Voices of Hospital Superintendents/Managers

12

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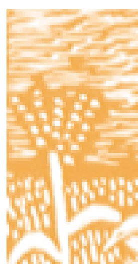
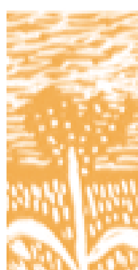
Introduction

Hospital Superintendents are among those health professionals at the forefront of the transformation and delivery of health services.[1] Hospitals have always been, and will remain central to the health care system and adequate health care cannot be provided without them.

This chapter is based on interviews with 15 Hospital Managers from 8 provinces. The managers were purposefully chosen for convenience of access and availability. There is an approximate 50-50 split between rural and urban. The interviews provide insights as to how changes in the health services are affecting their ability to manage a district hospital.



The chapter reflects on superintendents' answers to questions such as – What are some of the enabling factors, and some of the constraints? How much are they given the freedom to manage, or are there too many external factors retarding progress? What factors keep hospital managers in their jobs or what makes them want to leave? What are the rewards for working in these places?



Profile of Hospital Managers

The profile of the hospital superintendents is rapidly changing. While the tradition of the white male doctor as superintendent is still predominant, more women are beginning to head up hospitals. Of the 15 superintendents interviewed, six were women. Overall the women were new to the job, most having been in the post for a matter of months. In addition a trend is emerging of nurses and others health professionals taking the helm; four of the women superintendents were nurses.

Most of the superintendents had been in their post for only a few years, with tenure ranging from a few months to four years. The exception is rural superintendents, who had occupied their posts there for many years. The

variation in experience of the job is reflected in some of the responses. Most of the superintendents interviewed are in the 40-49 years age group category.

Overall Achievements

Most of the superintendents feel they have succeeded in:

- Improving the quality of care for their patients
- Bringing additional doctors on board
- Introducing new services
- Opening theatres
- Extending clinic opening hours.

For many the integration of health services in the district has made a great difference to their work, and collaboration with other health services has facilitated the introduction of dynamic new projects. An example from the Western Cape is of health services working together to provide antiretroviral drugs to HIV positive pregnant women. In other areas hospitals assist each other during times of crisis such as a typhoid outbreak or a rush of casualties following ritual circumcisions.

There is also a move towards community involvement in the hospital, for example having community members on the hospital board and addressing church groups about the services offered by the hospital.

"The superintendent is a figurehead in the community relationship with the hospital. When difficulties come, when things are not following normal patterns, its usually the superintendent who can cross boundaries more easily than anyone else."

Revenue Generation

Other achievements include charging patients referred by private practice doctors, resulting in revenue generation for the first time. Other partnerships with the private sector are being sought. Some superintendents have established links with universities to run projects.

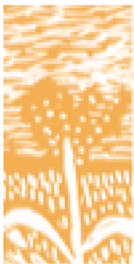
Another important enabling factor is financial control. Superintendents now have greater accountability for the finances of their institutions and for generating revenue. This control is not yet fully devolved, however benefits are already beginning to be felt. The need for more training in financial management was identified again and again.

Management Style

Along with the changing profile of the superintendent has come a new way of doing things and a more open management style. Hospital managers appear to be becoming more participatory and consultative in their management style, discussing matters with their heads of departments, recognising achievements of workers and dealing with conflict situations in a transparent and democratic way.

Some hospitals have instituted awards for staff who do outstanding work, others insist on taking time to explain to staff why changes are necessary and to keep staff abreast of new developments. One superintendent said that when they were reconstructing the hospital, he even asked the cleaners where the plugs should be placed.

"The architect was getting crazy that he had to listen to the cleaner and the porter, but they are the people who are using these things."

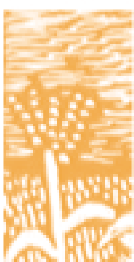


The outcome was that the reconstruction of this hospital was one of the most successful projects of its kind in the province.

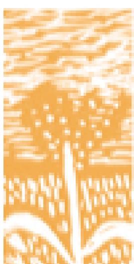
One of the obstacles to this participatory style of management, however, seems to be the matrons and the unyieldingly rigid and 'militaristic hierarchical nature' of the nursing corps. This often leads to feelings of low morale amongst the nurses.

"I think the biggest frustration was on the nursing side, not because of them personally but because of the whole structure of nursing and form filling and the whole bureaucratic process that has got caught up in nursing which prevented them from doing a whole lot of things that they were quite capable of doing."

The superintendents all felt they had made a lot of changes to the internal management of the hospital, putting structures in place that made it work more efficiently. Despite this there still appears to be a culture of crisis management and emergency meetings with inadequate time to focus on long-range plans.



