AN EVALUATION OF THE IMPLEMENTATION AND CAPACITY OF HOSPITAL BOARDS AT DISTRICT HOSPITALS IN KWAZULU-NATAL IN 2008

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ABSTRACT

Introduction

Hospital boards are vital structures that represent the needs and aspirations, of the community that hospitals serve.

Aim

This study aims to determine whether district-level hospital boards in KwaZulu-Natal (KZN) are equipped to support hospital management in the effective and efficient delivery of hospital services.

Methods

A quantitative, descriptive and cross-sectional health systems research study has been used. Thirty-two (32) of the thirty five (35) district hospitals in KZN participated in the study. Nineteen (19) chairpersons of hospital boards (CHB) and twenty-four (24) chief executive officers (CEO's) were telephonically interviewed using a structured but open-ended questionnaire. Ordinary board members at eleven district hospitals were interviewed over a period of four (4) months using an interview schedule. Minutes of fifty-eight (58) board meetings were scrutinised to establish what items were discussed at board meetings and how matters were dealt with. Hospitals were excluded from the study after five (5) failed attempts to involve them in the study.

Results

Hospital boards in KwaZulu-Natal (KZN) are interim structures. The role and responsibilities of hospital board members are unclear and their supervision is inadequate. Their commitment and ability to function is limited and they are not

representative of the community that they serve. There is a lack of clarity as to the real purpose of hospital boards. Training, orientation and induction of new members are weak. There was little evidence about how boards provide feedback to the community and health users.

Conclusion

Hospital boards will function adequately once legislative regulations have been passed, clear policies finalised and appointed board members are adequately trained and capacitated.

Recommendation

The KZN Department of Health should promulgate legislation that will govern hospital boards, appoint permanent hospital boards, develop policies and training manuals and capacitate board members on an on-going basis. (292 words)

DECLARATION

I, **Hans Jacob Human** declare that:

(i) The research reported in this dissertation, except where otherwise indicated, is my original research.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

(iii) This dissertation does not contain other person's data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

(iv) This dissertation does not contain another person's writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:

a) their words have been re-written but the general information attributed to them has been referenced;
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(vi) As the candidate's supervisor I agree/do not agree to the submission of this dissertation.

Signature: ……..Date: ……...

Supervisor: ……..Date: ……

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ACRONYMS AND ABBREVIATIONS

CHB	-	Chairperson of the Hospital Board
CEO	-	Chief Executive Officer
HOD	-	Head of Health Department for KwaZulu-Natal
KZNDOH	-	KwaZulu-Natal Department of Health
MEC HEALTH	-	Member of the Executive Council for Health
NDOH	-	National Department of Health
UKZN	-	University of KwaZulu-Natal

KEY WORDS

Hospital Boards, District Hospital, governance, Chairperson, Chief Executive Officer, community representatives, power and functions, accountability.

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CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

There is a strong drive by government to strengthen public participation, to establish governance structures and to ensure that it is more accountable to local communities. Hospital boards are therefore a tool that has been developed for this purpose and where communities can become partners in developing their own health services (Bennett, Msauli & Manjiya, 2001). Hospital boards are the link between the hospital and the community and share the concerns of the community to the hospital management. However, their lack of power renders them less influential than legally constituted boards with fiduciary powers (Claxton, Felder, Schactman & Altman, 1997). Community accountability encompasses the needs and interests of the people that reside in a certain geographical area and where there is a sense of interdependence and belonging (Griffith, 1987).

Community accountability includes the strengthening of the links between health improvements and community development (Gaum, 1996). Hospital boards are seen as the link between the hospitals and the communities that they serve, the bodies they represent, as well as with the organisations and bodies outside the hospitals (Middleton, 1987). Having a community-based board provides great insight into the needs of the community it represents through the interaction of the individual board members while members with unique expertise and insight should also serve as board members (Barry, 2005).

1.2 BACKGROUND TO THE RESEARCH

1.2.1 What is known so far?

The National Health Act, Act 61 of 2004, Section 41, requires that the Provincial Member of the Executive Committee (MEC) responsible for Health appoint a representative hospital board (National Department of Health, 2003). However, this section has never been put into operation. The KZN Health Act, Act no. 4 of 2000, Section 62, provides for the establishment of hospital boards. The KZN Health Care Bill was published for comment in 2007 and will replace the said Act (KwaZulu-Natal Health Care Bill, 2007). Hospital boards are therefore only interim structures with no clear mandate, powers or functions. The respective boards have been interim for many years and their contribution to enhanced service delivery is unknown. The Human Health Development Trust has been appointed by the MEC to capacitate and to train board members and hospital management on their role and function. This training took place during the latter part of 2006 and in 2007.

1.2.2 What needs to be known?

The re-drafted KZN Heath Act will soon be promulgated. It is important to know what the mandate, powers and functions of the hospital boards will be and how members are selected and appointed. It is also essential to understand how they will be capacitated and what the formal interaction with hospital management structures will be. Their links with stakeholders and role players are other critical issues to be addressed. Hospital boards' values, contributions and effectiveness must be monitored and evaluated and it should be determined how their performance will be measured. It is important to clarify the reporting structures and how these fit into the existing health system. The mechanisms to promote the boards to the users of hospital services must be determined. The function of hospital boards in other provinces and countries and lessons learned must be

incorporated when appointing boards. Lastly, the level of cooperation and interaction with management structures should be determined.

1.2.3 What is the importance of this study?

Interim hospital boards have been appointed by the MEC for Health, KwaZulu-Natal Province. An evaluation of their understanding, functioning and their contribution to the health system could assist to identify the gaps and weak areas that presently exist. The result of this study can be incorporated or considered when redrafting the Provincial Health Act. Hospital boards should contribute to the rendering of improved hospital services and board members and health users need to understand the role and functions of the board. It is important that hospital management buys into the process and supports the board. Lessons learned from other countries can assist the province in minimising the risk of making inappropriate appointments. It is also important to understand where the board fits into the overall health system, as well as its links with other health facilities and the office of the MEC for Health at Provincial level.

1.2.4 How will the study solve the problem?

Clear and implementable proposals that can add value to the health system will assist to establish effective hospital boards. The MEC would be in a position to consider the recommendations of this study when appointing hospital boards. Board members with adequate knowledge, competencies and an understanding of the health sector should be appointed. A possible output of the study may be the recommendation to develop induction programs for board members. Applicable and appropriate health policies and protocols can be developed that support hospital boards. Lessons learned from other provinces and countries could assist in developing effective hospital boards that will contribute positively to the rendering of improved district hospital services. Hospital boards will have clear

mandates and hospital management teams and the community will have a clear understanding of the role and function of the boards.

1.3 STATEMENT OF THE RESEARCH QUESTION

Are members of hospital boards equipped to contribute to the governance and delivery of district hospital services in KZN?

1.4 AIM OF THE RESEARCH

The aim of the study is to describe whether members of hospital boards at district hospitals in KZN are equipped to support hospital management in the effective and efficient delivery of district hospital services.

The purpose of this dissertation is to state, descriptively and analytically, the function of hospital boards and their impact on the rendering of improved district hospital health services.

The study describes the composition of hospital boards and assesses their knowledge, expertise and level of understanding of governance and management of the health system. The place of the hospital boards within the public health system is described and it was determined how the boards interact with external role players and stakeholders in KZN. In addition, governance arrangements and interactions between the management of the hospital and the hospital board is assessed. A number of recommendations to the relevant authorities are made to enhance the input of hospital boards.

The study provides evidence of the mandate, role and functions of hospital boards, as well as their contribution to the rendering of district hospital services.

1.5 SPECIFIC OBJECTIVES OF THE RESEARCH

The specific objectives of the study are:

a) To describe the demographic profile of hospital board members;
b) To assess the chairpersons of the hospital boards knowledge of the district hospital;
c) To describe how hospital boards network with stakeholders and role players;
d) To describe governance arrangements and interactions between the hospital management and the hospital board members; and
e) To make recommendations to policy makers and other relevant stakeholders.

1.6 ASSUMPTIONS UNDERLYING THE STUDY

The underlying assumption of the study is that the effective functioning of hospital boards is negatively impeded by their interim nature and, as legislation has not yet been promulgated, this impacts negatively on the effective functioning of these boards. A second assumption is that interim members of hospital boards do not represent the community that they serve and finally, that those members do not have a full understanding of their powers, role and function, nor the skills to oversee district hospitals.

1.7 OPERATIONAL DEFINITIONS USED IN THE STUDY

A *Chief Executive Officer* (CEO) means a health facility manager appointed to run the day to day affairs of such health care facility

The *district hospital* is a hospital at the first referral level and is responsible for a district of a defined geographical area containing a defined population and governed by the district management team. It provides a range of outpatient and inpatient services, mostly within the scope of general medical practitioners. For the purpose of this study it excludes tuberculosis, rehabilitation, chronic and specialised hospitals.

A *hospital board member* is defined as an interim hospital board member appointed by the MEC for Health of KZN.

A *hospital management team* consists of the CEO, medical manager, nursing services manager, human resources manager and the finance and systems manager.

A *regional hospital* is a facility that provides general medical practitioner and specialist services. It provides the basic specialties of surgery, medicine, orthopaedics, paediatrics, gynaecology and psychiatry, as well as radiological and anaesthetic services.

The *demographic profile* includes age, gender, race and educational qualification of hospital board members.

1.8 ORGANISATION OF THE REPORT

This report is organised into chapters. Chapter 1 gives an introduction and general overview of the study and focuses mainly on the research problem, the importance of the study and the background to the existence of hospital boards.

Chapter 2 assesses a detailed literature review and covers governance, the powers and functions of hospital boards, their composition, the skills of board members and legislation. Furthermore, it covers community participation and the interaction between the CEO and the board.

Chapter 3 discusses the research methodology, the study design and method of data collection. It sets out the sampling framework, data analysis and covers the issues of ethical clearance and participant consent.

Chapter 4 presents the results of the study in terms of the objectives thereof and provides a report on the findings.

Chapter 5 contains a discussion of the results in Chapter 4.

Chapter 6 discusses the conclusions drawn from the results of this study. Recommendations on how to improve the functioning of hospital boards and for further research are made.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

There are many published articles describing empirical research with regard to the functioning, powers and duties of hospital boards at both profitable and non-profitable hospitals. It focuses on governance, powers and functions of hospital boards, and the background and skills needed for board members. It furthermore focuses on community participation. Lastly, it describes the knowledge what board members should have and the interaction with their respective Chief Executive Officers. However, it appears that there are no published studies of the performance and functioning of hospital boards in the public sector in South Africa. Sources used include relevant legislation, articles published in medical and other journals and policy documentation published by the South African government, the World Health Organization and other organisations.

2.2 GOVERNANCE

The World Bank defines governance as the “exercise of political authority and the use of institutional resources to manage society’s problems and affairs” (World Bank, 1991).

A definition of hospital governance is that it “ … refers to the way in which control is exercised over hospitals and other health services, and the powers vested in the governing body, in this case the health authorities and district, provincial and national level, to exercise such control” (Monitor Company, 1996).

A more general definition of governance is “the responsibility and accountability for the overall operation” of an organisation (Bohen, 1995). Shortel, Gilles, Anderson, Erickson and Mitchell (1996) describe some of the challenges faced by hospital governance because of major changes in the delivery of healthcare, organisation and financing (Shortel et al., 1996). A well functioning district health system in South Africa will have governance structures and a clear legislative framework, with community participation. These are critical aspects of district planning and management (Gilson, Balfour, Goosen, 1997).

The governing board and top management constitute the axis of hospital governance in that they steer the overall performance of the hospital by defining its mission and by setting the broad objectives (Flynn, 2002).

Taylor (2000) defines governance as a “… shared process of top level organisational leadership, policy-making and decision-making” (Taylor, 2000). Bader (1993) adds that governance is an interdependent partnership of leaders.

Middleton (2005) stated that the board and management are both responsible for making policy and, once this is in place, the board steps back and lets management manage (Middleton 2006). Barry (2005) concurs with Middleton by stating that the board must have a clear understanding of its role and governing authority. He adds that a governance committee will ensure the education and orientation of board members (Barry, 2005).

It is the opinion of Stolzenberg that effective governance requires a board with sufficient authority to determine the course of hospital operations and policy, that it is focused on the interests of the hospital, and that it is as free as possible from political intervention. He adds that the governance structure must include public accountability and must improve efficiencies and render cost-effective services. Additional key aspects include broad-based community and hospital education and

government working with community leaders and representatives to create enabling legislation and to develop detailed work plans (Stolzenberg, 2000).

According to Knecht and Kazemek (2000) the governance structure should be aligned with the vision, mission, purpose and strategies of the hospital, which will assist it to perform its key roles and responsibilities (Knecht & Kazemek, 2001). They further argue that restructuring will lead to quicker and more effective decision-making, improved communication, mandatory orientation, annual goal setting and evaluation of the board and its individual members, as well as an increased focus on strategic and policy issues.

The governance of any organisation is affected by the makeup, size and other social and demographic factors of the board. In California it was found that different types of hospitals have systematically different objectives and therefore different focus areas (Eldenburg, Hermalin, Weisbach & Wosinska, 2003).

2.3 POWERS AND FUNCTIONS OF HOSPITAL BOARDS

The board provides leadership to assure cost-effective, accessible quality care for all living in the catchment area of the hospital (Seay & Sigmond, 1989). Board leaders must understand their contribution to the hospital's performance in order to enhance this for the benefit of the community (McDonagh, 2006). Committed boards that are serious about improvement and that invest in the necessary efforts will achieve effective governance for their respective hospital (Prybil, 2006).

Perrine (2003) reported that improved board meetings resulted in tangible benefits for the whole institution (Perrine, 2003). Hospital boards are responsible and accountable for their respective hospitals, but governance is not the sole responsibility of a board alone - rather a solemn partnership. According to Sheldon (1923) the CEO and the board should form a common body with a common motive, value and purpose to assure stability in the running and delivery

of services (Sheldon, 1923). This is echoed by Deming (1986) when he argues that this partnership must have a common and shared vision, a clear understanding of the organisation's commitment, the knowledge of what they want to create, as well as why and how they will go about doing it (Deming, 1986).

