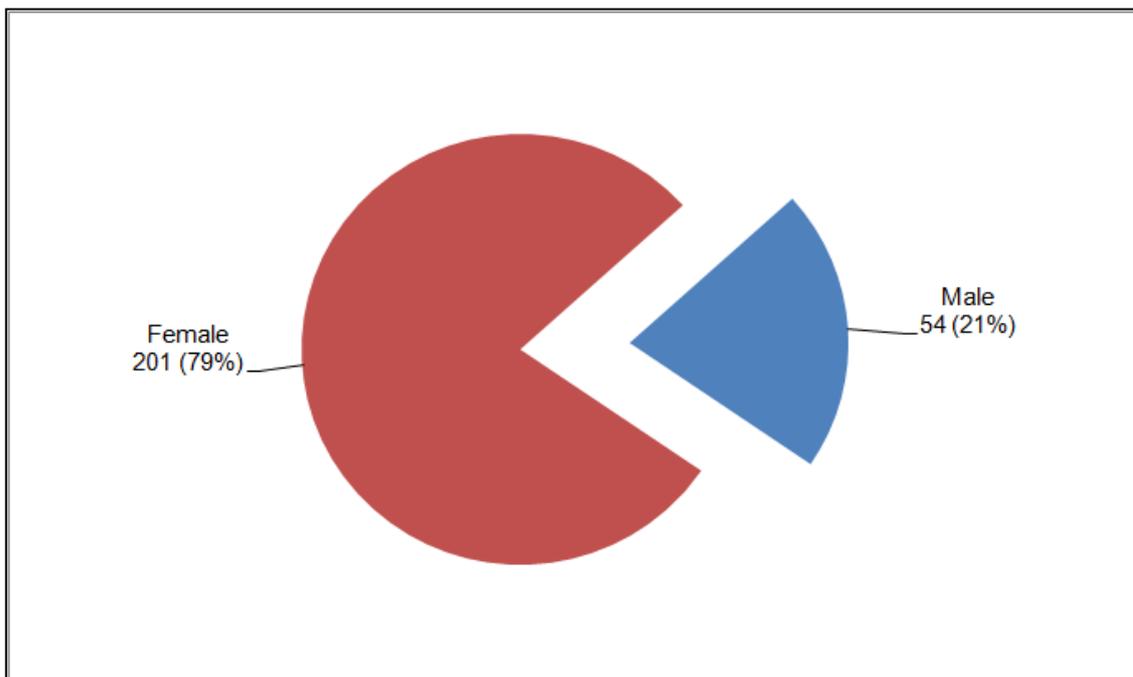


Figure 4.2: Respondents' Gender distribution

Figure 4.2 demonstrate the distribution of gender. Most of the participants were female (79%) and only 21% were male.

More than half of the respondents were nurses (57%) followed by allied healthcare workers (19%), (Figure 4.3).

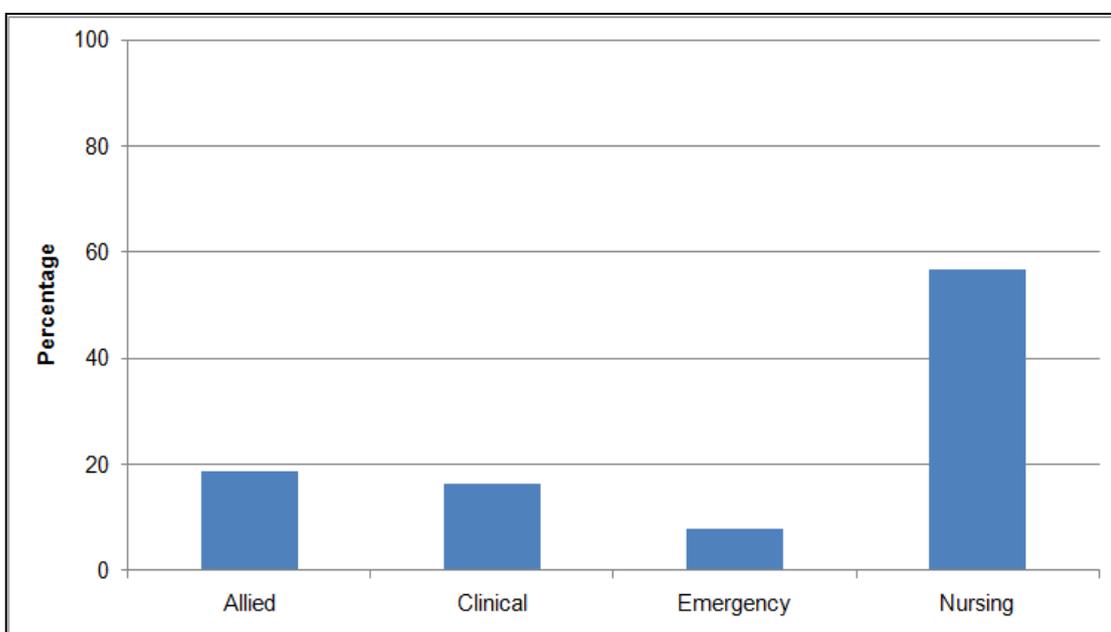


Figure 4.3: Respondents' distribution of categories

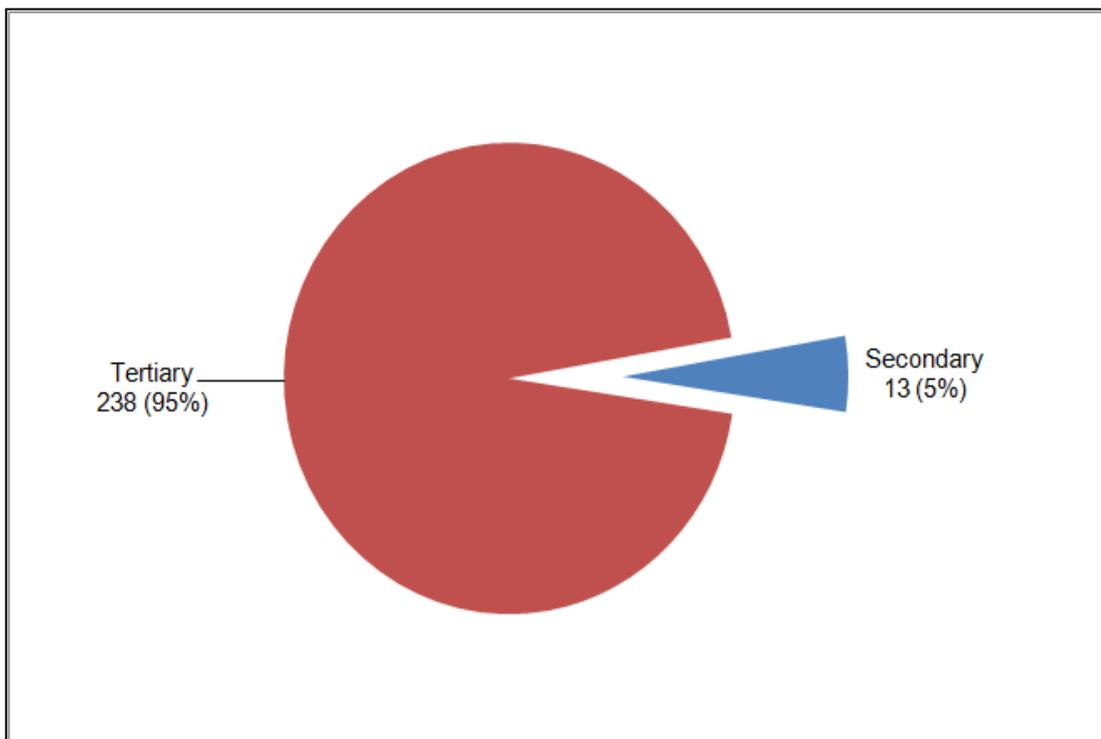


Figure 4.4: Respondents' distribution of level of education

Ninety five per cent of the participants had tertiary education and only 5% had secondary education (Figure 4.4).

4.4 Respondents knowledge of National Health Insurance scheme

Figure 4.5 presents the participants knowledge of NHI. A greater proportion (64%) of the respondents knew what the NHI is all about: “Of these, only 37% have detailed information on how the hospital is involved in its implementation” (data not shown).

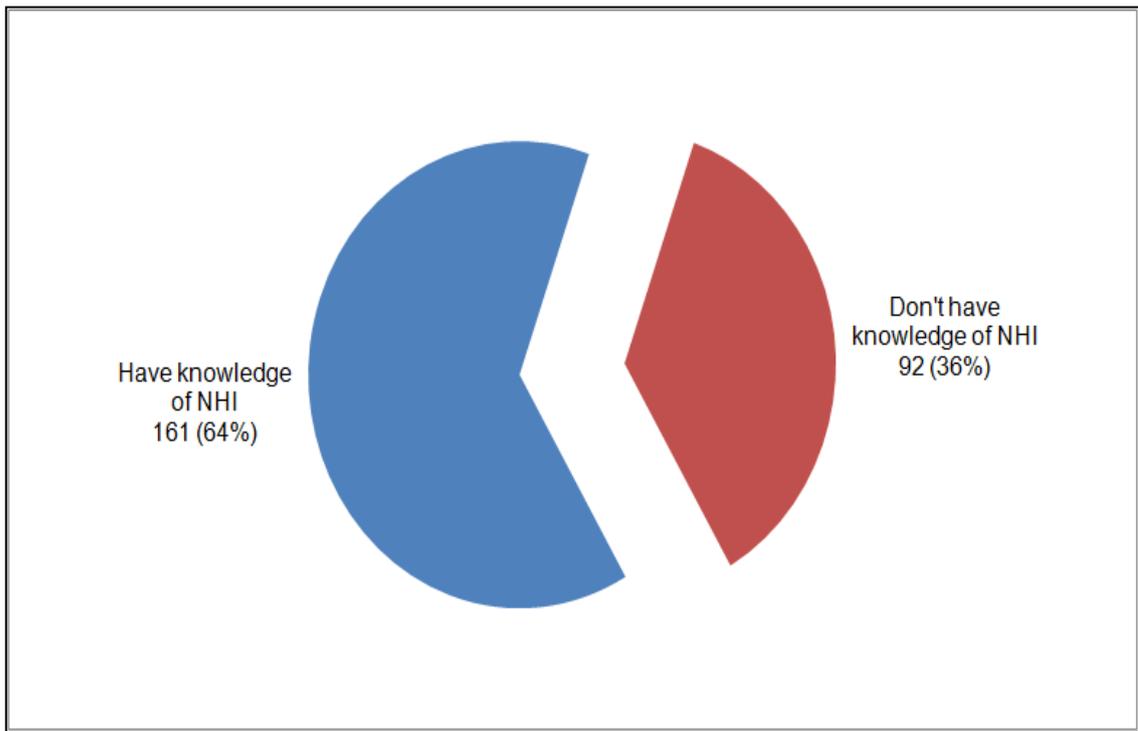


Figure 4.5: Respondents' knowledge of National Health Insurance scheme

The source of information about NHI is shown in Table 4.1. Of the 59 respondents who have detailed information on how the hospital is involved in implementing NHI, most reported that they heard about NHI on the media (37%) and hospital information (34%).

