ALIGNMENT OF THE STRATEGIC, TACTICAL AND OPERATIONAL MANAGEMENT LEVELS IN THE PUBLIC HEALTH FACILITIES IN VHEMBE DISTRICT, LIMPOPO PROVINCE

by

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RESEARCH DISSERTATION

Submitted in fulfillment of the requirements for the degree of

MASTERS IN BUSINESS ADMINISTRATION (MBA)

in the

FACULTY OF MANAGEMENT SCIENCES AND LAW

(Turfloop Graduate School of Leadership)

at the

UNIVERSITY OF LIMPOPO

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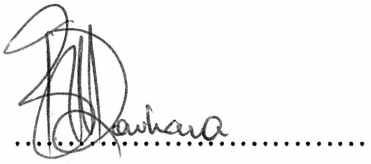
DECLARATION

I declare that the mini-dissertation hereby submitted to the University of Limpopo for a degree of Masters in Business Administration (MBA) in the Faculty of Management Sciences and Law has not previously been submitted by me at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.



27/02/2009

B.K.Davhana (Mrs.) Date

Student Number: [redacted]

Dedication

This study is dedicated to: -

- My dear husband Luke, for your consistent commitment in the development of your family and of myself in the most amazing ways. As for my children Mogami, Edzani and Khodani who had to live with the reality of a student mom. Thank you all.
- To all the managers who participated in this research.

SUMMARY

Health Care System delivery of every country is important for many reasons. Firstly, health services are provided through health systems. Secondly, many countries spend an important share of their national income on health systems. Thirdly, individuals often spend a considerable share of their family income on health. Finally, many health systems do not function as planned as evidenced by the media outcry and dissatisfaction about public health services in particular. Of importance is that the type of Health Care System in a country is strongly related to the historical context in which they have been developed and operated. This was clearly demonstrated as per milestones of the South African Health System. This is also important in describing the transitional pattern and its impact to the current delivery system in provinces and districts.

The research study was conducted with the main aim of describing the Strategic Alignment of management levels in Vhembe District.

There are seven hospitals in Vhembe District. The researcher interviewed the managers thereof.

A literature search was conducted to provide the current "as is" situation and to assist with literature control in the discussion of findings. The

literature is silent on what the managers actually do in these institutions. Rather information on what managers have to do floods the literature on Strategic management.

A qualitative, exploratory, description and contextual study was conducted. This type of research is conducted in a relatively new area of research which lacks established theories and findings.

The interviews were conducted to explore and describe how strategy is aligned in different hospitals.

Six themes summarise the findings as follows: -

- Every hospital has a strategic plan in place.
- A specific Strategic planning process is followed and all the hospital managers participate in hospital strategy development.
- A specific organogram for all the hospitals in the district exists.
- Monitoring process and specific tools are used for this purpose.
- National and Provincial Strategic Plans and Performance plans with targets and indicators do not match the resources available to hospitals.
- There are challenges relating to what is written on paper compared to what happens at hospital level.

The findings cannot be generalised due to the nature of qualitative research approach used in this study. However, the researcher hopes that the study may be repeated in other districts.

Recommendations were made with regard to further research, practice and further education and training.

Acknowledgement

- To God Almighty for the gift of Life and guidance by His Holy Spirit and my Saviour Jesus Christ.

- I am grateful to the University of Venda for the financial assistance and opportunity for further studies and development given to its employees.

- To my supervisor, Prof.Pelser for his tireless support and encouragement.

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CHAPTER 1
BACKGROUND AND RATIONALE

1.1 INTRODUCTION

In this introductory chapter the importance of health care systems in general is outlined. The milestones and historical underpinning and the developmental process that led to the current operating health system in South Africa are explained. These are followed by a description of the health care system of South Africa to pinpoint the Limpopo Provincial System and the District Health System of Vhembe. Research problems, research issues/question and research objectives are formulated. The chapter ends with a brief outline of the chapters that follows.

1.2 BACKGROUND AND ORIENTATION

Health care systems worldwide are in a continuous state of transition and the type of health care services in a country is strongly related to the historical context in which they have developed and operated. South Africa has seen its health system under go various transitional challenges that impacted negatively on the human resource, socio-cultural, political, administrative and financial-economic and the spectrum of care components. Other infrastructural needs, supporting service units (laboratories, medical equipment suppliers and pharmaceutical companies as well as organisations such as medical

research institutes, universities and training colleges did not escape the economic melt down and transitional dynamics taking place in the country.

From the outset, the health care delivery in Vhembe district of Limpopo Province has operated within the broader health system of the Republic of South Africa.

The importance of health systems globally has many aspects. Firstly, health services are provided to people through health systems. Secondly, many countries like South Africa spend an important share of their national income on the health system (7.7% of GDP, R100 billion) in 2007 of which 74% is spent on the private sector and 26% on the public sector (South African Health Report(SAHR) 2007). Thirdly, individuals often spend a considerable share of their family income on health. Finally, many health systems do not function as planned as evidenced by the media outcry and dissatisfaction about our public health services in particular.

The South African Health System is classified as the free market type according to Van Renburg & Pretorius (1993) citing Cockerham (1992). Two key characteristics of a free market health care system are:-

- Have both private and public systems of financing and organisation of health care services. South Africa has a two-tiered health care system comprising of the public health services that

provides the bulk of care to between 75% and 80% of the population and the private sector that provides services to the remaining 20% to 25% of the population. Medical schemes cover approximately 16% of the population (7 million out of a total population of about 47 million people) (South African Health Report 2007).

- Do not guarantee equal access to the general population and are most highly inequitable. This point is critical to the current perceptions about public health care services in South Africa as being very inferior (South African Health Report 2007).

An understanding of the milestones and the historical underpinnings (Foundation for Professional Development (FPD) 2007:43)of the public sector development of the South African health care system are outlined here under.

- ✓ **1883** – The first Public Health Act. Local authorities were given power to establish hospitals and departments while the government advanced half of the expenses and maintenance.
- ✓ **1910** – Union of four colonies: Cape of Good Hope, Natal, Transvaal and the Orange River Colony. Provincial Councils were established and were endowed with various health and inherited local government laws. There were

overlapping responsibilities and confusion with respect of public health particularly during the 1919 influenza epidemic.

- ✓ **1911** – Mission hospitals were established in rural areas where no local authority was capable of making a financial contribution.
- ✓ **1919** - Public Health Act No.36. Established the Department of Health with executive powers to advice and assist. The provincial administration retained the responsibility of administration of local government and establishment, maintenance and management of general hospitals, pauper medical relief and so forth.
- ✓ **1946** – The Public Health Amendment Act demarcated the functions of the Central government and the Provinces. The Provinces were responsible for the general hospital services and outpatient services.
- ✓ **From 1948** – Health Policy and Planning were determined by political rather than health criteria with the development of a homeland system in South Africa. This heralded the birth of fragmentation of service delivery and policy in the country.

- ✓ **1979** – Establishment of the Regional Health organisation of Southern Africa (RHOSA) in order to coordinate the numerous health departments.
- ✓ **1977** – The Health Act included for the first time Provincial Administration in the same way that local authorities were involved in 1883. The Department of Health had the function of coordinating both health services rendered by the Local Authorities and Provincial Administration as well as to provide additional services as may be necessary. This was after the 1976 Soweto uprising by blacks protesting against inferior education and the use of Afrikaans as a medium of instruction in black schools. The Health Act had no real effect on the fragmentation embodied in the three tiers of government and services.
- ✓ **1980** – A high degree of fragmentation continued to characterize the health care services and policy coordination. The implementation of the homeland policy and the tri-cameral system in 1883 led to the breaking up of administration into seventeen (17) different political entities. Disparities existed in resource allocations within and between provinces and between the provinces and homeland administration. Public facilities (hospitals and clinics, schools etc) were segregated with separate services

for the non-white population. This period is typified by excessive fragmentation of control and lack of policy direction, misallocation of resources, duplication of services and poor communication between the various levels.

- ✓ **1989 – 1990**: The public health system was officially desegregated. This resulted in patients who could afford it leaving the public sector and the subsequent growth in private hospitals as over crowding of historically white facilities occurred. Experienced white health practitioners and administrators left the public health facilities in the hands of the majority blacks who never occupied senior management and administrative positions in the health care system. The leadership role had been the sole preserve of the whites.
- ✓ **1990** – National Policy of Health Act, No 116 made provision for a Minister of National Health and Population Development to determine policy. The Act tried to coordinate health services and to reduce the role of provincial authorities.
- ✓ **Reforms since 1994** – Reforms were based on the new Constitution of the Republic of South Africa.
    a) Nine (9) provincial health administration were created and were responsible for delivery of both hospital and

primary health care (reorientation of health from a biomedical model and curative services to promotive and preventive health services at community and local clinic level).

b) Provincial administration transferred a portion of their budgets to the local authorities that had to render primary health care services.

c) Overall responsibility of health policy resided with the Minister of Health supported by the national Department of Health.

d) Financial arrangements of government were significantly changed with major implications for health services, which include a fiscal federal system affecting the financing and budgeting for health. These changes impacted negatively on:-

   1) Budget levels
   2) Inter-provincial equity
   3) Revenue raised from medical schemes and other user charges and
   4) Staff retention within the public sector – emigration and migration to private and other sectors.

In 2001 an estimated R8.3 billion was spent on pharmaceutical sales as follows: 24% public sector, 15% dispensing doctors and 61% private and hospital pharmacies (FPD 2007:65).

Sources of funding to the public sector were mainly provided by the government through taxes (income, company and sales). A small percentage came from patient user fees, local authority rates and taxes, Road Accident Fund and Commission on injury on duty. Medical scheme holders (16.5% of the total population) rarely use the public facilities except in cases whereby patients were admitted in the innovative private wards established in public hospitals. The contribution was insignificant. Other minor sources of funding were obtained from donor grants utilised for HIV/AIDS response by government (Foundation for Professional Development (FPD) 2007:65).

The macrostructure of public health services is organized in three tiers, National, Provincial and Local with the following roles and functions: -

a) Role of the National Department of Health

- Policy and legislation development.
- Setting of norms and standards

- Developing capacity at provincial and local authority levels
- Distribution of budget to provinces
- Health status monitoring
- International Liaison

b) Role of Provincial government

- Service delivery: **Primary Health care** service delivery is envisaged through a network of 53 health district which coincides with 53 district municipalities established for administrative purposes. Curative services are provided are provided through public sector hospitals. In 2000 there were 161 085 beds in the public sector. At present the public sector admits 3.3million patients per year and uses 60% of the public sector budget (FPD 2007:56).
- The classification of public sector hospitals is based on type and relative roles as set out under the subheading of District Health System below.

The reallocation of financial resources to primary health care has placed severe constraints on the ability of public hospitals to respond to increased demands generated by referrals from an expanding PHC system(FPD 2007:56).

Other added constraints include –

- Migration and emigration of skilled staff,

- An estimated R7billion accumulated backlog in maintenance (FPD citing 1994 HST survey). This picture may be different given the hospital revitalization programme of uplifting the infrastructure of hospitals.
- Lack of management information systems
- Inappropriate managerial systems
- Distorted referral system
- Maldistribution of beds (urban/rural and interprovincial)
- Instability in neighbouring states like in Zimbabwe. Recently the South African government and the Limpopo Provincial Health System had to reroute health resources to curb the spread of Cholera from Zimbabwe that caused the death of an estimated one thousand Zimbabweans in 2008. Several years ago it was floods in Mozambique and in 2008 xenophobic attacks in South Africa presented new health challenges and added challenges with regard to diversity and ethnicity in the provision of health services.

c) Role of the local Authorities

This is at the heart of the context of this research. In 1995 a Policy for the development of a District Health System (DHS) for South Africa was released and has since been used to guide the implementation of the DHS in South Africa (Department of Health Policies and Legislation 1994 – 2000).

The DHS is not yet functional in the Limpopo Province. As a result district hospitals still reports to the Provincial Administration. The Primary Health Care clinics also report to the district health directorate located in the Provincial government of Limpopo. The development of the system rests on a set of twelve principles that are mentioned as challenges to the current South African Health System, which are to:-

i) Overcome fragmentation

ii) Establish equitable health services

iii) Provide comprehensive services

iv) Operate efficiently and provide effective service delivery

v) Assure quality of service delivery

vii) Guarantee access to services

viii) Ensure local accountability

ix) Instill and mobilize community participation

x) Decentralise

xi) Ensure a developmental and inter-sectoral approach and

xii) Ensure sustainability

A DHS is defined by the WHO as a more or less a self contained segment of the national Health System which comprises a well- defined population, living in a clearly delineated administrative geographical area, whether rural or urban. It includes all institutions and individuals providing health care in the district, whether governmental, social security non-governmental, private or traditional.

The Pharmaceutical industry and medical equipment suppliers industry are still dominated by foreign and multinational suppliers. The South African Pharmaceutical industry is at least having a local market share of 30% while the balance consists of UK, US and Swiss owned multi-national companies (FPD 2007:65).

In view of current foreign exchange rates, the cost of importing medical supplies and commodities will further compromise health care delivery in the country and in the provinces.

What happens in the country will subsequently affect the provinces and ultimately affect the local government and its districts more severely because of how the system is constituted. It is within this context that Vhembe hospitals find themselves and will have to put in place strategies that mitigate the impact of these challenges to health delivery.

1.2.1 Overview of the District Health Process in Limpopo Province

The Province is situated in the north of the Republic of South Arica. The population of this province is estimated at 5.4million (Statistics South Africa 2007). This accounts for 11.3% of the South African population of about 47.9 million and is the fourth most populated province (Statistics South Africa Census 2006).

According to the socio-economic profile of Limpopo, 80% of the population lives in the rural areas and the majority of people are unemployed and not literate (Limpopo Province Annual Performance Plan 2000).

The Province shares the borders with Mozambique in the east, Zimbabwe in the north and Botswana in the west that put a load on the province because of the influx of refugees and emigrants from these countries.

The Province is made up of six districts which are Vhembe, Mopani, Capricorn, Bohlabela, Sekhukhune and Waterberg districts see Appendix A (Hospital & Nursing Yearbook 2008:190).

Each district has several municipalities that fall under the local government system. Vhembe district is in the historically former homeland of Venda and its hospitals are outlined as per attached Appendix A. Presently the district is constituted by Thulamela municipality, Makhado and Musina municipalities.

The district health system is not yet well developed however, systems are in place to render basic health services as efficiently as possible (FPD 2008).

Vhembe district, the coordinating office of which is situated in Thohoyandou, has eight public hospitals, which are Tshilidzini, Donald

Frazer, Hayani, Siloam, Musina, Makhado, Elim and Malamulele. Table 1.1 below presents the levels of the hospitals.

Table 1.1: Levels of hospitals in Vhembe district

Level	**Services**	**Referrals from**
District hospital e.g. Donald Frazer, Siloam, Musina, Elim, Malamulele and Louis Trichardt hospitals	Generalists only Level 1 care	Clinics and General Practitioners
Regional hospital e.g. Tshilidzini Hospital	Generalists, specialist services Psychiatry, Orthopaedic and so forth). Mostly level 2 care	Plus district hospitals
Provincial hospital None in Vhembe district.	Super specialist services and academic specialists. Mostly level 3 care	Plus regional hospitals
National / Central None in the district	Super specialist services and academic	Regional hospitals and interprovincial

	specialists. Mostly level 3 care	referrals.
Specialised Hayani Herberg Psychiatric hospital	Specialised groups like psychiatric hospitals, SANTA hospitals for Tuberculosis	All levels

The nine Provincial Health Departments are also very distinct and peculiar, for example the Gauteng Provincial Department of Health is completely unique and different compared to the Western Cape and Limpopo Provincial Health Departments.

An interview with the Limpopo Provincial Director: Strategic Planning and Policy of the Department of Health and Social Development revealed that the main aim of the office is to align the strategic processes at the corporate level only. Neither does In addition the office does not co-ordinate strategic planning at district levels but it assists the districts to draw up their strategic plans based on the National and Provincial Strategic priorities and goals.

In large and complex organisations such as hospitals managers are further identified by the scope of the specialisation such as theatre chief nurse, psychiatrist registrar, orthopaedic consultant and Human Resource managers (Booyens 1993:115).

Relatively few literature resources relatively examine what these managers really do; instead more detail explanation is given on what these managers are supposed to do. Similar observation was made Bridgman & Roemer (1973:1) that in the management of health services there are few authorities or "voices" at the top. In many situations the best thing that managers can do is to have faith (Bridgman & Roemer 1973: 1).

This investigation seeks to understand how these complex management dynamics and functions are aligned. This research gap is further complicated more by the fact that the department of health operates at national and provincial government level with major operations taking place at district and municipality levels. It is against this background that the researcher would like to investigate how the three levels are aligned predominantly up to public hospital levels in a specific Vhembe district.

The South African Health sector is currently undergoing rapid transformation. At the same time managers at all the levels have to understand what direction the Department of Health is taking in order to position their own organisations /hospitals. The Department of Health has released the 2006/07 – 2008/09 Strategic Plan, which outlines ten

major priorities and activities from 2006 to 2009. The Strategic Plan takes place within the context of the White Paper on Transforming Public Service Delivery (1997), which provides a framework for transforming the public service into an efficient, transparent and democratic institution that can serve the populace with distinction. In line with this commitment, the National Department has a set of service delivery standards, which it is pledged to uphold.

The Department of Health pledges to protect the rights of both internal and external clients in the following manner: -

- **All clients will be provided** with caring and effective services through an integrated and comprehensive approach.
- All clients will be provided with effective, efficient and courteous attention whether in person or through the use of electronic media.
- Mechanisms and processes to deal with complaints about services shall be available at each health facility and at provincial and national offices.
- Stakeholders will be consulted on matters that affect them through statutory bodies, internal Departmental meetings and informal communication as appropriate.
- Print and electronic media will be used to communicate health policies, service standards, legislation and other matters related to the mission of the Department in all official languages.

The Department of Health Strategic Plan (2006-2009) cites that the Director General will ensure that an operational plan is developed each year to strengthen service delivery by the National Department of Health. A process of monitoring the implementation and its outcomes is said to back this up. It could be argued that the Director General seems to try to participate or translate the Corporate Strategic Plan down to the operational level. This should not be the case ... or should it be? The Strategic Plan (2006-2009) cites that the Director General in his capacity as a strategic manager will at the same time ensure an operational planning activity, clearly on annual short-term basis. It can be expected that the role of senior managers at provincial level may overlap as is the case at national level mentioned above, which could further complicate the role of the chief executive officers of hospitals as strategic managers in their own right.

It is a thin line that separates the three management level in a specific district and municipality; hence the researcher's interest to investigate the phenomenon at district level.

New developments in the Gauteng Province as reported in the Sunday Times and City Press News papers of the 16th July 2006 and confirmed in *Gauteng Health Talk* magazine. Volume 1, issue 4 poses the question "Will public hospitals now be on the mend" (Chauke 2006:7 & Khuthala

2006: 26). The report follows the decision taken by the Department of Health to devolve powers, authority and accountability to Chief Executive Officers (CEOs) in academic hospitals. While unions, government and hospital management welcome the move; some specialists are quoted as being skeptical about this "decentralization" process.