Hospital boards in the Eastern Cape have three primary objectives, namely to support hospital management in meeting its responsibilities, to ensure that management meets its obligations in terms of its performance agreement and to ensure that management is responsive to the needs and views of the community (Monitor Company, 1996).

According to Bennett, Msauli, & Manjiya (2001) each hospital should develop its own vision, mission statement, strategic plan, operational plan and constitution (Bennett, et al. 2001).

Taylor argues that hospital boards should be responsible for the development of corporate policies and plans and monitor and measure organisational performance against these plans and policies. He further states that the hospital board acts as the voice of the hospital and provides a link between the hospital and its ownership (Taylor, 2000).

The board must develop the values of the hospital and Carver (1990) discussed key relationships, i.e. the CEO – board relationship, the board – community relationship, the mission/vision/goal relationship and lastly, the intra-board relationship among its members (Carver, 1990). According to Sinclair (1996) the roles of the board are threefold, i.e. to provide governance by determining its purpose, goals, objectives values and policies, to meet the needs of the community where possible, and to hire a competent CEO. He summarises this by stating that the hospital must provide the right service at the right place, at the right time and at an affordable cost (Sinclair, 1996). The board and management must

evaluate programmes to monitor whether quality care is provided and if targets and outcomes have been achieved (Middleton, 2006).

Barry is of the opinion that it is a key function of boards to focus their attention on strategic planning and fulfilling their mission (Barry, 2005).

Key characteristics of effective boards, as discussed by Prybil (2006), are summarised below. Firstly, there should be strong support by the parent body with clear expectations, adequate resources and oversight. Secondly, there should be a common understanding by the board and the CEO with regard to their roles, responsibilities, authority and organisational relationships. Thirdly, the support and leadership of the CEO is essential for a board to be successful. In addition, a sustained commitment and board development is critical. Furthermore, there should be a proper structure and staff resources to assist the board. Access to reliable information, with a well constructed board focusing on key governance is essential. Processes must be reviewed regularly and opportunities for improvement identified. Clinicians must be engaged in board activities and a board should engage proactively with its members, with constructive dialogue and promote inclusive decision-making processes (Prybil, 2006).

Articles nine and ten of the Western Cape Health Facility Boards Act, determine the functions and powers of hospital boards in the province. Boards must approve the mission, vision and values and advice management on policies. They must also participate in strategic planning and operational processes. Boards are responsible for improving the rendering of quality services, monitoring performance, effectiveness and efficiency. A further function is to ensure that the needs, concerns and complaints of patients and the community are addressed. Boards must foster community support, raise funds and be consulted in the appointment and evaluation of the head(s) of the health facility. Lastly, they must conduct regular inspections and report their findings of such visits. Article ten of the Act deals with powers of boards. Boards advise, make recommendations,

elicit information, request progress reports, review financial statements and conduct surveys, meetings and workshops in the community. They are further responsible for disseminating information to the community, appointing staff to serve the purposes of the board, raising and administering funds. Additional functions may be authorised by the MEC, if the MEC has the capacity to do so (Western Cape Health Facility Boards Act, 2001)

Philanthropic boards serve a representative function and are the link between the hospitals and the communities that they represent. They focus more on critical resources in the environment and therefore focus more on acting as fiduciary agents, rather than strategic change agents (Alexander, Ye, Lee & Weiner, 2006).

According to Bennett et al. (2001), community representatives serve on hospital boards to advocate for community needs and interests, to ensure quality of service, to participate in strategic planning and to consult with communities. They also provide feedback, monitor income and expenditure and assist in staff or public complaint resolution (Bennett et al., 2001). This has not happened in Zimbabwe. Loewenson found that Zimbabwean hospital boards had weak technical capacity, weak budgetary powers, low levels of beneficiary participation, non-participation of traditional structures and poor engagement with civil society (Loewenson, 1999).

The Healthcare Commission in Britain concluded in 2005 that the role of governors is unclear beyond their statutory duties and add that the present mechanism for asserting local choice remains uncertain (Healthcare Commission, 2005).

American hospital boards are weak in their ability to make significant impact on hospital performance as they have been delegated with limited responsibilities only, particularly related to raising revenue and retention, financial control and staffing issues. Their power, roles and the degree of autonomy from the Ministry of Health are important factors for their success (Bennet, Dakpallah, Gardner, Nittayarampong, Zurita, & Zwi, 1994).

If participation is to be enhanced, hospital boards must be involved in the development of policies and be able to prioritise areas for service delivery, be in a position to allocate resources, negotiate standards and even to audit and to evaluate the performance levels of the health system (Kahassy & Baum, 1996). At a board meeting of the St. Joseph Hospital in Orange, California, it was noted that the board had a lack of purpose and focus. Its members did not have complementary backgrounds, lacked knowledge and were not in a position to make balanced and informed decisions. They were also not aware of their fiduciary responsibilities. Another important aspect was the domination by non-board members, which prevented the board members from becoming a cohesive unit (Gautam, 2005).

Financial and quality oversight is the core responsibilities of the Sarasota County public hospital board in fulfilling its role. In addition, it is responsible for setting the strategic direction, its mission, for self-assessment and development, as well as to oversee management. It must also ensure compliance and focus on public policy issues
(www.Smh.com/section/corporate/about_us/pdf_files_corporate/Job%Description-SCPHB-053106.pdf).

2.4 COMPOSITION AND SKILLS OF BOARD MEMBERS

The composition of a board has an effect on strategic direction and hospitals must ask how compatible the backgrounds and composition of the board members and the populations that they represent are (Saleh, Vaughn, Roher, & Linden, 2002).

Hospital boards are responsible in meeting the health needs of the communities that they serve and studies indicate a low percentage of women (only 23%) serving on boards (Kazemek, Knecht, & Westfall, 2000).

At a meeting of the WHO Regional Committee for Africa it was proposed that the community have at least ten percent representation at board level (Fifty-third session of the WHO Regional Committee of Africa, 2003.) Bader (1991) argues that boards that are of a workable size of between seven and ten members excel in their governance role and that larger or smaller boards are generally ineffective (Bader, 1991). Knecht and Kazemek (2001) are in agreement when stating that experts in group dynamics believe that the optimum size of a decision-making body, like a hospital board, is between eight and ten members and that large boards are, by definition, therefore inefficient (Knecht & Kazemek, 2001). A Belgium survey indicated that the average size of a hospital board consists of ten voting members and, by law, a maximum of a third of board members may be independent experts. Many boards have a financial/economics expert and someone possessing legal knowledge (Eeckloo, Van Herck, Van Hulle, & Vleugels, 2004).

Tyler (2002) states that community standing is likely to have only a minimal bearing on the performance of a board member. She adds that board members usually serve two to three year terms and it is therefore of the utmost importance that the right people are selected to ensure effective board functioning. She recommends that an effective board consist of between ten and fifteen members, but that organisational needs would ultimately determine the size thereof (Tyler, 2002). According to Scott (2006) one way to ensure an effective link between the hospital and the community is to have a hospital board which is composed of a range of people, which includes minority representation (Scott, 2006). Molinari, Morlock, Alexander and Lyles (1993) however, report that hospital administrators are progressively increasing the number of administrators who serve on boards (Molinari et al., 1993).

Dolan (1996) is of the opinion that board members must have the opportunity and ability to fully participate in the governance process. He adds that continued

education is vital to the health care industry, including the education of board members (Dolan, 1996).

Dolan (1996) further states that board members need to evaluate their own performance as well as that of the board overall. It is Middleton's (2000) opinion that boards that consist of a cross-section of members from the community are a thing of the past. He believes that in a complex, sophisticated and involved health care, where the industry spends millions of dollars, board members must have the expertise and experience to deal with complex issues. He adds that a board meeting is not the venue where board members are educated. Members must have the experience to understand the issues before them in order to make informed decisions. He believes that the understanding of financial statements, business law, human resources, accounting, public relations and regulatory requirements are some of the skills needed by board members (Middleton, 2000).

To overcome community representation Middleton (2000) proposes that two community activists serve on the board, adding that there must not be too many committees. He agrees that critical committees, for example, audit, finance and compliance, should be in place. He states that ad hoc committees should be appointed when required and be dismissed once their work is done (Middleton, 2000). Barry (2005) states that too many committees result in a complicated decision-making process, adding to the heavy burden of management (Barry, 2005).

The Equity Project motivates that boards have some members who are more skilled in financial matters (Bennett et al., 2001).

Larson (2005) reports the following criteria when recruiting new members, i.e. board experience, achievement, willingness and preparedness to serve on the board, objectivity, a focus on strategy and a loyalty and commitment to the

hospital. He also advocated that a board should consist of twelve members only (Larson, 2005).

In Zimbabwe it was found that vague roles, limited authority; inadequate available information and weak representation were some of the factors that limited and even undermined board effectiveness (Loewenson, 1999). Pointer and Ewell (1994) report that advisory boards have limited powers and exist primarily to advice management or a higher authority (Pointer & Ewell, 1994).

Hospital boards in Sierra Leone are established in accordance with the Hospital Boards Act of 2003. Such a board is established for a group of hospitals. Boards have powers to acquire or dispose of any property. Members hold office for a period of four years and may be re-elected.

Gautam (2003) argues that board members should have complementary backgrounds and knowledge in order to make balanced and informed decisions and that the quality of board discussion depends on board members. He adds that the skills mix and backgrounds of board members should be appropriate and be based on the long term goals of the hospital (Gautam, 2003).

According to Bilchik (1999) the skills mix, qualifications and backgrounds of hospital board members must be appropriate (Bilchik, 1999).

Hospital boards often establish a number of committees, such as for quality assurance, training, fund-raising, ethics, community campaigns, information, and to deal with complaints/conflict (Bennett et al., 2001).

The Canadian Minister of Health determines what the qualifications of board members should be, if any, and the board appoints individual members to serve on the different sub-committees (Shap, 2006). This duel alliance contributes to the exchange of information and resources across boundaries and assists in holding

hospitals accountable to the communities that they serve (Pfeffer & Salancik, 1978).

2.5 LEGISLATION

The National Health Act, Act 61 of 2004, article 41, stipulates that the MEC of a province appoints a representative hospital board (National Health Act. 2004). However, this section has never been implemented.

The National Health Act further stipulates that a board shall consist of one representative from each university associated with the hospital, one representative from the provincial department in the province in which the relevant hospital is situated and not more than three representatives of the communities served by the hospital, including special interest groups representing users. A maximum of five representatives of staff and management may serve on the board of the hospital. Such representatives may, however, not vote at a meeting of the board (National Department of Health, 2004).

The KwaZulu-Natal Health Act, Act no. 4 of 2000, article 62, provides for the establishment of hospital boards. The boards have never been established as this section of the Act has not been enacted. The respective hospital boards have therefore been interim for many years (KwaZulu-Natal Provincial Department of Health, 2000).

The KZN Health Act, Act 4 of 2000, was passed on 3 August 2000. The implementation of the Act is awaiting finalisation and promulgation of regulations, as a legislative requirement for hospital boards is necessary before the Act can come into effect. According to the Act, the MEC must appoint hospital boards to ensure community participation that is viable and transparent. In the interim, the province uses a regulation promulgated in 1961, to govern hospital boards. All Boards are therefore interim and they make recommendations to the MEC only.

The KZN Health Care Bill that will replace the Act was published for comment in 2007. It includes a section that stipulates that the MEC appoint the hospital boards and it describes the proposed powers and functions of such boards (KwaZulu-Natal Health Care Bill, 2007).

The Western Cape Health Facility Boards Act stipulates that the MEC must appoint a board of not less than eight and not more than fourteen members. The Act prescribes that the board consist of community members and at least one person with technical expertise in business or law or finance or accounting. The head of the facility, one person representing clinical staff and one person representing non-clinical staff must also serve on the board. The MEC may also appoint a member of the Provincial Parliament, one or more elected local councillors or a representative of the Department. A community member is defined in article 6 of the regulation. Article seven of the Act stipulates that the term of office of a board member may not exceed a period of three years and that a member may not serve more than three consecutive terms (Western Cape Health Facility Boards Act, 2001).

The Eastern Cape Provincial Health Act, Act 10 1999, Chapter XVII deals with hospital boards. According to the Act, all board members must be from the community and may not represent political parties. There is a strong commitment to community representation. Section 5(3) states that community participation from provincial residents shall be encouraged to participate in the development and participation of health services through established forums and procedures. Certain non-voting members can be co-opted for specific purposes. Hospital boards have been established and trained and training manuals and guidelines are available (Eastern Cape Provincial Health Act, 2000).

The Free State Hospitals Act of 1996 addresses the establishment of hospital boards. It spells out the powers and functions and terms of reference of a board. These boards are in place and functional (Free State Hospitals Act, 1996).

Hospital boards have been appointed in Gauteng but they operate on different levels of functionality (Hall, Haynes & McCoy W, 2002). Chapter III of Ordinance 14 of 1958 deals with the establishment of hospital boards and describes in detail their size, composition, powers, functions and duties (Hospitals Ordinance, 1958).

The Northern Province Services Health Act, Act 5 of 1998 was accented on 4 January 1999. Chapter III deals with the establishment of Health Services Facilities Boards and describes the rights, powers, duties and functions of the hospital boards. Their main function is to make recommendations to the HOD, district manager or head of the institution (Northern Province Services Health Act, 2000). Hospital boards have been established in terms of the provisions made in the National Health Act and are to be found in the Mpumalanga province, but because of a lack of legislation, it is unclear when their term of office ends (Hall et al., 2000).

2.6 COMMUNITY PARTICIPATION IN GOVERNANCE STRUCTURES

Through its Ala Ata declaration in 1978 The World Health Organisation stated that "people have the right and duty to participate individually and collectively in the planning and implementation in their health care" (Wiseman et al, 2003).

There is a strong drive by government to strengthen public participation, to establish governance structures and to ensure that government is more accountable to local communities. A hospital board is therefore a tool that has been developed for this purpose, enabling communities to become partners in developing their own health services (Bennett et al., 2001).