Table 4.1: Source of information about NHI

	No	%
Hospital information	20	34
Media	22	37
Hospital information/media	2	3
Community gatherings	6	10
Workshop/conference you attended	4	7
Higher education institutions	2	3
Other	3	5
Total	59	100

Table 4.2 illustrates the relationship between knowledge of NHI and selected demographic information of the respondents. There was no statistical significant difference between knowledge of NHI and all selected demographics ($p>0.05$).

Table 4.2: Association between knowledge of NHI and selected demographics

	n	Have knowledge of NHI		Have no knowledge of NHI		p-value
		No	%	No	%	
Employees Categories						
Allied	48	33	69	15	31	0.376
Clinical	41	29	71	12	29	
Emergency	20	14	70	6	30	
Nurses	144	85	59	59	41	
Gender						
Female	201	125	62	76	38	0.347
Male	52	36	69	16	31	
Level of education						
Secondary	13	8	62	5	38	0.858
Tertiary	236	151	64	85	36	
Age (years)						
20-29	43	24	56	19	44	0.151
30-39	72	50	69	22	31	
40-49	51	32	63	19	37	
50+	30	14	47	16	53	

4.5 Healthcare workers perceptions with regard to NHI

Thirty nine per cent of the respondents said that healthcare workers are prepared for the implementation of the NHI in this facility (Table 4.3). There were a significant higher proportion of emergency services (60%) and nurses (48%) who said healthcare workers are prepared for the implementation of the NHI in this facility compared to allied (25%) and doctors(12%), ($p < 0.05$).

Table 4.3: Implementation and policy of the NHI

			Allied	Doctors	Emergency	Nurse	p-value
		n	n (%)	n (%)	n (%)	n (%)	
As a health care worker in your opinion would you say you are prepared for the implementation of the NHI in your facility?	Yes	98	12(25)	5(12)	12(60)	69(48)	<0.001
	No	77	14(29)	18(43)	6(30)	39(27)	
	Unsure	78	22(46)	19(45)	2(10)	35(25)	
With regard to the NHI policy contents, what are your thoughts about it?	Don't know	119	29(62)	25(63)	8(40)	57(40)	0.019
	Fair	56	8(17)	11(28)	5(25)	32(22)	
	Good	50	6(13)	2(5)	3(15)	39(27)	
	Excellent	25	4(9)	2(5)	4(20)	15(11)	
Which of the health care services as listed below do you think must be provided in Tertiary Hospitals?	All services	74	24(52)	12(29)	7(35)	31(22)	0.001
	Some services	176	22(48)	30(71)	13(65)	111(78)	
In your own view do you think your facility will be ready to provide the services you selected from the list above comprehensively when the NHI is implemented?	Definitely yes	59	13(27)	8(19)	9(45)	29(24)	0.410
	Yes but not all	99	21(44)	16(38)	8(40)	54(45)	
	No	27	5(10)	8(19)	2(10)	12(10)	
	Not sure	46	9(19)	10(24)	1(5)	26(22)	

Regarding NHI policy contents, 48% of the participants do not know about the policy contents of NHI ($p < 0.05$). A greater proportion of allied (62%) and doctors (63%) don't know about the policy contents of NHI compared to emergency services (40%) and nurses (40%)

About 70% of the respondents in this study believe that not all tertiary services should be provided in their institution. Just below half of allied (48%) compared to doctors (71%), emergency services (65%) and nurses (78%) said not all tertiary services should be provided in this institution.

Most (43%) of the participants said the facility is ready to provide tertiary services when NHI is implemented but not all, the findings were not statistically significant.

Figure 4.5 illustrates the general challenges during the implementation of the NHI in the institution are illustrated. The most common challenges mentioned by the respondents were administrative issues (30%), funding (21%) and personnel (11%).

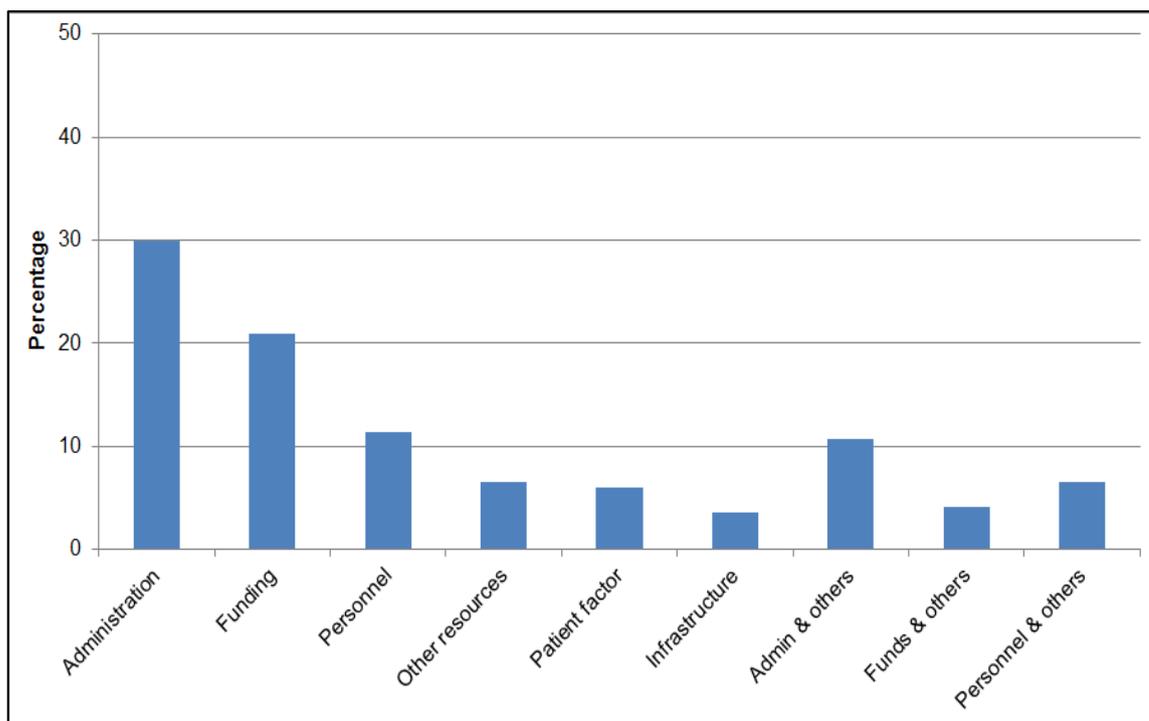


Figure 4.6: Challenges during the implementation of NHI

A large proportion of the healthcare workers (34%) said rehabilitative service is the common service the facility provides. A significant high proportion of allied (43%) and nurses (37%) said the facility provides rehabilitative service compared to doctors (26%) and emergency services workers (5%), ($p < 0.05$).

Sixty six per cent of the participants reported that the healthcare service provided in their institution is excellent and good. Less than half of allied (49%) compared to doctors (57%), emergency services (85%) and nurses (72%) said that the healthcare service provided in their institution is excellent and good ($p < 0.05$).

Table 4.4: Healthcare service offered in a facility

			Allied	Doctors	Emergency	Nurse	p-value
		n	n (%)	n (%)	n (%)	n (%)	
Service offered in the facility that constitute comprehensive healthcare	Preventative	51	5(11)	6(14)	10(50)	30(21)	0.002
	Curative	62	13(28)	15(36)	7(35)	27(19)	
	Palliative	55	9(19)	10(24)	2(10)	34(24)	
	Rehabilitative	85	20(43)	11(26)	1(5)	53(37)	
What extent are health care services provided	Excellent	60	6(13)	5(12)	8(40)	41(29)	0.019
	Good	107	17(36)	19(45)	9(45)	62(43)	
	Fair	65	19(40)	15(36)	3(15)	28(19)	
	Poor	21	5(11)	3(7)	0(0)	13(9)	