Other complexities in hospitals concerns the diverse professional fraternity in one district hospital as already mentioned above. There are various health officers/ workers and health administrators at different managerial levels who manage and administer delivery of health services to the public.

Different seniority levels of medical doctors, nurses, social workers, physiotherapists, radiographers, occupational therapists, human resource, technical services, pharmacists, dieticians, psychologists exist in hospital settings. Undoubtedly, plans that direct their operations have to be aligned to a certain extent for effective and efficient performance and productivity.

The research will address the alignment of the three management levels (Strategic, Tactical and Operational Management) in public health facilities in Vhembe district. The concept of alignment includes both the vertical and horizontal/ internal alignment aspects which will be defined and explained at the latter stage.

1.2.2 Media publicity on the state of Limpopo Health System:

City Press, 27 July 2008 (Walden: page 6): -

- The head line reads as follows: We have a state of emergency
- People are dying due to lack of ambulances
- Skewed distribution of emergency services in favour of urban areas and training of drivers and support staff is lagging behind the demand in the province.

City Press, 12th October 2008 (pages1, 8)

- Ailing health care in desperate need of cure.
- Limpopo has only 10% of medics required. The province has only 500 when it needs 6000.Only 45 of the 409 specialist positions have been filled. The majority of the 5 500 vacancies for doctors are not budgeted for because the supply does not meet the demand in the sector. All the universities in the country can produce only 1000 doctors annually.
- Limpopo Province has 16 321 nursing positions all budgeted for , but 20% of them are not filled.
- Many qualified professional are reluctant to live in Limpopo Province, which is predominantly rural and lack competitive facilities like schools for child rearing health practitioners.
- Poor salaries, dilapidated buildings and lack of human resources have combined to infect health services, while some provinces like

Gauteng do not even have a budget for the doctors needed to ease the crisis.

- So sick is the health system that even the national department does not know how many doctors are in the country and relies on the Health Professionals Council of South Africa (HPCSA) to provide these figures. Yet the country fails to take advantage of the influx of doctors and nurses from the region due to an Southern African Development Coalition (SADC) agreement prohibiting member countries from poaching medical specialists from each other. Only the Western Cape Province did not receive bad publicity in local media publicity.

It is against this backdrop that the research problem is formulated.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The political history and the many transitional periods undergone by the South African Health System have left legacy of poor development and instability in the public health sector. There is duplication and repetition of management levels at National, Provincial, district and hospital levels which compromises efficiency and effective operational delivery of services due to salary costs on human resources in administrative functions only.

There have been media and political debates on whether provinces should be reduced and revert back to the former four provinces (Transvaal, Free State, Natal and Cape Province); the names may not necessarily be the same as in the past for the sake of cost containment of health care services. The argument by the Minister of Finance in his 2007 budget speech cited the reason that service delivery takes place at local government as in the case of education, health, housing, electricity, water, sanitation and sewerage systems among others so what are credible reasons to spend more money in maintaining the National and Provincial levels to the detriment of service delivery at local government level? Hence it would be economically viable to devolve provincial expertise and skills to local government level and thus to better align the national strategy and the human rights charter. Currently the top structure at provincial level is top heavy and uses up financial resources mainly on salaries instead of being spent directly to service development and the implementation of quality service delivery. This skewed spending at higher levels compared to that at lower operational levels compromises delivery and alignment at district level of care.

At research and practice level there is silence on what managers actually do and how they do their jobs in health care delivery systems at provincial level - down to hospitals.

The public service structure is a non profit sector hence there is again wastage of resources due to this duplication of functions and roles. Kaplan & Norton (2006) describe this state of affairs as performance sapping, lost opportunities, wasted resources and a corporation whose value amounts to less than the sum of its parts.

1.4 PURPOSE AND JUSTIFICATION OF THE STUDY

The researcher embarked on the study for the following reasons: -

- This is a business and administrative research study conducted on qualitative methodology in the context of the paucity of health management research studies on strategic management of health facilities in the Limpopo Province and in its districts including Vhembe district.
- The study is expected to unearth several indicators that should add value in the Strategic management process in public health hospitals in the district for the purpose of future research activities.
- Finally an understanding of some aspects of this complex system with much historical baggage can be best described by starting from the lowest level of the district in a Province. The researcher assumes that if there is a potential do duplicate the study or to

repeat it in a different setting, this may be easily built up from the findings of this study.

1.5 RESEARCH QUESTION

How are the three strategic management levels at district public hospitals aligned?

1.6 AIM AND OBJECTIVES OF THE STUDY

The aim of the study is:

- To investigate the problem by means of in-depth interviews and establish how management in public hospitals is aligned.
- To produce a descriptive report on the experiences of managers in aligning strategy at different management levels .

1.7 PLAN OF THE RESEARCH REPORT

Chapter One: Background and orientation

The background and justification of the study are discussed in detail. A problem statement followed by the research question to be answered in the course of the study are also formulated.

Chapter Two: A definition of concepts is provided. Finally, a literature review provides the current state of knowledge dealing with the research topic.

Chapter Three: Research Design and Methodology are presented based on the objectives of the study mentioned in Chapter 1.

Chapter Four: Analysis, Findings and Presentation of data are provided.

Chapter Five: A detailed discussion of findings is presented. Finally conclusion and recommendations are made.

1.8 SUMMARY

Detailed background information on the dynamics and changes coupled with the history of the health care system of South Africa is provided to identify the current state of affairs. The health care system is a complex set-up the challenges of which need to be well understood particularly since the enquiry is done using qualitative methods. Against such a rich background the research process in the next chapter on a literature search will provide the "as is" theoretical picture on the strategic management implementation and alignment in diverse industries and particularly in the health sector.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter the researcher will also provide orientation of where alignment in management fits and its relevance to complex systems like the health care system. Some critical aspects that are of relevance to the current state of affairs about the research topic and on the research question are made. The concepts in the research topic are defined. Finally some tools on the framework of analysis will be discussed and will also be used to provide conclusions on this research.

2.2 DEFINITION OF CONCEPTS

Key concepts and definitions

Some concepts like the health system were introduced in Chapter One. In order to avoid vagueness and ambiguity, a few other central concepts are defined as applied in this research. These concepts are: -

- Health Management
- Public Health and Public Health Facility
- Strategic Management
- Align and alignment
- Corporate / Strategic Management level

- Business Unit / Tactical Management level
- Operational / Support Management level

2.2.1 Health Management

The World Health Organisation (1977:5 cited by FPD 2008 :43) states that "...Health Management is essentially a system of administrative roles and functions and tasks carried out by individuals at various levels of administration in order to improve the health of the people".

The nature of management entails four fundamental functions such as planning, organising, leading and staffing and finally controlling (Smit & Cronje 2004:8).

In the context of this research it is the public sector managers who are leading and supporting organised activities concerned with formulation, planning, directing and implementation of a public service such as health care.

Most authorities agree that managers bring together different resources and use them with a view to achieving organisational goals and objectives (Smit & Cronje 2004: 6). What managers actually do in the Vhembe district was part of the focus of this study.

2.2.2 Align and alignment

The *Reader's Digest Oxford Complete Wordfinder* (1993:37) defines the term align as to put in a straight line or bring oneself into agreement or alliance with a cause, policy or political party or, whatever and the common noun is alignment.

In the context of this research this concept is used as described by Kaplan & Norton (2006) and is about organisational alignment. They do not provide a specific definition as in the dictionary.

The term is used as a concept that provides an array of potent practices which includes: -

- Ways to leverage financial synergies across a diverse corporate portfolio through an effective monitoring and resource allocation process;
- Methods for encouraging the cross selling of products and services to create unique solutions for customers shared among multiple business units, and
- A technique for sharing common processes among units to gain economies of scale and capture knowledge and expertise.

Kaplan & Norton (2006:1) regard alignment as a source of economic value. They claim that enterprises that enjoy the greatest benefits from their performance management system are much better at aligning their corporate, business and support unit strategies and this indicates that

alignment, much like the synchronism achieved by a high performance rowing crew, produces dramatic benefits capable of producing significant payoffs for all types of enterprises.

The concept is also described as having a specific sequence that has to be managed as a process too.

A typical sequence and process according to Kaplan & Norton (2006:10) starts when the corporate headquarters articulates an enterprise value proposition that will create synergies among operating units, support units and external partners. A strategy map is clarified and clearly communicated to all business and support units (Kaplan & Norton 2006:13).

After the corporate headquarters has developed its strategy each business and support unit develops its long-range plan. They often choose their target customers and value proposition to be offered to the customers and then develop their people, systems, and culture to enhance internal operating processes, customer management processes and their innovation processes that deliver value to customers and their corporate parent (Kaplan & Norton 2006:13).

Next in the process is the alignment of internal support service units such as human resources, finance and planning that develop their long-range plans to support the strategies of the business units and enterprise priorities (Kaplan & Norton 2006:13).

Beyond the alignment of internal business and service units is an external alignment, whereby an enterprise can exploit additional opportunities by formulating plans that define relationships with its board of directors and external partners, such as customers, suppliers and joint ventures (Kaplan & Norton 2006:14). Each of the activities identified is an opportunity to create synergy and value according to Kaplan & Norton (2006:15).

Most organisations are said to attempt to create synergy, but in a fragmented, uncoordinated way. They do not view alignment as a management process and as a result when no one is responsible for the overall organisational alignment the opportunity to create value through synergy can be missed (Kaplan & Norton 2006:15).

The alignment process much like budgeting should be part of the annual governance cycle according to Kaplan & Norton (2006:15). Whenever plans are changed at the enterprise or business unit level, executives likely need to realign the organisation with the new direction. They further posit that the alignment process should be cyclic and must have a top-down bias. The targeted corporate synergy should be defined at the top and be realised in the business units. Just as the Chief Financial Officer (CFO) co-ordinates the budgeting process, a senior executive should coordinate the alignment process which is the responsibility for the Office of Strategy Management (OSM) (Kaplan & Norton 2006:15).

The annual planning process could provide an architecture around which the alignment process can be executed.

Finally, although it is not strictly part of organisational alignment, the enterprise must also align its employees with management processes with the strategy say Kaplan & Norton (2006:15). Having aligned and integrated strategies at all organisational units, little is yielded if employees are not aware of the strategy and are not motivated to help their organisational units to implement it. Enterprises must activate policies to communicate, educate, motivate and align employees with the strategy claim (Kaplan & Norton 2006:15). Furthermore they must also align their ongoing management processes – for resource allocation, target setting, initiative management, reporting, and reviews with the strategy (Kaplan & Norton 2006:16).

The current management processes in both profit and non-profit organisations is to ensure that there is alignment of management levels to create synergy (Kaplan & Norton 2006:16).

The Balanced Score Card is the centrepiece of this alignment system to manage the execution of strategy (Kaplan & Norton 2006: 251).All components of the management process can be designed to create alignment, claim Kaplan & Norton (2006: 261).

2.2.3 Health Care Delivery System

The World Health Organisation defines a Health Care delivery system as "all actors, institutions, and resources that undertake health actions" – where a health action is one where the primary intent is to improve health. A related definition by Roemer (1991) is "the combination of resources, organisation, and management that culminate to the delivery of health services to the population".

In many respects health policy and health care services in the developing countries like South Africa still bears the imprint of the colonial and apartheid legacy. Public Health Services are operated to serve the lower income classes while private practices and hospitals predominantly serves the upper and middle classes in urban areas and are predominantly funded by medical aid schemes. In socialist countries like Cuba public health services are designed to provide basic prevention and curative services to the entire population safe the limitations imposed on it by the current economic situation (Fried & Gaydos 2002:445). Israel's health care system has also distinguished itself in several areas to ensure that the entire population receives high quality health care by focusing on immunization which results in low infant mortality rate and preventable infection in the community (Fried & Gaydos 2002:210). This shows that public health services do not have to be of poor standard and be discriminatory in nature.

2.2.4 Strategic Management

The term strategy proliferates in discussion about business. Scholars and consultants have provided myriad models and frameworks for analysing strategic choices. Louw & Venter (2006:20) claim that Strategic Management is more than the management of strategic decisions-making process but is concerned with the overall effectiveness and choice of direction within a dynamic, complex and ambiguous environment.

This implies that strategic management is concerned with effective strategies that balance or align organisational resources and capabilities, values and goals with its external environment Louw & Venter (2006:20). Furthermore that the implementation of a strategy should be done in such a manner that all the organisational architecture and activities are synergistically integrated in order to achieve effective performance Louw & Venter (2006:20). The key issue that should unite all discussion of strategy is a clear sense of an organisation's objectives and a sense of how it will achieve these objectives (Stonich 1982 and Grant 2000). Strategic management is planned and implemented at three levels; Corporate, Business Unit and the Functional cum Operational levels (Thompson & Strickland 1999:44-52). These levels of strategies are outlined below: -

- **Corporate Strategy**

This is the overall managerial game plan for a diversified department. It extends companywide – an umbrella over a diversified company's businesses. In the context of this research it involves the overall department of Health game plan at National and Provincial levels (Thompson & Strickland 1999: 44). Top management in hospitals may assume this role too.

- **Business Unit strategy**

The term business strategy refers to the managerial game plan for a single business (Thompson & Strickland 1999: 47). In the context of this research the term implies Local government administration and District hospitals. The internal environment can again be distinguished using all three levels from top management down to the unit supervisors in operational units.

- **Operational cum functional strategy**

The terms concerns even narrower strategic initiatives and approaches for managing key operating units and for handling daily operating tasks (Thompson & Strickland 1999: 51). In the context of this research it involves activities taking place in hospitals and Primary Health Care facilities like health centre and clinics.

2.2.5 Public Health service facility and district health services

These were outlined in Chapter One as part of the background information of this study.

2.3 CURRENT LITERATURE ABOUT THE RESEARCH TOPIC

The main characteristics of health care delivery organisations are that they are inherently complex and are regarded as complex systems according to Clancy (2007:12). Porter-O' Grandy (2000:31) says health services have been so radically altered that it has transformed members of society. From public health to high –tech interventions, the quality and tenure of life have been enhanced and the life expectancy of populations have increased Porter-O' Grandy (2000:31).Clancy (2007:534) says it is because of the complexity of today's business environment that it has become difficult to point to "one best way " to structure such organisations. A complex environment means that there are a multiple states the overall system could evolve to (Clancy 2007:535).
The complexity is demonstrable for example that internally in one hospital it could be found that below the level of the Chief Executive Officer there may be seven to nine subdivisions e.g. Clinical care, nursing services, financial management, risk management, quality assurance,

liaison services, corporate services, information and records management and technical support just to mention a few (*Staatskoerant* 1997:17). This implies that there could be more than ten managers having to coordinate resources to achieve hospital objectives that are contingent on the evolving environment.

The nine Provincial Health Departments are also very distinct and peculiar, for example the Gauteng Provincial Department of Health is completely unique and different compared to the Western Cape and Limpopo Provincial Health Departments.

An interview with the Limpopo Provincial Director: Strategic Planning and Policy of the Department of Health and Social Development revealed that the main aim of the office is to align the strategic processes at the corporate level only. Neither does the office co-ordinates strategic planning at district levels but it assists the districts to draw up their strategic plans based on the National and Provincial Strategic priorities and goals.

According to Smit & Cronje (2004:3) the health care system like any other business and organizations aims to reach its goals as efficiently as possible. To achieve such goals, managers who are employed in these organisations are responsible for efficient performance with minimal waste of resources. Managers represent only a small fraction of employees in a large organisation like public hospitals.

The term manager covers many types of people. It includes directors in national and provincial departments of Health, Chief Executive Officers (CEO)of hospitals, nursing service managers, administrative managers, medical generalist and specialists. However, managers are also differentiated by their levels within the hospital for example there are many categories of nurses(assistant nurse, enrolled nurse, a professional nurse specialist nurses and nurse managers) the same applies to medical professionals who range from medical officers, registrars, consultants and specialists and so forth. Hellriegel & Slocum (1995:7) claim that there are three levels of management in organisations are Top or Strategic Management, Middle or Tactical Management and the Lower/first –line or operational management level.
In large and complex organisations like hospitals managers are further identified by the scope of their specialisation such as theatre chief nurse, psychiatrist registrar, orthopaedic consultant, Human Resource manager for example (Booyens 1993:115).

Few literature resources relatively examine what these managers really do; instead more detail explanation is given on what these managers are supposed to do. Similar observation was made Bridgman & Roemer (1973:1) many years ago that in the management of health services there are few authorities or "voices" at the top. In many situations the best

thing that managers can do is to have faith, they claimed (Bridgman & Roemer 1973: 1).

This research gap is complicated more by the fact that the department of health operates in national and provincial governments with major operations taking place at district and municipality levels.

The Department of Health Strategic Plan (2006-2009) cites that the Director General will ensure that an operational plan is developed each year to strengthen service delivery by the National Department of Health. A process of monitoring the implementation and its outcomes is said to back this up. It could be argued that the Director General seems to try to participate or translate the Corporate Strategic Plan down to the operational level which should not be the case... or should it be? The Strategic Plan (2006-2009) cites that the director general in his capacity as a strategic manager will at the same time ensure that there is an operational planning activity, on annual short-term basis. It can be expected that the role of senior managers at provincial level may be overlapping as is the case at national level mentioned above, which could further complicate the role of the chief executive officers in hospitals as strategic managers in their own right.

It is a thin line that separates the three management levels in a specific district and municipality; hence the researcher's interest to investigate the phenomenon at district level.

New developments as reported in the *Sunday Times* and *City Press* news papers of the 16th July 2006 poses the question " Will public hospitals now be on the mend" (Chauke 2006:7 & Khuthala 2006: 26). The report follows the decision taken by the Department of Health to devolve powers, authority and accountability to hospitals' Chief Executive Officers (CEOs) in academic hospitals. While unions, government and hospital management welcomed the move; some specialists were quoted as being skeptical about this "decentralization" process.

The other complexity is about the diverse professional fraternity in one district hospital as already mentioned above. There are different health officers/ workers and health administrators at different managerial levels who manage and administer delivery of health services to the public. Different seniority levels of medical doctors, nurses, social workers, physiotherapists, radiographers, occupational therapists, human resource, technical services, pharmacists, dieticians, psychologists exist in hospital settings. Undoubtedly, plans that direct their operations have to be aligned to a certain extent for effective and efficient performance and productivity.

The concept of alignment includes both the vertical and horizontal/ internal alignment aspects which will be defined and explained at the latter stage.

The managerial process described in most management textbooks represents a normative model that describes what managers should do in health service organisations – rather than what managers actually do in these organisations. Wolf, Bradle & Nelson (2005:54) explains that Mintzberg (1973, 1975) conducted a research study to measure what managers actually do. Through intensive case studies of five chief executives in different organisational settings (large urban hospital, consulting firm, research and development company, large urban school system and manufacturing company), he identified the existence of ten managerial roles. (Wolf, Bradle & Nelson 2005:54).

The empirical approach taken by Mintzberg has been applied to managers in health service organizations. Two questions are said to be critical in understanding the managerial roles in health services organizations: -

- Does the managerial role differ according to type of health service organization?
- Do non-managerial personnel perform managerial activities?

