Developing an Implementation Strategy for the Free Health Care Policy for Persons with Disabilities at Public Hospitals in KwaZulu-Natal

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by

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To every one of you, I declare "a blessing of God upon your lives."

DECLARATION

I **Daniel Simbeye** (student No. 206521430) declare that:

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

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

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

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ABSTRACT

This study focuses on the implementation strategy of free health care policy for disabled persons at hospital level in KwaZulu-Natal. Since the introduction nationally, in 2003 of free health care policy for disabled persons, no evaluation has been conducted in KwaZulu-Natal to inform health service managers and the KwaZulu-Natal Department of Health on the implementation of this policy. A provincial implementation strategy is needed for effective implementation of the policy. To date, no such provincial implementation strategy is available and the lack of an implementation strategy for this policy motivated this study.

METHODS

An exploratory qualitative study design was implemented to elicit information from health service providers and representatives of persons with disabilities to inform the development of an implementation strategy for the free health care policy for disabled persons at public hospitals in KwaZulu-Natal. Data was collected through interviews and focus group discussions. Data was analysed by utilising a thematic approach.

RESULTS

Respondents reported a variety of understandings with regard to policy context of the Free Health Care Policy for disabled persons, policy content in terms of purpose and eligibility, policy implementers and their roles in implementing the policy, and the implementation process of this policy at state hospitals of KwaZulu-Natal.

CONCLUSION

There is limited understanding of the Free Health Care Policy among some health service personnel and some disability groups, and this may have contributed to the erratic and poor implementation of the policy at public hospitals in KwaZulu-Natal. Factors necessary for policy implementation such as a communication strategy, guidelines for implementation, assessment of availability of resources, training of implementers, monitoring and evaluation strategy are crucial for effective implementation of any policy including the Free Health Care Policy for disabled persons.

DFINITION OF TERMS

1. Policy actor: individuals, organization or even the state and their actions that affect the policy (Buse et al., 2006).

2. Policy Content: Substance of a particular policy which details its constituent parts (Buse et al., 2006).

3. Policy Context: Systemic, political, economical, social or cultural factors, both national and international, which may have an effect on health policy (Buse et al., 2006).

4. Disability: the outcome of a complex relationship between the individual's health condition, personal factors and external environmental factors (WHO, 2008).

5. Disabled person: Any person who has attained the prescribed age and is, owing to his or her physical or mental disability, unfit to obtain by virtue of any service, employment or profession, the means needed to enable him or her to provide for his or her maintenance (NDSD, 2007).

6. Policy Implementation: Process of turning a policy into practice (Buse et al, 2006).

7. Policy: Broad statement of goals, objectives and means that create the framework for activity (Buse et al., 2006).

8. Policy implementation: what happens between policy expectations and (perceived) policy results (Buse et al., 2006).

9. Policy process: the way in which the policies are initiated, developed or formulated, negotiated, communicated, implemented or evaluated (Buse et al., 2006).

10. Health policy system: embracing courses of action and (inaction) that affect the set of institutions, services and funding arrangements of the health systems" (Buse et al., 2005 in Walt et al., 2008).

ACRONYMS

ANC	African National Congress
CEO	Chief Executive Officer
DHIS	District Health Information System
DOH	Department of Health
DHS	District Health System
FGD	Focus Group Discussion
FHCP	Free Health Care Policy
ICF	International Classifications of Functions
IMF	International Monetary Fund
IOL	Intraocular lens
KZN DOH	KwaZulu-Natal Department of Health
MECs	Member of Executive Committees
NGOs	Non-Governmental Organizations
NHI	National Health Insurance
NHS	National Health Service of the United Kingdom
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
PWDs	People with Disabilities
RAF	Road Accident Fund
NDOH	National Department of Health
NDSD	National Department of Social Development

OODP	Office of the Deputy President
SHI	Social Health Insurance
UPFS	Uniform Patient's Fees Structure
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UNDP	United Nations Development Programme
UNPFA	United Nations Population Fund
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The United Nations Convention on the Rights of Persons with Disabilities, to which South Africa is a signatory, recognizes the rights of persons with disabilities to free health care. The health article 25 of the UN Conventions stipulates that “State Parties shall provide disabled persons with the same range, quality and standard free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health (UN Conventions, 2007).

In addressing the problem of poor access and poor quality of health services for persons with disabilities (PWDs) in South Africa, the President of South Africa, on 14 February 2003, announced the provision of free health care to people with disabilities at hospital level, in addition to free health services rendered at clinic level (NDOH, 2003). The introduction of free health care for persons with disabilities in South Africa was a significant step in the improvement of the quality of life of disabled persons. The policy was introduced at a time when the impact of free health care for other priority groups had been felt throughout the country. The policy was also seen to offer the best opportunity to the government to deliver on its promise of a better life for all as well as the opportunity by the National Health System to focus on one of the most vulnerable groups in society (NDOH, 2003).