Relationship with staff and staff attitudes



Disputes around race, and the challenge of discipline seem to play a large part in the day-to-day lives of superintendents. According to those interviewed, a lot of time is spent on disciplinary matters and yet they feel ill equipped to deal with disciplinary issues, not having received any training in personnel management or labour relations.

However this challenge is viewed by some in a positive light, as one superintendent explained:

"Look I have always liked working with people and the most rewarding cherry on the cake is the fact that the unions and management have got to learn and to understand and to trust each other and talk to each other and move away from the confrontation approach to one of collaboration. That is probably the most exciting thing that I have felt."

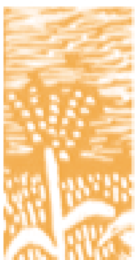
Another long serving superintendent commented:

"Discipline is another area of the Med Superintendent's job that is quite onerous. Discipline is the most unwanted bit in any job, to tell people off when they're not doing what they should, especially when they're recalcitrant ... In some sense, the Med Superintendent is in a better position to do it than the administrator, not quite so involved in the community, in the present situation being more of an outsider than other staff."

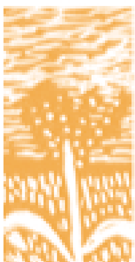
Some indicated that they had had to learn over many years, often through making mistakes that they wished they could have avoided. Overall they felt their staff worked hard, but there are never enough staff and the workload is overwhelming. Security is also a major concern, particularly for staff working the night shift.

An overall theme is the constant struggle to balance clinical work with administrative and managerial duties. Among the superintendents interviewed there is a keen awareness of the need to provide support to their own hospitals. They make sure they attend ward rounds, the importance of placing 'people above paper' was a common refrain, and they are intent on breaking down barriers between levels of staff.

The superintendents play a decisive role in setting the culture of the hospital. While one decided to introduce some stress to wake up his 'sleepy hospital', others were trying to find ways to unravel the tensions. Much of the friction is around race, but one superintendent said it was important to examine whether these problems were really about race or whether it was just being used as an excuse for some other problem.



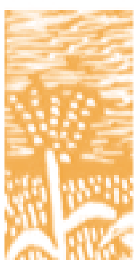
A few superintendents cited the poor work commitment of staff and high levels of theft as causes of tension. The need to recognise the diversity of language emerged as an important factor in setting the culture of the institution and one strategy is to have circulars and meetings in various languages. Funerals are also an important aspect for staff and with so many funerals now taking place, some superintendents only allow staff time off for the funeral of their immediate family members.



"There is still a lot that a person can do here and I have learned a lot about relationships with people and absence from work. For instance for one group of people a funeral is very important but for another group of people it is not. All the staff don't see it the same ... we have already said that with regards to close family we will try to let them go. But you need to go into the matter as with some people the aunt or uncle is just like a mom or dad."

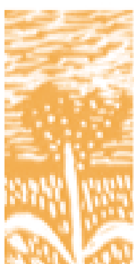
Superintendents of rural hospitals in particular, speak about the need to build a team of people working together and creating a sense of trying to achieve something together.

"Its the vision and the sense that we're going to make things work, regardless of what is happening on the outside."



Relationships with Province

One aspect touched upon frequently by hospital managers is whether they have support from above. There is a mixed picture, with some being well supported and others getting no support at all. There is often poor communication with the province, with one superintendent saying that he does not report to anyone. He said he had not had a single visit from the chief director in the five years he has been at the hospital. (Another superintendent in the same province has the same experience.) The regional director has visited only three times, in response to a specific request.

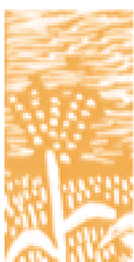


"There was no one appointed in the head office to see if hospitals were being run properly, and when head office made decisions affecting the hospitals, the superintendents were never consulted."

Some superintendents receive a lot of support from their province; one complains that the director he reports to visits too frequently. Others rely on medical superintendents in the area for advice or direction.

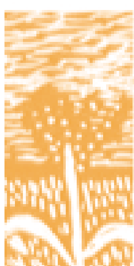
On the whole, superintendents seem to feel that their head offices present orders from a distance, without understanding the situation in the hospital and its surroundings.

"MECs, DDGs, chief directors, regional directors ... they only look at the politics and they're not here to see the disasters we are having. The only problem they consider is administration ... the patients and the doctors are not part of their considerations."



The challenges are often about getting through the bureaucratic tangle:

"For five years I've been asking (the province) for certain equipment and every year they say something strange, and for me strange means when they say 'there's no money in the system'. But I know I have budgeted for that ... and at the end of the year the money goes back somewhere."



