IMPLEMENTATION OF THE "BATHO PELE" (PEOPLE FIRST) PRINCIPLES IN ONE PUBLIC HOSPITAL IN SOUTH AFRICA: PATIENTS' EXPERIENCES

V.L. Khoza, MPH graduate
University of South Africa
Department of Health Studies

H.S. Du Toit, M Cur
University of South Africa
Department of Health Studies
Corresponding author: dtoiths@unisa.ac.za

J.H. Roos, D Litt et Phil
University of South Africa
Department of Health Studiess

ABSTRACT

The purpose of this quantitative, descriptive study was to identify shortcomings in the implementation of the Batho Pele Principles in a public hospital. The Batho Pele is an official document of the South African government, prescribing the conduct of public servants to improve public service delivery, according to eight principles. Findings were obtained from a range of patients who had been admitted to specific units for three or more days, and more evidence was gathered from articles in the mass media. Data were collected through conducting structured interviews with 100 respondents (n=100) and analysed by means of descriptive statistics. The research findings revealed that few of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with treatment in public hospitals. Shortcomings are attributed to insufficient management skills and knowledge at different levels of the health care system, as well as patients' lack of awareness about their health care rights and responsibilities.

KEYWORDS: Batho Pele Principles, health care policy, patients' rights, quality of health care, responsibilities of health care providers

INTRODUCTION AND BACKGROUND INFORMATION

The White Paper on the Transformation of the South African public services was published in October 1997 (South Africa, 1997:9). This document is also known as the Batho Pele Principles (BPP) which is a Sesotho expression meaning people first. The White Paper sets out eight principles against which a transformed South African public service will be judged, for its effectiveness in the delivery of services which meet

the basic needs of all South African citizens. These principles are consultation; service delivery; access; courtesy; information; openness and transparency; redress; and value for money (South Africa, 1997:9).

After 1994 and the first democratic election, the Constitution of the Republic of South Africa introduced a Bill of Rights which forms the cornerstone of democracy in South Africa. It enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom. Because all national departments have to adhere to the principles and rights in the Constitution, the Department of Health (DOH) is committed to upholding, promoting and protecting the rights of patients. This commitment is guided by the BPP and several legislative and policy documents.

This study focused on public services in a specific public hospital with reference to service delivery and the implementation of the BPP or the lack thereof. The BPP were interpreted along with other relevant DOH and hospital policy documents.

RESEARCH PROBLEM

Although the concept of human rights is fairly new in South Africa, one would expect to observe respect for human rights in the delivery of health care services since the implementation of the BPP in 1997. However, the position in a specific public hospital has revealed information about incidents contrary to the BPP. The incidents ranged from not having beds to admit patients from the casualty department, lack of supplies and patients complaining about nurses being disrespectful to them. It was evident from newspaper reports and informal conversations that the public was dissatisfied with service delivery at the hospital concerned.

PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to investigate the implementation of BPP as experienced by patients in a public hospital.

The two objectives of the research were to describe how patients experienced the implementation of the BPP and to identify shortfalls in the implementation of BPP, as described by the patients.

SIGNIFICANCE OF THE STUDY

The findings of the research will identify shortcomings in the implementation of the BPP and assist the management of public hospitals to revise the human resource development programmes to encourage the implementation of BPP in hospitals. This approach could enhance service delivery and benefit the patients and personnel of public hospitals.

OPERATIONAL DEFINITIONS USED IN THE RESEARCH REPORT

Batho Pele refers to an official national document formulated to improve public service delivery in South Africa, including the health care services (South Africa, 1997:9).

Charter implies an official document granting or defining rights (Oxford English Dictionary, 2004:479), and in this study refers to the care which a patient can expect from health care workers according to the Patients' Rights Charter (PRC) and BPP.

Responsibility is a term which means to act in return, to have an obligation, to account for something, being answerable to someone or something (Searle, 2004:174). Responsibility refers to the obligations of all categories of health care personnel in public hospitals, to respect the rights of patients and to deliver services in accordance with the BPP and related policies.

Right refers to that which is morally good or justified (Oxford English Dictionary, 2004:479). In the context of this study patients' rights refer to the care which a patient can expect from health care workers according to the PRC and BPP.