1.2 PROBLEM STATEMENT

Since the introduction nationally in 2003 of the free health care policy for persons with disabilities at hospital level, no evaluation has been conducted in KwaZulu-Natal of the implementation of the policy, to inform health service managers and the Department of Health regarding the level and success of implementation of this policy. The policy implementation review done by the National Department of Health in 2006 to assess the

implementation of the free health care policy for people with disabilities in five provinces, did not include KwaZulu-Natal (NDOH, 2007).

The National review revealed an evident commitment to policy implementation by health MECs and Heads of the Provincial Departments of Health. However, it highlighted the following limitations: lack of national criteria to determine who qualifies for free health care, lack of training of hospital staff on the policy, lack of awareness of the policy by communities and misunderstandings between the Department of Social Development and the Department of Health. The National Department of Health has also acknowledged that limitations in funding have resulted in not addressing most of the national review findings (Deputy Director: National Directorate Disability & Rehabilitation, 2009). However, posters of free health care for disabled persons have been distributed to provinces as an attempt to promote awareness of the policy.

In view of the above findings, a provincial implementation strategy is needed before an evaluation of the implementation of the policy can be conducted in KwaZulu-Natal. This study seeks to identify factors that need to be considered when developing a policy implementation strategy for free health care for disabled persons at hospital level in KwaZulu-Natal.

1.3 KWAZULU-NATAL PROVINCIAL PROFILE

KwaZulu-Natal is one of the nine provinces of the Republic of South Africa and is situated on the east coast of South Africa, bordering Mozambique and Swaziland in the north, Mpumalanga and Free State in the west, Eastern Cape in the south and Lesotho in the south west. The province comprises 92 100 square kilometres, constituting 7.6% of the total land area of the Country (KZN DOH, 2010). KwaZulu-Natal has the second largest population, with the 2010 mid-year population estimates revealing that about 11 million people (21.3%) live in the province (Stats SA, 2010).

1.4 DISABILITY PREVALENCE

The recent world report on disability by the World Health Organisation and the World Bank (2011) has estimated the 2010 global population at 6.9 billion, with 5.04 billion 15 years and over and 1.86 billion under 15 years. Of this global population, over a billion people including children have been estimated to be living with disability. This figure represents 15% of the global population.

The 2010 mid-year population estimates revealed the population of South Africa wa about 49.99 million (Stats SA, 2010). Of the total population of South Africa, the 2010 General Household Survey (GHS) by the Statistics South Africa reported that 6.3% of South Africans aged five years and older were disabled. The survey revealed that women were more likely to be disabled than men (Stats SA, 2010).

The World Health Organisation defines disability in the International Classification of Functioning, Disability and Health (ICF) as a dynamic interaction between health conditions and contextual factors, both personal and environmental factors (WHO, 2008; WHO 2011).

In South Africa, the White Paper on the Integrated National Disability Strategy (OODP, 1997) highlights factors that contribute to disability including: poverty, accidents, lack of information, unhealthy lifestyles, violence and the failure of medical services. According to Statistics South Africa (2001), most people with disabilities in South Africa are not employed, most live below the poverty line, and most cannot afford health service user fees. The high unemployment rate amongst disabled persons results in dependence on government social grants. The South Africa's Disability Prevalence Report (Statistics South Africa 2001) reflected that disabled persons suffer discrimination because of prejudice or ignorance, and lack access to essential services including health services. Schneider & Gilson (1999) confirmed that removal of user fees is one of several policies promoting accessible, quality and efficient primary health care.

1.5 SIGNFICANCE OF THE STUDY

KwaZulu-Natal was one of the provinces omitted in the previous free health care policy implementation review by the National Department of Health (NDOH, 2007). Thus the status of the implementation of the free health care policy for disabled persons in KwaZulu-Natal is not known. In the national review, it was found that there was poor implementation of the policy as a result of no agreed criteria, lack of training of hospital staff, lack of awareness and misunderstanding between departments (NDOH, 2007). Similar findings are likely to be found for KwaZulu-Natal, as there is no clearly articulated implementation strategy. Thus this study aims to elicit information that will guide the development of an implementation strategy for the free health care policy for disabled persons in KwaZulu-Natal in 2011.

1.6 RESEARCH AIM

The aim of the study is to elicit information that will guide the development of an implementation strategy for the free health care policy for disabled persons in KwaZulu-Natal in 2011.