The first question recognises the diversity of organisations in the public health service fields. The management of hospitals may be different from the management of community health centers. The second question

recognizes the unique features of many health service agencies. That a significant portion of personnel within the health service organizations is professional and they represent an important force in the operations of the organisation. It is important to understand the degree to which professionals do mainly administrative and managerial work and profession specific duties. Furthermore, the extent to which professional qualification like medicine, social work, nursing, pharmacist and so forth, add more value to the administrative acumen of a manager in the hospital.

Forrest and Johnson (1980) cited by Wolf, Bradle & Nelson (2005:55) attempted to answer the question as the extent that managerial roles differ in different types of health service organizations. They carried out a comparison of a set of administrative activities performed by chief executive officers in a national sample of hospitals with activities of the chief executive officer in a sample of mental health/ human services agencies in the state of Wisconsin. Analysis reveals that differences exist in both the number and nature of tasks performed by managers in the different settings. Hospital administrators performed fewer tasks than their counterparts in the mental health services. Moreover, the nature of the tasks performed suggests that administrators in mental health services are more likely to perform tasks that are deeply involved in the operations of the organisation and perform many tasks personally, which

are delegated to subordinates in the general hospital setting (Wolf, Bradle & Nelson 2005:54).

Another investigation is cited and explained by Wolf, Bradle & Nelson 2005:54 is that of Kuhl (1977) who compares the administrative activities performed by hospital administrators with activities performed by executives in prepaid health insurance plans (close equivalent to private clinics and hospitals in South Africa). Although there are a significant number of activities which hospital and health plan executives share, there are also a significant number, which they do not share. For example, the activities of hospital executives centres around managing large numbers of people, whereas the primary activities of prepaid health plan executives centre on the integration and maintenance of balance among major organisational components (financing, membership and contracts providing physicians). These differences reflect major characteristics of the two types of organisations and suggest that managers should be well aware of the nature of the organisation within which they function (Wolf, Bradle & Nelson 2005:56).

A study of administrative personnel and public health professionals reveals that management activities are not confined to administrative personnel(Kaiser et al .,1980) cited by (Wolf, Bradle & Nelson 2005:54). A significant number of non-administrative personnel such as public

health nurses and midwives are involved with tasks normally thought to be the total purview of administrative staff. These activities include determining salaries and fringe benefits for staff, improving access of health department's services by the community, obtaining department insurance, improving efficiency and productivity, determining the number and type of health department staff and maintaining liaison relationships with the general public and other health services in the community.

Although the above findings require additional analysis (with particular emphasis on assessing the intervening effects of organizational structure and style on role performance and organizational outcome), the available analysis has significant training implications. Training programmes for health professionals must include current managerial theories and methods, which are applied to the ever changing environmental threats and opportunities in local and global environments like health legislations and changing political systems (Gail, Witzel & Smith 2005: 86).

Gail, Witzel & Smith (2005: 86) argue that linking nursing professional practice model components and performance evaluation criteria with each of these foundational documents like organization mission, vision and value statements assures that their values, beliefs and intentions are evident in their daily work life.

2.4 FRAMEWORK OF ANALYSIS

2.4.1 Function and organisation of the health system

All Health Systems according to the WHO, have to perform at least the following five functions that are also used for analysing any system: -

- Production of resources
- Organisation of programmes
- Economic support mechanisms
- Delivery of services and
- Management of services

i) Production of resources (human and physical), these includes:-

a) Persons capable of providing health services

b) Facilities within which to render the services (including traditional healers)

c) Commodities: supplies

d) Knowledge that includes technology (ANX 2008:31).

ii) Organisation of programmes:

Health programmes are organized from the resources available, and also include an informal free market of health care. These programmes are usually divided into preventive

(local clinics and health centre), curative (hospitals), promotive (clinics and hospitals) and rehabilitative (specialised care like psychiatric hospitals, TB hospitals and so forth) (ANX 2008:31).

It is important to know the number of clinics, hospitals (private and public), number of beds in all the sectors in the provinces (See Appendix A).

iii) Economic support mechanisms:

These are resources necessary to finance the formation of health resources and the provision of the services they offer (ANX 2008:33). More affluent countries spend about 5-10% of GDP on health related issues (ANX 2008:38). South Africa spent 7.7% of GDP in 2005. Even though economic factors shape the health system, political policies also play a dominant role. Other factors that influence the health care sector are cultural issues and technological developments such as resources for disease control, X-rays, microbiology developments, communication and transport among others: religious organisations, community structures, family structures and language & cultural diversity (ANX 2008:40).

iv) Management methods:

To achieve the best feasible services there must be some sort of management. Planning of health systems can vary according to needs, according to available resources or according to political preferences or influential leaders (ANX 2008:33). The assumption in this research is that properly managed and aligned strategies in the health system will yield acceptable levels of service delivery. Hence the researcher would like to establish strategic alignment at all management levels in public institutions of the Vhembe district.

The organisation of the facility to implement strategy should be done very carefully so that what is needed is available before implementation. Staffing plays a major role to ensure cost-effective services if all the categories of staff are available.

v) Delivery of services in the public sector:

In South Africa, health care services are divided into: -

- Primary care (Clinic level)
- Secondary care (District Hospitals)
- Tertiary care (Regional or Provincial Academic hospitals).

2.4.2 Total Strategic Alignment

The effectiveness of execution of strategy is derived from two simple capabilities: -

1) The ability to clearly describe strategy
2) The ability to link strategy to the management system.

The net result is the ability to align all units, processes and systems of an organisation to its strategy (Kaplan & Norton 2006:259).

A simple management framework for strategy execution approach adds several important features to the classic "plan-do-check-act" closed-loop, goal-seeking process introduced by Deming (1982) in the quality movement as cited by Kaplan & Norton (2006:259) which are: -

- *Strategy* is identified as the focal point of the management system (Kaplan & Norton 2006:259).
- *Alignment* is identified as an explicit part of the management process. Executing strategy requires the highest level of integration and teamwork among organisational units and process (Kaplan & Norton 2006:259).
- *Executive leadership* is a necessary condition for successful strategy execution. Managing strategy is synonymous with managing change. Without strong executive leadership,

constructive change is not possible (Kaplan & Norton 2006:259).

With strategy clearly defined all components of the management process can be designed to create alignment (Kaplan & Norton 2006:260).

Alignment has four components, which are:-

- Strategic Fit
- Organisational alignment
- Human Capital Alignment
- Alignment of planning and control systems (Kaplan & Norton 2006:261).

a) Strategic fit

Refers to the degree to which the needs, demands, goals, objectives and/or structure of one component are consistent with the needs, demands, goals, objectives and/or structure of another component Louw & Venter (2006:375). This concept was introduced by Michael Porter, referring to the internal consistency of the activities that implement the differentiating components of the strategy (Kaplan & Norton 2006:261).

b) Organisational alignment

The concept explores how the various component of the organisation synchronise their activities to create integration and synergy (Kaplan &

Norton 2006:261). Strategy maps and balanced score cards provide executives with a mechanism to describe strategy at each level and to communicate it from one level to the next (Kaplan &Norton 2006:261). They also measure the extent to which goals requiring cross-organisation teamwork are being addressed among organisational units (Kaplan &Norton 2006:261).

In the context of health care institutions this is on the of system delivery of the key analysis criteria in terms of describing the efficiency and effectiveness (ANX 2008: 29).

c) Human Capital Alignment

Strategy is formulated at the top, but it must be executed at the bottom by machine operators, nurses in the wards, administrators, and maintenance staff. If employees do not understand the strategy or are not motivated to achieve it, the enterprise strategy is bound to fail says Kaplan & Norton (2006:261). Human Capital alignment is achieved when employees' goals, training and incentives become aligned with business strategy (Kaplan & Norton 2006:261).

d) Planning and Control systems alignment

The organisations planning, operations and control process allocate resources, drive action, monitor performance and adapt the strategy as may be necessary. A good strategy with well-aligned organisational units

will be futile if the management functions are mal-aligned. Planning and control systems alignment exists when management functions are linked to the strategy Kaplan & Norton (2006:263)

Louw & Venter (2006:374) further support the saying that successful strategy implementation depends on all the parts of the organisation being aligned to the strategy and working together as a whole to support the implementation of the strategy and they quote Daimler-Chrysler, South Africa's statement that " The achievement of our goals in East London has only been made possible through an alignment of all levels of our company to our targets".

2.4.3 The Nadler and Tushman Congruency and Fit Model

The following question will be asked as per Table 2.1 below: -

Table 2.1: Diagnosis of level of fit within the organisation

The Question	**Fit Component**
• Are the needs of the individuals met by the way the organisation is structured? • Are the goals of individuals compatible with the goals of	**Individual with the formal organisation**

the organisation? • What is the impact of policies, rules and regulations on individuals? • What behaviour is rewarded/ punished? • Do individuals hold accurate perceptions about the organisation?	
• Do individuals have the skills and ability to perform the work they do? • Are the right people in the right jobs • Are jobs designed to meet the needs of individuals? • Are the necessary resources available to assist individuals in completing their work?	**Individuals with the task**

• Are the needs of individuals met by the culture of the organisation? • Does the informal organisation use individual resources in a way that is consistent with the goals of the informal organisation? • What is the emergent leadership style and how does it impact on staff? • Are the values of the organisation appropriate, and what impact do they have on impact do they have on the individual?	**Individual with the informal organisation.**
• Does the structure of the organisation facilitate the completion of work that needs to be done? • Do policies, rules and the procedures facilitate work	**Task with the formal organisation**

that needs to be completed?	
• Does the culture of the organisation facilitate the completion of work that needs to be done? • Does the emergent leadership style encourage the completion of work? • Does the values of the organisation encourage the completion of work?	**Task with the informal organisation**
• Are the formal policies and procedures consistent with the emerging arrangements and behaviour? • Is the culture of the organisation aligned with the formal objectives of the organisation? • What are the values of the organisation?	**Organisation with the informal organisation**

• Are the values affected by the formal structure of the organisation? • Do the values of the leaders match the values of the organisation?	

(Louw & Venter 2006:375)

2.5 SUMMARY AND CONCLUSION

In concluding the literature search, the researcher observed that many studies on Management of Health facilities say very little about the current practices in the South African context. Most literature states what ought to be done and not necessarily what managers in health facilities are doing. Much information is available on management of private health facilities in the country because they are established for income and profit generation purposes. Further more such facilities are forth right about their services being available for medical aid holders.

This research project will assist in developing and highlighting further issues for research and should facilitate dialogue on what the managers are actually doing in public hospitals.

The researcher observed that most studies made recommendations regarding the importance of training of health personnel in current managerial methods for health facilities. It is hoped that this research will also make recommendations on training and development for effective and efficient implementations to align strategy from the planning offices for acceptable service delivery for the broader public.

Public Health Data Sources provide a spectrum of data available to public health decision makers with the intention of not only describing the data source but also identifying gaps in information availability and integration. Statistics South Africa releases an annual survey to assist policy makers and programme managers in evaluating and designing strategies for improving health services in the country (South Africa: Health Review 2004 & www.nrf.ac.za/sada & www.measudhs.com). The chapter closes with the theoretical framework tools available for managers to engage in a continuous realignment process when ever any kind of change occurs in the workplace.

CHAPTER 3

RESEACH DESIGN AND METHODODOLOGY

3.1 Introduction

Health care systems in every country in the world, regardless of their level of economic development are said to be struggling to manage multiple demands and pressures (Fried & Gaydos 2002: ix). In order to understand the current experiences in the South African health system a qualitative, exploratory, descriptive and contextual research approach was followed (Burns & Groove, 1993: 23; Morse & Field, 1996: 8). A research method is a plan to collect and analyse data that will answer the research question is one element of the design Boyd & Munhall (1993:439). A detailed discussion and justification of the research design will be provided in subsequent sections in this chapter.

3.2 The Qualitative, Exploratory, Descriptive and Conceptual research

Qualitative research is a inherently multimethod in focus says De Vos (2001). De Vos (2001) further posit that this multimethod focus or triangulation reflects an attempt to secure an in-depth understanding of the phenomenon in question with the belief that objective reality can

never be achieved and that a thing can be known through its representations.

Triangulation is not a tool or a strategy of validation but an alternative to validation as in quantitative research De Vos (2001) emphasises that the combination of multiple methodological practices, perspectives and observers in a single study may best be understood as a strategy that adds rigor, breath, complexity, richness and depth to any enquiry. Further more, this type of research is conducted in a relatively new area of research, which lacks established theories or findings. A specific research hypothesis may also not be feasible (Welman & Kruger 1999:24). Hence no specific hypothesis is provided neither will such be tested in this research. Specific concepts in this type of research are explained below.

3.2.1 Qualitative research

Qualitative research is about using qualitative methods for managing and analysing qualitative data according to Munhall & Boyd (1993: 439). It involves studying things in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people attach to them. This research is conducted to describe and promote understanding of human experiences. In particular there is very little research and knowledge available on the phenomenon of strategic

alignment of management levels in public health facilities. It involves personal experience, introspection, and cultural contexts, observational, interactional and visual tests that describe routine and problematic moments and meaning in individuals' lives.

De Vos (2001:3) cites that the many methodological practices of Qualitative Research may be viewed as soft science.

Unstructured observations and semi-structured conversations were used to obtain data from the informants that allowed the researcher to gain more knowledge of the problem concerned.

The research method and approach was also selected because the main aim of the study is to gain in-depth knowledge about the experiences of managers in public health facilities in Vhembe district and to establish the alignment of all the three levels of management Strategic, Tactical and operational levels) (Munhall & Boyd 1993:440).

Qualitative study is usually conducted when there is little known about a phenomenon (Morse & Field, 1996:8). An inductive approach was used in obtaining and analysing data from interviews because little was known about the alignment of management level in public health facilities (Mouton 1996:82).

3.2.2 Exploratory

Exploratory research on the other hand was used to establish facts and to gather completely accurate information regarding the experiences being studied, again for the same reasons that little was known about the topic under investigation (Burns & Groove, 1993: 23). The researcher remained open to all the ideas and explored them gain understanding of the implementation of strategies in public health hospitals. In this study the researcher wanted to explore and study the alignment of the three management levels so that the unknown can finally be described.

3.2.3 Descriptive study

The study is descriptive because an attempt was made to describe the strategic alignment of the management levels in public hospitals in Vhembe District. By using descriptive methods an attempt is being made to understand how this alignment occurs, to define its nature, and to explain why things are the way they are. It may be because one thing has caused another to change and there is a need to explain what the relationship between things is (Denzin &Lincoln 2000:19).

The three step process for descriptive phenomenology as explained by Streubert & Carpenter (1995:36) involves intuiting, analysing and describing a particular phenomenon as freely as possible. The researcher

suspends her beliefs about strategic alignment by bracketing and aimed at describing the experiences of the informants (Burns & Groove, 1993: 24). The data collected was transcribed (see Appendix F) and reviewed before the final description of the phenomenon was documented.

3.2.4 Contextual

The importance of context according to Welman & Kruger (1999:189) is that a person derives his or her true meaning from his or her life world, the world as lived by a person; by existing people also give meaning to their world.

The study was contextual because it is restricted to the district of Vhembe in Limpopo Province in the Republic of South Africa. The study was again conducted with managers in their naturalistic hospital setting. The following section deals with the strategies that were used to ensure the trustworthiness of qualitative data.

3.3 Methods to ensure trustworthiness

In quantitative research studies the concept here could be equated to reliability and validity of the research.

Lincoln and Guba's (in Morse & Field 1996: 118) model of ensuring trustworthiness was applied. In this model four criteria are applied to assess trustworthiness of research of any type, which are: -

- Credibility or truth value
- Applicability or transferability
- Consistency or dependability and
- Neutrality or confirmability.

Poggenpoel (in De Vos 1997: 343 – 345) agrees that Guba's model is comparatively well developed and has been used by most qualitative researchers in South Africa. The researcher kept to the principle and value of trustworthiness in conducting this research particularly that the researcher has satisfactory knowledge of the research design used. The four criteria of trustworthiness are explained briefly here under.

3.3.1 Truth value or credibility

Truth-value is usually obtained from accounts of human experiences as they are lived and perceived by informants. The researcher has to establish that truth is not an established independent fact by testing findings against various groups from which the data were drawn or persons who are familiar with the phenomenon being studied which is called triangulation.

3.3.2 Applicability

Applicability refers to the degree to which findings can be applied to other contexts and settings within groups. It includes the ability to generalise from findings to larger populations (Guba in Poggenpoel 1997: 349).

3.3.3 Consistency or validity

This third criterion of trustworthiness considers the consistency of the data, that is, whether the findings would be consistent if the inquiry were replicated with the same subjects or in similar context (Guba in Poggenpoel 1997: 349).

3.3.4 Neutrality

This criterion is about freedom from bias in the research procedures and results. It refers to the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivation and perspectives. A detailed discussion of measures to ensure trustworthiness forms part of Chapter Two.

Table 3.1 illustrates how the strategies were used to ensure trustworthiness of the qualitative data.

Table 3.1: Strategies to ensure trustworthiness

Strategies	Criteria	Application
Credibility	Continual interaction	The researcher conducted the interviews and spent time with both managers individually and in focus groups for follow-up to verify data (triangulation). Conversation was captured using a tape recorder.
	Manager checking	Literature control on strategy implementation and alignment was conducted.
	Reflexivity	Field notes were taken during data collection.

	Triangulation	Presentation of this study at departmental discussion seminars took place.
Transferability	Nominated sample	Purposive sampling of participants who have been involved in strategy implementation as managers in specific hospitals was done.
	Detailed description of results for any one to duplicate the study or apply in different settings	Detailed description of results including literature control is documented in this research report.
Dependability	Triangulation	Field notes and audiotapes were available. Transcriptions of audiotapes available.
	Description of the	A research method is

	research method.	fully described.
Confirmability	Peer group discussion Triangulation	Findings presented to departmental discussion group and to business school for finality. Field notes, transcription, and audio recordings carried out.

The discussion that follows will be on ethical conduct maintained during the research study.

3.4 Ethical issues and protection of the rights of participants

Subjects were invited to participate in the study and were given a background of the study and the significance of their participation, including the implication of voluntary participation, the meaning of informed consent, benefits of the research to the community, confidentiality and anonymity and the option to withdraw from the study at any given time.

The researcher has attached the following documents in compliance with conducting research at Limpopo University and from the Provincial Department of Health: -

a. Ethical clearance and permission to conduct the research at the Department of Health and Social Development
b. Letter from the University of Limpopo Post- graduate and Ethics Committee
c. Request letter to conduct research at Tshilidzini Hospital, Donald Frazer Hospital, Hayani Hospital, Siloam Hospital, Musina Hospital, Elim Hospital and Malamulele hospital.
d. Scheduling of appointments for interviews with hospital managers.

- **Ethical measures**

a) Confidentiality, anonymity and privacy

The researcher assured all the participants that all collected information would kept and used in such a manner that confidentiality and privacy of sensitive aspects of the research would only be shared with the study the supervisor. The research report would be presented to the managers first for their assurance before being shared publicly.

b) Informed consent

Voluntary participation and written consent of all the participants was sought and information about the research was given. Participants were informed about the right to withdraw from the research at any time without threat or loss of any benefit.

c) Benefit and freedom from harm

Participants were informed that the research would not cause them harm. The final research report would be presented and shared with all the institutions in compliance with the condition to conduct the research in these hospitals.