Hospital boards are the link between the hospital and the community and feed the concerns of the community to the hospital. However, their lack of power renders them less influential than legally constituted boards with fiduciary powers (Claxton,

Felder, Schactman, & Altman, 1997). Community accountability encompasses the needs and interests of the people that reside in a certain geographical area and where there is a sense of interdependence and belonging (Griffith, 1987).

Community accountability, with a focus on health issues, includes community health and strengthens the links between health improvement and community development (Gaum, 1996).

A hospital board is seen as the link between the hospital and the community it serves, the bodies it represents, as well as with the organisations and bodies outside the hospital (Middleton, 1987). Barry (2005) is of the opinion that a community-based board provides great insight into the needs of the community it represents through the interactions of individual board members, but adds that members with unique expertise and insight should be serving as board members (Barry, 2005).

Gorsky (2008) reported that an important goal of the National Health Service in Britain is to increase public involvement in health care. This led to the establishment of foundation trust "membership communities". Their main aim is to give local citizens a say in management and this should result in a greater responsiveness to hospital policies. Members can vote and stand as governors of the trusts and therefore ensure that governors genuinely represent the interests of the hospital users. Furthermore, they can hold the trust's boards accountable to the catchment population's needs (Gorsky, 2008).

Involvement in the community is essential to be accountable to the community uses the hospital services and a strong representative hospital board is therefore important (Couper & Hugo, 2000). They continue by stating that there must be a sense of "… being answerable to the community", that they are the voice of the community in the hospital, and hospitals must be answerable to the communities that they serve. Bennet et al. (2001) concurs that community members are

needed to advocate the needs and feelings of the community. They add that the community must be involved in the development of the strategies and policies of the hospital and must guide management in matters that affect them. They conclude that the role and function of the board must be advisory and supportive (Bennett et al., 2001).

It is important for board members to interact more often with the community that they represent. By speaking to civic organisations, talking to the media, listing community needs and concerns will ensure that the community feels that it has more say in the governance of the hospital (Becker, 1993). Becker (1993) adds that there should be more direct and protracted contact with the neediest people of the community. Board members are qualified to build bridges with health users, providers of services and agencies in the community and must establish close ties with the above. He also reports that the first step is to establish a baseline of information about the health status of the community that board members serve and, based on that information, develop a comprehensive plan on which to focus. Members must be able to put themselves in the place of the health users and management.

Regular reports on the progress made by the hospital and the services and benefits that the institution provides are a critical part of the future of the hospital and a key measure of the effectiveness of the governance process (Barry, 2005).

According to Weiner and Alexander (1998), hospital boards can increase their leverage by working with other local organisations and agencies, assessing capacity in the community, identifying unmet needs, avoiding duplication, collecting, tracking and communicating clinical and health information (Weiner & Alexander, 1998).

Hash states that boards with a greater mix of experts and community representation have a greater potential of community accountability (Hash, 1989).

On the other hand, writers highlighted the monitoring of the local environment and gathering information to exercise community accountability (Proenca, 1998).

In a report of the American Hospital Association it is stated that community health is strengthened if hospital boards create strong links with community agencies (American Hospital Association, 1993). Community members are the appropriate people to do this as they are able to identify community needs and are keen to protect the assets of the community (Kazemek et al., 2000). Community representation on hospital boards is believed to enhance a board's ability to reflect the interests of the people that they serve and to ensure that the policies, strategies and operations of the hospital are consistent with those interests (Scott, 1997). Communities should be encouraged to participate with management when they develop plans and should include councillors, clinic committees, NGO's and other political stakeholders (Pillay, Leon, Wilson, Barron, & Dudely, 2003).

Hospital boards with members that reside within the catchment area of the hospital are more accountable to the local community (Alexander et al., 2000). Community accountability is enhanced if these members use community standards to evaluate the performance of the hospital and the CEO and when reports are disseminated to the community (Alexander et al., 2000). Community accountability can also be exercised by ensuring that the management of the hospital identifies and responds to unmet community health needs, risk factors, health costs and other adverse health outcomes (Sigmond, 1995).

According to proposed Canadian legislation, the local health integration networks, i.e. non-profit corporations, must engage with the communities and entities involved with the local health system on an ongoing basis (Shap, 2006). Gorsky (2008) states that community involvement will enhance responsiveness and reduce health inequalities, but others argue that central control will still be dominant through national policies, priorities, targets and audits. There are also fears that by surrendering policy to local interest groups this may jeopardise equity.

He also states that it may be difficult to ensure that local representatives are vigorous and genuinely representative, that there is a non-partaking majority and only a small number of minority public-spirited activists (Gorsky, 2008).

2.7 KNOWLEDGE AND INTERACTION OF BOARD MEMBERS

Maron (1997) indicated that board members must focus on six points for the hospital boards to benefit, i.e. to have clear processes and consistent goals, clear expectations of what is expected of each and every member and an agreed work method, inclusive of how meetings are concluded. She adds that members must be responsible for specific tasks as well as how decisions should be made. They must anticipate possible areas of conflict and know how to address such potential conflict. Maron is further of the opinion that boards should have a clear mission and vision and agree on desired results. Self-assessment is a useful tool for stimulating the performance and internal processes of boards. She stated that all board members must be trained and orientated. Further assistance is to provide better background material to improve decision-making, for example, with budgeting. She also argued that the chain of command must be clear. The community must be given appropriate information with regard to the goals of the board and to buy into change, if needed. Identifying shortcomings and solutions will assist boards in implementing improvements successfully (Maron, 1997). Larson (2005) is of the opinion that education of board members is the best way to develop them and that the education curriculum should be developed in relationship with the strategic plans of the hospital (Larson, 2005).

Delbecq and Gill (1988) state that to select board members on any basis other than competence or merit is “selling short the value of governance” and board members that have not been appointed on merit will not focus on strategic issues but will pursue vested interests (Delbecq & Gill, 1988). Barry (2005) is of the opinion that it is the responsibility of the CEO and the chairperson of the board to ensure effective orientation and ongoing training for board members (Barry, 2005).

Friede (2007) is in agreement when he states that any hospital that provides continuing education for its board members contributes in promoting an optimal level of stewardship and he recommends that an appropriate manual should be given to every new board member (Friede, 2007).

The board must have a balanced skills mix and its members should possess complementary educational backgrounds and a clear understanding of the hospital environment, the community the board represents and sound management practices. Grobmeyr (2000) further states that the skills mix within hospital boards is critical and that this should be reviewed and defined annually. He adds that members must serve for a limited term, but does not propose how long this term should be (Grobmeyr, 2000). Skilled board members understand their role as well as the role of the CEO (www.Whs-seattle.com/manual/hospitalmanagement.html).

The South African National Health Act is in line with the above authors in that it stipulates that the Provincial MEC must appoint a representative board for each public health establishment and prescribes the functions and the procedures for the meetings of such a board. The Act is prescriptive in the number of community representatives that are allowed to serve on the board, the terms of office and the number of persons with expertise in specific areas. It determines that a maximum of three community members may serve on the board and that they must have expertise in areas such as accounting, financial management, human resources management, information management and legal matters (National Health Act, 2004).

Advocacy is becoming increasingly important, lobbyists must represent their interests while governing bodies and board members must influence legislature and bring their organisation's issues to the attention of higher policy makers and the legislature (Middleton, 2005).

Larson (2005) states that board members need information on clinical technology, strategic planning, finance, legal matters, human resources, quality improvement, marketing, faith-based sensitivities and community advocacy (Larson, 2005).

The orientation of hospital board members should include special attention to the health problems of the local community. They must invite representatives of the community and advisors from other local health care institutions to their board meetings and provide regular progress reports to achieve their community goals (Seay & Sigmond, 1989). According to McDonagh (2006), board members are no longer selected on the grounds of their social standing but that selection is based on their ability to think creatively and to be team players that contribute to the board and the hospital (McDonagh, 2006).

McDonagh (2006) states that the need exists for both theoretical education as well as practical application to improve the performance of a board. She argues that there must be continuous education for new board members and that they be assigned to a board mentor. Linked to this must be individual and group board assessment and succession planning (McDonagh, 2006).

Kazemek et al. (2000) reports that only a few hospital boards provide adequate information when orientating and educating board members and, on average, only sixteen hours per year is spent on this process (Kazemek et al., 2000). They add that periodic educational events should be held and external speakers invited to capacitate and assist board members. They also recommended that members be actively sought to increase the diversity of the board. This can be achieved by outlining their job descriptions and the expectations of the hospital.

Lewis (1996) states that a lesson learned is that effective governance begins with effective board member selection and that members must reflect the population that they serve and that business acumen is essential (Lewis, 1996).

2.8 INTERACTION BETWEEN THE CEO AND THE BOARD

Nadler stated that better corporate governance is a result of the good relationships between boards and health managers (Nadler, 2004). The relationship should consist of trust, respect, open communication, a commitment to the best interests of the hospital and to the health system, as well as to its patients and the community that the hospital serves (www.Whs-seattle.com/manual/hospitalmanagement.html).

The CEO can influence board performance and plays a unique role as he/she represents both management and governance (McDonagh, 2006). The chairperson of the board creates the climate in which the board operates. Good and effective chairpersons will create an environment of openness, candour, positive energy and a commitment to the vision of the hospital. There should be regular, honest meetings between the chairperson and the CEO, held in a candid way with mutual respect (Behan & Bolster, 2007).

In a rapidly changing environment it is important to re-examine the hospital board, including the way in which it is organised. The board must look at itself and decide what type of board it needs to be. There should be a readiness to make changes if needed. Agreement must be reached on priorities and timelines in order to improve and strengthen governance, on clear short and long-term responsibilities with achievable expectations.

The chairperson of the board should be in regular communication with the CEO and be the CEO's eyes and ears in the community. To be effective there must be clarity between the CEO and the chairperson of the board on their respective roles and responsibilities. There should be trust, communication, as well as openness and honesty (Mary & James, 2007). They add that there should be a willingness to tolerate different points of view and that a good relationship is critical to the effectiveness of the board (Mary & James, 2007).

According to Umbdenstock (2006), the CEO is the primary driver of the board's collective competency and effectiveness. He states that the CEO must provide essential information and leadership to objectively measure and openly report organisational performance, which will in turn assist the board to learn, grow and perform better. He concludes by stating that CEO's who facilitate the development of the board and its decision-making will directly contribute to its success and therefore the success of the organisation (Umbdenstock, 2006). Day and Klein (2005) report that CEO's, rather than governors; determine the agenda of the governing board (Day & Klein, 2005).

2.9 CONCLUSION TO THE LITERATURE REVIEW

Many authors describe the need of community participation in providing public and private health services. The roles, powers and functions of board members and how they should interact with the Chief Executive Officers have been discussed in detail. The composition, skills and competency needed have also been discussed in detail. However minimal information is available to describe impact and effectiveness of hospital boards in South Africa at public hospitals.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

The research methodology is discussed in this chapter. This includes the study design, study period, pilot study, data collection, sample size and other aspects as discussed hereunder.

The researcher obtained consent from the Biomedical Ethics Committee of the Nelson R Mandela Medical School, the Head Office of the KZN Provincial Department of Health, as well as from the CEO's of the respective district hospitals. The hospitals were selected using a convenience sampling method. The decision in terms of which board was to be interviewed was informed by the dates when the boards met and also to ensure that urban, rural and deep rural hospitals in the province had been included. The district hospitals used in the study are indicated in the attached maps. (Appendix H-J). The researcher conducted telephonic interviews with the CEO's and CHB's. This research was carried out over a period of four (4) months (February 2009 to May 2009).

3.2 STUDY DESIGN

A descriptive, qualitative and cross-sectional health systems research study design has been used. This study describes thirty two (32) district hospitals in KZN that granted permission to the researcher to use their hospitals as study sites.

3.3 TARGET POPULATION

The chairpersons of hospital boards and the hospital managers of the district hospitals situated in KwaZulu-Natal were interviewed. Thirty two (32) district hospitals participated in the study. A total of eighty four (84) participants were interviewed, consisting of twenty four (24) CEO's, nineteen (19) chairpersons of boards and forty one (41) ordinary board members. The researcher attended hospital boards that met during the data collection period and all of the eleven health districts were included. Furthermore, urban, rural and deep hospitals were selected.

Focus group discussions were conducted with board members attending the meeting of the board. Their backgrounds, competencies and participation were assessed by using a structured interview schedule.

3.4 SELECTION OF STUDY POPULATION

There was no sampling, as the population size was finite and reasonable to include all. The eleven hospital boards where ordinary members were interviewed were chosen through convenience sampling.

3.5 STUDY INSTRUMENT

Two questionnaires were developed to interview CEO's and chairpersons of hospital boards respectively. Structured and open-ended questions were used to gather data. (Annexure A and B). Minutes of three previous board meetings at most of the hospitals that took part in the study had been provided to the researcher by either email of facsimile.

Ordinary board members were interviewed by using an interview schedule (structured and open ended-questions) as per Annexure C.

Data variables were categorised as follows:-

- Current position of the respondent e.g. Chairperson of the hospital board / member of management, ordinary board member;
- Qualifications, knowledge and experience in the public health (hospital) sector;
- Perceptions of the functioning, powers and functions of hospital boards in KZN;
- Suggestions for improvements and recommendations of hospital boards;
- Demographic profile (age, sex, gender, language, and highest qualifications)
- Appointment of members and their representation of the community / catchment population of the hospital ;
- Training , orientation, induction of board members;
- The relationship between management, the board and the community they serve; and
- Communication, feedback and reporting channels and structures.

3.6 BIAS AND LIMITATIONS

The aim of the study was to describe hospital boards of district hospitals in KZN. Other provincial hospitals did not form part of the study and it is possible that different types of hospitals, such as TB hospitals, require a different type of hospital board, as their services, referral patterns disease profiles differ from those of district hospitals. Therefore this is not generalisable to all public hospitals.