1.7 OBJECTIVES

For the above aim to be attained, this research project has the following objectives:

i) Describe the understanding of the contextual factors influencing the development of the Free Health Care Policy for disabled persons in the Republic of South Africa.

ii) Describe the current knowledge amongst health care providers in KwaZulu-Natal with regard to the content of the Free Health Care Policy for disabled persons.

iii) Describe the current implementation in KwaZulu-Natal of the Free Health Policy for disabled persons.

1.8 CONCLUSION OF CHAPTER 1

The United Nations Convention and all its state members have recognised that Health is a human rights issue. The introduction of free health care in South Africa may be linked to the health transformation process stated in the 1994 ANC Health plan, continued increase of disability prevalence and double impact of disability on victims of disability, and South Africa being a signatory to the UN Convention on rights of persons with disabilities. The UN Convention on rights of persons with disability advocates for state parties to uphold the rights of disabled persons, including the provision of free health care. The premise of introducing free health care policy was to improve access and quality of health provided to disabled persons. Implementation of any policy requires an implementation strategy. The lack of an implementation strategy for the free health care policy for disabled persons in KwaZulu-Natal motivated this research study.

1.9 OUTLINE OF DISSERTATION

The dissertation is organised as follows:

- Chapter 2 presents the review of literature
- Chapter 3 discusses the methods
- Chapter 4 comprises the presentation of results
- Chapter 5 covers the discussion of findings
- Chapter 6 presents the conclusion

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter discusses critically the review of studies that describe the general implementation of free health care policies and how they are financed in both developed and developing countries. Furthermore, it describes the implementation of the free health care policy for disabled persons and its utilisation by person with disabilities. The policy implementation models and factors that may influence implementation of the Free Health Care Policy for persons with disabilities at hospital level have also been described. Finally, the conceptual framework that underpins this study has been elaborated.

The literature reviewed was sourced through searches of electronic databases: from Pubmed, Medline and Cochrane databases. The following key words were used in the search strategy: free health care policy, Implementation of policy, disability, Health services provision, and National Health Insurance.

2.2. FREE HEALTH CARE POLICIES AND FINANCING OF HEALTH SERVICES IN DEVELOPED COUNTRIES

Developed countries have in place many systems by which health care is provided to needy citizens. It may be state owned care delivery, as in the case of National Health Services (NHS) in United Kingdom, or managed care services offered by health insurance firms as in the United States of America (Thomas, 2009). Some western industrialized countries with developed economies provide health services to people including disabled persons, using the universal health cover system. In the United Kingdom, all residents are eligible for health care through the NHS and health services are provided free of charge at the point of care (Schabloski, 2008). A recent Health Policy survey focusing on health care access, cost and insurance coverage in eleven leading industrialized nations conducted by the Commonwealth fund showed that

Britain's health care services provide wide range of treatments at low cost among rich nations (Schoen et al., 2010). Other countries that are known to provide universal health coverage include Denmark and Canada. All permanent residents of Denmark are entitled to coverage under the health system, including primary and hospital care, which is free at point of services although many choose to supplement by purchasing private insurance. Canada also provides universal, medically necessary care for its population free of charge. However its essential single-payer system has created bottlenecks limiting timely access to services. Free health services for Canadians include virtually all hospital consultations, physician and diagnostic services as well as primary care services covered under the provincial Medicare plans (Schabloski, 2008).

All these countries finance their health system through taxation revenue. The universal health coverage for Denmark is financed through taxation at national level and Canada's health is also financed through tax and private insurance. The NHS in the United Kingdom, which is the largest publicly funded health system, is primarily funded on general tax revenues as well (Schabloski, 2008).

2.3. FREE HEALTH CARE POLICIES AND UTILIZATION OF HEALTH SERVICES IN AFRICA

2.3.1 EFFECTS OF USER FEES ON UTILIZATION OF HEALTH SERVICES IN AFRICA

During the 1980s many countries implemented user fees. The introduction of user fees can be traced to the structural adjustment policies that were initiated when developing countries underwent severe economic recession, described as the first "oil crisis". The International Monetary Fund (IMF) and the World Bank loaned money to those distressed countries, with stringent conditions attached (Nanda, 2002). However, the introduction of user fees resulted in decreased accessibility and affordability of health services for poor people. A review of user fees in a number of African countries, such as Ghana, the Democratic Republic of Congo, Uganda and Swaziland, has shown that the introduction of structural adjustment programmes resulted in a decrease in service utilization (Save the Children UK, 2008). Most affected by user fees are those who either have low income, or those needing

to make multiple visits to health facilities, or those who decide that their ailment is not serious enough to justify the costs (Nanda, 2002). Furthermore, over the twenty years of implementation of user fees, it has been widely recognised that fees present a major barrier to health services, that money raised through fees covers only a small portion of running costs for health facilities (usually less than 5%), that many households are usually impoverished by their efforts to meet user fee bills, and that the poor and vulnerable suffer the worst consequences of user fees (CREHS, 2009).