3.4 Population and Sampling

The term population in this context refers to the entire set of units in this study. The population for this study consisted of all the Chief Executive Officer (CEO) of hospitals in Vhembe districts and their respective hospital managers, which are Tshilidzini, Hayani, Donald Frazer, Siloam, Elim, Musina, Louis Trichardt and Malamulele hospitals..

The sample was drawn from the population of executives and managers that work in public health facilities in Vhembe district. Purposive

sampling (Treece & Treece, 1986:216 and Morse 1989:119) was used to invite managers for interviews. The following criteria were used in selecting participants:

- They had to be managers working Vhembe district public health hospitals in Limpopo Province;
- Managers should be able to articulate their experiences and feelings individually and within a group. English, Venda, Tsonga and Sotho languages were used during the interviews.

Sampling saturation was reached and established once four hospital managers had been interviewed at Tshilidzini, Hayani, Malamulele, Elim and Louis Trichardt hospitals. Saturation point is reached when no new information is forthcoming.

Table 3.2 below presents a profile of the sample in all the hospitals.

Table 3.2: Profile of Sample

Manager	**Description**
Chief Executive Officer (CEO) or Hospital managers. All other managers are deputy managers as identified below as specific managers of departments in the hospital.	1. Tshilidzini hospital – **M**ale – Public Administration qualifications – P13 2. Hayani hospital – **M**ale – Teacher by profession and Masters in Public Health –P12.

	3. Donald Frazer – **F**emale – Nurse Administrator and Nurse Educator –P12. 4. Elim Hospital – **M**ale - Psychologist with doctoral qualification –P12. 5. Louis Trichardt hospital – **M**ale – Social Worker by training and still does part time lecturing at the local university –P12. 6. Malamulele hospital – **F**emale – Nurse by training up to Masters level –P12. 7. Siloam Hospital – **M**ale- Medical Doctor by profession –P12. 8.Musina Hospital – **M**ale – Business Administration by training –P12. • 2Females: 5Males • Diversity in qualifications.
1. Nursing Managers in all hospitals	• All nurses by training • 5 Females: 2Males

	• Reports to the CEO • P11 • All the general and specialist wards in the hospital.
2. Financial Managers	• Have post-matric financial management qualifications. • P11 • Procurement and contract management and stores management services.
3. Quality Assurance Manager	• P12 with quality assurance practitioner at P11 • Implements Quality Assurance and Batho Pele Principles, formulates institutional standards, service delivery problems and recommends interventions.
4.Risk Manager	• P11 • Potential hospital risks, interventions, prevents inefficient use of funds and

	resources, investigates corruption, security services, inspection and investigation of various activities in the hospital.
5. Corporate Manager	• P11 • Human Resources, Human Resource Development, Labour Relations and Transport services.
6. Clinical Manager	• The most senior of all the other deputy managers at post level 12 • Renders clinical/ medical care and allied health services. • Forensic, pharmaceutical, dental, clinical psychology and other allied services like physiotherapy, occupational therapy among others.

7.Information and Records Manager	• P11 • Information technology and records management services and communication and information management.
8.Technical Support Services	• P9 • Manages general maintenance and maintains grounds.
9.Liaison Services	• P9 • Market the hospital, communication services and management of information.

The CEO has at least ten (10) managers reporting to him/her.

3.6 Data collection methods

Data collection was done by means of in-depth interviews with managers employed in Vhembe district public health hospitals. Audiotapes and field notes were used in order to increase the reliability of the information obtained from the managers. Triangulation and confirmation of the experiences as described above was established with the informant concerned being contacted to clarify and confirm the accuracy of

recorded data. Triangulation overcomes the intrinsic bias that comes from the use of a single method or single observer studies (Knalf & Breitmayer in Morse 1989:209).

3.6.1 Data collection process

a. An appointment was made through the CEO's personal assistant to deliver the letter requesting an interview with the managers.
b. Selected different categories of managers in each hospital were interviewed at a time convenient to them as scheduled in the board rooms and in offices of individual managers where clarity on specific issues was sought. It was very interesting that the researcher was always offered tea, water or soft drink even if the purpose of my presence at the hospital was clearly on student-researcher basis and not as health professional!
c. An appointment would be set with the CEO to discuss the interview process to clarify the details in the informed consent, time scheduling of interviews with groups or individual managers.
d. Most interviews were conducted for at least sixty (60) minutes using an audio-tape and taking field notes. Notes were taken to capture the gestures and expressions made by participants. Consent to use the audio tapes was sought prior the interviews and participants were aware of the tool.

e. The audio taped recordings were transcribed and reviewed for analysis.

f. Data was collected through unstructured and semi-structured, in-depth interviews. Participants were allowed to talk freely and mixing own language with English language when necessary. Each interview lasted sixty (60) minutes or more. Field notes were kept to describe the researcher's observations and experiences during the interview. A tape recorder was used to record the interviews, which were transcribed in English. Semi-structured questionnaires used during interview are attached as appendix H.

3.7 DATA ANALYSIS

In qualitative research data collection occurs simultaneously with data analysis. Tape recorded interviews were transcribed word for word. Data were analyzed according to Tesch's open-coding method (Creswell, 1994: 153 – 155) and Leininger's phases of analysis (Leininger 1991:19). A consensus discussion was held with participants and an independent coder to identify themes, categories and sub categories.

The following process was followed: -

Stage 1: Notes were made after each interview to record initial ideas the researcher had about the data or the research process.

Stage 2: The researcher studied the data intensively to become familiar with the data.

Stage 3: Themes were identified or major thought patterns emerging from the transcripts.

Stage 4: Categories were generated. This stage was the most time consuming but extremely important. Cards and colour pens were used to facilitate the process. Once the long list of categories were created, the researcher deleted some categories that were not useful or could be merged with others.

Stage 5: The transcriptions were reread along side the list of categories and themes and notes made of any relationships that could be identified. The researcher frequently returned to the participants to confirm the meaning and classification of themes and related categories and this is called triangulation. The researcher had to use independent coders of administrative nurse experts to check the appropriateness of the analysis.

Stage 6: The researcher completed and summarised findings them in Table 4.1 to systematically make sense of unstructured and semi-structured questions used during the conversations and interviews.

3.8 SUMMARY

Important aspects of the research method that was used in this study were discussed. The strategies to ensure trustworthiness and ethical measures were also discussed.

The chapter that follows will discuss the findings.

CHAPTER 4

FINDINGS OF THE RESEARCH

4.1 INTRODUCTION

The chapter presents patterns of results, findings and information from the interview responses. The data presented is based primarily on the research question, "How are the three strategic management levels at district public hospitals aligned"?

Because of the nature of qualitative methodology used in this study an additional section is provided for data collected that does not fit into the research question categories developed in the literature review in Chapter Two.

4.2 THE DESCRIPTION OF THE SAMPLE

A purposive sample was used to select all participants as described in Chapter Three. A profile of the sample was analysed in detail in the previous chapter. There are a few criticisms associated with purposeful sampling. By virtue of the selection process purposeful sampling is characterised by bias and Morse (1989:125) asserts that this criticism is valid. An unbiased sample violates the qualitative research principle of obtaining information from the experts (Morse 1989:125).

The second observation relating to purposeful sampling has to do with inside information of the researcher and of research done within own

profession and culture. Morse (1989:125) points out the importance of being aware of such insider information and prior knowledge hence bracketing of bias around research issues, is critical in qualitative research.

Bracketing is explained by Burns & Groove (1987:80) as a process whereby the researcher suspends or lays aside what is known about the experience being studied. The researcher gets rid of the preconceived ideas and reconstructs new ones. This process facilitates the "seeing" of all facets of the phenomenon and the formation of new constructs (De Vos 2001:337). The interview schedule, whether unstructured or partially structured is guided by the bracketing principle too.

4.3 FINDINGS

A data analysis was conducted of the transcribed interviews following Tesch's method of open coding (Creswell1994:155). The experiences of the managers were grouped into themes, categories and subcategories.

The use of themes, categories and subcategories of the experiences of managers as elicited from the interviews makes data analysis more manageable and sensible to consumers of qualitative research.

Table 4.1 summarises the themes, categories and subcategories of these findings.

4.3.1 An outline of the semi structured questions developed in the literature review includes the following:-

- Does the hospital have a Strategic Plan in place?
- Describe the process of how the strategic planning document was produced?
- Who participates in the development of the Strategic Plan?
- Can you describe the management structure, organogram of the hospital?
- How is the Strategic plan implemented and managed in this hospital?
- How do managers evaluate implementation of the strategic plan at different management levels?
- How are the Strategic plan and other operational plans communicated to the lower ranks and to the external community?

4.3.2 The six main themes identified are the following: -

1. The strategic planning document is available and in place in the hospital. Strategic management language is used in a slightly different manner.
2. A strategic plan process is followed to develop the strategic plan. The strategic plan is cascaded down from National government to

the Province and down to the District hospitals. In the hospital the process starts bottom up from the operational levels as part of the process of informing the institutional plan. This process starts from the National Department of Health (DoH) down to all the nine provinces. National performance plans and reports are compiled from various provincial reports by manager only.

The Department of Health in Limpopo comprises of both the Department of Health and Social Development (DH&SD) led by one MEC. At National level these are two distinct departments led by different ministers Honourable Mrs.Manto Tshabala–Msimang and Honourable Mr. Zola Skweyiya.

3. A specific departmental architecture together with an institutional organogram is in place (see Appendix I).
4. Monitoring processes and specific tools are used for this purpose. Monthly, quarterly and annual performance plans and reports are produced.
5. National and Provincial Strategic Plans and Performance Plans with targets and indicators do not match the resources available to hospitals.
6. There are challenges relating to what is written on paper and what happens at hospital level

7. The Strategic Plan and Management Processes, documents and structures are in place but there is still public out-cry about poor health services in the country.

Table 4.1 below presents the findings of the study and will be used as the basis for the discussion that will follow in Chapter 5.

Table 4.1 **Findings from the experiences of managers with regard strategic management processes in Vhembe hospitals**

Theme	Categories	Subcategories
1. Strategic planning document is available and in place in the hospital. Further more strategic management language is used in a different manner.	**1.1** Vision and Mission of the National and Provincial government are available. **1.2** National Strategic Plan can be accessed by CEOs from the national Department of Health Website. **1.3** Provincial Strategic Plan is available in all the hospitals. **1.4** The provincial government holds annual briefs with	**1.1.1** Each hospital has developed individual Vision and Mission statements. These are displayed strategically for every one to see. **1.1.2** A Business plan is used interchangeably with the Strategic Plan in hospital. **1.1.3** The Business Plan is translated into Institutional Annual Performance Plan.

	district managers to hand down the national and the provincial strategic objectives and to endorse hospital plans. **1.5** An Annual Performance plan is developed for monitoring and evaluation purposes. These are targets and indicators to be met in a specific year at province and institutional levels. **1.6** An Annual Business Plan is developed. This is a financial planning document that is	**1.1.4** Various hospital departments/ divisions/ sections draw up specific business and annual performance plans as baseline document for the following year. Each department has specific cost centre with different cost accounts as per sectional business plan. **1.1.5** Every hospital department can access hospital funds only if it has business plan in place.

	submitted to the provincial government in order to access hospital annual budget. No budget is allocated to hospitals without this document in compliance with the Public Financial Management Act (PFMA), No.1 1999 (as amended by Act 29 of 1999).	**1.1.5** Each section/ ward must further develop an operational plan with section specific targets and indicators to establish performance levels.
2. <u>A Strategic Plan process is followed to develop the Strategic Plan</u>.	**2.1** The strategic planning process is allocated a specific time in the third term to undertake a planning retreat. **2.2** A planning retreat is attended	**2.1.1** The strategic planning process in hospital starts bottom up. Different sections and wards have to conduct own SWOT Analysis and

	by the CEO/Hospital Manager and managers/ deputy managers. **2.3** The outcome from this meeting/retreat is a hospital strategic plan which will form the baseline document in the next year. **2.4** An institutional Strategic Plan will be formulated from the sectional presentations. A more detailed PEST/SWOT Analysis is added at this stage. **2.5** A format cascaded from the National and Provincial government is followed for	draw up plans based on their SWOT analysis. Final departmental plans will be presented at the senior managers' retreat to develop the hospital wide strategic plan. **2.1.2** Once the hospital strategic plan is endorsed by province and is available for implementation, various departments can then draw up operational plans/ operational business plans in line with the master plan.

	uniformity. **2.6** An institutional/hospital Strategic and Business plan documents are forwarded to the Provincial Administration, which refine the document and it be returned to the institution concerned. This step is done to confirm if provincial inputs represent the original hospital plan. Managers reported that there are usually more new changes that make it difficult to own. **2.7** Provincial administration forwards the business plan to	

	Treasury for funds to be released to hospitals. Once the process has reached this point, nothing from the plan can be changed. **2.8** The plan will have to be followed to the letter. The hospital financial manager ensures that the plan is followed as per budget allocation from Province. **2.9** The actual funds received are always less than the requested budget.	

3. <u>A specific departmental architecture together with an institutional organogram is in place</u>.	**3.1** See attached Appendix I. **3.2** The organizational architecture and organogram are similar throughout the district. **3.3** All hospitals are headed by the chief executive officer (CEO). All hospitals have the following sections: - • Quality Assurance support services. • Liaison services, • Clinical care services. • Nursing services. • Risk management and security services.	**3.1.1** See attached Appendix I. Same as in 3.1

	• Financial management services. • Corporate services (Human Resource, Training and Development, Labour Relations, Transport management services, Work-study and Job evaluation, Logistical support services and organizational development services). • Information and Record management. • Technical support services.	

	All the above divisions may differ in the post level depending on the level of the hospital	
4. <u>Monitoring processes and specific tools are used for this purpose</u>. *are developed*	**4.1** Performance Plans and Business Plans are cascaded down to the wards for roll out and implementation. **4.2** The Strategic Plan is implemented and monitored once the Business Plans and performance plans are in place. **4.3** The provincial DoH hands down targets and indicators to be achieved by hospitals on short and	**4.1.1** Weekly sectional performance monitoring. **4.1.2** Monthly performance meeting at sectional and management levels. **4.1.3** Quarterly meetings to monitor financial performance. **4.1.4** Managers reported concerns about the criteria for winning the awards. Secondly there is concern about salary disparity of different

	long term basis. **4.4** Provincial service standards awards are accorded to hospitals that exceed expected targets and indicators. **4.5** A provincial annual performance report is compiled and is available to the public.	categories of employees in hospitals. **4.1.5** Managers have to present to the institutional senior manager's committee how much was spent, how much is left and the variance which should indicate a trend towards overspending or under spending. **4.1.6** A hospital performance Excellence programme model is also in place. The programme includes issues like: - • Mortality and morbidity rates and pattern in the

		hospital. • Clinical audits. • Doctors visits to clinics. **4.1.7** Other monitoring tools include: - • Hospital Board Survey, • Tender committee reports, • Quality Assurance, • Infection Control and • Occupational Health reports, • Nursing audits, • Compliance Profile (to set district standards and norms), • Hotel services reports,

		• Service delivery improvement plans and reports. **4.1.8** Service standard awards are used and serve as motivational incentives to employees and to specific institutions. Various incentives and awards are available for best performers as motivational strategies at national, provincial and hospital levels. **4.1.9** Monthly Peer Review meetings are held by managers. This is critical as there are other targets and indicators that are shared across sections like record

		management, waiting time etc. Bottle necks and weakest links are identified and dealt with at such meetings. The managers used a term "grill meetings". **4.1.10** The following tools are used: • Peer reviews called "grilling process". • Quality Assurance committee • Annual Performance Report • Performance Awards for achievers

5.National and Provincial Strategic Plans and Performance Plans with targets and indicators do not match the resources available to hospitals.	**5.1** National and Provincial Strategic Plans and Performance Plans with targets and indicators do not match the resources available to hospitals. The National department has to wait for the Minister of Finance to pronounce the national health budget. **5.2** The provincial department has to wait for the national budget to be broken down to different provinces. Then the local governments and hospitals obtain their allotted share. **5.3** Provincial delegation is in some	**5.1.1** Most hospitals in the district are over seventy to above hundred years old as were built mainly by missionaries. Therefore infrastructural limitations impact on strategic performance outcome. **5.1.2** Most managers felt that they operate at about 65% efficiency based on the annual performance reports. **5.1.3** Provincial delegation on HR and Financial sections limits strategic direction in hospitals.

	instances different to national delegation. Provincial delegations also differ from province to province.	
6. <u>There are challenges with what is written in paper and what happens at hospital level.</u> The Strategic documents and structures are in place but there is still public out cry about poor health services in the country.	**6.1** There is no specific department or unit that Coordinates and deals with Communication challenges with regard to strategic planning implementation. **6.2** Political challenges i.e. demarcation of boundaries and provinces affected and changed and rerouted locations and names of areas where communities can access services .	**6.1.1** Once plans are in place there is little coordination at the implementation stage and there is no adequate communication of the process. Less time is available for planning due to limited financial resources and the process is usually rushed through and ignore to respond to questions raised in the process. If in-service education is provided

		in this regard it does not provide individualized assistance on own operational process and plan. Our people still needs more information to understand how district health services operate now. Hospitals do not have marketing and proper public relations structures in place. They depend on liaison officers who usually are not doing the actual marketing required to promote hospitals and give information about how district hospitals work.

		6.1.2 Some patients are forced to commute to furthest hospitals and clinics because of provincial municipality borders that are now in place since 1994. This is part of the problem of communicating political changes to communities. Our people think that it is hospital management that does the change. Who should talk about these issues, us or board members or hospital coordinator? Some one has to be appointed to do this. • Hospital revitalization plan has not reached most

		hospitals as new clinics and health centres had to first be built to meet national and provincial targets. • HR process has a serious bureaucracy. Advertisement of post is done at provincial level because hospitals are not allowed budgets to advertise posts. • Hospitals in the district can only procure assets not more than R50 000. Only the Provincial hospital can procure above R100 000.

		• Managers expressed the view that it is impossible to please every one because health issues are fraught with over sensitive perceptions and at times poor attitudes of providers and consumers of services.

4.4 CONCLUSION

Findings are presented. Discussion and interpretation through literature control is made in chapter 5.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

Alignment of strategic management levels in public hospitals in Vhembe District

5.1 INTRODUCTION

This chapter discusses the findings presented in Chapter Four within the context of literature control. Six main themes were identified and a thematic discussion is provided here under. Thematic analysis is one way of making sense of unstructured data systematically. The approach is extremely flexible and is creative in that it depends on the interpretive abilities of the researcher. The framework of analysis as provided in Chapter Two will be employed to describe the alignment of the strategy in public hospitals in Vhembe district.

5.2 THEMATIC ANALYSIS AND DISCUSSION OF THE FINDINGS

5.2.1 Theme 1: *Strategic planning document is available in hospitals*

As a point of departure the researcher assumed that due to the complexity inherent in health care facilities like hospitals there should be some kind of planning practice that is followed to manage the hospital.