The study does not compare the performance of hospitals with interim boards in place with those hospitals that have legally constituted boards. Board members may not be honest and/or may not have a full understanding of what is expected of a board member, as many of them have not been orientated and/or trained for

their roles, powers and functions. It is therefore possible that they could not fully contribute to the research questions.

In group discussions, some participants may have felt uncomfortable in honestly answering some of the questions posed to them.

The questionnaire was piloted at two hospitals to ensure clarity thereof. It is possible that some questions may not have been clear to some participants.

The researcher is known to some of the CEO's, therefore possibly introducing bias to the study, while some of them may not have been totally honest with regard to the performance of their boards and/or their relationship with their board.
Because of limited response caution must be exercised to generalize all hospital boards.

3.7 DATA COLLECTION, ANALYSIS AND STORAGE

Data has been collected by focus group discussions, and using structured and open questionnaires. Minutes of three previous hospital board meetings were faxed or emailed to the researcher.

Data was analysed by manually extracted it from the data sources and saved electronically. The MS Word program was used to produce the tables.

3.8 PILOT STUDY

The researcher piloted the questionnaires during December 2008 at two regional hospitals that also render district hospital services. The chairpersons of the hospital boards and the CEO's were interviewed and the two hospitals were selected using a convenience sample. The pilot resulted in a minor modification to

the questionnaires in that one question was added to determine whether board members should receive a stipend, and if so, how much?

3.9 ETHICS APPROVAL

The ethical approval was obtained from the Biomedical Research Ethics Committee of the Nelson R Mandela School of Medicine, South Africa (Reference number BC 89/08).

Permission was obtained from the KZN Department of Health and from hospital managers. Written consent was obtained from the participants of the study, i.e. the CEO's, chairpersons of hospital boards, as well as from ordinary members of the boards that took part. Participant's voluntarily signed the consent forms prior to participation in the study and confidentiality was maintained at all times. The participants only signed the forms after being informed about the research, the aim and specific objectives thereof, confidentiality and of their right of refusal to participate. A copy of the ethical approval and an example of the information sheet and consent form is annexed as appendices G, D and E respectively.

3.10 SUMMARY

A descriptive and cross-sectional health systems research study design has been used. A total of thirty two (32) hospitals granted permission to the researcher to use their hospitals as study sites. Twenty four (24) CEO's and nineteen (19) CHB's were telephonically interviewed, forty one (41) ordinary board members were interviewed and eleven board meetings were attended.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

In this chapter the results of the study are discussed. The replies to the questionnaires, the comments made by the participants and the themes of the board minutes are presented. The findings are presented in tabular format and the results are discussed in detail. Individuals are quoted to capture their opinions and feelings and to indicate their understanding, knowledge and contributions to improve the functioning of hospital boards.

4.2 PARTICIPANTS OF THE STUDY

The researcher requested permission from 35 district hospitals in the province of KwaZulu-Natal and 32 hospitals agreed to participate in the study. The three missing hospitals did not replied when requested by the researcher. The hospitals and individuals that participated are presented in Table 1. The actual study sites (hospitals) are indicated in Appendix H. The hospitals where CEO's and CHB's were interviewed are indicated in Appendix I and J respectively. The hospitals where the researcher attended the board meetings and where ordinary board members were interviewed are indicated in Appendix K.

Table 1 **Summary of hospitals visited, Chief Executive's, Chairpersons of Hospital Board's, board members interviewed and minutes of board meetings received in KwaZulu-Natal in 2008**

No. of district hospitals	No. of hospitals that granted permission to researcher	Number of board meetings attended	Number of board members interviewed	No. of CEO's interviewed	No .of CHB's interviewed	No. of minutes from hospital board received
35	32	11	41	24	19	58
	91.4%	34.4%	N/A	68.6%	59.4.%	N/A

4.3 COMPOSITION OF HOSPITAL BOARDS

The hospital boards are chaired by a chairperson selected by the ordinary board members, with the exception of one board that is chaired by the CEO, or in his absence, by the hospital's public relations officer. The reason cited by the CEO is that "... *the board members do not have the skills to chair their meeting*". It was found that the boards comprise of community members serving as board members, as well as the full executive management and the public relations officer. The latter serves as ex-officio member of the board, with the exception of one hospital where management is represented by the CEO and Deputy Nursing Manager only.

The size of the respective boards differ substantially, with some boards consisting of as few as five (5) members and larger boards with as many as eighteen (18) members. The median size of the boards of district hospitals is 8.7. The National Health Act prescribes that boards must consist of a maximum of eight (8) members, excluding management from the hospital (National Department of Health, 2004).

During the focus group discussions it became clear that there is no guiding document, act or regulation that prescribes the composition of hospital boards and that the individual hospital CEO's decide how big the board should be, based on their own interpretation and local circumstances, e.g. the number of tribal areas, the geographical area and the size of the catchment population.

Some CEO's or CHB's could not indicate how many members serve on their boards and up to sixty percent (60%) of members do not attend meetings. It was not clear to the CEO's how big a board should be. CEO's in charge of rural hospitals indicated that they are in the dark as to how big the board should be and one CEO said that *"… we decided that every Induna would be allowed to bring one person that will serve as a board member and that will determine the size of the board".*

4.4 GENDER, RACIAL AND AGE REPRESENTATION ON HOSPITAL BOARDS

According to the information provided by the respective CEO's, sixty six percent (66%) of the members are male and thirty-four percent (34%) female. The racial groups that serve on the boards are represented in Table 2 hereunder.

Table 2 Racial composition of district hospital boards in KwaZulu-Natal 2008

Race	African	Indian	White	Coloured
Total board members	221 (90.2%)	9 (3.7%)	10 (4.1%)	5 (2%)

From the study it is evident that the largest percentage of board members is between 46 and 60 years of age. The breakdown of the age population of board members is presented in Table 3.

Table 3 Age breakdown of board members at district hospitals in 2008

Age groups	18-30	31-45	46-60	61 – and older
Age	8 (3.5%)	87 (37.8%)	105 (5.6%	30 (13%)

4.5 QUALIFICATIONS OF BOARD MEMBERS

According to the National Health Act, the respective hospital boards should consist of persons that have a legal, financial and/or human resources background (National Department of Health, 2004).

The CEO's indicated that of a total of two hundred and forty-three (243) board member's, only three (3) members had a legal background, ten (10) a financial background, twenty-one (21) a nursing background and one (1) possessed a medical qualification. Members who owned their own businesses represent the businesses community. However, no member represents an official business organisation. A CEO indicated that it is "impossible" and "unrealistic" for the MEC to expect the hospital to find persons with legal, financial and other expertise to serve as board members *"… especially those that are situated in the rural areas of the province".* One CEO said that *"… there are not many educated people that stay in my community and educated people are not easy to be found and it should be flexible as to who may serve on the board".* Another CEO indicated that it would be good to have board members *"… with expertise, e.g. in human resources and financial matters and to get their expertise on the board".* However, he continues by stating that *"… outsiders do not have a real interest in local issues and are rather concerned about who will pay their transport and travelling claims".* He proposed that those persons rather serve as "*ex officio consultants*" on the board. Even hospitals in the cities and towns where interviews took place indicated that it is not possible to attract people with those qualifications. A

chairperson indicated that board members are headhunted, as it is difficult to find *"… intelligent persons that understand the workings and functioning of hospitals".*

4.6 ADVERTISING OF BOARD VACANCIES

When questioned on how CEO's advertised and fill vacancies, different responses were received. It became clear that the urban hospitals are inclined to advertise in the local newspaper and five (5) hospitals indicated that that this was their only method of sourcing board members. This method is in line with the prescriptions of the KZN Health Department, which states that all vacancies are to be advertised in a local newspaper.

One CEO stated that *"… if you advertise vacancies in a provincial published newspaper you will not attract any person".* Another CEO stated that he *"… will not succeed in finding any local person that represents my community".* Another said that *"... due to the moratorium placed on the use of advertising in the printed press I am not allowed to advertise in the newspaper".* One CEO indicated that by advertising in the newspaper you only receive *"… applicants seeking full-time employment".* In terms of the interviews held with the CEO's, ten (10) hospitals (32%) advertise vacancies by putting up posters at government buildings, the tribal authorities, clinics and other public places. At one (1) hospital (3%) it is the duty of the current chairperson to headhunt people by communicating with the local tribal leaders. At six (6) hospitals (16%) the person that vacates the board will be replaced by requesting the local Induna to nominate a person to serve on the board. At eight (8) (25%) hospitals, the CEO head hunts potential board members. At six (6) hospitals (16%), NGO's or CBO's have been targeted to serve on boards. A total of thirty-eight (38) members (17%) represent political parties/municipalities on boards. With the exception of eight (8) hospitals, all utilised a combination of different methods to attract new board members, as listed in Table 4.

Table 4 Methods used to advertise district hospital board vacancies in KwaZulu-Natal in 2008

Medium used	Tribal authority	Newspapers	Head-hunt	Posters in area	Mass meetings	Target NGO's and CBO's	Word of mouth
Number of methods used	6	12	8	10	1	6	1

4.7 APPOINTMENT OF THE MEMBERS OF HOSPITAL BOARDS

According to an internal provincial guideline, the MEC must appoint members of Hospital Boards. The same guideline prescribes that the vacancies should be advertised in a local newspaper. The prospective candidates should be interviewed by the CEO and a recommendation then forwarded to the Office of the MEC for consideration and appointment. At the first meeting of the board, a chairperson must be nominated and the name of the preferred candidate forwarded to the MEC for consideration and appointment. The document (Guidelines for interim hospital boards) is not clear with regard to the term of office of the board members serving on the respective boards. (KwaZulu-Natal Department of Health, undated)

A CEO said that because all boards in the province are only interim "… *I am not forwarding names to the MEC for official appointment.*" Another CEO stated that *"Nominees that have been forwarded to the Office of the MEC to be appointed are still waiting for their appointment letters"*. At one hospital it was stated by the CEO that *"… the MEC appointed a board member without such a vacancy being advertised, the applicant being interviewed and curriculum vitae being forwarded to Head Office"*. Concern was expressed with regard to the time it took to receive letters of appointment. As one CEO stated *"… a letter of recommendation as been forwarded more than one year ago and I am still waiting for an answer"*. This was echoed by another board member who stated *"It is frustrating to ask for curriculum*

vitaes and then wait for six months to hear from the MEC whether they are appointed". According to the CEO's, there are vacancies at seventeen of twenty-seven (63%) of hospitals and all positions had been vacant for longer than three months. It was found that only ten (10) hospitals had no vacancies. At some hospitals there are as many as ten vacancies, bringing the total number of vacancies to seventy-one (71).

A full breakdown of who is serving on the respective boards is presented in tabular format hereunder.

Table 5 Representation of communities serving on district hospital boards in KwaZulu-Natal in 2008

Categories of Representatives	Tribal authorities	Faith-based organisations	Business sector	Traditional healers	Organised labour	Local municipality/ councillors	NGO's and CBO's
No. of representatives	35 (23.3%)	28 (18.7%)	24 (16%)	5 (3.3%)	3 (2%)	43 (28.7%)	12 (8%)

4.8 TERM OF OFFICE OF BOARD MEMBERS

The researcher found that CEO's and CHB's were aware that the terms of office of board members should not exceed three years, as stipulated in the provincial guidelines. Different practices exist at various hospitals where board members only get replaced should a member resign, relocate or die. At only two (2) hospitals it was found that vacancies were advertised to reappoint the full board, not because the members had completed their terms of office, but because no board had existed in the past. The average number of years that CHB's serve on the respective boards is presented in Table 6 hereunder.

Table 6 Years serving as district hospital board member in KwaZulu-Natal as in 2008

Number of years service as board member	0-1	2-3	3-5	5-10	10-20	More than 20 years
No. of chairpersons of hospital boards	1	4	8	4	1	1

Furthermore, the guideline is not prescriptive on whether a member is permitted to serve more than one term of office. One of the hospital board members has served for as long as twenty (20) years and another, eighteen (18) years.

4.9 TRAINING OF BOARD MEMBERS

From the results of the interviews with the CEO's, CHB's and ordinary board members it is clear that this is a weakness resulting in the ineffective functioning of boards. CEO's, as well as the members, are not clear of the actual role and function of the respective boards. All agreed that the board is the link between the management of the hospital and the community that they serve. However, members could not describe the term "community" clearly and define it "as the users of hospital services".

Twenty-two (22) CEO's indicated that their members had received some external training that was provided by service providers/consultants appointed in 2006/7 by Head Office. It was found that at only seven (7) hospitals all board members had been trained and at fifteen hospitals some had been trained. No members had been trained at five (5) hospitals. Fifty-seven percent (57%) of CEO's indicated that the training provided was adequate and a further fifty-six percent (56%) of CEO's indicated that their board members had a full understanding of their role and functions. However, seventy eight percent (78%) of the CHB's interviewed indicated that members had been trained, but only forty-seven percent (47%) indicated that they had been adequately trained.

Eighty-seven percent (87%) of all training was done by during 2006/7 by consultants/service providers and only thirteen percent (13%) were trained by the hospital that they serve. A breakdown of when CHB's attended training is presented in Table 7 hereunder.

Table 7 Year when training of district hospital board members took place in KwaZulu-Natal

Year when training took place	2002	2003	2004	2005	2006	2007	2008
Boards trained	1	1	1	1	5	6	4

A CEO indicated that the training provided by the training company was *"poor"*. Another indicated that the *"… training should be according to the Health Act and should not be guided and led by the management"*. A board member indicated that *"… a meeting held at the head office was of more value than the training I attended"*. One chairperson indicated that *"… the guidelines I received attached to my letter of appointment differ radically with the contents of the training manual used by the consultants"*. A CEO indicated that *"… if boards are interim with no clear mandate, powers and delegations, on what can boards be trained"*.

At a meeting of one hospital board attended by the researcher, it was discussed that the outgoing board members were supposed to "train" and to "orientate" the new incoming members, but that this had never happened. It was then resolved that training is not needed and that the new members should just read the provincial guidelines. From the interviews it appears that training, if any, is done haphazardly. The role and function of board members is not clear and no standardised training manual is available for training or the orientation of newly appointed board members. One CEO mentioned that *"… training is much needed and it will assist to understand their roles and functions, as it is currently unclear"*.