The reduction and removal of user fees is believed to be one of the top policy priorities in Africa, and several countries have abolished user fees (CREHS, 2009). Studies conducted internationally have demonstrated that the removal of user fees has significantly increased health service utilization. According to Save the Children UK (2008), Madagascar experienced a sixteen percent (16%) increase in utilization of health services following the introduction, in the year 2000, of a free health care policy for pregnant women. While in Burundi, within a year of the user fees being removed, utilization by children underfive years increased by forty percent (40%). A recent study conducted in Zambia to review the performance of free health care at primary health care facilities after its introduction in 2006, also revealed increased utilization of services particularly in districts with high levels of poverty and material depravation (Masiye et al., 2010). In addition, the study showed that removal of user fees did not compromise the quality of health care services provided, as long as the removal process is carefully planned and implemented, and adequate resources are made available to cope with increased utilization that occur with removal of user fees.

2.4. FREE HEALTH CARE POLICIES AND THE UTILIZATION OF HEALTH SERVICES IN SOUTH AFRICA

Waivers in health care are generally intended to ensure a subsidized service for designated populations defined by geographical location, ethnicity or socio-economical level (World Bank, 2003). In South Africa, the introduction in 1994 of free health care for pregnant

women, lactating mothers and children under six years was implemented to improve access and quality of health services to vulnerable groups such as children, pregnant mothers and disabled persons. A number of studies have shown increased utilisation of health care services following removal of user fees. The study conducted by Schneider & Gilson (1999), stated that, following the introduction of free maternal health care in 1994 in South Africa, the utilization of antenatal care and health services at thirteen health facilities increased as did births at health facilities. A similar study conducted by Wilkinson et al. (1997) in Hlabisa, northern KwaZulu-Natal, to examine the attendance patterns before and after introduction of the free health policy for children under six and pregnant women, showed that the number of both new registrations and total visits to the under six clinics did not change significantly after the implementation of the policy. However, the study showed a substantial increase in the use of treatment services as compared to preventive services in clinics for children under six. The number of women registering for antenatal care also did not increase. Evidence from the study in South Africa in 2004 on the perceptions of nurses on implementation of free health care at primary health care facilities found that there was strong perception among nurses that free health care was good for patients and the community. About 44% of respondents also agreed that implementing free health care was rewarding for them personally while 59% felt professionally fulfilled (Walker & Gilson, 2004). However, the vast majority of nurses felt that the introduction of free health care had substantially increased their workload, which also compromised their professional practice.

2.5. FREE HEALTH CARE POLICY FOR DISABLED PERSONS IN SOUTH AFRICA

As stated above, the Free Health Care Policy for persons with disability in South Africa was officially introduced in 2003 after the introduction of a similar policy for pregnant women, lactating mothers and children under six years in 1994. An evaluation study of the implementation of free health services for people with disabilities conducted in the Free State Province of South Africa (Sookdin, 2005) revealed that there has been an increase in utilization of health services by persons with disability at health institutions where the policy

has been implemented. However, only 45% of the health facilities were implementing the policy. The study identified some implementation constraints, including problems of resource shortages, poor planning, inappropriate forms, lack of guidelines and poor communication of the policy as well as non-awareness of the policy and its implications by the beneficiaries.

As mentioned earlier, the National review on the implementation of the free health care policy for people with disabilities in five provinces conducted in October 2006, revealed poor implementation of the policy in all five provinces. In personal conversation with Deputy Director: National Directorate Disability and Rehabilitation in the Department of Health (2009), it was confirmed that due to limitations in funding, most of the national review findings have not been addressed by the Department of Health. However, posters of free health care for disabled persons have been distributed to provinces as an attempt to promote awareness of the policy. Furthermore, since the introduction of this policy in 2003, except for the policy booklet and eligibility assessment tool, no guidelines for implementation of the Free Health Care Policy for disabled persons were developed and distributed to provinces by the NDOH. It was also confirmed that no funding had been provided to provinces by the NDOH specifically for provision of free health services to disabled persons. However, the NDOH provided funding for communication and publicity of the Free Health Care Policy for disabled persons at national level (Deputy Director: National Directorate Disability & Rehabilitation, 2012). This may have contributed to the problems identified by the national review.