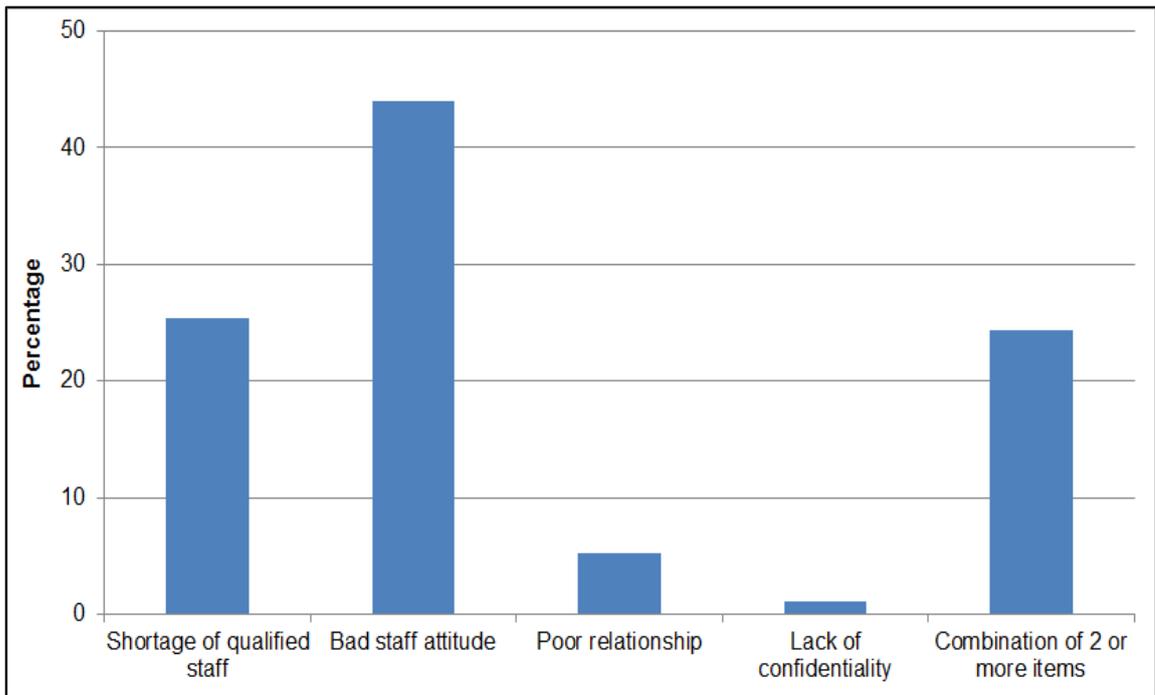


Figure 4.7: Reason for good, fair and poor quality of healthcare

Forty four per cent of the healthcare workers said that bad attitude of staff and shortage of qualified staff (25%) are the barriers for providing quality healthcare (Figure 4.7).

More than half of the respondents reported that healthcare workers positive attitude (56%) and training and/or hiring of staff (31%) will improve the quality of healthcare services (Figure 4.8). Some of the participants (6%) said good relationship between the community and the healthcare workers may improve the quality of healthcare services.

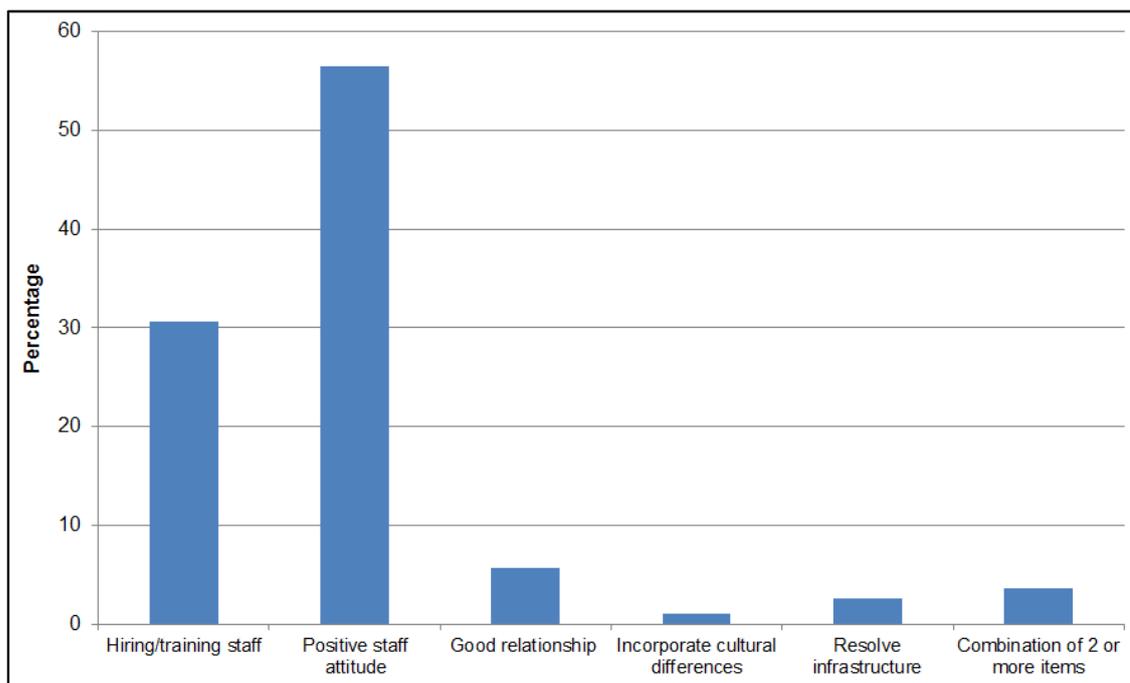


Figure 4.8: Measures to resolve poor quality of healthcare

Table 4.5: Continuity of health services

			Allied	Doctors	Emergency	Nurse	p-value
		n	n (%)	n (%)	n (%)	n (%)	
Facility provide continuous healthcare service	Yes	126	20(44)	18(44)	10(50)	78(54)	0.054
	No	65	15(33)	14(34)	9(45)	27(19)	
	Not sure	60	11(23)	9(22)	1(5)	39(27)	

Half of the healthcare workers in this study said that the facility provide continuous healthcare service and the results were not statistically significant ($p > 0.05$, Table 4.5). Ten per cent of the healthcare workers in this study said bad staff attitude as the obstacles for continuous healthcare service (Figure 4.9). Most participants (83%) reported that two or more of the items had negative impact on the continuous healthcare service.

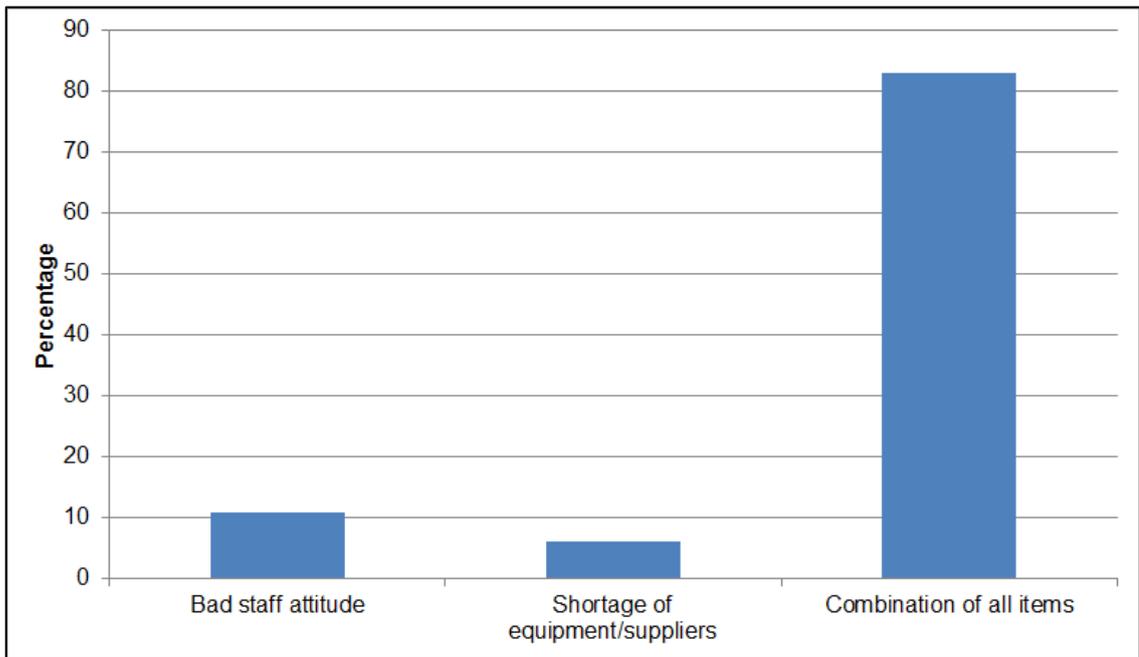


Figure 4.9: Barriers to continuous healthcare services

To improve continuous healthcare service the majority of the participants (88%) reported that two of more of the items should be made available (Figure 4.10).

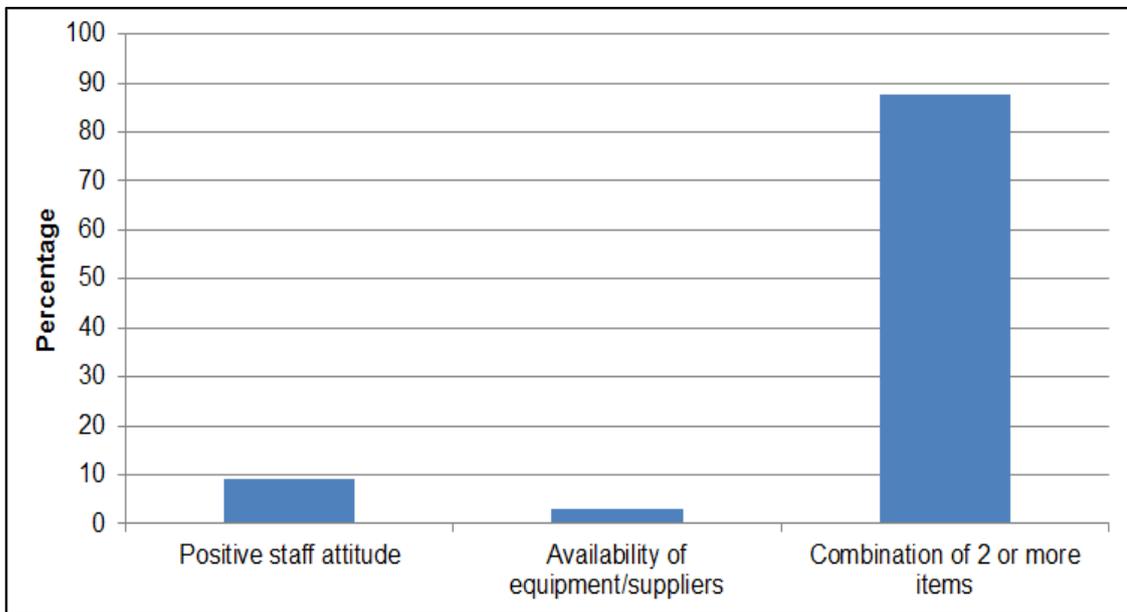


Figure 4.10: Measurement to improve continuous healthcare service

Table 4.6: Access to health services

			Allied	Doctors	Emergency	Nurse	p-value
Health service provided is accessible to all		n	n (%)	n (%)	n (%)	n (%)	0.061
	Yes	141	26(57)	17(41)	9(45)	89(62)	
	No	84	14(30)	19(45)	11(55)	40(28)	
	Not sure	27	6(13)	6(14)	-	15(10)	

More than half of the participants (56%) said that the healthcare services are accessible to all people in need of them. Table 4.6 presents the association between access to healthcare services and category of employees. There was no statistical association between healthcare services and category of employees ($p > 0.05$).

