

## **IMPROVING MOBILE SERVICE DELIVERY WITHIN ILEMBE HEALTH DISTRICT: A BATHO PELE PERSPECTIVE**

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### **Abstract**

Everything associated with wealth, happiness and long life depends on good health. Adept policy-makers must understand linkages between Government priorities, interfacing with the public. Health policy initiatives ought to be implemented effectively, efficiently and economically within local communities' proximity demonstrating results. Contextually, mobile health services are extensions of Primary Health Care (PHC) systems. The Department of Health (DoH) and iLembe Health District must ensure Batho Pele (People First) Principles maintain service standards. Mobile health services are not rendered in accordance with the policy framework and implementation strategy aimed at transforming public services, as stipulated in the White Paper on Transforming Public Service Delivery (Batho Pele White Paper, 1997). The purpose of this study therefore, was to evaluate the influence of mobile health services operationalising these principles to the district. The methodological approach included questionnaires administered to management, health care workers and clients within Maphumulo sub-district in iLembe. The quantitative approach utilising the post positivist worldview was applied through survey research and random sampling with a complement of 286 respondents. Data was interpreted for statistical significance of relationships amongst key variables through Factor Analysis and Cronbach's Alpha for score reliability. Data analysis illustrated that most health care workers (HCW) are considerate, offer required information to clients regardless of resource and infrastructure limitations. Empirically, managers, HCW and clients agreed mobile health services are delivered in relation to some of

Batho Pele Principles. However, this does not imply that challenges do not exist. The study revealed that efficient, economic and effective delivery of health services warrants multi-disciplinary and co-ordinated approaches involving clients' participation and feedback, including health service management and health care workers. Emphasis was on instilling a spirit of diakonia and culture of ensuring high quality service delivery mandates of Health and Government Departments. The authors conclude that necessary health care policies must be implemented properly. The need is to systematically institutionalise functional monitoring and evaluation systems to deliver quality services to citizens in an equitable manner through all possible means.

**Keywords:** Batho Pele, Health service delivery, Public service, Primary health care

**JEL Classification:** I 18 Government Policy. Regulation. Public Health

## 1. INTRODUCTION

The post-apartheid South African dispensation, which was voted to power in 1994, had a mandate to render relevant, economic, accessible and equitable services to the citizenry. The enormous burden of health related challenges placed emphasis on the need for health care to be served to the citizenry at or closest to their residence or place of their work. Therefore, mobile health services are required to fulfil health needs in a co-ordinated and complementary approach together with the existing fixed health facilities. However, concomitantly, there is an increasing mortality and morbidity rate of treatable and curable diseases primarily attributed to health services, but not always within reach of the poorest-of-the-poor who contribute to being the masses of people in the country. Hospitals and fixed clinics are currently limited in the provision of the range of health services, ranging from basic PHC to essential health services required by citizens, more especially in semi-rural and deep rural areas.

The inflexibly located health service facilities pose challenges of accessibility amongst others, *ipso facto*, travelling distance between themselves and health care users. It is therefore, imperative that health services be brought closer to the dependent communities. Provision of mobile health services seeks to awaken underserved and rural communities by developing a sustainable health system that increases access to the package of PHC services, health promotion and disease prevention. In this regard, the National Health Act, 2003 (Act No. 61 of 2003) in the Preamble recognises: “the requirement to rebuild the historical divisions and to create a society grounded on democratic values, social justice and fundamental human rights”.

One of the means of access is then, through the use of mobile health units, referred to as “clinics on wheels”, whose aim is to significantly reduce the health service delivery gap in respect of accessibility. This is done by bringing the much-needed health services to the people through trained health care personnel at designated service points. This type of service ostensibly addresses core health issues and aligns health services that appraises, educates, and empowers citizens about health issues. The focus is also on formulating policies and procedures that promote individual and community health efforts; linking people to appropriate and necessary personal health services; and securing the delivery of health care where it is non-existent.

The foregoing aspects are supported by authors Yu, Hill, Ricks, Bennet and Oriol (2017: 1), who state that mobile units are an inventive model of health service delivery. This approach to health service delivery may assist in overcoming health inequalities in susceptible communities and individuals. Yu *et al* (2017:1) emphasise that, this is achieved through the rendering of services by mobile clinics straight into communities by utilising current civic resources and whilst offering personalised, high-impact and affordable health care that is responsive and dynamic to evolving health care needs.