All the CEOs and their deputy managers reported that they had ***Strategic Plan documents developed and available in their hospitals***. The participants were all in agreement that the Strategic Plan is an important document that guides management strategies and gives direction to the institutional intentions. This assertion is in agreement with all research and authorities in the Strategic Planning field

The ***vision and mission*** statements are publicly displayed on the walls of offices and wards of the hospital. These differ from one hospital to another. All the participants reported that the vision and mission informs Strategic intent and Strategic implementation in hospitals.

The use of the vision and mission in performance management did not feature strongly with regard to how these two concepts are used to guide professional practice and performance management in the hospital. As non-profit organisations the value of the vision and mission did not feature as powerfully as compared to the business plan.

It was not the goal of this study to analyse the vision and mission of institutions.

Availability of a Strategic Plan in the institution led the researcher to understand the established process that is followed to develop the document.

It was evident that the purpose and goal of the hospital was well understood as documented, called the strategic intent by Louw &Venter (2006:xi). By the time four hospitals had been visited the researcher concluded that every hospital had this document in place and all were using exactly the same format, sequencing of heading and subheadings from the provincial guidelines to hospitals.

The ***vocabulary of strategy and strategic management*** is well developed among all the participants. However, to include a ***"glossary"*** or a section on operational terms and definitions used in the Strategic Plans of hospitals would help a lot in assisting other stakeholders to understand the use of terms in the document e.g. *Strategic plan, Performance Plan and Business Plan need to be clarified.*

There was an understanding "that the vision represents the future aspiration of the hospital" while "the mission is what the institution is currently doing to achieve its vision", a view supported by Smit & Cronje (2006:17).

Strategy as a plan provides overall direction and course of action (Louw & Venter 2006:18). Further more this is the starting point before the actual implementation can be thought of.

The planning viewpoint is that decision-making is a formal, logical, top-down structured process (Thompson & Martin 2005:25) in which strategy is formulated through a rational analysis of the organisation, its performance and external environment (Louw & Venter 2006:15).

As a plan, strategy formation is a process of conception and formal nature which is then implemented through organisational layers, structures and control system as demonstrated by the second theme discussed below (Louw & Venter 2006:15).

When it comes to the management level at hospitals, consideration is made on the baseline data as per previous strategic plans.

The political environment including the State of Nation address and the State of and Province address are highly considered as factors to regarded as external opportunities or threats. One manager said "with every election process we should expect a different focus as different people are brought in to lead departments. The same process was followed at Provincial level (Department of Health & Social Development Health Vote 7, Annual Performance Plan 2007.8 2009/2010). Finally, the demographics and Epidemiological profile is highlighted in the process.

This exercise usually takes place towards the end of the third quarter of the financial year and it usually lasts for an average of three days.

One manager said this process should take place earlier on in the year to mitigate the impact of pressure to come up with all the plans for submission to province for the subsequent allocation of hospital budgets.

One CEO said a draw back in the process is that there is usually limited time to draw up the actual plan. "This results in giving the provincial government data and information that do not reflect the actual wishes of the hospitals. At times this makes it difficult to own inputs from the provincial".

According to the strategic planning management process model of Louw & Venter (2006: xi), the strategic analysis may have to answer the following questions, which are: -

i) What do we want to become (purpose and goals)? This line of questioning involves the macro-environment analysis and the industry environment analysis.

ii) What is our current situation? This line of questioning seeks to analyse the internal environment.

This process takes the whole first quadrant of the model, see figure 5.1 without implying that the strategic process is cyclic or linear in nature. The framework of analysing strategic management process in Louw & Venter (2006), Thompson & Strickland (1999), Smit & Cronje (2004), Grant (1994), Stonich (1995) and other authors on the

Strategic Planning Process) is based on the modern competitive landscape. Globalization has accelerated the free flow of goods between countries, constantly placing pressure on organizations to be competitive (Louw & Venter 2006:6).

In 1999, South Africa was rated 175th in the overall Health System Performance Ranking of selected countries (WHOs' World Health Report 2000) against countries like Argentina -75, Bangladesh – 88, Cameroon – 164, Egypt -63, Ghana – 135, Haiti – 138, India – 112, Mexico – 61, Morocco - 29, USA – 37 and Zambia – 182. Such global competitive indices play a marketing role in tourism one of the major income generating strengths for countries globally. Hence South Africa cannot afford to be complacent in this regard, particularly that poorer countries which also spend lower Health Expenditure as percentage of Gross Domestic Product (GDP) as compared to South Africa performs better in the performance ranking index (South African Health Review 2006:33).

It would seem that such competitive indices would serve more purpose at Provincial and National level to ensure that focus on strategy gives attention to such international factors.

It can be concluded that this stage in the Strategic Management Process is very critical for all the levels of management to take it very seriously and to build enough skills and capacity among all health

personnel to understand the importance of environmental monitoring as part of baseline information.

The documentation of the sector situation analysis should be comprehensive and convincing enough to justify use of such data collected in the formation of an aligned Strategic Management process.

5.2.2 Theme 2: There is a Strategic planning process that is followed to produce the Strategic Plan in hospitals

All the participants reported that the Strategic Plan at institutional level is informed by the Strategic Plan from the Province, which obtained its guidelines from the National Plan; this is in agreement with the model by Schutte (1963:46) that guidelines should flow from corporate level down to the operational level.

The term that was used by participants to describe this process was that "the Strategic Plan is cascaded downwards to the Provinces. Then the Provinces roll the process down to the districts in local governments. The provincial government hold annual briefs with district managers for workshopping on changes introduced in the national and the provincial strategic plans to facilitate compliance by managers in the compilation of their annual performance plans.

According to Louw & Venter (2006: xi) three strategies should be the outcome of the strategy development process and are: -

i) Corporate level strategy

ii) Business level strategy and

iii) The Global competitive advantage the organisation holds.

Thompson & Strickland (1999:45) depicts the process as the Strategy making Pyramid. The Strategy is cascaded from Corporate level (National level), down to business units in 9 Provinces with their peculiarities) of the diversified companies and further cascaded to Functional and operational levels of managements (Hospitals). In the case of single businesses like in single hospitals, Thompson and Strickland(1999:45) depicts a pyramid process that starts with business strategy from the executive level managers, down to functional strategy by functional managers (sectional managers) and finally down to the operational strategy which is developed by unit managers.

All the participants have been to at least one strategic planning exercise outside the hospital environment to develop a strategic planning document for the hospital. On average this exercise has taken place more than three times in the past four years.

On the question of what is actually done in this process, all participants said the "process is bottom up". The "area" managers together with their subordinates compile a document on issues that have to be provided for

in the business plan and for the subsequent development of operational plans. This first process takes place at hospital settings. The term area manager was used inter-changeably with the term "sectional" head/ manager e.g. nursing manager, clinical manager or financial manager who all report to the CEO.

At the level of hospital Strategic Development phase, all the managers were in agreement that the following plans are produced at the end of the process which are: -

i) Institutional Strategic Plans

ii) Institutional Business Plans

iii) Sectional Business Plans

iv) Sectional Operational Plans and

v) Sectional performance Plans.

The Strategic planning concepts and language used to describe some of the commonly used terms in the strategic management and planning field of study was slightly different as observed by the plans provided above and phases of the process outlined here under.

At Malamulele hospital the process was described as taking place through three phases as follows: -

Phase 1:-

- SWOT Analysis is conducted at sectional levels. At this point the Demographic information is analysed followed by the

Epidemiological profile impacting on the section. For example if the context is the nursing section they analyse the current socio-economic level of patients that were admitted in their wards, ten prevalent diseases in the area and the top five causes of death in the region.

- Hospital performance indicators like average patient waiting time, length of stay in the hospital, usage and bed utilisation rate, and patient's satisfaction rate in the hospital are calculated and matched with the average daily patients' costs of admission and treatment in the hospital.
- Every section have to state the current services that are provided and finally major strategic challenges are outlined. Examples of challenges mentioned by all the hospitals were quality improvements, poor support services of the core business; budget provided to sections constantly does not meet service delivery needs, human resource shortages, and poor governance.

- **Phase 2**: -
- Review of previous service delivery report and challenges, recommended format to be followed from the province. Institutions have to align their format with provincial provision and to review the entire "balanced score card". The balanced score card was mentioned to be in use at only one district hospital.

- Looking at available financial resources to deliver health care in the locality.
- All the indicators and targets for the integrated annual programme were examined.

Phase 3: -

Involves looking at how individual sections are going to contribute to the institutional business plan.

Finally an institutional strategic plan, performance cum business plan is developed.

In one hospital the manager stated that indeed some kind of Strategic Planning was conducted, "however due to time and resource limitations I doubt that we are engaged in a true strategic planning exercise." The manager continued, " The purpose of strategy is to identify your internal resources and balance that with the external opportunities. In our case whether your plan directs you to do things differently that will not help because of the huge limitations posed by the financial mandate and procurement authorisation powers for district hospitals. Further more it is difficult for hospitals to attend to the Primary Health Care needs with such a skeleton staff component. "No hospital has an advertising budget therefore cannot advertise and appoint its staff directly. That is the responsibility of the Provincial administration. The selection and appointment process takes long because Province must collect all the

post requirements by all the hospitals and advertise,select, appoint and distribute staff to different hospitals".

The same sentiments were raised with regard to strategic procurement of equipment and resources to provide effective health services. "District hospitals cannot procure items costing more than R50 000.00 outside the tender process and without the approval by Province." One manager said" I am able to procure above the limit set by Province because at our hospital we submitted capacity evidence due to the qualifications of our financial manager." "If you do not have the human resource capacity you cannot be allowed to exceed the procurement mandate." "I have once fast tracked the appointment process of hiring medical doctors by personally submitting all the paper work to the Province for the appointment of institutional recruitment of medical doctors. My motivation was accepted and I was able to have the necessary doctors I needed in a short space of time than it would have been the case had I followed the tall order." "The challenge is that by the time the adverts are out most of the targeted professionals are already absorbed by other competitors particularly in urban areas."

5.2.3 Theme3:*A specific departmental structure or organogram is in place.*

The pattern is the same throughout all the provinces and districts (see Appendix I).

This is a new administrative organisation in hospitals. The old high pyramids are replaced by flatter structure that is supposed to hasten decision making processes in hospitals. To this end internal processes were reported to be functional and operating well.

Of great interest was the fact that CEOs were appointed from different educational backgrounds. Ranging from social workers, nurses, teachers, administrators , medical doctors and so forth unlike in the past when this was the preserve for medical doctors only. However, every CEO has to have a Masters in Public Health or be in the process of acquiring the qualification.

"The managers reported that there are different directorates for different levels of hospitals. There is the District Hospital Directorate and the Regional Hospital Directorate located in the Limpopo Provincial Department of Health . Because the District Health System is not yet well developed in the Province, all the hospital levels in the district still reports directly to the regional hospital directorate. One participant said: "Compared to other colleagues in other provinces with the well developed District Health System, we are better off because the hierarchy is flatter

and processes are faster". Only the Primary Health Care clinics reports to the District Health Directorate. Except in Limpopo Province and Eastern Cape Province, all district hospitals report to the District Health System Directorate reported one manager.

5.2.4 Theme 4: The Strategic Plan is implemented and monitored once the Business Plans and performance plans are developed.

All financial managers said that: "No one can touch the budget without a business plan at provincial and district level in compliance with the PFMA." "Each department has a specific cost centre with different cost accounts where specific budgets are allocated, accessed and monitored." Thompson & Strickland (1999:310) support the notion that implementing strategy forces a manger into the budget making process. Kaplan & Norton (2006:280) posit that if a budget linkage is introduced in the organisation through a balanced score card, an opportunity arises to convert the budget process into a useful means of strategic resource allocation.

The managers confirmed this process in all the hospitals. The balanced score card makes it possible to transform strategic implementation into one that contributes to both strategic outcomes and operational performance (Kaplan & Norton 2006:280). According to all CEOs the

statements by Kaplan &Norton (2006) contradicts the practice in the Provincial and district health systems. "We are limited by the financial delegation from the province which means that district hospitals are not authorised to procure equipments above R50 000.00. One CEO then said "such limitations do not allow managers to manoeuver freely to achieve strategic excellence. Thompson & Strickland (1999: 310) would agree with the managers because they suggest that organisational units need big enough budgets to carry out their parts of the strategic plan.
In principle, what is written in black and white is not in sync with what happens in practice. According to the Hospital Review(2008) the ratio of doctor to patient in Limpopo Province was standing at 1:9000 and for nurse patient ratio at 1:450. The recommended ratio according to WHO should be 1:2 500 and 1: 250 for doctors and nurses respectively.

5.2.5 Theme 5: National and Provincial Strategic Plans and Performance Plans with targets and indicators do not match the resources available to hospitals.

" We are expected to visit clinics on weekly basis but because of Human Resource limitations we mostly fail to comply."

"We are expected to comply with specific waiting period time by patients, and to render specific standards of care. But because of limitations in infrastructural and availability of commodities and supplies,

such targets and expected criteria are difficult and at times impossible to meet."

"We are expected to render services within specific areas but because of the municipality demarcation of borders, some clients fail to comply and insist on demanding services from the facilities they have always associated with either due to proximity and familiarity."

Most managers felt that the strategy could be better implemented if there was an office or a specific department responsible to co-ordinate the put plans in place. "There is no one responsible for co-ordination, therefore we still continue working as silos". One manager reported that: "the model used to manage hospitals fell short of implementing this European model in totality because in such countries they have a CEO who is solely responsible with Strategy implementation, which is not the case in South Africa."

At Provincial level the infrastructural challenge was reported at the level where specialist facilities and resources were unavailable or not meeting the required infrastructural standards." We are expected to raise revenue through the use of private wards for medical aid scheme patients, but the hospitals are not allowed to use the income raised for hospital improvements; only a certain percentage can be used by hospitals. Again there is little incentives to

maximize and improve such profit generating exercises." Thus the best strategies in place cannot be fully exploited."

The challenge becomes that of "what informed the targets to be achieved from the Provincial Administration if no creative ways are in place for individual hospitals to innovatively solve some of these challenges through own means with the support of the Province." In one hospital participants blamed the challenge of targets from the point of view that all institutional Strategic Plans were approved at Provincial level and at times the changes to the plans meet with the difficulty of ownership by institutions."

"The process of Strategic Planning should be started earlier in the year and more time should be made available to complete the job instead of hurrying to submit to Province whereby the final document is mainly due to the corrections on the part of the Province." "Bottlenecks ruin the whole institution."

"Most managers felt strongly that with all the controls in place they could do better if more autonomy and more mandate was accorded hospitals".

Indeed. The Strategic understanding, training and experience in hospitals ARE limited by the bureaucratic hierarchy. One manager reported that in analysing the external environment the political climate counts a great deal if the thrust and focus of a specific government is in place".

Peer reviews only focus on failure with regard overspending and under spending of finances.

5.2.6 Theme 6: There are challenges with what is written in paper and what happens at hospital level

This theme developed out of the following question the researcher asked "From what I understand and regarding theory and practice of Strategic Planning and management, what you have described shows that you are doing well with the Strategic management process. What I need to further understand from your point of view is why then is there media and public outcry about the services rendered by public hospitals like this one?

5.3 INTERPRETATION OF THE ALIGNMENT AND THE MANAGEMENT OF ALIGNMENT OF THE STRATEGY

The challenge of managing in a changing environment was demonstrated in Chapter One as per milestone of the South African Health System. In South Africa, the establishment of democracy and the Constitution since 1994 produced majority rule for the first time in 300 years. The challenge of translating a liberation organisation into a ruling party brought with it challenges and opportunities that were likened and described as: "repairing a leaking ship that is already sailing in the deep

seas." They had to take over and lead a with the legacy of a dysfunctional system of the past and create an inclusive delivery of houses, water & sanitation, jobs, health and education, and so forth with limited resources in a limited space of time for government to be seen making inroads in redress and equity. This state of affairs brought with it too much change that needed the management dynamics and leadership capacity to monitor stability and change. One manager said: "with every election process we should expect different focus as different people are brought in to lead departments." Unfortunately these political changes are not adequately planned for together with the intention of governance, leadership, management and administration.

One of the managers accurately diagnosed and recommended that: " a department or a senior manager should be appointed to monitor and lead the process so that there should be alignment at all times with every mal-alignment that occurs with every change that occurs as Kaplan & Norton (2006:245) posits.

Alignment is not a one-time event because change is constant, says Kaplan & Norton (2006:245). Competition in the health industry, regulatory and macro-environmental changes, changes brought about by technology, customer/ health consumers and employees needs are forever changing in the sector. Hence the institutional Strategies and their implementation must therefore continually evolve.

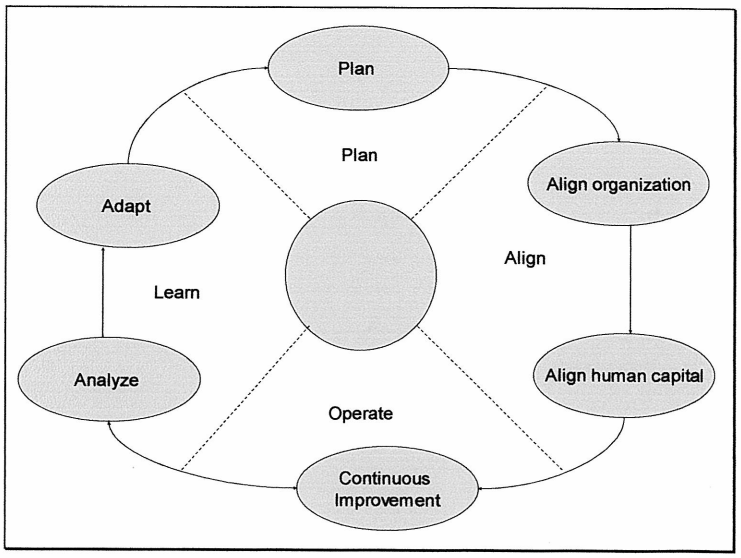
National and Provisional government together with their institutions have all the necessary structures in place to deliver a competitive and world class public health service. They are unfortunately limited by not attending to critical alignment processes within the implementation phase of the strategic planning process.

Hospitals have already in place the culture of conducting a multiday off-site meeting organised by the strategic planning senior management team. The team engage in an exercise to review and update the company's strategy in the light of changing circumstances and the new knowledge gained since the last strategy was formulated. The update involves many traditional techniques of strategic planning like environmental scan, demographic and epidemiological analysis, and SWOT analysis.

The exercise should not end with all the good works done up to that stage.

Figure 5 below depicts the framework that could be applied as suggested by Kaplan & Norton (2006:260).

Figure 5: Framework of strategy alignment



The following detailed organisation alignment exercise should be conducted to include: -

- Organisation alignment

  Strategy maps and Balanced Scorecards (BSC) provide executives with a mechanism to describe strategy at each level and to communicate it from one level if such a tool is developed. A simplified example of a BSC would a single page containing the following information:

Balanced Scorecard (BSC)2008 Objectives
1. **Financial**: a) Use 25% of the budget in the first two months.
b) Increase private ward income by 20% in 2008

2.	**Patients**: a) Implement JIT patients' queries. b) At least 25% improvement within 24hrs of admission.
3.	**Process**: a) Reduce queuing time to 30minutes. b) Reduce hospitalisation to 3.5 days. .
4.	**Learning/ Growth and Innovation**: a) Implement BSC in-service training monthly. b) Develop improved Business Process Mapping(BPM).