The barriers for access to healthcare services are shown in Figure 4.11. Seven per cent reported lack of insurance as the common barrier; however, most of the participants (86%) reported a combination of two or more items as the common source of barriers.

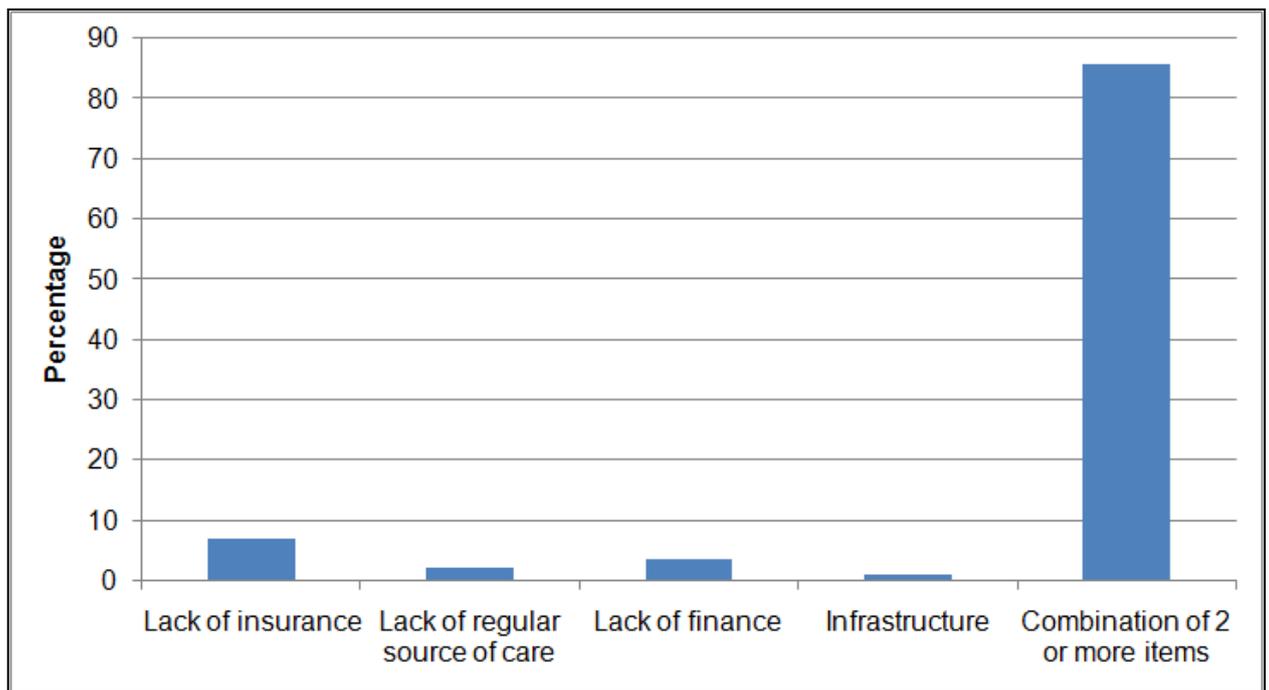


Figure 4.11: Barriers for community accessing healthcare services

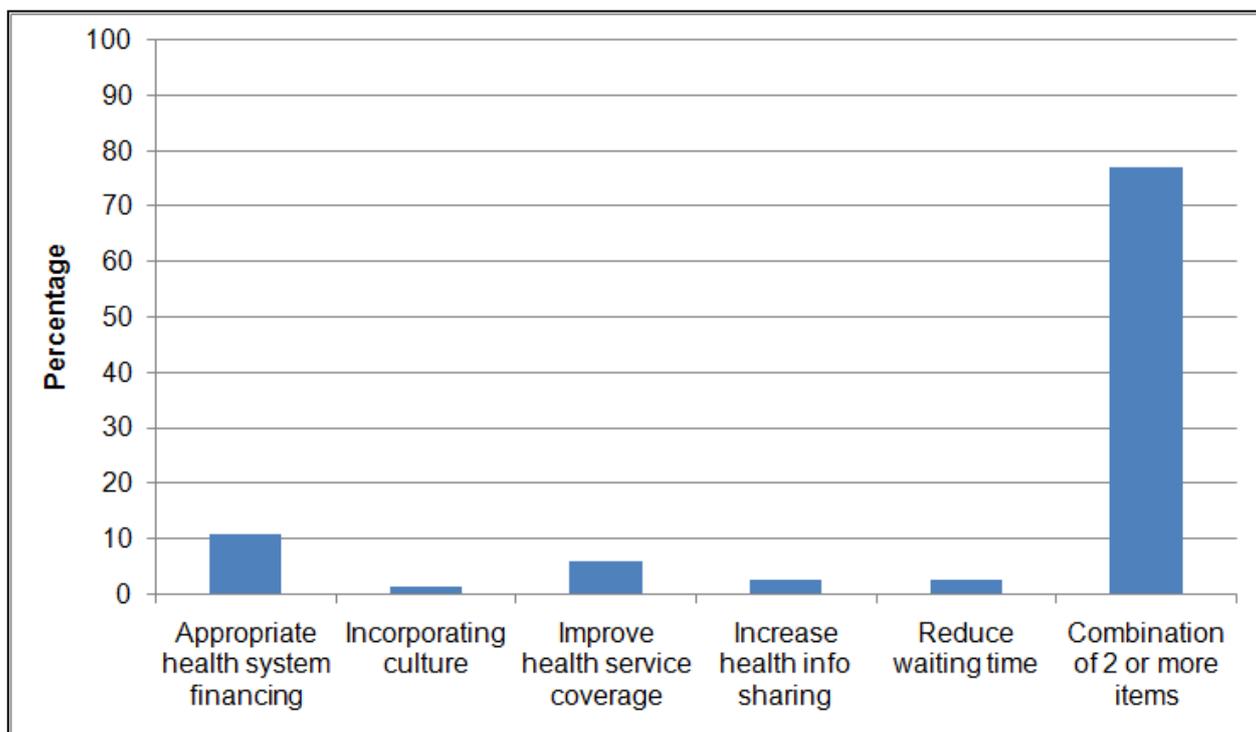


Figure 4.12: Measure to improve community access to healthcare

Appropriate health system financing (11%) and improve health service coverage (6%) were the measured reported by respondents that will improve community access to healthcare (Figure 4.12). Two-third of the participants reported a combination of two or more items that will improve community access to healthcare.

Table 4.7: Healthcare workers adherence to required waiting times

			Allied	Doctors	Emergency	Nurse	p-value
		n	n (%)	n (%)	n (%)	n (%)	
Adhere to require waiting time	Yes	150	33(73)	16(40)	14(70)	87(60)	0.032
	No	82	11(25)	18(45)	6(30)	47(33)	
	Not sure	17	1(2)	6(15)	-	10(7)	

Sixty per cent of the respondents reported that the institution adhere to the required waiting time (Table 4.7). A significant high proportion of allied (73%) and emergency health service (70%) said that the facility adhere to the require waiting time compared to nurses (60%) and doctors (40%) ($p < 0.05$).

Table 4.8: Barrier and measure to adhere to waiting time

		No	%
Barrier to adhere to waiting time	Staff factor	9	11
	Patient factor	4	5
	infrastructure	2	2
	Administration	10	12
	finance& other resources	3	4
	Combination of 3 or more of these items	54	66
Total		82	100
Measurement applicable to adhere to waiting time	Staff factor	16	20
	Staff, patient & infrastructure	20	24
	Patient factor	6	7
	Patient & infrastructure	1	1
	infrastructure	4	5
	Infrastructure, finance& other resources	3	4
	finance& other resources	9	11
Combination of 3 or more of items		23	28
Total		82	100

Table 4.8 illustrates the barriers and measures for healthcare facility to adhere to waiting time. The personnel (11%) and administrative factors (12%) were the main barriers for the facility to adhere to waiting time. The personnel, patient and infrastructure (44%) were measurement reported by the respondents applicable for the facility to adherence to waiting time.

4.6 Summary

In this chapter, the results of the study are presented and interpreted. The respondents' response rate, demographic characteristics, knowledge of the NHI and perceptions regarding the NHI were analysed. In the next chapter, the results are discussed and compared with the studies reviewed in chapter 2.

CHAPTER 5

5. DISCUSSIONS AND CONCLUSION

5.1 Introduction

In this chapter the results and interpretation of the findings are discussed in accordance with the objectives of the study. The findings of the current study are compared with other studies focusing on respondents' demographic characteristics, knowledge of the NHI and perceptions regarding the NHI. The study limitations, conclusion and recommendations of the study are indicated.

5.2 Results and discussions

5.2.1 Demographic distribution

In our study the age distribution of participants (n=256) shows that the respondents were in the age group 30-39 years (29%), followed by those aged 40-49 years (20%) and Twenty two per cent of the participants did not indicate their age. Inconsistent findings were reported in a study conducted in South Africa amongst PHC nurses on the National Health Insurance in Johannesburg Metro District D2, most participants in the study were in the age category 50-59 years (34%) and few participants were in the age category 25-29 years (11%) and 40-49 years (11%) (Khuzwayo, 2015). Regarding gender (79%) of the participants were female and only (21%) were male. The findings were in contrast to the study conducted in south Africa and Bangladesh George Mukhari Hospital by (Bezuidenhout and Matlala, 2014) on health care workers, where most participants were males (males=42, females=38). Contrasting findings were reported again in a study conducted on health reforms at Bangladesh amongst health care workers where it is shown that 50% (941) were male (Cockcroft, 2011). There was some similarities in terms of some participants not indicating their age (n=101) (Bezuidenhout and Matlala, 2014). In terms of educational qualifications most of the participants in the current study had tertiary level of education (95%), only 5% had secondary education and this findings were similar to the study by (Bezuidenhout and Matlala, 2014) were 34.6% of the participants had a tertiary

level of education while 32.5% had a secondary level. In the current study more than half of the respondents were nurses (57%) followed by allied (19%), doctors (18%) and then EMS. Contrasting findings were reported in a study conducted on health reforms at Bangladesh amongst health care workers where it is reported that 73% (1368) were paramedical workers, 17% (314) were nurses, and 184 (10%) were doctors.