### **1.1 Conceptualising and contextualising health service delivery *vis-à-vis* Public Administration**

Following the dawn of democracy in South Africa post 1994, there was an opportunity for new legislation and policies to be introduced, passed and enacted. The aim was to bring about transformation, and to redress the historical disparities, more significantly within the government sphere. The DoH has the mandate of ensuring a long and healthy life for all South Africans in accordance with the values and principles, as contained in Chapter 2, sub-section 27 of the Constitution (Republic of South Africa, 1996). This Constitutional imperative envisions a mission that ensures services are provided impartially, fairly and equitably. It is imperative for the DoH to determine the quality and effectiveness of health service delivery provision through the transformation that has occurred in and following implementation of health legislation and policy documents. This can be achieved by responding timeously, effectively and efficiently to the health requirements of the citizens. The endorsement and adoption of the PHC approach at the International Conference on Primary Health Care and the Alma-Ata Declaration (World Health Organisation, 1978: 3) affirms that PHC “forms an essential element of the country’s health system. The approach is the essential function and key focus of the complete social and economic development of the community.” It is obligatory health care, which is based on concrete, systematically reliable and publically suitable practices which are made comprehensively *accessible* to citizens through *consultation* and participation. These are the two identified Batho Pele Principles (as emphasised in the paper).

Mainstreaming of PHC was the mandate of the democratic government, and it was premised on legislation constituted in and through the Constitution (Republic of South Africa, 1996). This called for transformation of health services, using the Batho Pele framework, development and implementation of health policies within the Public Administration system to advance the quality of life of communities and raise living standards of all South Africans. In this paradigm, the typologies that informed health service delivery

includes the legislative framework, PHC Policy, Batho Pele framework, policy dynamics and the delivery thereof within Public Administration and New Public Management perspectives, as the key determinants for enhanced health service delivery.

## 1.2 Policy Domain and Primary Health Care

The development of the African National Congress's (ANC) National Health Plan (NHP), which was framed on the Alma-Ata Declaration as alluded to earlier, and prior to 1994, anticipated the essential functioning and reorganisation of the national health system premised on the PHC policy domain.

The term 'Primary Health Care Approach' is linked with the health care rudiments of the Alma-Ata Declaration as such, and is condensed aptly as follows (Global Health Watch 3, 2011: 45-58):

- *Firstly*, it emphasises an *all-inclusive* methodology to health through strategies directed at endorsing and shielding health services. The focus thus, places more importance on preventative measures and opposes the bias of many health care systems therefore promoting a multi-disciplinary approach to health.
- *Secondly*, it promotes *integration* – of various medical services within health institutions, of health programmes and of different spheres of the health care system.
- *Thirdly*, it emphasizes *equity*. This seeks to rectify the disregard of country populaces, as well as community and economically relegated sectors, within many health care systems.
- *Fourthly*, it campaigns for the usage of '*appropriate*' health technology, and health services that are socially and culturally acceptable.
- *Fifthly*, it accentuates appropriate and effective *community participation* within the health care system.
- *Lastly*, it embraces a robust *human rights standpoint* on health by upholding the essential human right to health, and the

obligation of administrations to develop the necessary policies, strategies and plans of action.

The above elements of the PHC approach echoes the core values and the ideologies enshrined in the Constitution (Republic of South Africa, 1996), Batho Pele Principles and the Patients' Rights Charter, therefore complementing the study that was undertaken hereto.

Post 1994, South Africa joined a few other countries of the world, such as Australia and South Korea (National Health Insurance), where the overhauling and advancement of the health system commenced with a transparent political will and assurance. As such, it ensured equitable resource distribution and reform of the health system in line with the District Health System (DHS). The DHS is defined as: "the lower-most management constituent that establishes health care service provision through clinics, health centres and district hospitals in a geographically demarcated region", thus rendering health care services in accordance with the principles of the PHC approach (World Health Organisation, 1978: 3). The NHP (ANC, 1994) endeavoured to make comprehensive, community-based health care more accessible through the notable establishment of PHC centres as a foundation to the system.