- Human Capital Alignment

To assess the extent to which employee goals, training, selection and retention and incentives are aligned with hospital strategy. Such reports should be presented at seminars, conferences and strategic committees like hospital boards and citizen meetings which are already in place from the innovative and creative thinking processes in place (Kaplan & Norton 2006:262-263). Both intrinsic and extrinsic motivations should be analysed with regard to the appropriateness and the extent the rewards are achieving the intended purposes. It cannot be allowed that such lucrative rewards and incentives already in place be wasted in conflicts and dissatisfaction of employees on how they are awarded.

Kaplan & Norton (2006:264) suggests that intrinsic motivation has to be communicated and the employees educated through the appeal by leaders to create employee desire to work for a successful hospital that makes a positive contribution to society and the world.

The vision and mission should not only be displayed but should be internalised in the internal network systems and culture of the hospitals. The tool recommended by Kaplan & Norton (2006:265) is the use of Strategy Maps and Balanced Scorecard to communicate strategy–both what the hospital wants to achieve and how the hospital intends to realize its strategic outcomes. The tools were mentioned by some managers during the interviews, the challenge is that there is no specific office like is common practice in corporate environment with the establishment of the Office of Strategic management Kaplan & Norton 2006:262).

- A Strategic Fit exercise

To assess the extent to which internal networks and performance drivers are aligned with clients and community value propositions gained during citizen days and board meetings.

All the hospitals have Quality Assurance and Risk offices and managers in place. With innovation and some creative use of these structures that are already in place the component of the office of

strategic management can be built in until a time the institutions can afford to operate a planning office of this nature.

-Best practice and benchmarking should be inculcated and the culture of continuous improvement be built and developed.

- Employee competencies like skills, knowledge and behaviour that are critical to the value creation for clients, have to be aligned with the strategy.

- Planning and Control systems Alignment

Again it is pleasing that management systems for planning, operations and performance controls are in place.

Every section has Business and Performance plans with clear targets, criteria, costs and time frame. Peer reviews are conducted on monthly basis. Monitoring and evaluation is done by management committees on a monthly and quarterly basis. Incentives for best performers are in place at section, hospital, provincial and national level and citizens reports, to crown it all! The million-dollar question was "If such stringent controls are in place, where then is the weakest link"? An interesting response came from one of the managers that: "You can never satisfy everybody. A single bottleneck dents the whole system, no matter how small." "Until a specific person is assigned to coordinate and align areas these problems will not go anywhere".

Over and above the need for co-ordination, quality management including TQM process re-engineering are powerful tools for organisations to use for continuous improvements, particularly that all the hospitals have a Quality Assurance management department. Indeed a team-based approach and synergy should minimise working in isolation. An example that was given was one whereby a patient file goes missing. If the team-based approach is used and proper tracking or record keeping is maintained, it should be simple to trace the whereabouts of the file. All the departments should be involved and collectively adopt patients' files as everybody's responsibility and not only a problem for records office.

The control process should not be viewed as a burden of a threat and negative exposure to departments as is the case now. This process should be seen as providing opportunities for learning. Kaplan & Norton (2006:284) suggest that the ability to detect deviation from the target, to determine cause of these deviations and to take corrective actions as required is a critical process for learning than about control. The participants were spot on to say that a specific person or a specific office should be in place to assist them in the details of dealing with control processes instead of seeing it as a grilling process.

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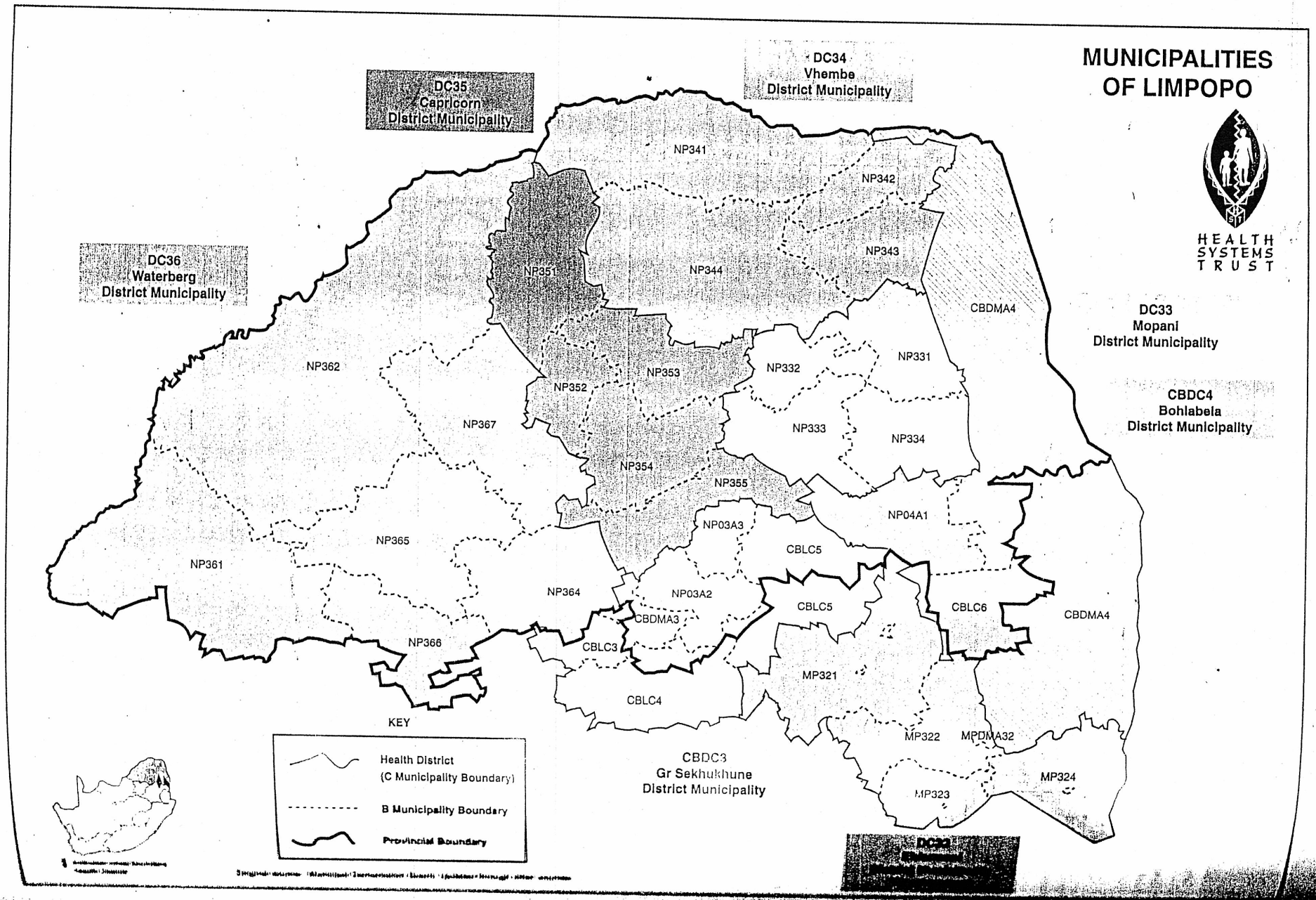
APPENDIX A

- **Municipalities and Districts in Limpopo Province including Vhembe District**

- **Hospitals in Vhembe District**

Limpopo

Category A and C Municipality	Category B Municipality		Population 2002	Area (km²)	Number of public health facilities										
					CHC	Clinic	Mobile Service	Satellite Clinic	District Hospital	National Central Hosp	Provincial Tertiary Hosp	Regional Hospital	Specialised Hospital	Public hosp total
CBDC3														
Sekhukhune District Municipality	CBDMA3	Schuinsdraai Nature Reserve												0
		District Managed Area	31	118										0
	CBLC3	Greater Marble Hall Municipality				7								1
	CBLC4	Greater Groblersdal Municipality			1	7	2		1					2
	CBLC5	Greater Tubatse Municipality			2	18	4		2					2
	NP03A2	Makhuduthamaga Municipality	319 953	2 228		21	7		2					2
	NP03A3	Fetakgomo Municipality	115 006	1 123	1	11								0
CBDC4														
Bohlabela District Municipality	CBDMA4	Kruger National Park District Managed Area	3 884	21 271										0
	CBLC6	Bushbuckridge Municipality	644 861	2 591	2	33	5		2			1		3
	NP04A1	Mbuleng Municipality	104 177	3 247		9	2		1					1
DC33														
Mopani District Municipality	NP331	Greater Giyani Municipality	257 531	2 967	2	20	4		1				1	2
	NP332	Greater Letaba Municipality	238 217	1 871		18	4		2					2
	NP333	Greater Tzaneen Municipality	408 849	3 260	4	30	11		2			1		3
	NP334	Ba-Phalaborwa Municipality	129 063	3 000	1	8	3		2					2
DC34														
Vhembe District Municipality	NP341	Messina Municipality	39 263	7 578		2	2		1					1
	NP342	Mutale Municipality	82 091	2 293	1	14	3		1					1
	NP343	Thulamela Municipality	636 576	2 958	2	48	3		2			1	1	4
	NP344	Makhado Municipality	542 623	8 548	5	45	12		3					3
DC35														
Capricorn District Municipality	NP351	Blouberg Municipality	179 104	4 541	2	14	3		2					2
	NP352	Aganang Municipality	174 485	1 852		6	3		1					1
	NP353	Molemole Municipality	127 579	3 347		6	1		1					1
	NP354	Polokwane Municipality	503 601	3 775	3	29	13		2		2			4
	NP355	Lepelle-Nkumpi Municipality	276 337	3 470	1	19	6		2				1	3
DC36														
Waterberg District Municipality	NP361	Thabazimbi Municipality	69 747	9 855		6	4		1					1
	NP362	Lephalale Municipality	103 095	19 605		7	6		2					2
	NP364	Mookgopong Municipality	17 280	4 284		3	1							0
	NP365	Modimolle Municipality	59 407	5 228		3	6		1					1
	NP366	Bela-Bela Municipality	56 459	3 373		4	3					1		1
	NP367	Mogalakwena Municipality	333 395	6 184	1	26	9		2			1		3
Limpopo Province			5 424 585	129 479	25	382	111	0	33	0	2	5	3	43


MUNICIPALITIES OF LIMPOPO
HEALTH SYSTEMS TRUST
DC34 Vhembe District Municipality
DC35 Capricorn District Municipality
DC36 Waterberg District Municipality
DC33 Mopani District Municipality
CBDC4 Bohlabela District Municipality
CBDC3 Gr Sekhukhune District Municipality
NP341
NP342
NP343
NP344
NP351
NP352
NP353
NP354
NP355
NP362
NP367
NP365
NP361
NP364
NP366
NP332
NP331
NP333
NP334
NP03A3
NP03A2
CBDMA4
CBLC5
CBLC6
CBDMA3
CBLC3
CBLC4
MP321
MP322
MPDMA32
MP323
MP324
KEY
Health District (C Municipality Boundary)
B Municipality Boundary
Provincial Boundary

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Key to Meaning of Symbols

Administrations

1 Medical Senior Superintendent/ Manager / CEO/ MD

2 Secretary / Administration

3 Matron / Business Development Heads (Followed by Number of Nursing Staff)

Hospital Services

A	General Medical	LA	Linear Accelerator for Cancer
AN	Anesthesiology	M	Intensive Care
ARV	Anti Retroviral Treatment	MR	MR Scanner
B	General Surgical	N	High Care
BA	Number of Theatres	NE	Neurology and/or Neuro Surgery
C	Maternity (No of Beds)	NN	Neo – Natal Intensive Care / Surgery
CA	Casualty / Dept / Trauma.	O	Orthopaedic
CL	Catherisation Labs	OC	Oncology Unit
CT	Cardio – Thoracic	OT	Occupational Therapy
D	Aged & Chronic Sick	P	Medical Laboratory Service
DA	Drug & Alcohol Dependency	PA	Pathology
DF	Dental Facilities	PD	Pediatric
ES	Endoscope Surgery	RH	Reproductive Health
F	Infectious Cases	RU	Renal Unit
FW	Folateng Ward	SC	C.A.T. Scanner
H	Physiotherapy	SD	Step Down Facility
HC	Handicapped	SM	M.R.I Scanner
HD	Haemodialysis	ST	Stoma - Therapy
HP	Heliport / Helipad	T	Trauma Unit
IM	Intellectual Disability (Mental Retard.)	TB	Tuberculosis
J	Specialist Services Available	V	Vascular Surgery
JR	Joint Replacements	X	X - ray
K	Spinal Cord Injuries Unit		24 Hour Services
L	Psychiatric		

LIMPOPO PUBLIC HOSPITALS

Dept of Health & Welfare, P. Bag x9302, Pietersburg 0700 • Ph: (015) 295 2851

INSTITUTION	CONTACT DETAILS	NUMBER OF BEDS			SERVICES PROVIDED (SEE KEY TO SYMBOLS)	ADMINISTRATOR (SEE KEY TO SYMBOLS)
		PTE	GEN	TOT		
Bela Bela Hospital *(District)*	Chris Hani Drive, Bela Bela P. Bag x1618. Bela Bela (Warmbaths) 0480 Ph: (014) 736 2121 Fax: (014) 736 5512	-	133	133	A,B,BA(2),C(35),CA,D,DF, ES,H,J,L(10),M(8),O,OT, P,TBX	1 M E Letshkgohla 2 Mr. T. Nkolele 3 Mrs. S.J.W. Kriel (151)
Blouberg Hospital *(District)*	P. Bag 5077, Bochum 0790 Ph: (015) 501 0505 Fax: (015) 501 0505	-	41	41	A,B,BA,C(12),DF,H,RH, TB,X	1 Ms M.M. Maponya 2 Mr. M.P. Letsoalo 3. Ms M.M. Maponya (28)
Botlokwa Health Centre *(District)*	Matoks Village P. Bag x544, Dwarsrivier 0812 Ph: (015) 527 0023 / 58 / 9 Fax: (015) 527 1921	-	88	88	A,B,B(2),C,CA,D,X	1 Dr. M.A. Pheeha 3 Ms. Morokolo (89)
CN Phatudi Hospital *(District)*	Makhwibidung Village, Shiluvane P. Bag x4056, Tzaneen 0850 Ph: (015) 355 8000 Fax: (015) 355 3434	-	130	130	A,ARV,B,BA(2),C(30),CA, DF,F,H,L,O,OT,P,PD,RH, TB,X,	1 Ms. M.S. Mabitsela 2 Mr M.M. Baloyi 3 Ms Ramavhoya (151)
Dilokong Hospital *(District)*	P. Bag x9119, Driekop 1129 Gowe Village, R37 Rd, Modikwa Junction Ph: (013) 214 7265 Fax: (013) 214 7201	-	324	324	A,ARV,B,BA(3),C(36),CA,D F,F,H,HC,L,O,OT,P,PD,RH, SD,TB,X	1 M.M. Mashishi 2 Mr. M.J. Lekgeu 3 M.M. Moshwana (200)
Donald Fraser Hospital *(District)*	P. Bag x1172, Vhufuli 0971 (Thohoyandou) Ph: (015) 963 1778 Fax: (015) 963 1796	-	349	349	A,B,BA(2),C(70),CA,D, F,H,DF,L(80),N(4),OT, P,TB(20),X	1 Mrs K E Maholwana Dr Kwinda 2 N J Mphaphuli 3 L E N Mzana (314)
Dr Machupe Mphahlele Hospital (previously Groothoek Hospital)			Closed			
Duiwelskloof Hospital *(District)*	Hospital St, Duiwelskloof P. Bag x744, Duiwelskloof 0835 Ph: (015) 309 9241 Fax: (015) 309 9828	-	17	17	A,B,BA(2),C(2),CA,D,DA, DF,F,HD,PD,RH,X	1 Dr. Spies 3 Mrs. Manoko
Elim Hospital *(District)*	Mahanges Kraal, Elim Pvt Bag X312, Elim Hospital 0960 Ph: (015) 556 3201 Fax: (015) 556 3160	-	271	271	A,ARV,B,BA(4),C(63),CA, DF,H,L(21),N,OT,P,PD, RH,TB, Eye Department	1 Dr. M.W. Madzivhandila 2 Mrs S Muthambi 3 M N Chabalala (461)
Ellisras Hospital *(District)*	Cnr Apiesdoring & Aalwyn Sts P. Bag x218, Ellisras. 0555 Ph: (014) 763 2227 / 8 / 9 Fax: (014) 763 2406	-	82	82	A,B,BA(2)C(30),CA,HP,P,X	1 Dr. Swefane 2 Mr. Matobela 3 Sr. Mbezi
Evuxakeni Hospital *(Psychiatric)*	3063 Section A, Giyani P. Bag x9661, Giyani 0826 Ph: (015) 812 1138 Fax: (015) 812 1139	-	500	500	L(50),IM,OT	1 B. Maluleke (105)
FH Odendaal Hospital *(Specialized)*	Location 1: Berg St., Modimole Location 2: Cnr Voortrekker & Leyds, P. Bag x1007 Modimole (Nylstroom) 0510 Ph: (014) 717 5257 Fax: 717 1257	6	112	118	A,B,BA(2),C(16),CA,DF,H HP,J,P,X	3 Ms R Abrie (92)
George Masebe Hospital *(District)*	P. Bag x2201 Suswe 0612 Ph: (015) 423 6000 Fax: (015) 423 6004	-	252	252	A,B,C(49),F,H,L,O,P,TB,X	1 Dr. Tesso 2 Mr. Mojela 3 Mrs Lesabane
Groblersdal Hospital *(Provincial)*	Pvt. Bag x8604, Groblersdal 0470 Ph: (013) 262 3024 Fax: (013) 262 2764					1 Zandi Mabindisa (CEO)
Hayani Hospital *(Psychiatric))*	P. Bag x2272, Sibasa 0970 (Near Makwarela Location) Ph: (015) 963 1120/3 Fax: 963 2334	-	384	384	H,L(348),OT Psychiatric	1 Mr N E Muvari 2 Mr Mufamadi 3 Mr. Lavheluni (184)
HC Boshoff Hospital		See Dilokong Hospital				
Helena Franz Hospital *(District)*	P. Bag x5002, Bochum 0790 Ph: (015) 505 0750 / 60 Fax: (015) 505 0761	-	149	149	A,B,BA(3),C(20),CA,DF,H, OT,P,PD,TB(27),X.	1 Mr. M. Matlakala 3 Mr. M.J. Tepanyega
Jane Furse Memorial Hospital *(District)*	Farm 1 Vergelegen A Jane Furse P. Bag x429, Jane Furse Hospital 1085. Ph: (013) 265 9400/7 Fax: (013) 265 9659	10	242	252	A,AN,ARV,B,BA(3),C(36), CA,D,F,FW,H,HP,IM,L,O, OT,P,PD,RH,SD,TB(109),X Eye Services	1 T.W. Mkosana (CEO) 2 M.D. Matlala 3 M.R. Tshoga
Kgapane Hospital *(District)*	P. Bag x742, Ga-kgapane 0838 Ph: (015) 328 3510 / 18 Fax: (015) 328 3506	-	178	178	A,AN,ARV,B,BA(3),C(40), CA,D,DF,F,H,L,NN,O,OT, P,PD,RH,SD,TB,X	1 Dr M B G Moshobane 2 Mr R G Mateta 3 M E Mavangwa (141)