Policy is usually a written document to ensure standardisation and provide guidance to all health practitioners (Bezuidenhout, 2008:42). In this study the term "policy" refers to national and hospital policies that guide the actions of health care personnel in order to implement the BPP.

Quality is described by Muller et al. (2006:534) as the degree of excellence or the extent to which an organisation meets clients' needs and exceeds their expectations. In the context of the study it refers to the health care rendered in a public hospital in line with official government and hospital policies.

RESEARCH DESIGN AND METHODOLOGY

A quantitative descriptive approach was used as it intended to explore and document the implementation of BPP, as experienced by patients in selected nursing units in a public hospital. The descriptive research design was appropriate in this study since little is known about the phenomenon and a description allowed identification of shortfalls in the implementation of the BPP (Burns & Grove, 2005:747).

Population and sampling

The accessible population comprised the patients from a specific provincial hospital in the Ekurhuleni District of the Gauteng Province, South Africa. Patients in a public hospital were chosen because all public servants are obliged to care for their customers in line with the stipulations of the BPP. Non-probability sampling was used which means that not every element of the population had an opportunity to be included in the sample. A sample of one hundred respondents was chosen from long-stay wards, namely the medical, surgical and orthopedic wards. It was assumed that patients who stayed for at

least three days would be able to share more information on the implementation of BPP as opposed to patients who were admitted on a short-term stay. The inclusion criteria stated that patients should be adult male or female patients from the designated wards who were at least 18 years old, fully mentally orientated, from all races, skilled in reading and writing and admitted to the ward for three or more days.

Research instrument

A structured interview schedule (Brink et al., 2006:148) was developed, based on different policy documents and the literature review. The instrument included open and closed-ended questions and consisted of five sections, namely acuity level of the patient; demographic information; Batho Pele Principles; Patients' Rights Charter and quality assurance.

The instrument was pre-tested with ten respondents to determine whether the respondents understood the instructions and questions and to monitor the amount of time taken by the researcher and the research assistant to complete the interview and record the answers on the schedule (Polit & Beck, 2004:728).

The research assistant was familiar with the public hospital and had experience of completing interview schedules. The researcher briefed the assistant on the content and nature of the interview schedule and the ethics of data collection. The assistant also assisted during the pre-testing of the instrument.

Data collection

Data collection was done in the three nursing units in consultation with the unit managers on days that suited the ward during February and March 2008. Respondents who met the inclusion criteria were identified with the assistance of the unit managers and possible respondents were approached personally. Those who were willing to participate and who gave informed consent were interviewed by the researcher or research assistant who recorded the responses on the interview schedule. The process was repeated until the sample size of 100 had been reached (Brink et al., 2006:136).

Data analysis

The MS Excel program was used to capture and analyse the data and findings were presented in tables and graphical format. Responses to the open-ended questions were grouped, analysed and described.

Reliability and validity

According to Brink et al. (2006) validity refers to the ability of an instrument to measure exactly what it is supposed to measure and nothing else. Simple language was used in the interview schedules to ensure that respondents understood the questions. Face validity refers to whether the instrument is measuring the content desired for the study (Burns & Grove, 2005:737). This was enhanced by including the concepts relevant to BPP as

identified in the reviewed literature. Content validity concerns the representativeness of the concepts in the measuring instrument of the variable being measured (Brink et al, 2006:160; Polit & Beck, 2004:423). In this study content validity was achieved by including all aspects relevant to BPP in the questions.

Ethical considerations

Permission to conduct the study was obtained from the Gauteng Department of Health (GDOH), the Ekurhuleni Health District (Region B), the nursing service manager of the hospital and the Research and Ethics Committee of the Department of Health Studies, University of South Africa.

Respondents gave informed written consent. Beneficence was maintained because the respondents were assured that they would not be harmed physically from fatigue due to the time needed to complete the interview schedule or psychologically from stress or fear. Respondents had the right to ask questions, to refuse to give information, to ask for clarification or to terminate their participation at any stage during the research. Anonymity was maintained and the identity of respondents was not recorded on the interview schedule. Confidentiality was protected and promoted throughout the study by assuring that no unauthorised person could access data from the completed interview schedules (Burns & Grove, 2005:728; Polit & Beck, 2004:711).