A board member indicated that *"… refresher courses are needed from time to time".* Another CHB said that *"there is a lack of training sessions and we have attended only one training opportunity in twelve years".* A CHB indicated that the predominant language used by the training provider was isiZulu and that he was not able to follow and *"… therefore deemed it as a waste of time to attend".*

It is further clear that, as policies and/or regulations that govern hospital boards do not exist, even the CEO's are not clear on what new board members must be orientated, other than to use the provincial guidelines.

It is an open question whether the CEO's have a full understanding of the role and functions of hospital boards. At one board the researcher was told that they have been trained but they *"… cannot practice their role and functions as they do not have transport to go to the hospital or the clinics due to the vastness of the area".* At a certain hospital the members of the board indicated that the *"… training was adequate but a futile exercise and it was a waste of time as the powers and functions of hospital boards have not been promulgated".*

A CEO indicated that the training given by a service provider, who was appointed by the Head Office in 2007, "….*was a once-off event and, with new policies, a rapidly changing health sector environment, together with members that come and go, regular training and re-orientation is necessary*.

None of the hospitals that took part in the study had access to locally developed training manuals.

4.10 COMMUNITY REPRESENTATION AND MECHANISMS OF COMMUNICATION BETWEEN THE HOSPITAL BOARD AND THE COMMUNITY

The researcher questioned board members about who they represented and how they communicated with their respective constituencies. Different responses were received to this question and are described in more detail. With regard to who they represent, the standard reply was *their community*. However, participants interviewed could not identify their "community" other than the general public working and living in a certain geographical area. For example, one person represents a Hospice and only gave feedback to his organisation. A retired nurse who serves as a board member could not indicate to whom she gave feedback. One member is a former staff employee that had retired more than ten years ago and no longer resides in the town where the hospital is situated. She could not demonstrate who she represented or how she provided feedback to the residents of the sub district. Some business owners serving on boards are not members of an organization, such as the local chamber of commerce, but still claim that they provide feedback to the business community. A CHB indicated that *" … I am a pastor of a church and announced decisions made by the board at my church".* However, he could not indicate how, as a representative of faith-based organisations; feedback is provided via a structured platform to other churches in his area. Individual members that are appointed by the MEC or by the CEO could not indicate who they truly represented and what communication strategy and methods they used to communicate as the spokesperson/representative of the community.

Due to financial constraints no open days had been held at any of the participating hospitals during the past financial year and no formal feedback mechanisms were in place to communicate with the community.

The only “official” structure that appears to be in place is in respect of the members that represent the tribal authorities, via the Nkosi and Indunas. They claim to give feedback when the tribal authorities meet. However, no evidence in the form of minutes of meetings held could be produced.

At two hospitals, the board members indicated that they oversee clinic health committees and visit the clinics situated in the catchment area of the respective hospitals in spite thereof that the provincial health act stipulates that clinic health committees are to be established by the relevant MEC’s for Health (National Health Act, 2004). No minutes or other evidence could, however, be produced with regard to the links between the hospital boards and clinic health committees that they claim to visit and network with.

A number of board members indicated that they serve on the municipal council and discuss matters affecting the hospital at council meetings. Again, no minutes of board meetings are officially forwarded to the office of the mayor or municipal manager to be tabled at the following meeting of the local council and no evidence could by found by the researcher to verify these statements.

Boards interviewed, could provide no evidence of resolutions that had been published in the local newspaper or presented via community radio stations. No newsletters or information leaflets, reports or statements were displayed on the notice boards of any of the district hospitals visited.

At none of the hospitals where interviews took place could a communication strategy be found describing how the board interacted formally with the community, i.e. the users and the visitors of the hospitals that they claim to represent.

4.11 ATTENDANCE OF MEETINGS

Board members use various means of transport to attend meetings. In the deep rural hospitals almost all board members are collected by means of hospital transport to attend meetings. Twenty-three percent (23%) of hospitals collect all members to attend meetings. Fifty-four percent (54%) of board members use their own transport only and at the remaining twenty-three percent (23%) of hospitals some members are fetched and others use their own transport.

Different hospitals use different methods to ensure that members attend meetings. At one hospital, transport claims are paid using petty cash to reimburse members when they use public transport. Only three hospitals reimburse members by paying a transport allowance. At another hospital, funds from the account of the hospital board are used to pay members that attend their meetings, at a flat rate of one hundred rand. A CEO reported that it was difficult to pay subsistence and travelling allowances because members must *"… first be registered on the provincial database, as payments are made electronically and that poses difficulties".* Another CEO reported that *"… members submit their claim forms to Head Office and I am not sure if they get their money".* Members of boards expressed unhappiness that they had to use private transport and were not being paid. One member stated that *"… I attended a training session, use my own transport to attend meetings, meet with complainants and use my own cell phone at my own cost and that this is unacceptable".*

4.12 FREQUENCY AND ATTENDANCE OF BOARD MEETINGS

All hospital CEO's and CHB's indicated that their boards meet quarterly, with the exception of one hospital where their board meets every second month. A chairperson of one hospital mentioned that *"it is the CEO who decides how often the board should meet and our last meeting was one year ago".* All CHB's

interviewed indicated that *ad hoc* meetings requested by the CEO, in addition to the planned meetings, took place from time to time.

The attendance of board meetings, as indicated by the respective CEO's is presented in Table 8 below.

Table 8 Percentage attendance of members at district hospital board meetings in KwaZulu-Natal in 2008

% Attendance	20%	40%	60%	80%	100%
No. of hospitals	0 (0%)	8 (27.6%)	8 (27.6%)	9 (31%)	2 (6.9%)

Results indicate that at sixty percent (60%) of hospitals, less than fifty-five percent (55%) of members attend board meetings.

According to the CHB's, forty-seven percent (47%) receive their agenda and minutes seven days in advance. At thirty-three percent (33 %) of the hospitals, minutes and agendas are distributed fourteen days in advance and thirteen percent (13%) receive minutes three weeks in advance. At two hospitals, the board members only receive their documentation at the meeting. A CEO reported that *"… the hospital sent text messages by cell phone to inform members of the date of the next meeting as well as the items to be discussed".*

A number of CEO's indicated that it was too difficult and expensive to hand-deliver the minutes and agendas in advance, as members do not have access to fax machines, and many had no postal addresses. At all of the hospitals, reports compiled by the different managers were only distributed at the meeting or, alternatively, verbal reports were given. Two CEO's stated that if it was left to the board members, no meeting would be held and that their respective boards would not be active at all.

It is general practice at urban hospitals that the minutes are hand-delivered, mailed, faxed or collected by the individual board members.

The researcher attended ten board meetings to carry out focus discussions with ordinary board members. At one (1) board meeting no member attended and at three (3) hospitals only the chairperson and one (1) additional member attended.

4.13 CONTRIBUTION TO IMPROVED HOSPITAL PERFORMANCE

CEO's, CHB's and ordinary board members believed that they contributed positively to improve the performance of hospitals. Some of their examples cited are that they were *"… successful in convincing the MEC to open an emergency medical rescue base station at the hospital"*. Another was to *"… convince the MEC to close a nursing school due to community fights about the school".* A further example was *"… to protect the CEO against the community demands of being killed, dismissed or displaced".*

However, no evidence could be produced of real improvement of patient care or the improvement of the rendering of hospital services. No monitoring and/or evaluation system or tool had been developed at any of the hospitals to measure the performance of the hospitals and/or that of the boards. When questioned whether any portfolio had been allocated to board members, the standard reply was negative, with the exception of three boards. The portfolios described at the three hospitals was that of overseeing the human resources department, the finance department and administration section. In addition, at one hospital, a board member is tasked with fund-raising and at another hospital a board member is responsible for overseeing the infrastructure and maintenance sections of the hospital. At one hospital a monthly programme had been developed and board members are allocated to do inspections and to submit a typed report on their findings at the next board meeting. According to this board this overseeing

resulted in a remarkable improvement of the wards inspected. The same board also inspected the work quality when the hospital was upgrading their infrastructure.

Eleven (11) CHB's indicated that the board oversees the CEO and the executive management team. However, it is not clear how this is being done and what tools, methods or systems are being used to oversee the performance of top management. No written reports have been drafted by any of the hospitals where the CHB's indicated that they oversee the CEO's.

Two (2) hospitals indicated that authority was granted to board members to enter the hospital at any time to inspect and to oversee the hospital. Only two (2) hospitals have a board member serving on a complaints committee and who is present when complaints and suggestion boxes are opened. Only one (1) hospital board encourages or facilitates ward visits before commencing with board meetings. This is, however, not the routine at every meeting.

Only one (1) hospital invited the board to take part in its annual strategic planning session. None of the focus groups and CHB's interviewed was invited to take part in drawing up the annual budget, assist with operational planning and the development of business plans.

The standard items that are discussed at board meetings, as indicated by the CHB's, are listed in Table 9 below.

Table 9 **Standard items discussed at district hospital board meetings in KwaZulu-Natal in 2008**

Standard items discussed	Finances	Medical matters	Policy	Communication	Projects	Campaigns	Governance
Indicated by CHB's	15 (100%)	12 (80%)	13 (86.7%)	15 (100%)	14 (93.3%)	13 (86.7%)	12 (80%)
Indicated by CEO's	25 (100%)	24 (96%)	15 (60%)	20 (80%)	19 (76%)	24 (96%)	25 (100%)

According to the data presented in the above table it is evident that there are vast differences between the two groups in their perception and understanding of their roles and functions. For example, eighty-seven percent (87%) of CHB's indicated that they discuss policy issues, whereas only sixty percent (60%) of CEO's indicated that their boards are involved in this activity.

When studying the minutes of board meetings, it became clear that, in general, a combination of the following items had been tabled and discussed at a number of hospital boards: non-attendance or poor attendance of board meetings; board vacancies; improvement/challenges with regard to infrastructure; matters pertaining to clinics, clients bypassing clinics; staff shortages; medicine shortages and drug recalls; fraud and corruption among staff; quality of care; inspection reports and feedback; sponsorships; mortuary; staff training; hospital statistics; equipment; financial constraints; TB projects; the Soccer World Cup; EMRS services; psychiatry patients; bed occupancy rates; cleaning, gardening and security contracts/services; planned patient transport; complaints; public relations issues; volunteers; tuck shops; hawkers; awards to staff; visitors' parking; staff misconduct; events; projects; training of board members; ATM machines; safety of staff and accommodation shortages.

4.14 KNOWLEDGE OF CHAIRPERSONS OF HOSPITAL BOARDS

The CEO's were asked to provide information on a few basic indicators of the hospitals that they serve. The CHB's were asked the same question to determine whether they had some basic knowledge of the respective hospitals that they represent. The indicators used were: the allocated budget - if the hospital overspent and, if yes, the amount overspent; the number of fixed and mobile clinics; the catchment population that the hospital serves. Not a single CHB could accurately state what the allocated budget had been, the amount overspent and what the catchment population was. 92% were correct in indicating the numbers of operational clinics and 96% were correct in indicating the number of mobile clinics that were under the control of the respective hospitals.

4.15 OPENNESS, TRUST AND CO-OPERATION BETWEEN THE BOARD AND THE EXECUTIVE MANAGEMENT

On the question about relationships between the board and the executive management, the general consensus was that this was *good* to *excellent*. However, at one board it was mentioned that they *"… are not sure if management will tell us all their problems"* and *"... they possibly kept quiet about key issues".* A CHB at a hospital stated that the CEO had not arranged any board meetings and that the last meeting held was almost a year ago.

Only forty-two percent (42%) of CEO's believed that boards contributed positively to improved performance, whilst sixty-one percent (61%) of CHB's believed that they were contributing positively.

Fifty-four percent (54%) of CEO's indicated that the board contributed to an improved vision and mission, whereas seventy-two percent (72%) of the CHB's indicated that they contributed to an improved hospital vision and mission.

Eighty-five percent (85%) of CEO's believe that there is trust between management and the hospital boards, but only sixty-one percent (61%) of CHB's are of the same opinion.

There was general consensus that member participation of the board was adequate.

The responses made by the respective CEO's and CHB's are captured in Table 10 below.

Table 10 Relationships, co-operation, improved performance and trust at district hospital boards in KwaZulu-Natal in 2008

Relationships between the board and management					
	Poor	**Weak**	**Average**	**Good**	**Excellent**
CEO's	1 (3.8%)	1 (3.8%)	2 (7.7%)	10 (38.5%)	12 (46.2%)
CHB's	1 (4.6%)	0 (0%)	2 (11.1%)	7 (38.9%)	8 (44.4%)
Improved performance due to hospital board					
	Poor	**Weak**	**Average**	**Good**	**Excellent**
CEO's	2 (7.7%)	4 (15.4%)	4 (15.4%)	11 (42.3%)	5 (19.2)
CHB's	0 (0%)	0 (0%)	4 (22.2%)	11 (61.1%)	3 (16.7%)
Improved vision & mission due to hospital board					
	Poor	**Weak**	**Average**	**Good**	**Excellent**
CEO's	3 (11.5%)	2 (7.7%)	7 (26.9%)	12 (46.1%)	2 (7.7%)
CHB's	1 (5.6%)	0 (0%)	4 (22.2%)	11 (61.1%)	2 (11.1%)

Trust between the board and management					
	Poor	**Weak**	**Average**	**Good**	**Excellent**
CEO's	0 (0%)	1 (3.8%)	3 (11.5%)	13 (50%)	9 (34.6%)
CHB's	1 (5.6%)	3 (16.7%)	3 (16.7%)	9 (50%)	2 (11.1%)

4.16 SUPERVISORY POWERS AND FUNCTIONS OF HOSPITAL BOARDS OR ROLES AND RESPONSIBILITIES OF BOARDS

As indicated earlier in the report, members are not clear on what the powers and functions of hospital board should be, as all boards are still interim.

Chairpersons of boards were questioned on what powers they had and what their function was and the information gathered is presented in Table 11 hereunder.