The health districts have the responsibility of ensuring that there is an equitable distribution of health services to all citizens. Mobile health services can assist in bridging the gap between fixed health care facilities on the one hand, and the ever increasing users of health care services on the other. In this context, Clemen-Stone (1995: 825) notes that there is a considerable increase in the number of mobile health clinics throughout the districts of the country due to the involvement of donor funding. It can be inferred, that human resources are a critical component in determining the need and the number of mobile health units, and in fulfilling significant roles, so that client needs are met and service provision is at its optimal. These services include the PHC package, focusing primarily on health promotion and education, health screening, physical assessment for minor ailments and pre- and ante-natal services. The huge burden of

disease, new incidence rates and its prevalence, especially in the rural poor communities necessitates an improved, integrated healthcare service, which is community-focused. Mobile health units can assist in providing health care services in the clients' settings at designated service points.

To further give effect to the above, mobile health care units form an extension of fixed health facilities, and aims to attend to the health issues of communities by delivering promotive, preventive, curative and rehabilitative health services within available resources. It requires health care workers to socially and technically work as teams to adhere to the needs of the community. According to Tanser, Hosegood, Benzler and Solarsh (2001: 826), the proximity of PHC services has been a noteworthy factor in determining the health standing of the population. In addition to the proximity, is the aspect of physical accessibility of the health care facility and services to the users. Tanser *et al* (2001: 826) further states that this is "governed by the geographic setting of client homesteads in relation to existing facilities, by physical and geographical barriers, and by availability of transport to the health facilities." Physical accessibility to a health service point may be a factor to the decreased attendance rates at health care facilities. The introduction of mobile health services was therefore, to provide the necessary health care to people closer to their homes, and help ease the accessibility challenges. This study focused on accessibility as one of the crucial factors to be explored, which mobile health services aims to address, as an important aspect for due consideration by the DoH. Authors Egunjobi, Habib & Vaughan and Van der Stuyft *et al.* cited (in Tanser *et al.* 2001: 827) have studied various social factors that affect the use of health care services. Some of these socio-cultural factors included the income of the health care user, the quality of care received at the health care facility, the health care user's perceived level of illness experienced, the availability of transport and the relationship that the health care user has with the health care facility staff.

### 1.3 Contextualising the Batho Pele Framework

Job creation, health, education, nutrition, housing, water, social welfare and security have been identified as the prioritised cluster programmes of the Reconstruction and Development Programme (RDP), (RDP: 1994). However, The White Paper on Transforming Public Service Delivery (Department of Public Service and Administration, 1997: 1) provides the legislative guidelines on how service delivery transformation should be addressed to remedy the disparities of the past, and confirm the provision of enhanced quality of services, which strives to advance the quality of life of the people of the country. It is stated as follows: “...a changed South African public sector will be assessed by a single criterion, in that, its effectiveness in providing services which is responsive to fundamental requirements of all South African citizens. Enhancing service delivery is therefore, the definitive aim of the public service transformation”. The resolve of the White Paper on the Transformation of the Public Service (Department of Public Service and Administration, 1995: 4) “is to create a policy context to steer the introduction and implementation of new policies and legislation intended at transforming the South African public service.” It is primarily about how services in the public sector are delivered, and explicitly about the efficiency and effectiveness of the manner in which the delivery of health care is provided through the Batho Pele approach. This emphasis is in accordance with international ‘best’ practices, and demonstrates commitment to the significance of service delivery and customer care for the citizenry from the public officials and public services.

It was therefore, clear that henceforth, public institutions such as the DoH would be guided by service standards, and a service ethos that would be responsive to the requirements of the population, and be of exceptional quality. Based on two statutory frameworks; the guiding principles of the *White Paper on Transformation of the Public Service (1995)* and the *Constitution (Republic of South Africa, 1996)*, the Batho Pele-“People First” and the White Paper on Transforming Public Service Delivery (Department of Public Service and



Administration, 1997: 3) was formulated to “deliver a policy outline and a practical application approach for the transformation of public service delivery”. This approach strongly signifies the government’s assurance to adopting a citizen-oriented methodology for improvement of service delivery.