LIMPOPO PUBLIC HOSPITALS

Dept of Health & Welfare, P. Bag x9302, Pietersburg 0700 • Ph: (015) 295 2851

INSTITUTION	CONTACT DETAILS	NUMBER OF BEDS			SERVICES PROVIDED (SEE KEY TO SYMBOLS)	ADMINISTRATOR (SEE KEY TO SYMBOLS)
		PTE	GEN	TOT		
Lebowakgomo Hospital *(District)*	Pvt. Bag x14, Chuenespoort 0745 Ph: (015) 633 5305/6900 Fax: (015) 632 6718					
Letaba Hospital *(Provincial)*	Cnr of Lydenburg & Tarentaal Rd, Nkowankowa P. Bag x1430 Letaba 0870 Ph: (015) 303 1711 Fax: 303 0207	-	293	293	A,B,BA(3),C(30),CA,DF,H,L(25),M(2),O,OT,P,TB(32),X,	1 Dr Muhlari (Act.) 3 P.T. Matodzi (253)
Louis Trichardt Memorial Hospital *(District)*	Cnr Snyman & Hospital St. P. Bag x2417 Louis Trichardt Ph: (015) 516 0148 Fax: 516 3252	-	52	52	A,ARV,B,BA(1),C(10),CA,DF,F,H,HP,IM,N,NN,OT,P,PD,RH,X	1 A.G.C.D. Tshimauswu 2 L. Buys 3 P.C. Raulinga (90)
Malamulele Hospital *(District)*	Hospital St, Malamulele P.Bag x9245, Malamulele 0982 Ph: (015) 851 0026 Fax: (015) 851 0620	-	182	182	A,B,BA(1),C(34),CA,D,DF,F,H,L,O,OT,P,TB,X	1 Mrs. Risengea 3 Mr. R. Mabaso
Mankweng Hospital *(Tertiary)*	Houtbosdorp Street, Sovenga 0727 P. Bag x1117, Sovenga 0727 Ph: (015) 267 1000/2 Fax: 267 0206	-	462	462	A,AN,ARV,B,BA(3),C(42),CA,DF,ES,F,H,L,M,N,NN,O,OT,P,PD,RH,SC,SD,X	1 Dr. J. McCutcheou 2 Mr. J. Letsie 3 Mrs. E.M. Legodi
M. L. Malatjie Hospital *(District)*	Namakgale Township, Cnr Ackson Malatji & Maphutha Sts P. Bag x11020, Namakgale 1391 Ph: (015) 769 1520 Fax: 769 3531	-	151	151	A,B,BA(2),C(3),CA,D,DF,F,H,IM,OT,P,PD,RH,RU,X	1 M.A.Peter 2 Y. Smit 3 K.M. Shaik (148)
Mapulaneng Hospital		See Mpumalanga Public Hospitals				
Matlala Hospital *(District)*	No. 1 Tsimanyane Village, Marble Hall P. Bag x9624, Marblehall 0450 Ph: (013) 264 9600 Fax: 264 9616	-	228	228	A,AN,ARV,B,BA(2),C(38),CA,DF,F,H,L,O,P,PA,PD,TB,X 24 Hour	1 Mr. M.L. Morewane 3 Ms M.E. Phokane (116)
Mecklenburg Hospital *(District)*	Moroke Village, Burgersfort P. Bag x1012 Burgersfort 1150 Ph: (015) 619 9940 Fax: (015) 616 0152	-	108	108		1 Dr. K. Kabwa 3 Mrs. M.N. Phalane
Messina Hospital *(District)*	1572 Whyte Rd, Musina P. Bag x60 Musina 0900 Ph: (015) 534 0446 Fax: 534 0819	-	65	65	A,ARV,B,BA(1),C(10),CA,DF,H,OT,P,PD,RH,TB,X	1 N.S. Netshivhambe 2 M.F. Mohlabe 3 M.C. Seko (95)
Mokopane Hospital *(Provincial)*	806C Vredenberg Rd, next to Mahwelereng P. Bag x2466 Mokopane 0600 Ph: (015) 483 4000 Fax: 483 2405	-	250	250	A,B,BA(3),C(40),F,X	1 A.M. Ntsewa 3 R.R. Matholo
Nkhensani Hospital *(District)*	Section A next to Giyani Tech. College P. Bag x9581, Giyani 0826 Ph: (015) 812 3242 Fax: (015) 812 2461	8	242	250	A,AN,ARV,B,BA(3),C(49),CA,D,DF,H,HC,L(70),O,OOC,OT,P,PD,RH,SD,TB,X	1 A.E. Mboweni 2 Mr. N.S. Mgimeti 3 N.M. Mackaukau (232)
Phalaborwa Hospital *(District)*	Grosvenor Cres., Phalaborwa 1389 P. Bag x1004 Phalaborwa 1930 Ph: (015) 781 3511 Fax: (015) 781 5480	-	27	27	A,B,BA(2),C(5),CA,HP,N(2),P,X	1 Mrs. H.R. Peter 3 Mrs. M.F. Raubottom (31)
Philadelphia Dennilton Hospital *(District)*	Ph: (013) 983 0112 Fax: (013) 983 1016					1 Z. Mabindisa (CEO)
Polokwane Hospital *(Tertiary)*	Cnr Dorp & Hospital Streets P. Bag x9316 Polokwane 0700 Ph: (015) 287 5000 / 1 / 2 Fax: (015) 297 2604	-	421	421	A,B,BA(6),C(32),CA,D,DF,ES,F,H,HP,J,M(6),O,OT,OC,P,RH,SC,ST,X	1 Dr. J. McCutchen 3 Ms. Serakoane (478)
Sekororo Hospital *(District)*	Between Madeira & Metz Village P. Bag x404 Trichardtsdal 0890 Ph: (015) 383 9400 Fax: 383 0427	-	208	208	A,B,BA(2),C(17),CA,D,DF,F,H,L(4),P,TB(40),X	1 Mr. Mkuna (Act) 2 R.M. Malembe
Seshego Hospital *(District)*	Cnr Nelson Mandela Dr. & Bookelo St. Zone 1, Seshego P. Bag x4016 Seshego 0742 Ph: (015) 223 5141 Fax: 223 6169	-	36	36	A,B,BA(3),C(34),CA	1 Mrs. Patura 3 Mrs Monelala
Siloam Hospital *(District)*	Siloam Village, Dzanani P. Bag x2432 Louis Trichardt 0920 Ph: (015) 973 0004 Fax: 973 0607	-	220	220	A,ARV,B,BA(2),C(50),CA,DF,H,L,OC,OT,P,PD,RH,SD,TB Clinic,X Ophthalmic clinic	1 Dr H.E. Munyadziwa 2 Mr. A.H. Netsianda 3 Ms M M Moshapo (260)

LIMPOPO PUBLIC HOSPITALS

Dept of Health & Welfare, P. Bag x9302, Pietersburg 0700 • Ph: (015) 295 2851

INSTITUTION	CONTACT DETAILS	NUMBER OF BEDS			SERVICES PROVIDED (SEE KEY TO SYMBOLS)	ADMINISTRATOR (SEE KEY TO SYMBOLS)
		PTE	GEN	TOT		
St. Ritas Hospital *(Regional)*	Glen Cowie Rd, Glen Cowie P. Bag x1303 Glen Cowie 1061 Ph: (013) 298 1000 / 1012 Fax: (013) 298 1067	-	400	400	A,AN,B,BA(4),C(72), CA,DF,D,F,J,O,OT,P, PD,RH,RB,X	1 Dr. Tipay 2 Mr. Mogadime 3 Mrs. S.S. Malekane
Thabamoopo Hospital *(Specialized)*	Lebowakgomo town Zone A P. Bag x37, Cheunespoort. 0745 Ph: (015) 632 4112/3 Fax: 632 5205	-	786	786	A,D,DA,H,IM,L,OT,TB	1 M E Chokoe (CEO) 3 Christina Chokwe (act) (298)
Thabazimbi Hospital *(District)*	1 Hospital St, Thabazimbi P. Bag x79, Thabazimbi 0380 Ph: (014) 777 1599 Fax: 777 1599	-	56	56	A,B,BA(2),C(20),CA,J, P,X1	1 Mr M A Makinta 2 Ms C Mabula 3 Mrs. S.E. Olivier (63)
Tintswalo Hospital		See Mpumalanga Public Hospitals				
Tshilidzini Hospital *(Provincial)*	R524 Punda Maria Rd, Venda P. Bag x924, Shayandine 0945 Ph: (015) 964 1061 / 8 Fax: (015) 964 1492	-	507	507	A,B,BA(4),C,CA,DF,TB,F,H, OT,J,L,M,NN,O,OC,P,RH,X	1 Mr. A.P. Mphaphuli 3 Ms Tshikazhi
Van Velden Memorial Hospital *(District)*	Cnr Hospital & Third St. Tzaneen P. Bag x4014, Tzaneen 0850 Ph: (015) 307 8800 Fax: 307 3512	-	84	84	A,B,BA(3),C(20),CA,J, M,P,X	1 Mrs. Madika 3 Ms Mtembule (29)
Voortrekker Hospital *(District)*	2 Geyser St. Mokopane (Potgietersrus) P. Bag x2495, Mokopane 0600 Ph: (015) 491 2236 Fax: 491 3855	8	83	91	A,ARV,B,BA(3)C(16),CA, DF,F,H,HC,IM,J,L,OT,P,PD, RH, TB,X	1 M.T. Kekana 2 Ms R.J. Molebale 3 Ms. R.M. Mongalo (93)
Warmbaths Hospital	See Bela Bela Hospital					
Witpoort Hospital *(District)*	P. Bag x01 Lephalale (Ellisras) 0555 Ph: (014) 769 0025 Fax: 769 0064	-	70	70	A,B,BA(2),C(10),CA,L,TB,X	1 Mrs M.D. Kekana 3 Mrs. M D Kekana (32)
WF Knobel Hospital *(District)*	P. Bag x65, Lonsdale 0710 Stand 1,Volcanus, next to Lonsdale Ph: (015) 221 1500 Fax: 221 1591	-	258	258	A,B,BA(1),C(60),CA,,H, L(10),P,TB(52),X	1 Ms Mabyana 2 C M Lephalala 3 M E Thoka (act)
Zebediela Hospital *(District)*	Pvt. Bag X342, Gompies, 0631 Ph: (015) 662 0787/1186 Fax: (015) 662 0173					1. Dr Marishane

LIMPOPO PRIVATE HOSPITALS

INSTITUTION	CONTACT DETAILS	NUMBER OF BEDS			SERVICES PROVIDED (SEE KEY TO SYMBOLS)	ADMINISTRATOR (SEE KEY TO SYMBOLS)
		PTE	GEN	TOT		
Curamed Thabazimbi *(Medi-Clinic)*	1 Hospital St, Thabazimbi P. Box 1845, Thabazimbi 080 Ph: (014) 777 2097 Fax: 777 2099	19	-	19	A,B,BA(2),C(14),CA,F,H, HP,L,X	1 Mrs. C. van der Walt 3 Mrs. C. van der Walt
Limpopo Medi – Clinic	C/n Thabo Mbeki & Burger St. P. Box 6078, Polokwane North 0700 Ph: (015) 290 3600 Fax: 290 3905	186	-	186	A,AN,B,BA(6),C(23),CA,DF, ES,H,HD,J,L,M,N,NE,NN,O OC,P,PA,RH,RU,SM,ST,X	1 A. Spek 3 Sarie van der Walt
Marapong Private Hospital *(Medi-Clinic)*	P. Box 5274, Onverwacht 0557 175 Mosethla St, Marapong Res. Area, Enkelbult, Lephalale 0556 Ph: (014) 768 2380 Fax: 768 2203	12	-	12		1 Sr Celia Sharp 3 Sr Celia Sharp
Matikwana Hospital *(Life Healthcare)*		See Mpumalanga Private Hospitals				
Shiluvane Hospital *(Life Esidimeni)*	P. Bag x1568, Tzaneen 0850 Ezekhaya Farm, Ritavi District, Tzaneen Ph: (015) 355 3436 Fax: (015) 355 3438	-	160	160	D,DF,H,OT,X	1 Mrs. P. Hlongwane
St. Vincent's Hospital	P. Bag x1612, Warmbaths 0480 Quagga St, Bela Bela Ph: (014) 736 2310 Fax: (014) 736 4260	83	-	83	A,B,BA(2),C(14),CA,F,H,HP L,X 24 hours	1 Mr P E du Preez 2 Mrs. M. van Staden 3 Miss A Wilson (22)
Tzaneen Medi-Clinic	R71 Wolkberg Rd, Tzaneen P. Box 2613, Tzaneen 0850 Ph: (015) 306 8500 Fax: 306 8699	16	48	64	A,AN,B,BA(2),C(12),CA,CT, D,DA,DF,ES,F,HC,J,JR,K, M,N,NN,O,P,PA,X	1 Mr. Zane Fanie 3 Sr. S. Hermann (45)

APPENDIX B

- **Request to conduct research at hospitals**

(Specimen of documents that were sent to hospitals)

University of Venda & Limpopo University
Private Bag X5050
THOHOYANDOU
LIMPOPO
11 June 2008

The CEO

NZHELELE Health Center

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a post graduate student at the University of Limpopo at the school of graduate leadership. I am interested in studying, ***Alignment of the three management levels (strategic, tactical and operational management plans) in public health hospitals in Vhembe district.***

This study is conducted under the supervision of Prof. J. Pelser who is also the HOD of the MBA programme at the above mentioned campus.

The study has been approved by the Ethics Committee of the University of Limpopo as per attached copy.
I have also attached an endorsement letter from the Limpopo Provincial Government - Department of Health and Social Development.

The objective of the study is to:

- To explore and describe the experiences of managers in the three levels of management in your hospital.
- To describe the strategic alignment of the three management levels.
- To make recommendations to management training, practice and research based on the findings of this research.

It is for this purpose that I request your permission to conduct interviews with you as a hospital manager and other managers of different divisions/ units etc.

The interviews will be conducted within 30-60 minutes.

An audio tape will be used to capture our conversation.

I believe that this study will benefit our hospitals, district and the province as we engage in a discourse the roles of different managers in our complex healthcare facilities and system.

The name and dignity of each participant will be preserved by observing the following ethical standards throughout the research process:

- Informed Consent be completed prior to participating in the project,
- Voluntary participation and freedom to withdraw from the project without a penalty,
- Names of participants and their community will not be mentioned in the technical report,
- Field notes materials will be kept under lock and key to ensure confidentiality,
- information related to the interviews will only be accessible to my supervisors and,
- field notes will be destroyed and audio tapes will be erased as soon as the project is concluded and
- The summary of the research study will be made available to participants, hospitals and to the department as a requirement from the authorising bodies.

Thank you in anticipation.

Bao Keabetswe Davhana

Researcher

APPENDIX C

- **Consent Form for Participants**

INFORMED CONSENT DOCUMENT

RE: ***Alignment of the three management levels (Strategic, Tactical and Operational plans) in public health facilities in Vhembe.***

The above matter refers:

1. Researcher:

Bao K. Davhana, a Masters in Business and Administration student at the University of Limpopo – Turfloop Graduate School of Leadership. I interested in studying the different management levels in our complex system are ***Aligned from the district level to the provincial level.***
I would be pleased if you would be prepared to assist me by answering questions about your experiences as a manager in the healthcare system in our district.

This study is conducted under the supervision of Prof.Pelser, the head of MBA programme in Limpopo University.

The study has been approved by the Ethics Committee of the University of Limpopo (s attached authorisation document).

2. The purpose and objectives of the study:

Although most managers know precisely their roles and functions in their workplaces, little is known about how they align their plans to the cooperate strategy. The purpose of this study is to describe the experiences of managers in this regard.

- To explore and describe the experiences of managers in the three levels of management in your hospital.

- To describe the strategic alignment of the three management levels.
- To make recommendations to management training, practice and research based on the findings of this research.

3. Benefits

Your participation in this study will benefit the hospital and our district by achieving the objectives set out in this project.

4. Procedure

If you choose to participate in the study you will be asked to participate in a 45-60 minutes interview / conversation with the researcher. The interviews will be conducted at you hospital offices or as may be allowed by management.

An audio tape will be used to capture data and for verification of the findings by my supervisors.

5. Voluntary Participation and Confidentiality

Participant: I.....am giving my consent to be interviewed by Bao Davhana.

It has been explained to me that my name and dignity as a participant will be preserved by the researcher through observing the following ethical standards throughout the research process:

- voluntary participation and freedom to withdraw without a penalty
- making decision based on thorough information given to me,
- my name and my community will not be mentioned during discussions,
- field notes will be kept under lock and key to ensure confidentiality,

- information related to the interviews will only be accessible to the researcher's supervisors and the independent coder,
- field notes will be destroyed and audio tapes will be erased as soon as possible, and
- The summary of the research study will be made available to me if I so wish.
- I am informed and aware that there are no official costs associated with my participation.

Participant's signature.....Date.....

Researcher, signature.....Date.....

Thank you.

Mrs.Bao K.Davhana
Researcher

APPENDIX D

- **Limpopo Provincial Government: Department of Health and Social Development – PERMISSION LETTER TO CONDUCT RESEARCH IN VHEMBE HOSPITALS.**

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquiries: Malomane EL

Ref: 4/2/2

6 December, 2007

Ms BK Dhavhana
University of Venda for Science and Technology

Dear Ms BK Dhavhana

"Alignment of the three Management levels (Strategic, Tactical and Operational Management) in public Health Facilities within Vhembe District"

- Permission is hereby granted to Ms BK Dhavhana to conduct the study as mentioned in Vhembe District in Limpopo Province South Africa
- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study,
- The Researcher/s should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institution management where the study is being conducted should be made aware of this,
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

APPENDIX E

- **Authorisation to conduct the research from the Limpopo University Ethics Committee**

UNIVERSITY OF LIMPOPO
TURFLOOP GRADUATE SCHOOL OF LEADERSHIP
P.O. Box 756, FAUNA PARK, 0787
Tel: 015 290 2832
Fax: 015 290 2832
Email:mba@edupark.ac.za

Faculty of Management Sciences & Law

To : Department of Health and Social Development

From : Prof van Niekerk
Acting MBA Programme Manager

Date : 20 April 2007

Subject : **Permission to conduct research at Department of Health and Social Development**

In persuit of her MBA –degree, Mrs Davhana BK (200630212) has to submit a research report. Please be so kind to allow her to interview your staff to access the required information.

Mrs Davhana's research proposal was approved by the post –graduate and the ethics committee of the University of Limpopo

Thank you for your support in this matter

.....