RESEARCH FINDINGS AND INTERPRETATIONS

The research population is described in terms of certain demographic and acuity information. The remainder of the research findings and interpretation are described according to the six BPP included in the study.

Demographic information

The ages of the respondents ranged from 18 to 60 years. Sixty-one percent (n=61) of the respondents were males, while 39% (n=39) were females. All the respondents had attended school, ranging from primary to tertiary level. Eight percent (n=8) had completed tertiary level education while 43% (n=43) had attended secondary schools. Twenty-nine percent (n=29) had completed their junior secondary schooling and 20% (n=20) had completed only the primary school level. All respondents were able to read the BPP and PRC displayed in the wards.

Acuity levels of patients

Ten percent (n=10) of the respondents had been in the ward for three days only, while 45% (n=45) had been admitted for 4-10 days. Forty-five percent (n=45) were admitted to the wards for more than ten days. This information was important, because the longer a patient stayed in hospital, the better he/she could report on hospital experiences and render valuable inputs to the study.

Batho Pele principles

The following findings are preceded by a brief description of the specific implementation guidelines for each principle according to the Batho Pele White Paper (South Africa 1997).

Setting of service standards

Specific and measurable standards for the quality of services should be published at national, provincial and departmental levels. Standards should be displayed and performance of health care providers must be measured at least once a year. Users should be able to judge whether the promised services were received or not (South Africa, 1997:16–17). Service standards cannot be reached without resources and infrastructure.

In a public hospital, service standards pertaining to the functioning of the ward are to be displayed on the wall in the unit so that they can be visible to patients and their families. These include the shift rosters for the nurses; ward rounds; schedule for serving of meals; schedules for nurses' tea and lunch times; and schedules for visiting times.

It was found that 35% (n=35) of respondents mentioned some shortages of equipment for example beds and walking aids as well as shortages of stock such as bed linen and daily attire. Some of the respondents had to wear the same attire for 3–4 days before receiving clean clothing. Forty four percent of respondents reported a shortage of toilet paper. Structural problems such as one bathroom for 30 patients were also mentioned.

The majority of respondents, 92% (n=92) were satisfied with the convenience of visiting hours whilst 41% (n=41) indicated that visiting hours were not long enough to accommodate visitors from faraway places or visitors with transport problems.

The physical environment was investigated in terms of hygiene, security and noise. Thirty percent (n=30) of respondents reported that wards were dirty or sometimes dirty and they commented on unhygienic bathrooms and toilets, dirty wards and bed lockers. Twenty-six percent (n=26) indicated that the hospital security was inadequate or not always adequate. Twenty percent (n=20) complained about the noise and mentioned staff, prison warders, radios and trolleys as sources of noise.

Increasing access

This service delivery principle includes access of health services to patients who were previously disadvantaged as a result of the lack of infrastructure and barriers to access such as social, cultural, physical, communication and attitude factors (South Africa, 1997:18). Access to health care is also addressed in the PRC and it describes the availability of adequate resources in order to deliver health care services.

When compared to South Africa's demographics, this study revealed a balanced proportion of the different races receiving the same standard of health care. The majority

of respondents, 78% (n=78) were Africans, 18% (n=18) were Whites, 2% (n=2) were Coloureds and 2% (n=2) were Indians.

Twenty-three percent (n=23) of respondents reported shortages of stock and equipment. They commented on having to wait long periods for a bed so that they could be admitted, shortages of ward accessories such as walking aids and monkey chains and shortages of bed linen. Ten percent (n=10) of respondents reported that toilet paper was not supplied and 31% (n=31) said it was not always supplied.

The principle of ensuring courtesy

Patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding, as well as with consideration and respect. Discourtesy must not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioural norms to junior health care workers (South Africa, 1997:19). Courtesy is underwritten by the Bill of Rights and the PRC.

Respondents revealed violations of their rights to be treated with respect and human dignity. Thirty-seven percent (n=37) of respondents reported that staff members were not or not always friendly and the conduct of staff was described as nasty, rude and short-tempered. Thirteen percent (n=13) reported that doctors do not always treat them with respect, some doctors even shouted at them in front of the other patients. Contrary to the disrespectful conduct of professional staff, 96% (n=96) reported that the cleaners treated them with respect.