5.2.2 Knowledge of the NHI

Overall in the current study most of the health care workers across the four categories (nursing, clinical, allied and EMS) have an idea of what NHI is about (64%). Knowledge was tested on participants having detailed information on how the facility is involved in the implementation of the NHI, the source of information on the NHI and on the NHI policy contents.

Similar findings were reported in the study conducted at George Mukhari Hospital in South Africa where most of the healthcare workers (54.58%) were knowledgeable about the NHI (Bezuidenhout and Matlala, 2014). Similar findings were indicated again in a study conducted in South Africa amongst civil servants from the health and education sectors in four of South Africa's nine province (Gauteng, Western Cape, KwaZulu-Natal and North West) in which the results showed that the minority of participants' stated lack of information as an important obstacles to enrolment for a scheme 23.7% (lower skilled and skilled) (Govender et al 2013). Mulupi et al (2013) reported consistent findings in a study conducted at Kenya under the theme Communities' perceptions and understanding of the National Hospital Insurance Fund where it is said the majority of household survey respondents knew that the NHIF existed in the country (91.2%).

The findings are encouraging because the success of health reforms is depended amongst others on health care workers as providers of services. It is said it is necessary to include them during the strategic planning and implementation of the reform process in order for them to be informed about the reform because their reaction may have desirable or undesirable outcomes towards the reform (Rigoli and Dussault, 2003).

In our study participants knowledge of the NHI policy contents show that 48% of the participants did not know about the policy contents of NHI. Statistically significant findings indicates that a greater proportion of allied (62%) and doctors (63%) don't know

about the policy contents of NHI compared to emergency services (40%) and nurses (40%), ($p < 0.05$).

Inconsistent findings were indicated in a study conducted in Kenya amongst the community members, of the 77% participants, only 55.7% reported that they were aware of the procedures required to join a CBHI (Mulupi et al, 2013). Sekhejane (2014) in a policy brief on South African National Health Insurance (NHI) Policy: Prospects and Challenges for its Efficient Implementation reported consistent findings were it is stated that in view of past failures in the implementation of such initiatives and their viability in South Africa, it is important for government to understand that little is known and understood by the service providers and users; thus it is important that the government ensure that both users and providers understand the policy.

The findings are discouraging because most of the health care workers being members of the community and vital role players in the NHI policy seems to be lacking important information regarding their role in the implementation of the NHI. Rigoli and Dussault (2003) in a review on the interface between health sector reform and human resources in health states that it is important to encourage health care workers to participate in the planning stage of the reform at facility level with the aim of maximising support towards the project.

In the current study of those who had detailed information on how their facility is involved in implementing the NHI, their source of information about the NHI was mostly media (37%) and hospital information (34%).

Similar findings were reported in a study conducted at Kenya amongst community members where the respondents said that their source of information about NHIF was mainly passed through relatives who belonged to CBHIs (44.8%) and the media (21.1%) (Mulupi et al, 2013). Consistent findings were reported in South Africa where views from private general practitioners were sought on the NHI, it is said that most respondents had a fairly accurate understanding of the objectives and mechanisms of the proposals, largely via medical associations, discussions with colleagues and the media (Surender et al, 2014). It is clear that media has been reported to be the common source of information used to communicate health reforms, of interest in this study health care workers received information through the hospital information which is encouraging that information is shared at facility level but what is worrying is that it seems like most of the respondents were not reached.

5.2.3 Perceptions on the implementation of the NHI at the facility

In our study a proportion of about 39% of the participants said that healthcare workers are prepared for the implementation of the NHI in their facilities. The study further reveals that there were a significantly higher proportion of emergency services (60%) and nurses (48%) who said healthcare workers are prepared for the implementation of the NHI in their facility compared to allied (25%) and doctors (12%), ($p < 0.05$), which is statistically significant.

In a study conducted in South Africa amongst General Practitioner in private practices in which perceptions regarding the understanding and costing of NHI was assessed, the results showed differing thoughts about the NHI which are consistent with our study, where it is said most were ambivalent about NHI, with 47% taking a neutral stance; only 21.5% supported it and 32.5% did not and this was because the GP's were uncomfortable with the lack of clarity and control of risks with NHI (Moosa, 2012). Another study conducted in South Africa amongst private sector general practitioners from the Eastern Cape Province revealed consistent result to the current study were it is reported that overall there was substantial resistance to the NHI proposals, though there were some important differences within the profession. The study found a divide in opinion between well-resourced private GPs, and smaller, single-person practices often located in less affluent areas. While the majority of GPs from better resourced practices felt that the proposed reforms were detrimental, doctors running smaller practices were more likely to welcome the idea of NHI as a means by which to bolster and stabilise their incomes. Inconsistent with the study findings it is further said public sector GPs were also generally supportive of the reform, feeling that an expansion of the private sector would lessen their workload (Surrender et al, 2015).

Amandla (2009) reported inconsistent findings in a summary analysis submitted to Congress of SA Trade Unions on the 7 June 2009 on the Cost/Benefits estimates of the National Health Insurance were it is indicated that Professor Ralph Kirsch said even though there tended to be a resistance by government to utilising private sector expertise, doctors had reaffirmed their endorsement of universal access.

Furthermore inconsistent findings are reported in a study on private sector perspectives on National Health Insurance conducted in South Africa, it is said that despite the lack of consultation and transparency there remains substantial goodwill from all stakeholders to

see reform and to participate in the reforms. Statements from stakeholder groups representing the hospital industry, the pharmaceutical industry, the medical scheme industry and the actuarial profession reveal a commitment to the goals of achieving universal access to quality health care for all South Africans, as well as a commitment to open engagement and debate (Ramjee and McLeod, 2010). Khuzwayo (2015) in a study conducted amongst PHC nurses in South Africa on the NHI report consistent findings in terms of nurses being ready for the implementation of the NHI were it is said that the general views of the nurses are positive towards the NHI. Nurses are positive and ready to support the implementation of the project but proper buy-ins, stakeholder engagement and proper planning needs to be in place in order for the successful implementation of the project.

The findings indicates that the views and perceptions of health care workers in both the private and the public sector on the NHI have been conducted, generally it seems like health care workers are ready for the implementation of the NHI but there are some issues that are need to be addressed first which are viewed to be important to the successful achievement of the goal of universal access to health care in South Africa.

5.2.4 Perceived general challenges during the implementation of the NHI

In the current study most of the participants indicated administrative (30%), funding (21%) and personnel (11%) issues as the most common challenges that may be expected during the implementation of the NHI.

In a study conducted at Bangladesh amongst Health workers and their professional bodies similar findings were reported were it is said that their continuing dissatisfaction (Nearly one half of the health workers) (45%) in relation to the difficulties fulfilling their duties, is due to inadequate supplies and infrastructure, bad behaviour of patients, and administrative problems and this issues may have undermined the effectiveness of the HPSP (Cockcroft et al, 2011).

Mosadeghrad (2014) in a study on factors influencing healthcare service quality in eight hospitals in Iran amongst providers, managers, policy-makers and payers reported consistent results and indicated that the barriers relate to the provider's socio-demographic variables, competency (skill and knowledge) and motivation and satisfaction (organisational policies, co-workers, recognition, job security, job identity and chances for

promotion. All of these factors have impeded the delivery of quality patient services particularly in the public health sector. Furthermore, Amandla (2009) in a summary analysis submitted to Congress of South African Trade Unions on the 7 June 2009 on the Cost/Benefits estimates of the National Health Insurance concur with the findings in the current study were it is reported that Professor Ralph Kirsch said “However, there need to be changes in the public sector at the level of governance, delivery and funding.”

The above studies indicate similar trends in terms of health sector systemic challenges in various countries that impact on the success of health reforms. The successful implementation of any health reform need to take these challenges seriously and continuously address them utilising the tried and tested measures. A review on the interface between health sector reform and human resources in health by Rigoli and Dussault (2003) also highlight that the implementation process of the health reform is as important as a good technical design because this will help in ensuring that managerial or financial tools are well adapted to the proposed changes.

5.2.5 Perceptions on the key characteristics of the service delivery building blocks linked to NHI

In the current study, health care workers’ perceptions were sought based on the building block characteristic of service comprehensiveness, continuity, access and waiting times in a facility. Participants were asked to indicate whether their sections are delivering services in accordance to the characteristics, if not or unsure and it further asked them to identify the barriers as well as measures to address the barriers.

More than half (56%) of the participants said that the healthcare services are accessible to all people in need of them. Karima (2013) in the research on the Health Sector in Ghana: A Comprehensive Assessment showed that Ghanaians are using more health services than they have in the past. There is better access to health services based on income and geography. Contributing factors are higher per capita income and increased access to risk-pooling schemes and to private health facilities. The population uses public and non-public health facilities equally.

Sixty per cent of the respondents reported that the institution adhere to the required waiting time. A significant high proportion of allied (73%) and emergency health service (70%)

said that the facility adhere to the require waiting time compared to nurses (60%) and doctors (40%), ($p < 0.05$). Sastry et al (2015) in a study conducted in two clinics western cape in South Africa reported that in clinic A, mean pharmacy waiting time was reduced from 129 min (median 86 min) to 102 mins (52 min; $p < 0.0001$). In clinic B, mean wait times fell from 275 min (median 256 min) to 196 min (161 min; $p < 0.0001$). It is further said to achieve these reductions, clinics made operational changes that included procedural improvements, software adjustments, and customisation of processes by type of patient visit. These functional changes were enabled by the engagement of clinic leadership, the team's past experience with improvement collaborations, and the joint development of targeted and locally-appropriate solutions that drew on staff ideas and capabilities.