UNIVERSITY OF LIMPOPO
TURFLOOP GRADUATE SCHOOL
OF LEADERSHIP
20 APR 2007
SIGN
SCHOOL ADMINISTRATOR

APPENDIX F

Functions of the National and Provincial Departments of Health

APPENDIX F:

Functions of the National and Provincial Departments of Health

Functions of the National Department	Functions of the Provincial Department
1. Provide leadership in the formulation of health policy and legislation, including the development of the NHS. 2. Provide leadership in quality assurance, including formulation of norms and standards. 3. Build the capacity of the provincial health departments and municipalities, to enable them to ensure the provision of effective health services. 4. Ensure equity in the allocation of resource to the provinces and municipalities and their appropriate utilisation. 5. Provide leadership in planning for and the strategic management of the resource available for health care. 6. Provide services which cannot be cost-effectively delivered elsewhere. 7. Develop coordinated information systems and monitor the progress made in the achievement of national health goals. 8. Provide appropriate regulation of the public and private health sectors, and regulate health – related activities in other sectors. 9. Support the provinces and municipalities in	1. Ensuring the provision of regional and specialized hospital services, as well as academic health services, where relevant. 2. Ensure appropriate human resource management and development. 3. Ensuring the rendering and coordination of medical emergency services (including ambulance services). 4. Ensuring the rendering of medico – legal services. 5. Ensuring the rendering of health services to those detained, arrested or charged. 6. Ensuring the planning and management of a provincial health information system. 7. Ensuring quality control of all health services and facilities. 8. Ensuring the screening of applications for licensing and the inspection of private health facilities. 9. Ensuring the formulation and implementation of provincial health policies, norms and standards and legislation. 10. Ensuring the interprovincial and intersectoral coordination and collaboration.

ensuring access to cost effective and appropriate health commodities; and 10. Liaise with national health departments in other countries and international agencies.	11. Ensuring coordination of the funding and financial management (the budgetary process) of district health services. 12. Ensuring the provision of technical and logistical support to health districts 13. Ensuring the rendering of specific provincial service programmes, e.g. tuberculosis programmes. 14. Ensuring the provision of non-personal health services. 15. Ensuring the provision and maintenance of equipment, vehicles and health care facilities. 16. Ensure effective collaboration on health matters at the community level. 17. Ensure the provision of occupational health services. 18. Ensure research on, and the planning, coordination, monitoring and evaluation of the health services rendered in the province, and 19. Ensure functions delegated by the national level are carried out.

APPENDIX G

Interview Transcript with one CEO

And: -

- **Reflection thoughts and planned questions for next visits.**

Interview with CEO of one district hospital
30 July 2008 @ CEO's Office@16h00

Key: R – researcher
C - CEO

R: Thank you for according me this opportunity. I am grateful for the consent to participate in this research. Firs allow me to go through the consent form. The research grant does not cover and provide for any financial incentives for participants. However, I believe that this research will benefit you and your institution in many ways including a presentation of the findings, engaging me on any other issue that may emanate form this project. Because of my passion in administration and management I intent to continue with this kind of activity and I hope that we may even start a research culture on health management issues.

C: Thank you too for according our institution this opportunity in participating in this project. Indeed I hope that this may be a start of positive things in our institutions.

R: Let me start with this question, do you engage in a Strategic Planning process at this hospital?

C:Actually we have copies of the Strategic Plans from the National and Provincial departments. However, at institutional level, I wonder if I could

say it is proper to say we develop a Strategic Plan. I could say yes we do, but it takes a slightly different approach.

When I started at this hospital in 2004 it was difficult. I had to start from scratch to develop my own Strategic Plan. There was nothing and I cannot explain how they got on along but they managed the hospital.
I believe you are aware that at national and provincial levels there are different directorates for different level of hospitals. There is a District Hospital directorate and a Regional hospital directorate. We therefore receive annual performance plans with targets and indicators to be achieved in a specific year.

It is not possible to fully comply with the annual targets and indicators but we have to draw our specific annual plans. For example, province may say the target average length of hospital stay should be four days. In our case given the size of the hospital and challenges of human resources and finances I may plan to reduce that length of stay at hospital and maximize the use of local primary health clinics.

R: Did I understand you well that you report directly to province and not to the district office.
C; Yes. There are only two provinces where the district health system is not in place yet. It is Limpopo and I think Eastern Cape Province.

However last year in December a new structure was introduced and we thought it would be implemented from the beginning of this year, unfortunately it has not yet happened.

R: Do you think you are disadvantaged by this set up.

C: There are gaps in all the systems. There are bureaucratic lengthy processes involved in our situation which create gaps that impede the achievement of certain goals.

We have limited delegated powers. For example with HR Delegation we cannot do advertising for the posts identified. We have to submit our staff requirements to the Province where advertisement is done. This may delay availability of required personnel at the appropriate time. As a result your hospital plan may not be effective resulting in failure to achieve even the core business of sending medical staff to primary health clinics. If you may want a specific post to be filled in for example five(5) weeks that is impossible.

There are also constraints with regard Financial Delegation too with regard procurement. We cannot procure anything that cost more than R100 000 unless province is satisfied that you have the capacity to manage such a process. Until recently I have been allowed to procure at R100 000 on tender basis because I have the capacity to do so. Most institutions that do not have CFO are still operating at R50 000 procurement on tender basis. This is also dependent on the Provinces. The National office has approved and allow hospital up to R200 000, but

again this has to be supported by appropriate capacity within the hospital's Financial skills.

This challenge I can say that it limits us to perform at around 65% effectiveness. How can you reduce waiting time for and queues if you are still waiting for the province to advertise or if there is no enough funds to implement your plans. You should remember that hospitals are labour intensive and Human resources is key to reaching your core business in district hospitals. There is no way that you can have a recruitment and retention strategy. Personnel sometimes stay long in acting positions and once they have gained experienced they run away to lucrative avenues. You can't stop them Bureaucracy is a challenge in this situation. However, other managers in other provinces were the DHS is in operation they are complaining that it is more problematic because decisions are centralized at the district office. However they have a more effective primary health system in place wherein clinics are strictly integrated with the district hospital plans. However they complain of more rigidity and more bureaucracy in the sense that they feel that we have faster process in place yet reporting directly to province.

Different sectional managers have different delegated powers. In clinical section we are allowed to recruit without following the normal recruitment process. If I want to employ a doctor or a nurse I am allowed to employ while the process is still unfolding with regard approval process. Because we have lots of expatriate medical doctors seeking

employment in South Africa I currently have 70% expatriates who just come to our hospital and we just employ right away after all the necessary internal formalities are done at hospital level. Then I will involve the province to formalize the recruitment. As a result I have managed to reduce waiting time and queues from over five(5) hours to 1.5 hours. I now have 12 full time doctors and 11 sessional doctors as a result. We are able to visit PHC clinics at least once a week and the health centre two times a week. A thing that was impossible when I first started here with only two doctors. I don't know how they managed before then.

R: This is very interesting. Please take me through the process of developing the hospital strategic plan.

C: Since I have introduced the planning concepts we have had three prior planning retreats. The sectional managers were complaining of more work then but I showed them that in the long run they will be better off in their operations.

The first time it was a true prior planning because we did not have anything at institutional level except for the provincial annual performance plans. The second year it was a review of the first plan we had for the hospital which served as our baseline plan. The subsequent retreats we looked at what we can add. I think the provinces came up with annual performance plan concepts because one have to consider

that with every political change or changes in political office there is bound to have changes across institutions.

R: What do you specifically do until a final baseline document is produced?

C: The process starts at ward and unit level in specific sections. Every department must do own SWOT Analysis to base their plan on. Myself and the managers we refine the inputs from the sections. However we add by doing PEST Analysis. Once a draft plan is produced this is forwarded to Province for endorsement. A Business plan will then be developed from the Strategic plan to access our annual budget. Then the sectional managers will have to develop their operational plans using the master plan.

R: I would like to understand how different managers develop their plans. I know that at provincial level there are specific directorates that are similar to sections that exists in the hospital setting. For example there is a directorate for nursing directorate, allied and security directorate, Quality Assurance directorate and Risk and Security management directorate. Please explain to me how the different sectional managers develop their plans in line with provincial provision and the hospital specific plan.

C: Actually, every section gets hold of the performance plan from the province. Then they have to follow the guideline from the provincial plan in order to develop the hospital specific targets and indicators. All the

sectional plans have to link with the hospital plans. Just as we have follow the overall performance plan from the province.

R: I think we have to pause for now. Before we can end this conversation, I would like to know if I can follow up with any of your sectional manager.

C: I have made them aware of the project and that they should not be surprised by your presence in the hospital. However, there are some who are in Hollywood position.

R: What is that, I am sorry I do not understand what that means?

C. (Laughing) That means there are those that are in acting positions and are still new. They have not participated fully in the process, I do not think there is much that they can assist with. However, the following have participated in the whole process to date and they will be waiting to assist you:

1. The nursing service manager
2. Allied manager
3. Risk and Security manager –
4. Technical manager

R: Thank you very much for giving me this eye opening interview and the support you assured me in this research process. Thank you very much. Good bye.

I wonder if you do not mind me having your mobile number in case there could be something I need to clarify with you as I will be transcribing this interview/

C: By all means (cell number given). You are welcome to contact me for any clarification.

After going through this transcript the researcher compiled the following questions for clarity: -

1. What do your meaning of Strategic Plan
2. When did you first train about this plan and process
3. Would you say that at hospital level the concept of strategic management, tactical management and operational management are used frequently or do you use other terms for this purpose?
4. What is your understanding of the alignment of the three management levels
5. In your understanding what management level are you in relation to province
6. Are you satisfied with what you do now compared to what the actual reality is on the ground about Strategic Plan?
7. What is the level of understanding of your managers on the concept?

8. What was your experience the first time you applied the process and the implementation.
9. What do you think are real time benefits of having a Strategic Plan in your hospital.
10. Do you think that it is necessary to have your Strategic plan or your plan aligned to the national and the provincial plans?
11. Out of 1-5 please rate the extent to which you are aligned to the :-
    - National level
    - Provincial level
    - Inert institutional sections
12. Is possible for me to have a look at the vision and mission of the hospital and related plans you have in place.
13. Which plan are you most satisfied with
14. Can I please have a look at your organogram

Lessons learnt and improvements done on subsequent interviews: -

1. Introduction should be uniform.
2. Attend to the objectives of the research

3. What will happen with the findings question from participants . I assured participants that no comparison of hospitals. Each will receive their presentation.

4. A seminar will be organised to do the research presentation to all the district hospital managers as way of thanking them and for information giving. The researcher intends to invite the supervisor Prof.Pelser to this presentation to add more experience in bettering the Strategic plan implementation at our district hospitals.

5. Finally, the provincial directorate will be provided with the report on the outcome of the whole research outcome.

APPENDIX H

An outline of the semi structured questions developed in the literature review includes the following

Appendix H

An outline of the semi structured questions developed in the literature review includes the following:-

- Does the hospital have a Strategic Plan in place?
- Describe the process of how the strategic planning document was produced?
- Who participates in the development of the Strategic Plan?
- Can you describe the management structure, organogram of the hospital?
- How is the Strategic plan implemented and managed in this hospital?
- How do managers evaluate implementation of the strategic plan at different management levels?
- How are the Strategic plan and other operational plans communicated to the lower ranks and to the external community?

APPENDIX I

- **Organogram of District and Provincial Hospitals in Vhembe District**

UPDATED ORGANISATION AND ESTABLISHMENT STRUCTURE: HAYANI SPECIALISED HOSPITAL 2007

HAYANI SPECIALSED HOSPITAL

PURPOSE: TO PROVIDE A COMPREHENSIVE HEALTH CARE SERVICES AT DISTRICT HOSPITAL LEVEL

FUNCTIONS:
1. Render:
   a) quality assurance support services
   b) liaison services
   c) clinical care services
   d) nursing services
   e) risk management services
   f) financial management services
   g) corporate services
   h) information and records management
   i) technical support services

1 Chief Executive Officer L12
1 Secretary L5

QUALITY ASSURANCE SUPPORT SERVICES

PURPOSE: TO PROVIDE QUALITY ASSURANCE

FUNCTIONS:
1. Implement quality assurance/Bathopele Principles.
2. Formulate institutional standards.
3. Compile monthly reports on Bathopele related complaints.
4. Develop database on equipment equity.
5. Implement domain specific standards.
6. Advise the institution managment on services delivery problem, make the necessary interventions and communicate such to hospital management.

1 Manager L11
1 Quality Assurance Practitioner L10

LIAISON SERVICES

PURPOSE: TO PROVIDE LIAISON SERVICES

FUNCTIONS:
1. Render information services.
2. Manage communication services.
3. Market hospital activities.

1 Liaison Officer L9

SUBDIVISION: CLINICAL CARE SERVICES

PURPOSE: TO RENDER CLINICAL CARE AND ALLIED HEALTH SERVICES

FUNCTIONS:
1. Provide medical services.
2. Provide pharmaceutical services.
3. Provide clinical psychology services.
4. Provide ARV dietetics services.
5. Provide occupational health services.
6. Provide physiotherapy services.
7. Provide community environmental healthservices.
8. Provide ARV social work services.

1 Clinical Manager L12
see Page 2

SUBDIVISION: NURSING SERVICES

PURPOSE: TO RENDER NURSING SERVICES

FUNCTIONS:
1. Provide patient care services in:
   a) general inpatient care
   b)acute psychiatric inpatient care.
   c) chronic psychiatric inpatient care.
   d) forensic and maximum security services.
   e) CSSD and nursing personnel
   f) outpatient and ARV clinic
   g) occupational health and infection control

1 Manager: Nursing PN-A9
see Page 3

SUBDIVISION: RISK MANAGEMENT SERVICES

PURPOSE: TO RENDER RISK MANAGEMENT SUPPORT SERVICES

FUNCTIONS:
1. To identify potential risk in the hospital and interveition required to manage the risk.
2. Evaluate measures to prevent the inefficient utilisation of funds and resources in the hospital.
3. Investigate corrupt business practices and measures to prevent them.
4. Manage security services.
5. Inspections and investigations. of various activities within the hospital.

1 Deputy Manager L9
1 Senior Administrative Officer L8
1 Administrative Officer L7

SUBDIVISION: FINANCIAL MANAGEMENT SERVICES

PURPOSE: TO PROVIDE FINANCIAL MANAGEMENT SERVICES

FUNCTIONS:
1. Provide:
   a) financial management services.
   b) procurement and contract management services.
   c) stores management services.

1 Deputy Manager L9
see Page 4

SUBDIVISION: CORPORATE SERVICES

PURPOSE: TO RENDER CORPORATE SERVICES

FUNCTIONS:
1.Provide:
   a) human resource management.
   b) human resource development and planning.
   c) labour relations services.
   d) organisational development services.
   e) transport management services
   f) logistical support services.

1 Deputy Manager L9
see Page 5

SUBDIVISION: INFORMATION AND RECORDS MANAGEMENT

PURPOSE: TO RENDER INFORMATION AND RECORDS MANAGEMENT SERVICES

FUNCTIONS:
1. Provide:
   a) information management services.
   b) records management services.
   c) information technology.

1 Deputy Manager L9
See Page 6

SUBDIVISION: TECHNICAL SUPPORT SERVICES

PURPOSE: TO PROVIDE TECHNICAL SUPPORT SERVICES

FUNCTIONS:
1. Manage general maintenance.
2. Maintain grounds.

1 Artisan Superintendent L8
1 Artisan Foreman L7
4 Artisan L5
1 Senior Foreman: Grounds L4
2 Foreman: Grounds L3
6 Operator: Boiler L2
6 Tradesman Aid L2
15 Groundsman L2

TSHILIDZINI REGIONAL HOSPITAL

PURPOSE: TO PROVIDE A COMPREHENSIVE HEALTH CARE SERVICES AT REGIONAL HOSPITAL LEVEL

FUNCTIONS:
1. Render:
   a) quality assurance support services
   b) liaison services
   c) clinical care services
   d) nursing services
   e) risk management services
   f) financial management services
   g) corporate services
   h) information and records management
   i) technical support services

1 Chief Executive Officer L13
1 Personal Assistant L7

QUALITY ASSURANCE SUPPORT SERVICES

PURPOSE: TO PROVIDE QUALITY ASSURANCE

FUNCTIONS:
1. Implement quality assurance/Batlhopele Principles.
2. Formulate institutional standards.
3. Compile monthly reports on Batlhopele related complaints.
4. Develop database on equipment equity.
5. Implement domain specific standards.
6. Advise the institution managment on services delivery problem, make the necessary interventions and communicate such to hospital management.

1 Manager L12
1 Quality Assurance Practitioner L11

LIAISON SERVICES

PURPOSE: TO PROVIDE LIAISON SERVICES

FUNCTIONS:
1. Render information services.
2. Manage communication services.
3. Market hospital activities.

1 Liaison Officer L9

SUBDIVISION: CLINICAL CARE SERVICES

PURPOSE: TO RENDER CLINICAL CARE AND ALLIED HEALTH SERVICES

FUNCTIONS:
1. Render medical services in:
   a) orthopaedics
   b) paediatrics
   c) family medicine
   d) obstetrics and gynaecology
   e) general surgery
   f) internal medicine
   g) anaesthesiology
   h) psychiatric
   i) ARV services

2 Provide
   a) forensic services
   b) dental/oral hygiene services
   c) pharmaceutical services
   d) clinical psychology services
   e) allied health services

1 Clinical Manager L12
See Page 2

SUBDIVISION: NURSING SERVICES

PURPOSE: TO RENDER NURSING SERVICES

FUNCTIONS:
1. Provide patient care services in:
   a) general wards
   b) general surgery
   c)obstetrics and gynaecology
   d) paediatrics
   e) theatre services
   f) general outpatient services
   g) intensive care ward
   h) psychiatric ward
   i) occupational health and infection control.
   j) nursing administration.
   k) nursing personnel development and training.

1 Manager: Nursing PN-A8
see Page 3

SUBDIVISION: RISK MANAGEMENT SERVICES

PURPOSE: TO RENDER RISK MANAGEMENT SUPPORT SERVICES

FUNCTIONS:
1. To identify potential risk in the hospital and intervention required to manage the risk.
2. Evaluate measures to prevent the inefficient utilisation of funds and resources in the hospital.
3. Investigate corrupt business practices and measures to prevent them.
4. Manage security services.
5. Inspections and investigations of various activities within the hospital.

1 Manager L11
1 Deputy Manager L9
2 Senior Administrative Officer L8

SUBDIVISION: FINANCIAL MANAGEMENT SERVICES

PURPOSE: TO PROVIDE FINANCIAL MANAGEMENT SERVICES

FUNCTIONS:
1. Provide:
   a) financial management services.
   b) procurement and contract management services.
   c) stores management services.

1 Manager L11
see Page 4

SUBDIVISION: CORPORATE SERVICES

PURPOSE: TO RENDER CORPORATE SERVICES

FUNCTIONS:
1.Provide:
   a) human resource management.
   b) human resource development and planning.
   c) labour relations services.
   d) organisational development services.
   e) transport management services.

1 Manager L11
see Page 5

SUBDIVISION: INFORMATION AND RECORDS MANAGEMENT

PURPOSE: TO RENDER INFORMATION AND RECORDS MANAGEMENT SERVICES

FUNCTIONS:
1. Provide:
   a) information management services.
   b) records management services.
   c) information technology.

1 Manager L11
See Page 6

SUBDIVISION: TECHNICAL SUPPORT SERVICES

PURPOSE: TO PROVIDE TECHNICAL SUPPORT SERVICES

FUNCTIONS:
1. Manage general maintenance
2. Maintain grounds

1 Senior Artisan Superintendent L9
see Page 7