The main thrust of Batho Pele is that it is a customer-positioned approach that is pursued to enhance the capability of health institutions to ensure and exceed the expectations of customers or clients by persistently orientating organisational structure, behaviour and a work culture to attain this objective. The emphasis is therefore, on the following aspects of Batho Pele which aimed to “present a renewed approach to service delivery; a methodology that places emphasis on systems, procedures, attitudes and behaviour within the public service and re-orient them in the clients’ favour. This is a strategy that places people first” (White Paper on Transforming Public Service Delivery of 1997 Section 1.2.12); and the launching of the Batho Pele White Paper in 1997 was not a ‘public relations’ assignment, but it was a strategic intent to imbibe a culture of accountability and caring by public officials to the citizenry. This strategy hopes to encourage government officials to become more service-oriented; endeavour to achieve excellence, and to pledge to unceasing service delivery improvements. Batho Pele is an apparatus through its Principles, which permits clients to ensure public officials account for the quality of services rendered. It signals the government’s strong intentions to promote a citizen-oriented approach to service delivery improvement.

## **2. From NEW PUBLIC MANAGEMENT to PUBLIC HEALTH GOVERNANCE**

The New Public Management (NPM) approach has been conceptualised to describe a management culture which positions the client at the core of service delivery, and holds the public official accountable for results, (Hood, 1991: 3-19). This creates an ideal

opportunity for innovation and improved service delivery, of bringing services closer to the people and of providing “one stop” service centres. The plight of a responsive and accountable service occurs when health care workers pay little or no attention to the values and legislative prescripts of the public service and the DoH, which becomes a focal point relating to the governance of health. It is within this context, that Levin (2012: 9) states that a change in attitudes, behaviours and “values in action” is an essential public service skill requirement. The author further concedes that the NPM paradigm has its core focus on improving service delivery.

Hughes (2003: 58-59) states that NPM identifies that there is a need for unswerving accountability between managers and the public, as the consequences of a mandate for a “client focus”. The Batho Pele framework expresses the “*language of NPM*” and links the concept that the citizens are “customers” and holds government accountable for actions and omissions in service delivery. Hence, NPM as an advancement from traditional Public Administration practices in a post-modernist era has placed emphasis on citizen-oriented service delivery grounded on the execution of the Batho Pele Principles. The NPM is linked to the effective, efficient and economic use of resources through the conception of “*public-value- for- public-money*”, which is another Batho Pele Principle emphasised in the paper. The NPM has also progressed along the concept of a ‘new’ public service being a paradigm shift for service delivery within the government health sector, where concepts such as *efficiency and productivity* are positioned in the broader background of democracy, community and public interest (Hope, 2001: 122). The latter should be premised on these elements as described in Hope. These include the following salient aspects:

- Serve, rather than steer: Health officials should be duty-bound to assist clients express and meet their collective interests, instead of attempting to dominate or direct society in different directions;

- Public interest is the goal, not the by-product: Health care managers should participate in building collective and collaborative public interests;
- Think and plan strategically, act democratically: Policies and health programs that meet public requirements can be most effectively and responsibly attained through combined efforts and co-operative processes;
- Serve citizens, not customers: Health officials should not simply react to the demands of “customers” but concentrate on constructing associations of trust and teamwork with and amongst citizens;
- Health officials should be attentive and accountable upon executing their obligations on the basis of statutory and policy frameworks;
- Need for collaboration and shared leadership with mutual respect is preferred when working with clients in the service industry relating to health; and
- Intention is not to focus on self-enrichment.

It can be said, that these *tenets* are interrelated with the Batho Pele Principles in improving health service delivery; hence their emphasis is significant and relevant in the research that was undertaken.

### **3. RESEARCH METHODOLOGY, FINDINGS AND INTERPRETATION OF RESULTS**

Data was collected inductively using a quantitative approach through the design and administration of a questionnaire. Data obtained through the questionnaires focused on pertinent information relevant to the objectives of the research and the Batho Pele Principles. The worldview was that of social constructivism. The study relied on the participants’ views and meaning of the situation being studied.

A total of 286 questionnaires were issued, which included 250 to clients, 24 to HCW and 12 to management. They were chosen according to the inclusion and demographic criteria for the research