The most common barriers indicated by participants are the following: bad staff attitude, personnel factors such as shortage of staff, shortage of qualified staff, shortage of equipment and supplies, lack of insurance, lack of regular source of care, lack of finance, infrastructure and administrative factors.

Numerous studies report consistent findings to our study. Shisana et al (2006), in a study conducted in South Africa on public perceptions on national health insurance: moving towards universal health coverage reported that although less than 20% of the population have private insurance coverage, the majority of doctors, dentists and specialists work in the private sector owing to low remuneration and adverse working conditions in the public sector. In terms of staff shortage and insurance coverage similar findings are reported Shisana et al (2006), they stated that the number of nurses being registered in South Africa is declining, the migration of health professionals and the impact of the HIV/AIDS epidemic are exerting additional pressure on health workers, creating stress and overload. Health care inflation is several times higher than general inflation. This is largely because of personnel and pharmaceutical costs, together with over-treatment and overuse of health services, particularly in the private sector. All these factors impact on the ability of the health care. Similarly 16.1% had great difficulty in affording the cost of prescription drugs, with variation by race (blacks 18.4%, whites 15.9%, Indians 14.7%, coloureds 11.3%).

Consistent findings were reported in another study conducted in South Africa around private hospitals, pharmaceutical industry, medical practitioners, nurses, traditional

healers, pharmacists and pharmacy owners. It is said that the inequities in provider distribution is, at least in part, attributable to government policy and public sector working conditions. It is widely acknowledged that there is a human resource shortage in the public sector, that there is a large number of vacant posts and that there is insufficient training of nurses occurring due to the closure of nursing colleges. Poor working conditions in the public sector relate inter alia to the lack of equipment, the unavailability of drugs, the prevalence of HIV and the attitudes of co-workers. Emigration of health workers has also had a significant impact. (Ramjee and McLeod, 2010).

Similar results to the current study have been reported at Ghana in a study on the comprehensive assessment of the health system, it has been shown that Ghana faces critical bottlenecks where it is said that although in many cases quantity and access have increased, quality of care remains problematic. The Health Sector in Ghana (CHPS) or primary health care clinics; in fact, both of these investments have been below target. Capital investment in hospitals is based on administrative levels (regions, districts) rather than on need-based standards. Furthermore, planning for the location of these hospitals has been poorly coordinated with the non-public sector. Several districts have multiple hospitals whereas other districts have none. Shortage exists of both lower-level health facilities as well as equipment at the sub district level. Capital investment maintenance on a recurring basis is also inadequate (Karima, 2013).

Furthermore it has been documented that the recruitment of HWs, especially physicians, remains a challenge, although the present situation represents a reversal of an earlier emigration trend. Training of physicians is low relative to the country's needs, and a shortage of midwives also exists. As HWs age and recruitment remains low, many lower-level facilities, including CHPS, face shortages. Retention of HWs, especially in rural and remote areas and in the norther regions, has also been a challenge. Quality of care and HWs' competencies and productivity are rated as low. These factors also deter patient access. Although absenteeism is modest, HWs' attitudes toward clients are poor, and motivation is low, (Karima, 2013).

An analyses from a unique multi-country study on accessibility and quality of health services for individuals with disabilities in four sub-Saharan countries (South Africa, Sudan, Malawi and Namibia) also show similar barriers as in our study were it is said lack

of transport, availability of services, inadequate drugs or equipment, and costs are the four major barriers for access (Eide et al, 2015).

Similar findings were reported in a study conducted at three BHOMA intervention Districts of Zambia in which interviews were conducted amongst the health centres in-charge, Chairpersons of the Neighbourhood health committee (NHC) and a pharmacist at facility level and district level it was the clinical care specialists and District Director of health. The results illustrate that building block specific weaknesses had cross cutting effect in other health system building blocks which is an essential element of systems thinking. Challenges noted in service delivery were linked to human resources, medical supplies, information flow, governance and finance building blocks either directly or indirectly. Several barriers were identified as hindering access to health services by the local communities. These included supply side barriers: Shortage of qualified health workers, bad staff attitude, poor relationships between community and health staff, long waiting time, confidentiality and the gender of health workers. Demand side barriers: Long distance to health facility, cost of transport and cultural practices. Participating communities seemed to lack the capacity to hold health workers accountable for the drugs and services (Mutale et al, 2013).

Halwindi et al (2013) in a study on Factors Perceived by Caretakers as Barriers to Health Care for Under-Five Children in Mazabuka District, Zambia also highlighted similar findings where it is said the major factors perceived as barriers were poor quality of health services, unavailability of medicines, financial constraints, weak outreach programmes, bad scheduling of health programmes, poor communication, long distance to RHCs and low awareness levels of the importance of taking children for child health week among caretakers.

The findings indicated above as barriers to the provision of quality health care are linked to health service delivery in various countries under specific health reforms, South Africa is not an island in this regard according to what the health care workers in our study have indicated and this is worrying in terms of the successful implementation of the NHI.

In this study the common findings in terms of the measures to deal with the barriers identified are hiring/training staff, positive staff attitude, good relationship between the community and health care providers, incorporate cultural differences, resolving infrastructural challenges, improving on availability of equipment and supplies,

appropriate health system financing, improve health system coverage, increase health information sharing, reducing waiting times, improving on staff factor, improving on patient factors and improve on financial resources. Respondents were asked to choose more than one of the provided options.

Similar findings to our study were reported by Gibson et al (2015) in a study aimed at identifying enablers and barriers to implementing CD (chronic disease) interventions in PHC settings that provide care to Indigenous peoples and this relate to improving on training, incorporating cultural differences and addressing staff factors . It is said that under enablers that the interventions should be aimed at achieving adequate and feasible training to staff to effectively implement the CD intervention, Cultural awareness training, recruitment, training and employment of Indigenous Health Workers, staff support in their work, reasonable workloads and adequate living conditions for remote staff should be considered and ensuring that Providers receive guidance on how to communicate with their patients.

Consistent with the current study findings it has been reported in a study on factors affecting provision of service quality in the public health sector: A Case of Kenyatta National Hospital. Interviews were conducted on sixteen doctors, thirty two nurses, twenty nine clinical officers, fourteen laboratory technologists and twelve pharmacists and it has been documented that organization must enhance employee's capacity in order to improve provision of service quality. Adequate number of high skilled and experienced employees must be employed continuously, discourage ineffective recruitment, encourage monitoring of doctors and staff, ensure that performance and practice standards are met to enhance service quality provision. This would lead to proper medication services, patient satisfaction, good relationship between medical providers and patients, enable the participation in multi-disciplinary and attracts more patient hence effective improvement of hospital growth (Wanjau, 2012).

Furthermore it has been concluded that public health sectors should improve the level of adoption of technology and willingness to invest and advance in modern technology in order to facilitate service assessment, improve process and communication which are essential for effective and efficient service quality in public health sector in Kenya. Technology adoption in health institutions would enable the provision of high-quality

medicine to patients, reduce time lags in getting lab and imaging results, ensure the resulting system meets the needs of clinicians and improve the accessibility of relevant information efficiently and effectively (Wanjau, 2012).

Use of more than one communication means to inform, persuade and educate the customer is also required. From the findings the study concluded that management should emphasize on the use of upward, horizontal and vertical communication channels in order to provide information to upper level managers about activities and performances throughout the organization as well as improving individual participation in provision of services (Wanjau, 2012).

It is further said effective communication would enable the accessibility to treatment, quality of health care, efficient admissions; diagnostic testing and patient follow-up also reduce risk of hospital admission, intubation and poor prescribed medication, delayed diagnosis, misdiagnosis, and inappropriate referral (Wanjau, 2012). Again it has been indicated that delivery of service quality health in the health sectors should be improved through effective allocation of financial resources in public health sector in order to promote other functions that contribute to service delivery, reduce the bureaucracy in financial management and offer funds for purchase of high quality health equipment and employing of more competent staff (Wanjau, 2012).

Similar findings to our study have been reported in a study conducted at Senegal on the implementation of 5S management method for lean healthcare at a health centre to assess staff perception, it is said that majority of respondents perceived that the 5S program (5S stands for five Japanese words, Seiri, Seiton, Seisou, Seiketsu, and Shitsuke, which broadly refer to maintaining cleanliness for the improvement of healthcare services) brought on changes in each of the following areas: 1) visible or physical areas of the health centre (all respondents said 'Yes'), 2) services provided to patients (Yes=19; No=1; Don't know=1), 3) their own daily routines (all respondents said 'Yes'), and 4) the work of other health centre staff members (Yes=17, No=2, Don't know=2), (Kanamori et al, 2015).

It is encouraging to know that health care workers in the current study seem to believe that there are measures that can be implemented to deal with the barriers relating to health services delivery which can be effected during the implementation of the NHI.

5.3 Limitations

Perceptual studies are susceptible to subjective experiences therefore it may not be possible to deduce whether the respondents is being truthful or accurate in reporting.

The questions were pre-coded with an option of other for some and this might have swayed the respondents towards the responses listed or respondents due to time constraints limiting themselves to the listed options, thereby impacting on the views and perceptions of health care workers.

Only few perceptual studies on a strata of health care workers were published in South Africa and Sub-Saharan Africa and hence local literature is minimal for the purpose of comparisons thereof.

Generalisation of the results will be advised against as the study was conducted on only health care workers from nursing, clinical, allied and EMS staff at Pietersburg and Tertiary Hospitals. However, this can be beneficial for the evaluation and modification of the existing policy guidelines on health reforms.

Caution is exercised in drawing conclusion in this study, due to the nature of study design (cross-sectional study) and the sample size, which is relatively small.

5.4 Conclusion

The Health care workers of Pietersburg and Mankweng tertiary Hospitals from nursing, clinical, allied and EMS sections generally had an idea about the NHI but few knew about the NHI policy.

Health care workers' lack of knowledge about the NHI policy as the main drivers of the reform is of grave concern.

Health care workers' readiness to implement the NHI in their facility is acceptable, a major concern is around the category of doctors.