Table 11 Supervisory powers, functions and responsibilities of district hospital boards in KwaZulu-Natal in 2008

Functions	Approve budgets	Monitor income and expenditure	Arrange campaigns	Appoint staff	Discipline staff	Promote the hospital	Introduce new programs	Investigate complaints
Yes	5	11	9	0	4	14	10	14
No	10	4	6	15	11	1	5	1

Function	Resolve staff grievances	Decide on tenders and quotations	Have access to files	Consult with the comm.-unities	Take part in strategic planning
Yes	7	1	2	15	5
No	8	14	13	0	10

Oversee management	Advocate community needs	Ensure quality of services	Evaluate policies	Give instructions to staff	Involved in policy implementation
11	15	15	5	1	5
4	0	0	10	14	10

From the above table it is clear that the main role of boards is to promote the hospital, investigate complaints, to be the communication link between management of the hospital and the community that they serve and to ensure quality service.

This was emphasised by one CHB when he stated that *"… it seems that the board is administering the board funds and is a go-between the management and the community and nothing else".*

Four (4) CHB's indicated that hospital boards must be part of the process to advertise, interview and to appoint staff. One CHB said that *"… they know the local community and can assist the management by being part of the interviews".* Another chairperson wished to be involved in the allocation of budgets when he stated that *"… the board must be consulted when the Head of Department or Chief Finance Officer allocate the budget".*

One board member stated that *"… we are ineffective because we have no real powers and it does not make sense to have a board without any powers."* He added that *"… we hear about nice things that happened in the past and that we are wasting our time".*

It has been established under point 3.6 that boards have, to some extent, been trained in their role and function and provincial guidelines have been made available to CEO's and newly appointed board members. However, it is clear from the results that a number of boards involve themselves with matters or functions for which they have no authority, for example, dealing with staff discipline, the approval of budgets and having access to staff and patient files, to mention a few.

A CHB indicated that *"It would be good if all (board members) understood their role and functions and could be trained".* A CHB indicated that *"… we need more powers to oversee clinic committees as there in no movement at some clinics."*

4.17 REMUNERATION AND REWARDS

Everybody interviewed, with the exception of one CEO and one CHB, indicated the need to pay either a stipend to board members, or as a minimum, to pay board

members a travel allowance to reimburse their expenses for attending board meetings. A CHB indicated that he is fully aware that voluntarism meant that you render your civil duties for free. However he motivated that he *"… uses my private car, cell phone and computer to network, to meet, promote and to advocate the hospital, all of this in my own time".* The proposed stipend/allowance to be paid ranges from R1 000 to R3 500 per month or from R 200 to R 500 per meeting attended. Other participants interviewed indicated that it would be appropriate to pay their actual transport expenses.

A common reply was that it would be much easier to attract a better calibre and more committed person if some remuneration was paid. Full-time employees or business owners are busy people and it is *"… to their financial detriment to attend meetings without being paid".* A member mentioned that *"… I am being paid to attend FET Board meetings, municipal councillors are being paid and why not us?"* All interviewed were not happy with the fact that, as a result of a provincial moratorium, food was no longer provided at board meetings. One person stated that *"… we have to travel far and are sitting the whole day in a meeting with low blood sugar levels".* There is a general feeling of unhappiness regarding the offering of their free services and they are of the opinion that the hospital can at least provide some catering at board meetings. One CHB said "*… we work for the government and there is not even a meal at the board meeting and I am coming from far"*. Another CHB said that *"... if they want to promote good attendance, reimbursement must be put forward".* One CHB indicated that *"... few Africans can attend, so subsistence and travelling expenses must be paid".*

4.18 REFERRAL OF ITEMS DISCUSSED AT HOSPITAL BOARDS TO A HIGHER LEVEL OF AUTHORITY

It was found that a small number of hospital boards referred a few items to a higher level of authority. Only seven (7) items were referred to the district office, four (4) to their Head Office, and six items (6) were referred to the Office of the

MEC. Items referred to the district office include inadequate budgets, conflict resolution, poor infrastructure, the need to build additional clinics and additional accommodation for staff. Items referred to the Head Office included the poor attendance of board meetings, death threats against a CEO and the poor performance of clinics. Typically, items referred to the MEC were about staff shortages, poor roads, a lack of adequate accommodation, requests to investigate allegations of corruption, poor infrastructure, and a lack of schools and the influx of patients from the former Transkei.

A board member expressed his dissatisfaction with the MEC when he stated *"…we possess powers to liaise with the MEC but it does not seem to work as we do not meet with the MEC or the Executive".*

Another hospital indicated that a meeting with the MEC resulted in the opening of a new emergency medical rescue service base station at the hospital and that the board was of the opinion that it was because of their intervention. The same board also mentioned that they now have additional clinics because of their interventions. One hospital board indicated that *"…we manage to discuss the shortage of doctors with Head Office and they sorted it out".* A CHB mentioned that only after a letter was forwarded to the MEC the commander in charge of the local police station started to investigate a charge of arson at the hospital.

On two occasions the MEC actually did meet with the local hospital board and only one hospital board indicated that such a meeting led to improved service delivery at their hospital.

The forwarding of minutes of meetings to a higher level is presented in Table 12.

Table 12 Forwarding of minutes of meetings of district hospital boards in KwaZulu-Natal in 2008 to higher authority

No. minutes forwarded at all	Minutes forwarded to district office	Minutes forwarded to HOD	Minutes forwarded to MEC	Combination
12	6	6	4	0

4.19 IMPACT OF HOSPITAL BOARDS

All interviewed indicated that they did make a positive difference. The replies and reasons cited differ from board to board but is appears that the general consensus was that hospital boards were an effective link between the hospital and community.

A board member indicated that *"... if there are an uproar in the community they will be at the forefront and will sort out the issues".* A member of the same board also mentioned that they are *"… pushing to empower local people".* Another indicated that they protected the CEO when the community demanded that the CEO be dismissed.

A board member mentioned that they participated in hospital activities, walk around the hospital, know the staff and report issues of concern to the CEO and management.

All boards indicated that they investigate complaints and discuss such complaints at the following board meeting. At two (2) hospitals, board members represent the board on a complaints committee and are present when the complaint boxes are opened.

A board member mentioned that they had negotiated successfully with a bank to install an automated teller machine at their hospital.

Three (3) boards interviewed indicated that they visit clinics and address issues raised at ground level.

Another board member indicated that they represent different sectors and that they give feedback to all of them. The same person said that staff members inform them about issues, that they do ward rounds and that the staff knows that they are there to oversee them. He added that if patients' files get "lost" they intervene to assist the patients.

A board member mentioned that they use their board funds to sponsor events and are involved in open days.

One board responded that the misuse and abuse of the hospital public toilets by street vendors was stopped because of their intervention. A member of the same board mentioned that the hospital received some additional computers because of their efforts. At another board it was reported that an illegal structure built at their hospital's main gate was demolished because of their intervention and support.

4.20 PORTFOLIOS OF HOSPITAL BOARDS

All boards are chaired by a chairperson, with the exception of one hospital where the CEO stated that the board members *"… do not have the understanding or capacity to chair meetings".* In his absence the public relations officer chairs the meeting.

It is, however, not clear how the chairperson is appointed. According to the provincial guidelines, the MEC should appoint the chairperson nominated by the

board members at their first meeting and it is the responsibility to provide the secretariat. (Guidelines for Interim Boards). At one of the meetings that the researcher attended, the deputy chairperson was elected and took over when the chairperson resigned. No resolution was taken to forward the name of the new chairperson to the office of the MEC.

4.21 SUMMARY

Mainly unqualified members that represent the community serve on hospital boards. Various methods are being used by the different CEO's to recruit new board members and some of them serve for up to twenty years. Only at seven of the hospitals were all the members trained and only 47% board members indicated that they have been adequately trained. There is very limited evidence that board members provide feedback to the community they represent and no or little evidence could be produced that hospital boards actually contribute to improved hospital performance.

The findings have been discussed in this chapter and the research questions have been unpacked. Valuable information was gathered to understand the key aspects that contribute to the effective functioning of hospital boards. With this gained knowledge, the researcher can now, in the next chapter, make recommendations to policy-makers.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

The underlying principle is that hospital boards are vital and important to advocates for the health system in order to meet the needs of the users.

The purpose of the study was to assess and evaluate whether boards function properly and do, in fact, contribute to improved hospital performance. It also aimed to describe the demographic profile of hospital boards, assesses the chairpersons' knowledge of the district hospital and how hospital boards network with stakeholders and role players. Lastly, it describes governance and interactions between hospital management and the hospital boards in making recommendations to policy makers and other relevant stakeholders.

5.2 THE FUNCTIONING AND PERFORMANCE OF HOSPITAL BOARDS

The study found that there are a range of factors that contribute to the limited functioning of hospital boards in general. It is evident that the roles and responsibilities of board members are unclear and their commitment and ability to function is limited because of constraints placed on them with regard to time, transport, remuneration and a lack of funds, knowledge, skills and understanding of a very complex health sector. The question arises whether the selected board members are representative of the community and if the selection process was appropriate for the specific hospital.

There is a lack of clarity in terms of the real purpose and function of hospital boards, other than acting as a link between the hospital and the health service users. The interim status of boards, without regulations that prescribe their functions, mandates and authority (power), result in their ineffective functioning.

Training, orientation and induction of board members are weak and limited. New members are not trained or orientated and are required to observe and learn when attending board meetings. Hospitals use different methods to capacitate board members. Training is not driven and coordinated by the provincial head office and no training manuals are available. As a result, the respective boards do not function optimally and feel disempowered to serve their communities and to adequately represent the interests of their constituencies.

It also appears that poor or non-attendance of board meetings by members may hinder the effective functioning of the boards.

One of the key functions of a board is to network with community bodies and foster community support. The board and management must evaluate programmes to monitor whether quality care is being provided and whether targets and outcomes have been met.

The board must contribute to the vision and mission of the hospital. It should further advise management on policies, while participating in strategic planning and operational processes. Boards are also responsible for improving the quality of rendered services and for monitoring performance, effectiveness and efficiency.

Hospital boards should be involved when developing the hospital's vision, mission statement, strategic and operational plans. Boards should develop their own constitution and procedures in compliance with a provincial framework.

5.3 DEMOGRAPHIC PROFILE OF HOSPITAL BOARD MEMBERS

The hospitals represent the demographic profile of the communities that they serve. Older persons serve on the boards as fifty eight (58%) percent of board members are forty six (46) years and older. Few board members with formal academic qualifications were found. Those members that possessed a formal qualification were mainly qualified in nursing, biblical studies or teaching. Only three (3) members were qualified in law and there was not a single board member among participants with a qualification in human resources. Only ten (10) members have some training in finance. This poses a concern, as it is not clear where the MEC for Health could source adequate numbers of board members with the right skills mix to serve on hospital boards, particularly in the rural and deep rural regions. At urban hospitals the racial composition of boards does not reflect the racial mix of the residents of the respective towns.

5.4 CHAIRPERSONS' KNOWLEDGE OF THE DISTRICT HOSPITALS

The CHB's knowledge of the respective hospitals that they represent is weak and the few basic questions utilized to test levels of understanding and insight could not be answered correctly. Some CHB's acknowledged that budgets were presented at previous meetings, but that they could not remember the amounts of funds allocated or spent by the hospital.

5.5 NETWORKING AND COMMUNICATION

No evidence was produced on how the boards formally interact with the communities that they represent, other than to investigate individual complaints or to be present when staff opened the complaint and suggestion boxes. It appears that board members mainly provide feedback from rural hospitals when reporting to the community via the structures of the traditional leadership of that specific community. At some hospitals, minutes of meetings were forwarded to either their

provincial Head Office or the district offices. Very few hospitals had boards that actually met with the MEC for Health or the respective district managers to discuss matters of concern.

There is little evidence of the formal mechanisms board members use to access input from the communities that they represent and how they provide feedback on the resolutions passed at boards meetings. It is not clear whether the community is really represented. Board members are not paid a stipend or a travelling allowance and do not receive any meals whilst attending meetings. This may contribute to the low attendance figures and minimal feedback given to the constituencies that they represent.

Board members, especially those in the rural communities, appear to be ineffective as they live in poverty and do not have the financial resources to meet with the community to discuss complaints, to consult, to conduct mini surveys or to promote the services of the hospital. They represent large geographical areas and do not have the means to travel around in their respective areas to meet with complainants and to provide them with feedback.

It is also not clear how a board member prepares for a board meeting. A period of approximately two-and-a-half months could lapse after a board meeting until the set of minutes of that meeting is received, posing yet another challenge. Items are placed on the agenda for deliberation and discussion only when the minutes of the previous meeting are handed out at the next meeting.

5.6 APPOINTMENT OF BOARD MEMBERS

A clear guideline regarding the appointment of board members is not available.

Board members are not appointed in a transparent manner and different hospitals use different methods to invite persons to serve on their respective boards. It

seems that rural hospitals replace members by requesting names from the traditional leadership to fill vacancies. This, however, differs from board to board. At some boards, members are targeted for appointment and only a few boards appointed members that had responded to advertisements placed in local newspapers. No hospital interviewed applicants before submitting their names to the office of the MEC for appointment. Some members have served on boards for more than ten years, as there is no fixed term of office prescribed by head office. Participants in the study are not certain whether there is a prescribed period of service for board members.

In order to ensure that the board is of a workable size, between seven and ten members should be appointed. Board members do not have a good understanding of financial matters and accounting, legal knowledge, human resources knowledge and of the legislative environment. Board members do not have complementary backgrounds and knowledge and minorities is not represented. Furthermore, members of the hospital do not have a balanced skills mix, and does not have a clear understanding of the hospital environment, the community that they represent and of management practices.

Hospital boards do not have strong links with community agencies (NGO's and CBO's) to enhance community health.

Provincial representative(s), preferably the district health manager or his/her deputy, are not serving as ex-officio members. Management, led by the CEO, serve on the board of the hospital and are not voting at a meeting of the board. The CEO officially represents management and form the link between the board and the hospital.