Table 1: Courtesy shown towards patients (n=100)

Gestures of courtesy experienced	Yes	No	Not sure	n
Staff members were friendly	63%	23%	14%	100
Treated with respect by doctors	87%	5%	8%	100
Treated with respect by cleaners	96%	1%	3%	100
Treated with dignity by staff members	87%	1%	12%	100
Staff members were helpful	73%	22%	5%	100
Were introduced to the unit manager	18%	70%	12%	100
Staff members respond to patients' needs	74%	25%	1%	100

Courtesy is displayed in many ways and manifests in lay terms as good manners. Respondents were asked if they were treated with dignity and 87% (n=87) responded positively. The validity of these responses is in question when responses to a number of other items are observed such as 27% (n=27) said staff members were not or not always helpful, 70% (n=70) reported that the unit manager did not introduce her/himself to them and 25% (n=25) of respondents said staff members did not listen or respond to the needs of the patients.

Providing more and better information to patients

This principle on the provision of information aims to empower patients to understand the health services they are entitled to receive, their illness, diagnosis and treatment. The White Paper states that health care providers should determine what patients need to know and then decide on the best way to provide the information in understandable language free from jargon (South Africa 1997:19). The policy on quality in health care for South Africa states that patients who are well informed are able to participate in the treatment decisions and are more likely to comply with their treatment plans (NDOH, 2007:13).

The primary documents that should inform patients about the obligation of health care providers and the rights of patients are the BPP and the PRC. This study revealed that both these documents were either not displayed noticeably in the wards or the respondents did not realise the importance of these documents. Some respondents (52%; n=52) did not observe the BPP and only 63.0% (n=63) had not observed the PRC document.

Respondents were well informed about visiting hours and about medical, surgical and nursing procedures to be performed. Forty-four percent (n=44) of the respondents were not well informed about the daily ward routine. Although 73% (n=73) of the patients reported that their illnesses had been explained to them, only 55% (n=55) said they had received all the information they needed and 68% (n=68) had not been informed about their test results.

Table 2: Information patients received (n=100)

Type of information	Yes	No	Not sure
BPP clearly displayed in the ward	48%	52%	0%
PRC clearly displayed in the ward	37%	28%	35%
Daily ward routine explained	56%	44%	0%
Nature of illness explained	73%	22%	5%
All information about treatment received	55%	35%	10%
Test results received	27%	68%	5%

The general public needs to be informed and educated about their rights and the responsibilities of health care providers. Nurses and doctors must realise that information about their diagnosis, condition and treatment empowers patients to contribute to and participate in their health care. Furthermore, sharing of information demonstrates respect for the dignity of patients.

Remedying mistakes and failures/redress

The principle of redress requires an effective approach to handling complaints which should be viewed as opportunities to identify and address problems and improve service delivery. Complaints should be addressed without delay, must be investigated fully and

impartially and must be treated confidentially to protect the complainant. The hospital must have a strategy for providing feedback about complaints that will serve as training opportunities for health care providers. All staff must know the procedure for handling complaints (South Africa, 1997:21–22).

The study revealed many matters about which 30% or more of the respondents were unhappy or dissatisfied. These included: inadequate equipment in the ward; not being informed about the ward routine; lack of information about treatment; staff members being unfriendly; patients not introduced to the unit manager and doctor; patients not involved in decision making; no room available for private consultation or conversation; toilet paper not supplied; dissatisfaction with food and clean attire not available. Despite these findings, 90% (n=90) of respondents did not file official complaints.

This might be because they were unaware of their rights to complain, which should have been clearly visible in the BPP and PRC documents displayed in the hospital wards. Patients should have been informed about the complaints procedures, or another reason could have been the absence of complaint/suggestion boxes in the wards. Fifty-nine percent (n=59) of respondents reported that there was no complaint/suggestion box in the wards.