Health care workers have reported about the level of quality of service provided in their facility based on the building blocks characteristic of service comprehensiveness, continuity, access and waiting times. These results are discouraging because it means health care workers do not always adhere to this characteristics which are some of the measures used to evaluate the effectiveness of health reforms.

Health care workers have identified numerous barriers and improvement measures related to the health system, provider and the user for the success of the NHI, amongst others staff attitude, relationship between health care providers and the community, insurance coverage, infrastructure and leadership were mentioned.

This information remains crucial because it is the corner stone upon which health reforms rests. Therefore this study confirms the findings of previous studies that showed that, overall the views and perceptions of providers of care as the guiding tools towards the success of the health reform.

5.5 Recommendations

The lack of detailed information by some of the health care workers on the NHI is a reflection that information is made available but to a lesser extent.

It is important that facility managers, head of divisions, curriculum designers and lecturing staff adopt the NHI like other programmes such as the Millennium Development Goals at training institutions and facility level in order to give clear guidance on its implementation. The reluctance from the doctors to implement the NHI need to be further explored through a number of relevant platforms in order to get into the gist of their concerns.

The current monitoring and evaluation systems utilised to address service barriers should be relooked and any area of weakness should be strengthened.

The necessary resources required to mitigate against the identified barriers should be made non-negotiable priorities within the NHI policy.

5.6 Summary

In this chapter the results and interpretation of the findings were discussed in accordance with the objectives of the study. The findings of the current study were compared with other studies focusing on respondents' demographic characteristics, knowledge of the NHI and perceptions regarding the NHI. The study limitations, conclusion and recommendations of the study are indicated.

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APPENDICES



APPENDIX (A): Participants Information Leaflet

STUDY TOPIC: views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province.

Please read this information about the study and feel free to ask any questions should you need any clarity before deciding to take part in this study on “views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province”.

I am currently working at Warmbaths Hospital in the Waterberg District, and a Master of Public Health student from the University of Limpopo, Medunsa Campus. For the purposes of my Master’s degree course in Public Health, I am going to conduct a study at Polokwane and Mankweng Tertiary Hospitals in the Limpopo province in order to assess the health care workers’ views and perceptions regarding the National Health Insurance at Polokwane-Mankweng Hospital in this province.

A questionnaire will be used to collect the data. The questionnaire will be completed anonymously in a private area and will take approximately thirty to forty five minutes (30-45 min) to complete. You can ask the researcher or assistant at any time if any of the questions included in the questionnaire are not clear. At any time you are free to let us know if you do no longer wish to participate in the study you will not be refused to withdraw from it. In addition, your name will not be recorded and all personal information about you will be kept confidential during and after the study.

The study has been approved by the University of Limpopo, Medunsa Campus Research and Ethics Committee (MREC), and permission to conduct the study has been granted by the Capricorn district department of health management, Limpopo province. All the

facility managers of the selected facilities where the research will be conducted have also gave us permission of access.

If you agree to participate in the study, you will not be required to sign a consent form to indicate your willingness to participate. Because of the significance of the study on health care workers' views and perceptions on the NHI, we will be very thankful if you will be prepared to take part in this study.

Please feel free to contact myself on (Cell no: 0824217377) or my supervisor, Dr Samuel Mndzebele at (Tel: 012 521 4175), if you have any further questions regarding this study on

“Views and perceptions of HCWS on the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province”.

Kind regards,

Ms Makwena Margaret Matsi (MPH student).



APPENDIX-B: Informed Consent

This informed consent is for Health care workers working at Polokwane-Mankweng Hospital complex and who are invited to participate in research titled “views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province”.

I have read the information the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I know that choosing to/ or not to participate in this study will not affect my job or job-related evaluations in any way.

I know that this study has been approved by the MEDUNSA Campus Research and Ethics Committee (MREC), University of Limpopo and permission has been granted by the management of Polokwane- Mankweng hospital complex to conduct the study. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

Name of participant _____ Signature _____
Date _____

Name of researcher _____ Signature _____ Date _____



APPENDIX(C-1): Request letter to conduct research at Polokwane Tertiary Hospital

Box 215
Medunsa Campus
University of Limpopo
MEDUNSA
0204
Date

The CEO: Pietersburg Tertiary Hospital

Private Bag X9315, Polokwane

0700

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT POLOKWANE
TERTIARY HOSPITAL**

Dear Mr Seate

My name is Makwena Margaret Matsi and I am a Masters of Public Health Student in the University of Limpopo (Medunsa campus). The research I wish to conduct for my Master's dissertation is on "views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province".

This project will be conducted under the supervision of Dr Samuel Mndzebele who is a Senior-Lecturer in the Department of Public Health (Health systems management and policy) in the University of Limpopo (Medunsa campus).I hereby seek your permission to collect data from the Health Care Workers from Salary level 6 to 10 in your facility.

I have provided you with a copy of my proposal which includes copies of the questionnaires and consent forms to be used in the research process, as well as a copy of the approval letter which I received from the University of Limpopo Medunsa Campus

Research and Ethics Committee (MREC). Upon completion of the study, I undertake to provide the Department of Health Limpopo Province- Capricorn District, Polokwane and Mankweng Tertiary Hospitals with a bound copy of the full research report.

If you require any further information, please do not hesitate to contact me on cell phone number: 0824217377 and e-mail address: makwenamatsi@live.co.za.

Thank you for your time and consideration.

Yours sincerely,

Makwena Margaret Matsi (MPH Student).



APPENDIX(C-2): Request letter to conduct research at Mankweng Tertiary Hospital

Box 215
Medunsa Campus
University of Limpopo
MEDUNSA
0204
Date

The CEO: Mankweng Tertiary Hospital

Private Bag X1117

Sovenga

0727

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT POLOKWANE
TERTIARY HOSPITAL

Dear Dr Mongwe

My name is Makwena Margaret Matsi and I am a Masters of Public Health Student in the University of Limpopo (Medunsa campus). The research I wish to conduct for my Master's dissertation is on "views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province".

This project will be conducted under the supervision of Dr Samuel Mndzebele who is a Senior-Lecturer in the Department of Public Health (Health systems management and policy) in the University of Limpopo (Medunsa campus).I hereby seek your permission to collect data from the Health Care Workers from Salary level 6 to 10 in your facility.

I have provided you with a copy of my proposal which includes copies of the questionnaires and consent forms to be used in the research process, as well as a copy of the approval letter which I received from the University of Limpopo Medunsa Campus Research and Ethics Committee (MREC). Upon completion of the study, I undertake to provide the Department of Health Limpopo Province- Capricorn District, Polokwane and Mankweng Tertiary Hospitals with a bound copy of the full research report.

If you require any further information, please do not hesitate to contact me on cell phone number: 0824217377 and e-mail address: makwenamatsi@live.co.za.

Thank you for your time and consideration.

Yours sincerely,

Makwena Margaret Matsi (MPH Student).



APPENDIX (D): Letter to request permission to Pre-Test Questionnaire

629

Zone 8

Seshego

0699

Date

The Head of Institution

Warmbaths Hospital

Private Bag X 1618

Bela-Bela

0480

Dear Dr R Escobar

REQUEST FOR PERMISSION TO PRE-TEST A SELF-ADMINISTERED QUESTIONNAIRE FOR MASTERS QUALIFICATION IN PUBLIC HEALTH

I am a student doing Masters Degree in Public Health at the University of Limpopo (Medunsa campus) and requesting your permission to pre-test a self-administered questionnaire amongst the health care workers at Warmbaths Hospital. The intention is to test the validity and reliability of my questionnaire resulting from my research proposal titled: “views and perceptions of HCWS regarding the NHI at Polokwane-Mankweng tertiary hospital, Limpopo province”.

My target is 20 health care workers from Nursing, Clinical, Allied Health and Emergency Medical services. The purpose of this study is to assess the Health Care Workers’

perspective regarding the National Health Insurance at Polokwane-Mankweng Hospital complex.

Herein I have furnished you with my contact details should additional information be required: Cell: 0824217377 or e-mail at makwenamatsi@live.co.za. You may also contact my Supervisor: Dr. SL. Mndzebele,
Tel: (012) 521 4175.

Thanking you in anticipation.

Yours Sincerely,

Ms Makwena Margaret Matsi (MPH Student)



APPENDIX (E): Data Collection Tool - Self Administered Questionnaire

Dear sir/madam

This questionnaire is a tool of collecting information about the views and perceptions of health care workers on the NHI. It is part of the study for MPH programme at the University of Limpopo. Please note that it has been approved by the ethics committee of the University. Your participation is voluntary and although the study may not benefit you personally, it will be of benefit to the community. By filling this questionnaire you have consented to participate in the study.

Instruction

Please answer the following questions by ticking (✓) in the relevant block or writing down your answer in the space provided.

EXAMPLE OF HOW TO COMPLETE THE QUESTIONNAIRE

What is your Gender?

If you are Female, then you will tick (✓) in column 2 as indicated below

Male	1
Female	2✓

Section A- Background information

This section of the questionnaire requires demographic information. Although we are aware of the sensitivity of the questions in this section, the information will allow us to compare groups of respondents. Once again, we assure you that your response will remain anonymous.

“Please choose your response from the options provided by ticking on the relevant coding indicated in numbers, or the responses provided in the columns”

1. What is your Gender?

Male	1
Female	2

2. What is your age?

3. Which racial group are you?

Black	1
Coloured	2
Indian	3
White	4

4. What is your highest educational qualification?

Grade 11 or lower (std 9 or lower)	1
Grade 12 (Matric, std 10)	2
Post-Matric Diploma or certificate	3
Baccalaureate Degree(s)	4
Post Graduate Diploma	5
Post- Graduate Degree(s)	6

5. How would you describe your economic status in terms of the following salary level?

Please choose the relevant answer below,

Level 3	1
Level 4	2

Level 5	3
Level 6	4
Level 7	5
Level 8	6
Level 9	7
Level 10	8
Level 11	9
Level 12	10

6. What is the number of individuals in your household?

Section B – Views and Perceptions on the NHI

These sections assess your views and perceptions on the National Health Insurance (NHI), please study each question thoroughly and answer honestly.