5.7 GOVERNANCE ARRANGEMENTS

Although the national health act is not yet in force, the prescriptions therein on the composition of hospital boards cannot be complied with, as it is not possible to find suitable persons with the prescribed qualifications.

Some hospitals have standardised agendas containing standing items on which to report, while minimal discussion takes place at other hospital board meetings. It appears that if the CEO and his/her management team do not place items for discussion on the agendas for board meetings, very little would be discussed. With the exception of three hospitals, portfolios are not allocated and no expertise exists to question or oversee the performance of hospital management.

5.8 INTERACTION BETWEEN HOSPITAL MANAGEMENT AND THE HOSPITAL BOARD

It generally appears that there is trust, cooperation and understanding between the boards and hospital management. However, the boards do not have clarity on or have knowledge of their powers and functions and are not involved in critical areas such as budget allocation, strategic planning, monitoring, and evaluation and in meeting the targets set by the province, districts and hospitals. It therefore appears that the boards do not hold management to account for its performance. Boards therefore mainly discuss a few complaints and other non-strategic issues with limited focus on governance. They only meet four times a year and it is an open question as to how effective their governance is, particularly without the real insight of a specialised and dynamic health care environment.

The chairperson are not assisting the CEO in recruiting and interviewing potential new board members, using criteria such as previous board experience, personal and professional achievements, willingness and preparedness to serve on the board.

The community are not given appropriate information about the goals of the board and community participation from provincial residents is not encouraged through established forums.

Different standing committees (portfolios) are not established focussing on key issues such as finance, human resources, quality improvement, complaints, communication, networking and marketing.

No a bi-annual reports, linked to the financial year and using a prescribed provincial template are submitted to the office of the MEC.

Dedicated funds are not available to ensure the effective and efficient functioning of hospital boards.

Furthermore, it seems that some CEO's use the hospital boards to advocate on their behalf for more resources.

5.9 TRAINING, DEVELOPMENT, CAPACITY BUILDING AND MENTORSHIP OF BOARD MEMBERS

Individual and group board assessment and succession planning can go far to identity gaps and weaknesses and to develop in-house developmental programmes. Succession planning is critical in order to plan for the smooth transition of functions between outgoing and new, incoming board members.

Team building, attended by both board members and management will assist to ensure a cohesive board with common understanding and support of management. Management will have a clearer understanding of the community needs and strategic plans can be developed to address these deficiencies.

Continued education, which is absent, is vital to the health care industry, including board members. No mentorship programmes and training manuals could be found that could assist in developing the strategic plans of the hospital. This could create an understanding of how board members could work with other local organisations and agencies and how to assess capacity in the community. The lack of training and understanding results in the poor identification of unmet needs, not to determine duplications, as well as the poor collection, tracking and communication of clinical and health information. The lack of capacity building activities addresses issues such as information and clinical technology, strategic planning, finance, legal matters, human resources, quality improvement, marketing, faith-based sensitivities and community advocacy.

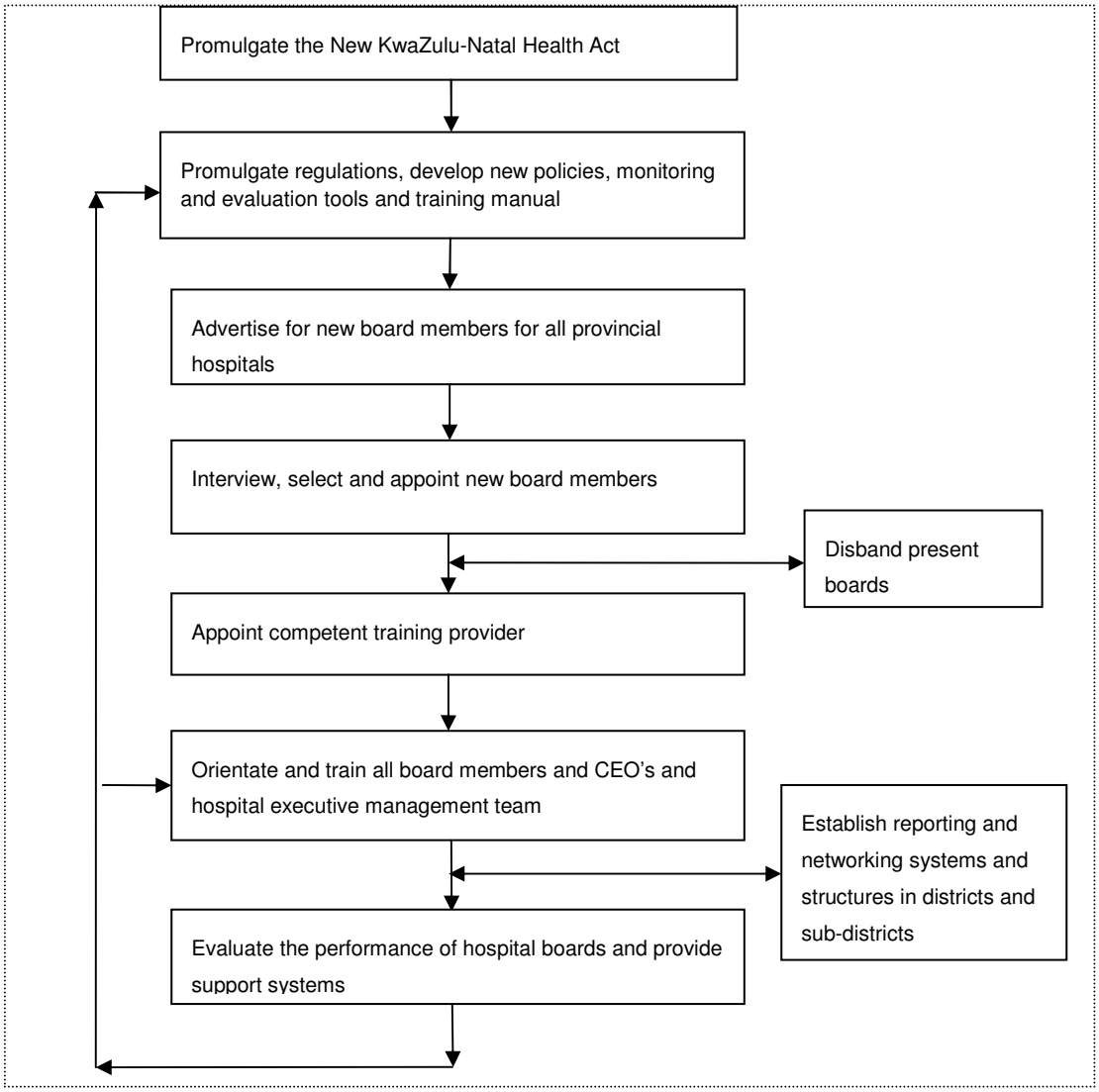
CHAPTER 6

RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

This chapter deals with the recommendations for consideration made to policy makers and the MEC emanating from this study when appointing hospital boards in order to enhance the performance of these boards. It is recommended that the following process be followed to enhance the governance of hospital boards.

Figure 1: Flow diagram: Process to be followed to improve the functioning of hospital boards



6.2 RECOMMENDATIONS

6.2.1 Training, development, capacity building and mentorship of hospital board members

The province should be responsible for developing and printing a standardised training programme in both English and a local language. This manual should be provided to the CEO's and all newly appointed board members. All new hospital

board members must be trained and orientated and every serving board member should be re-orientated annually during his/her term of office.

A further strategy is to create a mentorship programme and to ensure that a new board member is assigned to a board mentor. This could be the chairperson of the board or a mature and experienced board member with at least two years service as a member of that board.

Periodic educational events and external speakers could assist in engaging board members in creating better understanding of the complex and dynamic environments in which hospitals operate.

The CEO and the chairperson of the board should be responsible for ensuring that effective orientation and ongoing training is provided to the board members.

6.2.2 Membership of boards

It is recommended that municipal councillors, the disabled and representatives of youth, women's, faith-based organisations and other sectors serve on the board.

The chairperson and deputy chairperson should be selected from the local community that the hospital serves. There should be adequate representation of age, gender and ethnic groupings. Fifty percent (50%) of board members should be female.

The terms of office of board members should be staggered to promote continuity.

6.2.3 Payment of board members

Board members should volunteer their services and should not be paid. However, their travel expenses must be reimbursed, or official transport should be provided

to them to attend board meetings. Meals should be provided, as many members have to travel long distances to attend meetings.

6.2.4 Attendance of board meetings and other activities

Meetings and venues should be carefully considered so that members from disadvantaged communities are able to attend meetings and serve on committees.

6.2.5 Powers, functions and responsibilities of boards

It must be ensured that the needs, concerns and complaints of patients and the community are addressed. They should assist in issues of redress to the public, but not to involve themselves in labour matters, as these are governed by the Labour Relations Act and collective agreements reached at the relevant Bargaining Chambers.

The boards should be allowed to raise funds for special projects and to administer these funds in an appropriate manner as prescribed by the relevant financial regulations and treasury practice notes.

Boards must conduct regular audits and report their findings of such visits, in a standardised format developed by their head office, to management. They should advise, make recommendations and obtain information, request progress reports and review financial statements. In the community they should conduct surveys and hold meetings and workshops. They are further responsible for disseminating information to the community.

Hospital boards should develop a partnership with management to prioritise areas for service delivery, the allocation of resources, negotiation of standards and even to audit and evaluate the performance levels of the hospital, bearing in mind that

different types of hospitals have different objectives and systems, and therefore different areas of focus.

The CEO and the hospital board should reach mutual agreement on their roles, responsibilities, authority, organisational relationships and access to reliable information, with a focus on key governance issues.

6.2.6 Legislation and governance

Currently all hospital boards are only interim with no clear powers, responsibilities and functions. Legislation must be promulgated to legalise the hospital boards in KwaZulu-Natal.

Additional functions may be authorised by the MEC for Health if they have the capacity to do so.

There should be clarity on the respective roles and responsibilities of the CEO, the chairperson of the board and the board itself.

It is recommended that members are not permitted to serve on the board for terms longer than three years and for no more than three consecutive terms. It is further recommended that boards meet at least quarterly, but not more than six times annually.

6.3 CONCLUSION

This study evaluated the performance of hospital boards at district hospitals within the Province of KwaZulu-Natal. In this study, eleven (11) hospitals boards were visited and a total of forty one (41) participants who attended focus group sessions were interviewed. Twenty-four (24) CEO's and nineteen (19) CHB's were telephonically interviewed.

The results of the study revealed that the size and composition of boards of the different district hospitals in the province differ significantly.

All KZN hospital boards are interim and not all of the present board members have officially been appointed by the MEC. The hospital boards do not have an independent role. It was observed that principles of good governance were not adhered to and at some hospitals the board-CEO relationship is weak with limited trust and co-operation. There is no evidence of accountability and responsibility.

Hospital boards are not involved in determining the mission, vision, core values, business plans, strategic goals, objectives and targets of hospitals and are mainly regarded as the “link” or “buffer” between the hospitals and the communities that they serve.

The CEO accounts to his or her direct supervisor, i.e. the district manager, and does not therefore account to and/or report to the hospital board. The hospital board is seen as the rubber stamping body and strategic direction of management.

The roles, functions and powers of hospital boards are not clear and there is little evidence that decisions made by boards improve the health status of the communities that they represent. No monitoring tools or systems exist to evaluate board performance. Hospital boards with own their funds do not have financial statements audited by independent accountants.

Hospital boards do not meet regularly and their governance role is weak. They do not have adequate insight into the delivery of complex and dynamic, ever changing hospital services and neither do they possess the capacity to make informed decisions and provide guidance to management.

No mechanisms are in place for community structures and different stakeholders to provide input to the board for enhanced service delivery.

6.4 RECOMMENDATIONS FOR FURTHER STUDY

Further research needs to be done to determine the level of impact of hospital boards on the communities that they represent.

In addition, research can be used to determine whether hospitals perform better where hospital boards with a legislative mandates, defined powers and functions are in place, compared with hospitals with interim boards with no legislation.

6.5 LIMITATIONS

It was not possible to interview all of the district hospitals with hospital boards and some hospital boards that were not interviewed may function differently.

The researcher is known to some of the CEO's and consequently some of them who were interviewed may not have been entirely honest with the information that they provided, therefore possibly rendering some results unreliable.

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APPENDIX A

Questionnaire for the Chairperson of the hospital board

Please complete this anonymous questionnaire. The information will be kept confidential.

Where applicable please mark your preferred choice with an X in the appropriate block

It will take only approximately between 10 to 15 minutes to complete the questionnaire

Name of District Hospital		
No of Beds		
Catchment population		
No of fixed clinics		
No of mobile clinics		
Size of catchment area(square km's)		
Budget allocation for the 2007/08 financial year (Hospital only)	R	
Did the hospital overspend?	Yes	No
With what amount?		

Hospital Board

How many members serve on the Board		
How many males and females	Males	Females
Ages of males		
Ages of females		
If no, please explain		

When was it established?					
Is it an interim Board?	Yes	No			
How long do members serve (on average) on the Board?	Less than one year	More than one year	Full term of office		
Are vacancies filled?	Yes	No			
If yes how long before they are filled?	Less than 3 months	More than 3 months			

Personal information

How many Board members are representing the following groups?	African	Indian	White	Colored	
Your age	20 – 30	30-50	0lder than 50		
Your sex	Male	Female			
Home language	isiZulu	English	Afrikaans	Other	
Oral proficiency in English	Excellent	Good	To some extend	Poor	
Proficiency in written English	Excellent	Good	To some extend	Poor	
Highest qualification					
No of Board Members representing?	Church groups				
	Non governmental organizations				
	Political parties				
	Organized labour				
	Traditional healers				
	Traditional leaders				
	Municipality				
How long have you been a Board member?	Less than 1 year	1 to 2 years	2 to 3 years	More than 3 years	

Administrative arrangements

How often does the Board meet?	Monthly	Bi-monthly	Quarterly	Other

Typical topics discussed at Board meetings

Financial	Yes	No
Medical	Yes	No
Policy	Yes	No
Communications	Yes	No
Projects	Yes	No
Campaigns	Yes	No
Governance	Yes	No
Other	Yes	No

Please explain

How do members get to meetings	Fetched	Taxi	Bus	Own transport
Average attendance of members at meetings	None	50%	75%	100%

Is portfolios allocated to Board members?	Yes	No

If yes please indicate the portfolio and responsibilities

Does the Board have their own bank account?	Yes	No

If yes, for what purposes do they use their funding?