study. Of the questionnaires issued to clients, 203 were returned, indicating an 81.2% response rate. There was 100% response rate from HCW and from management. This reflects a positive return rate and lends credibility to the data. A reliability coefficient of .07 or higher is considered acceptable using Cronbach's Alpha score for all items that constituted the questionnaire to confirm its reliability. It is evident that all of the sections have reliability values that exceed the recommended value of 0.7 which implies an elevated degree of dependable rating by the respondents for the various sections. The high reliability score emphasises that HCW engages with clients in a courteous manner during consultation and provides health education in accordance with the principles of preventative and promotive health. Obtaining feedback from clients is an evaluative strategy for the improvement of health services rendered. This is highlighted in the KwaZulu-Natal Citizens' Charter, where the citizens are encouraged to "participate in the monitoring of the efficiency and effectiveness with which delivery of services is effected." (KZN Citizens' Charter, 2015-2020). This is a significant finding as it highlights the adherence to the Code of Conduct by HCW in the execution of their duties. More than 93% of the respondents attended a mobile health point. This is a significant finding in the study, which confirms that deep rural communities rely extensively on the health care services which are rendered from the mobile health units instead of travelling to fixed health care facilities due to amongst others, financial, infrastructure and travel constraints. The provision of mobile health services is an effective approach in bringing services closer to the people, and is in keeping with the key Principles of Batho Pele. Furthermore, there is emphasis on infrastructure development to ensure that services are accessible at health care centres. The State of the Nation Address, 2014 and the current 2018 address by the respective Presidents echoes the need for attention on health care by implementing universal health coverage through the National Health Insurance (State of the Nation Address 2018). This is synergistic with the National Development Plan, 2030 that incorporates the key indicators of the Industrial Policy Action Plan, the New Growth Path and the Infrastructure Plan.

Suggestions for improvement put forward by the authors can be classified under the following areas for improvement in accordance with the relevant Batho Pele Principles:

AREAS FOR IMPROVEMENT	BATHO PELE PRINCIPLE
<p><b>Sukuma Sakhe Forum</b></p> <p>The Forum has representation from all government departments and is ward-based. It is deemed appropriate for providing information related to health services and for marketing health services.</p>	<p><b>Consultation, Information</b></p>
<p><b>Provision of Resources</b></p> <p>Adequacy of supplies of medicines, equipment, budget and staff will enable the full package of PHC services to be rendered in order to achieve the realistic health requirements of the community.</p>	<p><b>Improve Service Standards</b></p>
<p><b>Training and Development</b></p> <p>Update staff on the latest policies, procedures and guidelines to ensure effective and efficient health service provision.</p>	<p><b>Providing Leadership and Strategic Direction, Encouraging Innovation and Rewarding Excellence</b></p>
<p><b>Increase Mobile Health Service Points</b></p> <p>Ensure equitable access to health services, decrease travelling costs and time, and decrease waiting times at the mobile points.</p>	<p><b>Improving Accessibility</b></p>

The empirical study revealed, that managers, HCW and clients all agree that although mobile health services are delivered in relation to Batho Pele Principles, however, there are still challenges that exist. There are shortages of human resources, supplies and some essential equipment. Furthermore, the Batho Pele programme is also not integrated in the strategic planning processes, and there is currently no synergy between the implementation of Batho Pele in relation to employee performance management and development system. There is room for improvement in relation to service standards through the provision of additional resources.

#### 4. CONCLUSION

The study that was undertaken has attempted to explore, from clients' viewpoints, the impact of the existing mobile health services in meeting their health needs. Managers were included as decision-makers with the necessary authority to institutionalise Batho Pele and direct changes, whilst HCW are the implementers of the activities identified for improvement. The Batho Pele perspective was used as a foundation on which health service delivery was rated. It was revealed that whilst health services are available, there is still room for improvement to meet service standards, and add quality enhancements. To instil a spirit of *diakonia* and a culture of ensuring high quality service delivery in HCW and amongst public officials' commitment, is a challenging yet critical issue in order to meet the obligation of the Government and the DoH. It is ultimately necessary, that policies are implemented properly. Monitoring and evaluation should continue in order to deliver health services to the citizens that is equitably distributed, and has the desired impact through all possible means.

There are numerous programmes that are being rolled out to mobile health clinics as part of the PHC package of care. Referral of clients from hospitals to fixed clinics and identified sites in the community for the collection of chronic medication including anti-retroviral medication, places greater need for health education and monitoring and evaluation by HCW to ensure compliance and timeous follow up. Mobile health services are part of the broader representation in health service delivery, as they delve into the areas closest to where clients work and reside. Based on the responses from clients regarding the availability of the different services required, and that which is currently being provided by mobile health units, is the need to evaluate the impact of the different services offered by mobile health services in improving key health indicators. This could also necessitate the development of appropriate assessment tools, which would improve health service delivery standards and could be an area of future research on its own.

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