1. Do you have an idea of what the NHI is about?

Yes	1
No	2

2. The NHI is said to be the proposed health services funding system which will replace the current two- tiered system, do you have detailed information on how your facility is going to be involved in its implementation?

Yes	1
No	2

3. If your response is [yes] in question (2) above, how did you then hear about the NHI?

Hospital information	1
Media	2
Community gatherings	3
Workshop/conference you attended	4
Higher education institutions	5
Other (please specify)	6

4. As a health care worker in your opinion would you say you are prepared for the implementation of the NHI in your facility?

Yes	1
No	2
Uncertain	3

5. With regard to the NHI policy contents, what are your thoughts about it?

I don't know about it	1
I think it is fair	2
I think it is good	3

I think it is excellent	4
-------------------------	---

6. This question regarding the NHI policy is content specific, which of the health care services as listed below do you think must be provided in Tertiary Hospitals? You may tick more than one option as listed below.

Cardiology services	1
Cardiothoracic services	2
Craniofacial services	3
Diagnostic radiology services	4
Ear, nose and throat (ENT) services	5
Endocrinology services	6
Geriatrics services	7
Haematology services	8
Human genetics services	9
Infectious diseases services	10
General surgery services	11
Orthopaedic services	12
General medicine services	13
Paediatrics services	14
Obstetrics & Gynaecology services	15
Radiology and Anaesthetics services	16

7. In your own view do you think your facility will be ready to provide the services you selected from the list above comprehensively when the NHI is implemented?

Definitely yes	1
Yes but not all	2
No	3
Not sure	4

8. In your opinion what may be the challenges in general during the implementation of the NHI in your facility?

Administration e.g. lack of skilled managers, poor implementation of policies	1
Funding	2
Health care Personnel	3
Other resources such as supplies, structure and etc.	4
Patients related factors e.g. increased needs	5
Infrastructure e.g. buildings and transport	6
Others please specify here	7

9. From the response indicated from question (8) above, in your own experience how long would it take to resolve these challenges?

--

The policy objective of NHI is to ensure that everyone has access to appropriate, efficient and quality health services including Hospital Based services, this objective is also aimed at addressing the WHO Health service building blocks that remains to be the corner stone for the NHI. The following questions are focused on the key characteristics related to the health service delivery building block linking it to NHI. Please tick in the relevant block or specify were necessary

10. Which service/s does your facility offer from the following that constitute comprehensive health care? You may tick more than one response.

Preventative	1
Curative	2
Palliative	3
Rehabilitative	4

11. To what extent from the options you have chosen above are the health care services provided?

Excellent	
Good	
Fair	
poor	

12. If your response is good, fair or poor in the above question, of those services, which of the reasons below describes the barriers?

Shortage of qualified health workers	1
Bad staff attitude	2
Poor relationships between community and health staff	3
Lack of confidentiality	4
Gender of health workers	5
Long distance to health facility, cost of transport	6
cultural practices	7

Other (please specify)	8
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13. From the measures identified below, which combination will help in resolving the barriers mentioned in (12)?

Hiring/training qualified health workers	1
Positive staff attitude	2
Good relationship between community and health workers	3
Incorporate cultural differences in the health care system	4
Resolving infrastructural challenges e.g. transport system	5
Other (please specify)	6
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The following questions are based on the service delivery characteristic of Continuity implying that Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle.

14. In your own view does your facility provide health care services based on this characteristic?

Yes	1
No	2
Not certain	3

15. If your response in (14) is [No] what obstacles do you believe prevent the community from receiving continuous health services from your facility? You may tick more than one option.

Bad staff attitude	1
Shortage of equipment and supplies	2
Shortage of staff	3
Lack of specialised services at facility	4
Long distance to health facility	5
Transport costs	6
Cultural practices	7
Shortage of funds	8
Lack of information	9
Other (please specify)	10
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16. If your response in (14) is [No] what measures can be used to improve continuity of services? You may choose more than one responses.

Positive staff attitude	1
Availability of supplies and equipment	2

Provision of wide range of specialised services	3
Improve staffing	4
Availability of funds	5
Sharing information e.g. in meetings	6
Incorporate cultural differences in the health care system	7
Improving on availability of infrastructure e.g. transport	8
	9
Others (please specify)	10
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One of the characteristics states that Services should be directly and permanently accessible with no undue barriers of cost, language, culture, or geography, please answer the following questions which seeks to determine your perception regarding community access to services in your facility/section

17. From your section, would you say that the services you provide are accessible to all the people in need of them?

Yes	1
No	2
Not certain	3

18. This question is a continuation from the above, if you ticked [No], identify from the options identified below the barriers to accessing services in your section? You may choose more than one response.

Lack of insurance coverage	1
Lack of a regular source of care	2
Lack of financial resources	3
Structural barriers such shortage of space to work	4
The health care financing system	5

Linguistic barriers e.g. inability to use sign language or interpret	6
Lack of diversity in the health care workforce	7
Long waiting times for services	8
Delay in seeking medical care	9
Others (please specify)	10
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.....	

19. If your response in (17) is [No] what measures can be used to improve community access to services in your section, choose from the options provided? You may choose a number of responses.

Appropriate health system financing	1
Incorporating cultural diversity	2
Improving health service coverage	3
Increase health information sharing	4
Reducing long waiting times	5
Others (please specify)	6
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“Health services should be of high quality, i.e. they must be effective, safe, centred on the patient’s needs and given in a timely fashion”

20. From the characteristic indicated above, monitoring of patient waiting times is one of the ministerial priorities and health care workers in their service provision are to adhere to the required waiting times, is your section compliant?

Yes	1
-----	---

No	2
Not certain	3

21. If your response in (20) is [No] in your view what are the barriers to adhering to the required waiting times? You may choose more than one option.

Staff factors	1
Patient factors	2
Structural factors	3
Administrative factors	4
Factors related to financial and material resources	5
Others (please specify)	6
.....	
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22. This question is a continuation from the above, what measure/s can be applied to help your section to adhere to the required waiting times?

Resolving staff factors e.g. bad staff attitude, shortage and etc.	1
Resolving patient factors e.g. lack of information, bad attitude and etc.	2
Resolving facility infrastructural challenges e.g. shortage of consulting rooms, poor/lack of signage and etc.	3
Availability of financial and material resources	4
Others (please specify)	5
.....	
.....	

Thank you very much; your participation is highly appreciated

[APPENDICE F: MREC Certificate](#)



MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 05/2014
PROJECT NUMBER: MREC/H/169/2014: PG

PROJECT:

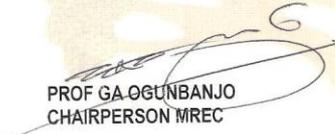
Title: Views and perceptions of healthcare workers on the National Health Insurance at Polokwane-Mankweng Tertiary Hospital, Limpopo Province.

Researcher: Miss MM Matsi
Supervisor: Dr SL Mndzebele
Department: Public Health
School: Health Care Sciences
Degree: MPH

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 05 June 2014


PROF. G.A. OGUNBANJO
CHAIRPERSON MREC



The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)
Expiry date: 11 October 2016

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.





LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Matsi MM
University of Limpopo – Medunsa Campus
MEDUNSA
0204

Greetings,

Views and perceptions of Healthcare workers on the National Health Insurance at Polokwane-Mankweng Tertiary Hospital.

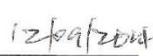
The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.



Head of Department



Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

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**ETHICS COMMITTEE
CLEARANCE CERTIFICATE
UNIVERSITY OF LIMPOPO
POLOKWANE MANKWENG HOSPITAL
COMPLEX**



PROJECT NUMBER : PMREC – 86/2015

TITLE : Views and perceptions of healthcare workers on the National Health Insurance at Polokwane Mankweng Hospital, Limpopo Province

RESEARCHER : Ms MM Matsi

ALL PARTICIPANTS : N/A
Supervisor : Dr SL Mndzebele

DATE CONSIDERED : 05 February 2015

DECISION OF COMMITTEE
- Approved

DATE : 09 February 2015


PROF A J MBOKAZI
Chairperson of Polokwane Mankweng
Hospital Complex Ethics Committee

NOTE: *The budget for research has to be considered separately. Ethics committee is not providing any funds for projects.*

APPENDIX G (3): Data Collection permission letter from Pietersburg Hospital



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
PIETERSBURG HOSPITAL

TO : MAKWENA MARGARET MATSI
MPH STUDENT

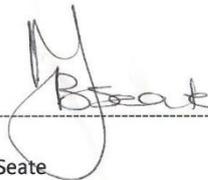
FROM : T B SEATE
CEO: PIETERSBURG HOSPITAL

DATE : 09 OCTOBER 2014

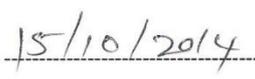
RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT POLOKWANETERTIARY HOSPITAL

1. The above matter refers.
2. Your request to conduct research is granted
3. You will be expected to avail the report about your research to the institution.

Thank you in advance



T B Seate



DATE

CEO: Pietersburg Hospital

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PHD 094(1)

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APPENDIX G (4): Data collection permission letter from Mankweng Hospital



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

MANKWENG HOSPITAL

Ref: S5/3/1/2

Enq: Makola M.M

From: HR Utilization and Capacity Development

Date: 18 February 2015

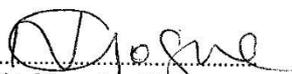
**To: Matsi M.M
University of Limpopo -Medunsa
MEDUNSA
0204**



PERMISSION TO CONDUCT RESEARCH AT MANKWENG HOSPITAL: MATSI M.M

1. The above matter has reference.
2. This is to confirm that Matsi M.M has been granted permission to conduct research on " Views and perceptions of Health workers on the National Health Insurance at Polokwane –Mankweng Tertiary Hospital".
3. She will be conducting research as from Monday, 23 February 2015 to Friday, 17 April 2015 .
4. Attached please find her application letter, Ethics Committee Clearance (University of Limpopo – Polokwane Mankweng Hospital Complex), approval letter from Provincial Office, Medunsa Research and Ethics Committee clearance certificate (University of Limpopo –Medunsa Campus) and Questionnaire, Research proposal and data collection tool.

Thanking you in advance


.....
Chief Executive Officer

.....2015/2/19
Date