Getting the best possible value for money

The White Paper states that services should be cost effective and delivered within departmental resource allocations. Procedures should be simplified and waste and inefficiency eliminated (South Africa, 1997:22). This principle is of importance for unit managers to plan, organise and control all resources in such a way that cost effective patient care can be rendered. Nursing units must control their resources in order to prevent unnecessary shortages, for example linen shortages. This principle is closely related to *access to health care* as discussed in the PRC.

CONCLUSIONS

The implementation of each of the six identified BPP was described in terms of everyday nursing in the three selected hospital wards. The shortfalls that were identified could be classified in terms of hospital management, unit management and patient awareness.

Hospital management

Insufficient planning and budgeting for capital expenditures such as equipment and ineffective utilisation of equipment deter the implementation of the BPP "increasing access". The fact that the BPP, PRC and complaint boxes were not placed conspicuously in the units impeded the implementation of the BPPs concerned with the setting of service standards, providing more and better information, and remedying mistakes and failures/redress.

Unit management

Ineffective planning, organisation and control by the unit manager caused the ineffective implementation of the BPP of "increasing access", thus hampering the delivery of quality services to patients at the participating public hospital in South Africa.

Patients' awareness levels

A lack of awareness and understanding of the BPP and the PRC by patients and the general public hindered the implementation of the BPP "remedying mistakes and failures/redress".

The BPP were not all implemented in the hospital's wards where data were collected. However, with increased awareness and effective monitoring, based on relevant in-service education programmes, most identified problems could be addressed successfully.

RECOMMENDATIONS

Recommendations are suggested in terms of research, management and education.

Research

A more extensive study should be done at the same hospital, including all the hospital wards/units and other departments that deal directly with patients. Such an extensive study should be repeated at other hospitals in the district and province to ensure improvement of the implementation of the BPP. Research and scientific evidence should form the basis for evidence-based clinical practice to secure a health care system in which the BPP are central.

Management

Identified problem areas such as respect and courtesy towards patients and shortages of stock and equipment should be addressed and monitored on a continuous basis. All levels of management should ensure that quality assurance programmes are implemented and all levels of health care staff members are monitored.

Education

The implementation of the BPP and PRC should be an integral part of the human resource development programme and care should be taken that all categories of staff are included in the training sessions. Strategies to ensure that patients are aware of and understand the BPP and the PRC should be planned, implemented and evaluated on a continuing basis.

LIMITATIONS OF THE STUDY

The respondents were selected from three hospital wards in one hospital only. The inclusion of more and different hospital wards/departments, such as the radiology department and the dispensary, might have provided a more complete picture of the implementation of the BPP in the hospital as such.

REFERENCES

Bezuidenhout, M.C. 2008. Nursing service policy and procedure manuals. In *Introduction of health services management* edited by S.W.Booyens. 3rd Edition. Cape Town: Juta.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2006 *Fundamentals of research methodology for health care* professionals. 2nd Edition. Cape Town: Juta.

Burns, N. & Grove, S.K. 2005. *The practice of nursing research: conduct, critique and utilization*. 5th Edition. Philadelphia: W.B. Saunders.

Muller, M., Bezuidenhout, M. & Jooste, K. 2006. *Health care service management*. Cape Town: Juta.

GDOH – see Gauteng Department of Health

National Department of Health. 2002. *Patients rights charter.* Available: http://capegateway.gov.za/eng/your_gove/595/pubs/public_P3162 (Accessed on 26 August 2010).

NDOH see National Department of Health

National Department of Health. 2007. *A policy on quality in health care for South Africa.* Pretoria.

Oxford English Dictionary. 2004. 6th Edition. New York: Oxford University Press.

Polit, D.F. & Beck, C.T. 2004. *Nursing research: principles and methods*. 7th Edition. Philadelphia: J.B.Lippincott.

Searle, C. 2004. *Professional practice. A South African nursing perspective. 4th* Edition. Durban: Heinemann.

South Africa (Republic). 1997. *White paper of transforming public service delivery (Batho Pele White Paper)* (No.1459 of 1997). Pretoria: Department of Public Service and Administration.

The Patients' Rights Charter. 2002. Department of Health. Available: http://www.doh.gov.za/docs/legislation/patientsrigtht/chartere.html (Accessed on 20 October 2010).