In their relations with the provincial head office, most superintendents prefer 'minimal government'. They want head office to help them out with their needs but not to interfere too much.

"I didn't see head office as the boss when I took over, but more as a resource that we could utilise. I think head office doesn't always see it the same way as I do."

He said that a number of hospitals in his area find that when things get really difficult, head office does not have the resources that are needed and lacks the ability to give support.

In turn, provincial head offices try to sort out problems but they are often not able to because they depend on getting approval from higher levels.

Foreign Doctors

Government's increasing restrictions on foreign doctors are a frustration because foreign doctors form a large recruitment pool for hospitals. Foreign doctors are still working on an insecure contract basis and there has been no progress in getting these contracts reviewed.

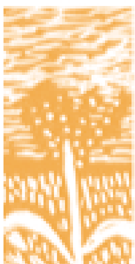
"That is the attitude. Foreigners are there to be used quickly and we must get as much out of them as we can," he said. "But we are also people with families and we need stability."

In many areas community service has not helped hospitals and the policy of replacing foreign doctors with community service doctors is not working. Often community service doctors require so much time and supervision that they can do little to relieve the workload.

"To think that a junior doctor who is still shaking when he's called to theatre or at nights, after nine months ... can replace a doctor who has been working for 37 years."

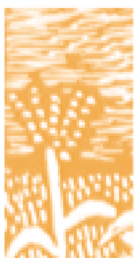
One black foreign doctor was given the task of transforming a purely white hospital in a deeply conservative town.

"It was a total headache ... There was resistance from patients, from management, from staff. It was easier for me as a foreigner to do it than it would have been for a black South African because I didn't identify with any group."



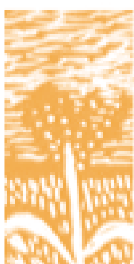
Policies of the Health System

"Everyone has a policy - many are very good but the sheer number of them sometimes makes them bad," said a superintendent. "Change is a good thing, but when there's too much of it you get instability and the staff become discouraged because they feel threatened all the time."



Some of the new national health policies have made a difference to their lives in the hospital. The most positive aspects for many are the primary health care approach and the development of the district health system, enabling hospitals to work far more closely with other health services in the area. For the first time some of their doctors are going out to visit clinics, taking some of the burden away from the hospital.

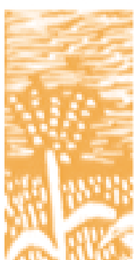
Despite sound policies, implementation remains problematic. The termination of pregnancy policy is particularly problematic for rural hospitals where staff and/or the community do not support it, and there is pressure from the province to do more terminations.



Overall, superintendents feel that the Batho Pele policy and the Patients Rights Charter will facilitate improving quality of care.

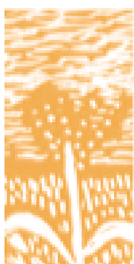
Frustrations

Superintendents identified numerous frustrations, often beginning with the security of their own positions. There are often long delays in being appointed to the post – one superintendent said it took two years for him to be formally appointed to the position. Their salary scales are sometimes seen as unfair with other doctors earning more than them, and they complain of a lack of promotion opportunities and little administrative support. One superintendent said that during the 14 months that he was acting in the post, he was the lowest paid doctor in the entire hospital. Despite the responsibility he carried, he was paid less than the matron.

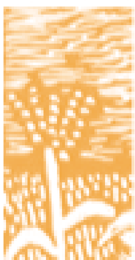


The way the health services are structured means that superintendents often do not have the authority to resolve many of the problems they face in their hospitals. The level of control they have over their environment and in setting their own programmes impacts critically upon smooth running of the hospital. Superintendents try to control their environment, but there are often external demands over which they have little control.

One superintendent said:



"I have no control over time, if something comes up from the district or the region then you have to change your plan."



And another:

"Lets put it this way I can give my top right hand that I am very organised, when I am left on my own, but I am called to far too many meetings, so it allows me two days a week to actually plan and organise my hospital, it makes it slightly difficult, if you are never there. It gets rather funny when one of your staff members asks you – please send a photo of yourself because we want to remember what you look like. When they need you, you are not there."

Some do feel in control and are able to refuse to attend meetings when there is inadequate notice or if they believe it would be a waste of time.

Most had learnt what they needed to know 'on the job'.

"The skills I had was to learn – to learn and change every day."

Many identified a desperate needed for training in a variety of areas, but even when there are training courses available it is usually impossible for them to leave the hospital for the length of time required.