Appointment of members

How does the hospital fill vacancies on the Board?

Advertised in newspaper	
Requested by organization to serve	
Appointed by MEC without you applying	
Notice at hospital	
Informed via campaign in area	
Other	

Please explain

Communication issues

How are matters raised dealt with

Locally	Yes	No
Referred to District Office	Yes	No
Referred to Head Office	Yes	No
Referred to MEC	Yes	No
Referred to HOD	Yes	No
Combination	Yes	No

Examples of referred items

Administrative matters

Have you been trained on your role and function in the Hospital Board?	Yes	No	
If yes, how long was the training?	One day	2-3 days	3-5 days
Who trained you?	Hospital staff	Head office	Consultant
Was the training adequate?	Yes	No	

If no, please explain

Do you have a full understanding of your role and function		Yes	No
Do you have authority and/or take part in:		Yes	No
	Approve budgets	Yes	No
	Monitor income and expenditure	Yes	No
	Arrange campaigns	Yes	No
	Appoint staff	Yes	No
	Resolve conflict and mediate staff grievances	Yes	No
	Discipline staff	Yes	No
	Promote the hospital (e.g. road shows)	Yes	No
	Introduce new programs	Yes	No
	Decide on tenders and quotations	Yes	No
	Investigate complaints	Yes	No
	Have access to patient /staff records	Yes	No
	Give confidential information to non governmental bodies you represent	Yes	No
	Launch campaigns	Yes	No
	Oversee the hospital manager ant top management	Yes	No
	Take part in the strategic planning process	Yes	No
	Advocate community needs	Yes	No
	Ensure quality of service	Yes	No
	Consult with communities	Yes	No
	Involved in the implementation of policies	Yes	No
	Evaluate policies	Yes	No
	Give instructions to staff	Yes	No

If yes please explain

Was the training related to the vision and mission of the hospital?	Yes	No	
Is there adequate member participation?	Yes	No	
Do the members get the agenda in advance?	Yes	No	
If yes how long in advance?	7 days	14 days	21 days

Co-operation

Do you believe that there is a sound relationship with management?	Poor	Weak	Average	Good	Excellent
Do you belief that the board contribute to improved hospital performance?	Poor	Weak	Average	Good	Excellent
Do you believe the board contribute positively to the vision and mission of the hospital	Poor	Weak	Average	Good	Excellent
Do you believe that there is trust between management and board members	Poor	Weak	Average	Good	Excellent

General

Do you need additional delegated authority/powers to be effective?	Yes	No

If yes please motivate

Any general remarks/suggestions to improve the functioning of the Hospital Board

APPENDIX B

Chief Executive Officer Questionnaire

Please complete this anonymous questionnaire. The information will be kept confidential.
Where applicable please mark your preferred choice with an X in the appropriate block

It will take only approximately between 10 to 15 minutes to complete the questionnaire

General information

Name of District Hospital	
Name of Hospital Manager	
Postal Address	
Tel no	
Fax no	
Email address	
No of Beds	
Catchment population	
No of fixed clinics	
No of mobile clinics	
Size of catchment area(square km's)	
Budget allocation for the 2007/08 financial year (Hospital only)	
Did the hospital overspend?	
With what amount?	

Hospital Board

Do you have a Hospital Board?	Yes	No

If no please explain

If yes, when was it established?				
When were the members appointed to the Hospital Board?				
Is it an interim board?	Yes	No		
How many members serve on the Board				
How long are they on average serving on the Board?	Less than one year	More than one year	Full term of office	
Are you a member of the Board?	Yes	No		
Are there any vacancies on the Hospital Board?	Yes	No		
If yes, how many?				
Are vacancies filled?	Yes	No		
If yes how long before they are filled?	Less than 3 months	More than 3 months		
How long on average, have members served on the Board?				
Race composition – total number	African	Indian	White	Colored
Gender	No of males	No of females		
Age	18-30	31-45	46-60	61 and older
Their verbal English skills	Excellent	Good	To some extend	Poor
Proficiency in written English	Excellent	Good	To some extend	Poor
Who attends Hospital Board meetings	Hospital Manager only	Hospital Executive	Others	
If others, please explain				
Are meetings dominated by non-board members?	Yes	No		

Qualifications of members

No of persons with a legal qualification	Number	Type of qualification	
No of persons with financial qualification	Number	Type of qualification	

No with nursing qualification	Number	Type of qualification	
No of persons with medical qualification	Number	Type of qualification	
No of members from the business community	Number		
No of members from the faith based community	Number		
No of members from NGO's and CBO's	Number		
No of members from political parties	Number		
No of members from organized labour	Number		
No of members from traditional healers	Number		
No of members from traditional leaders	Number		

Administrative arrangements

How often does the Board meet?	Monthly	Bi-monthly	Quarterly	Other

Typical topics discussed at Board meetings

Financial	
Medical	
Policy	
Communications	
Projects	
Campaigns	
Governance	
Other	

Please explain

How do members get to meetings	Fetched	Taxi	Bus	Own transport	
Average percentage of attendance	20%	40%	60%	80%	100%
Is portfolios allocated to board members?	Yes	No			

If yes please indicate

Does the board have their own bank account?	Yes	No

If yes, for what purposes do they use their funding?

Appointment of members

How do you advertise vacancies?	
Advertised in newspaper	
Invitations via to identifies organizations	
Target identified individuals	
If yes, who decided to target the individuals?	
Appointed by MEC with no local involvement	
Marketing campaigns in area	
Combination of the above	

If combination please explain

Communication issues

How are matters raised dealt with

Locally		Yes	No
Referred to District Office		Yes	No
Referred to Head Office		Yes	No
Referred to MEC		Yes	No
Referred to HOD		Yes	No
Combination		Yes	No

Examples of referred items

Examples of referred items

In which language are the meetings conducted?	English	Zulu
Is it necessary to provide translating services at meetings?	Yes	No

Administrative matters

Is there any attempt to interfere in day to day administrative matters?	Yes	No
If yes, by whom?		

If yes please explain

Has the members being trained on their role and function?	Yes	No
When were they trained?		
Was everybody trained?	Yes	No
Was the training adequate?	Yes	No
Do the members have a full understanding of their role and function?	Yes	No

If no please explain

Are minutes of meetings forwarded to a higher level?	Yes	No

If yes please explain

Was the agenda related to the vision and mission of the hospital?	Yes	No	
Is there adequate member participation?	Yes	No	
Do the members get the agenda in advance?	Yes	No	
If yes how long in advance?	7 days	14 days	21 days

Co-operation

Do you believe that there is a sound relationship between the hospital management and the members of the Board?	Poor	Weak	Average	Good	Excellent
Do you believe that the Board contributes to improved hospital performance?	Poor	Weak	Average	Good	Excellent
Do you believe the Board contribute positively to the vision and mission of the hospital	Poor	Weak	Average	Good	Excellent

Do you believe that there is trust between management and Board members	Poor	Weak	Average	Good	Excellent

General

Any general remarks/suggestions to improve the functioning of the Hospital Board

Other

Please attach a copy of minutes of your four previous board meetings

APPENDIX C

Interview schedule for focus group discussions: Hospital board members

Name of hospital _____

Date of interview _____

Total number of appointed board members _____

No of Board members attending focus group discussions _____

Ages of Board Members _____

Background information

How did you know about a vacancy on the board?

_____

_____

_____

_____

_____

Any vacancies on the present board? _____

How long are members serving on average on board? _____

_____

How many males/females? _____

Composition of race groups _____

Who are members representing? _____

_____

_____

_____

_____

_____

_____

_____

Do you represent an organisation on the board and if yes who?

_____

_____

_____

_____

_____

_____

How do members get to board meetings?

Competence

Highest qualification of board members

Have you been trained on your role and function in the board?

If trained please explain who trained you?

Was the training adequate and if no please explain?

Participation

Does the board communicate in your home language and if not do you follow the discussions and debate adequately?

What authority do you have and/or what issues are dealt with at board meetings?

Do you get the agenda and minutes of previous meeting in advance and if yes how long?

Do you believe there is a sound relationship with management and please motivate?

Do you believe that you are making a positive difference and please motivate?

Is there trust openness and transparency between the board and management and motivate this?

What do you need more to be more effective?

Are board meetings dominated by any party/person/group and if yes please explain?

How does the board feed back to their constituencies that they represent?

Do you believe that board members should be paid and if yes how much per month?

General comments / remarks

APPENDIX D

Information letter to participants

Re: An evaluation of the implementation and capacity of hospital boards at district hospitals in KwaZulu-Natal in 2008.

Dear participant

This questionnaire forms part of a study in partial fulfillment of the requirements for the Degree of Masters of Public Health.

The questionnaire has been developed as a tool to assess the knowledge, attitudes and effectiveness of members of Hospital Boards and Hospital Managers at District Hospitals in the Province of KwaZulu-Natal. In addition it aims to identify gaps and weaknesses that exist and to make recommendations to improve the governance and the role that Hospital Boards can play.

You are hereby requested to partake in the research study and your participation is voluntary. Refusal to take park will not lead to any penalty, loss or benefit to which you are entitled.

All of the Chairpersons of District Hospital Boards and Hospital Managers from 35 of the district hospitals in the Province of KwaZulu-Natal will be requested to take part in the research.

Confidentiality

Identifiable information if any, obtained in connection with this study will remain confidential and will not be disclosed.

You will be assigned a confidentional ID number to be used on all questionnaires and this number will only be retained by the undersigned.

Your answers will not be shared with any other administrators from this hospital or elsewhere, except organizations that may asses if for the purposes of quality assurance and data analysis and may include the Universities Research Ethics Committee. If results

are published, it may lead to individual/cohort identification. The questionnaires will be kept for a period and will be disposed of afterwards.

Aggregated data will be analyzed, so that trends in knowledge, skills and attitude can be assessed and gaps determined. No information will be disclosed that would reveal your identity or individual answers.

It will be appreciated to complete the form as honestly.

It will take you approximately 15 minutes to complete the questionnaire.

For any questions or enquiries please feel free to contact the study supervisor Professor CC Jinabhai at tel. no. 031- 2064386 or email at jinabhai@ukzn.ac.za. You may contact the Biomedical Research Ethics Administrator or Chair for reporting complaints/problems: Biomedical Research Ethics, Private Bag X 54001, Durban, 4000. Telephone number +27 (0) 31-2604769 /1074, Fax number +27 (0) 31-2604609 of email at bngwenyap@ukzn.az.za

Thank you for taking part in the survey

H J Human

APPENDIX E

CONSENT FORM

Consent to participate in research that aims to evaluate the implementation of hospital boards at district hospitals in the public health sector in KwaZulu-Natal in 2008.

You have been asked to participate in a research study.

You have been informed about the study by Mr. H J Human.

You may contact Mr. H J Human at the Church of Scotland Hospital, telephone no. 033-4932004 or cell no. 083 450 2004 during office hours if you have questions about the research.

You may contact the Medical Research Office at the Nelson R Mandela School of Medicine at

031-260 4604 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate.

_____	_____	_____
Signature of Participant	Print Name	Date
_____	_____	_____
Signature of Witness	Print name	Date
(Where applicable)		
_____	_____	_____
Signature of Translator	Print name	Date
(Where applicable)		

APPENDIX F

PERMISSION FROM THE KWAZULU-NATAL PROVINCIAL DEPARTMENT OF HEALTH

ax sent by : 0354744914 ESHOWE HOSPITAL 21-11-08 09:45 Pg: 4

0354744914

NOV.19,2008 13:41 0333943782 HEALTH SERVICE DELIVERY

0333943782

HEALTH
KwaZulu-Natal

Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 395 2805
Fax.: 033 – 394 3782
Email.: xolani.xaba@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM090/08
Enquiries : Mr X. Xaba
Telephone : 033 – 395 2805

04 November 2008

Dear Mr Human

Subject: Approval of a Research Proposal

1. The research proposal titled **'An evaluation of the implementation and capacity of Hospital Boards at District Hospitals in KwaZulu Natal in 2008"** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at District Hospitals **SUBJECT** to permission by Institutional Managers.

2. You are requested to undertake the following:
   a. Make the necessary arrangement with identified facilities before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za.

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr S.S.S. Buthelezi
Chairperson: Provincial Health Research Committee.

APPENDIX G

APPROVAL FROM THE BIOMEDICAL RESEARCH ETHICS COMMITTEE OF THE NELSON R MANDELA SCHOOL OF MEDICINE, SOUTH AFRICA

UNIVERSITY OF
KWAZULU-NATAL

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/ResearchEthics11415.aspx

11 February 2009

Mr H.J Human
Private Bag X502
Tugela Ferry
3010

Dear Mr Human

PROTOCOL: An evaluation of the implementation and capacity of Hospital Boards at District Hospitals in KwaZulu - Natal in 2008. Mr HJ Human. Ref No: BE089/08.

EXPEDITED APPLICATION - RATIFICATION

This letter serves to notify you that at a full sitting of the Biomedical Research Ethics Committee meeting held on **09 February 2009**, the Committee **RATIFIED** the sub-committee's decision to approve the above study.

Yours sincerely

Ramnara

Ms D Ramnarain
Senior Administrator: Biomedical Research Ethics

APPENDIX H

MAP OF KWAZULU-NATAL: HOSPITAL BOARDS INTERVIEWED AND PILOT SITES IN 2008

APPENDIX I

MAP OF KWAZULU-NATAL: HOSPITAL CHIEF EXECUTIVE OFFICERS INTERVIEWED IN 2008

APPENDIX J

MAP OF KWAZULU-NATAL: HOSPITAL CHAIRPERSONS OF HOSPITAL BOARDS INTERVIEWED IN 2008