Training is available for staff, but there is a sense that there are too many new and different health programmes, each requiring training, being thrown at staff all at once. There is felt to be little coherence between the various programmes, and staff are not given enough time between each programme to implement what they learn.

Poor infrastructure is another source of frustration. There are run down facilities that need attention, buildings that need to be upgraded, lack of transport and, in some cases, no ambulances at all.

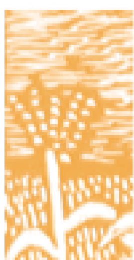
One rural hospital had not had an ambulance for over a year and in two recent emergencies it had had to transport the patients to the referral hospital in a bakkie. Despite the consequences for the patients' lives, the hospital is not allowed to send them to the nearest hospital 150 km away, because it is in a different province, and they have to follow referral procedure and send them in the bakkie to a hospital in the same province 300 km away.

A further frustration is the lack of consultation with hospitals in planning services. One superintendent's closing remarks were:

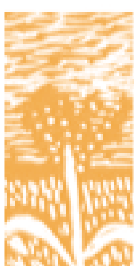
"The most burning issue in my life as a hospital manager is that I have seen over and over and over again that my senior managers are not talking to the planners for effective planning and they are not talking to you as managers in order to effect those plans. We are kept in the dark. All alone. We do not make input into senior management decisions; we do not make input into senior planning decisions and it makes our lives very, very difficult. If my staff are demotivated or they are totally dissatisfied with the work you provided. What can I tell them if I don't know?"

Impact of the work on Superintendents

Although most superintendents feel that their job is demanding, they generally have a lot of control over what they do and plenty of social support to implement their agenda. This is confirmed by the results of the self-administered questionnaires relating to their stress at work. Most combine high levels of personal achievement with low levels of emotional exhaustion. Although superintendents work closely in a team, they emerge as self-directed, often having to come up with highly creative and resourceful ways to get around bureaucratic obstacles.



A lot of the job is lobbying and advocating for what they need - from funding and linen to recruiting skilled doctors. They also have to be arbitrators. Personal characteristics such as being able to give staff guidance and support and to delegate responsibility are critical. Their years of experience make an important difference. The position requires assertiveness and the more mature superintendents seem to cope better with the demands of the job.

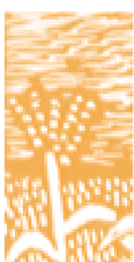


And it is a demanding job; superintendents are available 24 hours a day, seven days a week. One female hospital manager often has to drive the ambulance at night because there is no one else around to do it. Yet surprisingly more than one superintendent interviewed said they took the job because they wanted to spend more time with their family!

Conclusion

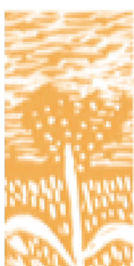
Most public hospitals are severely under-managed, mainly due to:

- Limited responsibility and authority accorded to hospital managers
- Ineffective and inappropriate structures and systems of management
- Limitations in the number and skills of managers
- Insufficient operational authority or incentives for managers to manage budgets efficiently
- The existing organisational culture within hospitals.



Hospital management must be strengthened fundamentally. Only then can health resources spent on hospitals be reduced significantly, without seriously compromising the quality and accessibility of hospital care.[2]

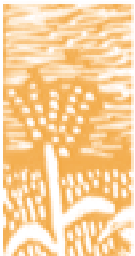
Despite the many difficulties they face, the superintendents interviewed are highly committed to their job and to making a difference. They care deeply about improving the quality of health care for their patients. Sometimes the reward is as simple as seeing a patient get through, and in smaller hospitals the rewards are often even clearer because superintendents can see the impact they have more easily.



"To work in the public sector is a wonderful experience, to help the community in the best way you can with the limited resources you have is a very rewarding experience."

All speak of the variety that the job offers, with every day bringing some new challenge. Sometimes the challenge is finding ways of running a hospital when the water and electricity supplies are down. Even getting linen is an enormous task.

"I don't think there has been one day that has been the same as the previous one. And maybe sometimes it was too much, but the main inspiration is to try and help as much as I could, make things better for the people, but together with all those around me."



The information received from these interviews concurs with the statement from the Report into the State of Public Services: **'The process of transforming the public service has not yet successfully addressed issues of organisational culture and behaviour'.**

References

1 Department of Health. White Paper for the Transformation of the Health System in South Africa. Chapter 17: Role of Hospitals. 1997.

2 Report into the State of Public Services. Available from http://www.gov.za/reports/2001/spservice.pdf. (Human resource management issues and related transformation matters are a major concern in the public service.)

Acknowledgements

The authors wish to express their thanks to Sue Valentine of Health-e for undertaking some of the interviews on which this chapter is based.