2.6. METHODOLOGICAL CONSIDERATIONS IN RESEARCH ON FREE HEALTH CARE POLICIES

Methodological choices depend on the study objectives and the specific area of research of the free health care policy. For example, in studies conducted in South Africa to evaluate the impact of the free health care policy for pregnant women and children under-six years,

retrospective data was obtained in reviewing utilisation rates, using antenatal attendance registers, birth registers and attendance registers at the under-six clinics (Schneider & Gilson, 1999; Wilkinson et al., 1997; McCoy, 1996). The concern is that the use of retrospective data in these studies, with poor health information, may have compromised the reliability of results. Therefore the results may be interpreted with caution, as data obtained from registers in public health facilities may be incomplete and inaccurate.

In the study conducted in the Free State Province (Sookdin, 2005) to evaluate the impact of free health services for persons with disabilities, the method used to determine the impact of the policy may be a limitation to the study. Firstly, evaluation of the impact of a policy requires a longer period of follow-up assessments; secondly, the researcher did not state how respondents from the disability sector (persons with disabilities) were selected and how selection bias was controlled. Possible confounders could have included: type of disability, age, source of income, degree of disability, and urban or rural origin.

In the review of the free health care policy for persons with disabilities in five provinces by the South African Department of Health (NDOH, 2007), the methodology used by the project team raises concerns, as they did not state why and how two hospitals per province were selected, or the level of care they provided, whether tertiary, secondary or primary. Furthermore, the project team did not indicate how disabled persons were selected, nor did it state whether the disabled persons interviewed were a good representation of the disability sector. The sample size of respondents per province was not sufficient to allow for generalizability of the results.

2.7. DEFINITION OF DISABILITY

There is a lack of consistency in defining disability which is the major stumbling block in the identification and the diagnosis of people with disabilities, and in the development of research programmes. This also poses challenges in the development and implementation of policies concerning disability. Dube (2005) has highlighted that one of the limiting factors towards policy implementation relating to disability is the lack of a clear definition of

disability. This study has used the definition of disability according to the World Health Organization and the World Bank through the International Classification and Functioning and Health as "the outcome of a complex relationship between the individual's health condition, personal factors and external environmental factors (WHO & World Bank, 2011:4). However, according to the KwaZulu-Natal Department of Health's Disability and Rehabilitation policy, disability has been defined as "a loss or elimination of opportunities to take part in the life of community equitably with others by persons having physical, sensory, psychological, developmental, learning, neurological, or other impairment, which may be permanent, temporary or episodic in nature thereby causing activity limitation and participation restriction in the mainstream of society" (KZN-DOH, 2008:3).

Disability can be described as moderate or severe. In the World Health Organization study on global burden of diseases, severe disability has been defined as class VI and VII which is equivalent to having blindness, Down's Syndrome, quadriplegia, severe depression or psychosis; while moderate disability is defined as class III and lower which is equivalent to having angina, arthritis, low vision or alcohol dependency (WHO, 2004).

2.8. IMPLEMENTATION OF HEALTH POLICY

DeLeon (1999 in Buse et al., 2005) defines implementation as "what happens between policy expectations and (perceived) policy results. In policy analysis, two main approaches of policy implementation have been described by theorists: top-down and bottom-up models of policy implementation. Buse et al. (2005) described the top-down model policy implementation as linear sequence of activities in which there is a clear division between policy formulation and policy execution. In this model, policies set at national or international level have to be communicated to subordinate levels such as hospitals or clinics which are then charged with putting policies into practice. Hogwood and Gunn (1984) recommended a set of requirements to be met if policies were to achieve their objectives in the top-down approaches. The bottom-up model is the opposite of top-down approaches, in that policy implementers often play a part in policy implementation, and not merely as managers of policy percolated downwards, but as active participants in an extremely complex process that informs policy upwards (Walt, 1994).

2.8.1 FACTORS THAT INFLUENCE POLICY IMPLEMENTATION

Reich (1996) has argued that economic and health policy analysts tend to provide detailed prescriptions without clear instructions or explanations on why things go wrong. Walt (1994) further observed that there appears to be an assumption that fate or managers will carry out the desired changes in policy, and that there is little reason for a specific strategy for implementation. Policy analysts have however described some factors that may influence policy change including the free health care policy. These include:

a) Information about the policy. Lack of information or explanation about the policy to the health workers (actors) may be a barrier to effective implementation of the free health care policy. A study conducted in South Africa in 2003 on the perceptions of nurses on implementation of free health care at primary health care, revealed that inadequate information or little explanation about the policy was the source of anger and frustration among health workers as implementers of the policy. About 38% of the respondents claimed they heard about the introduction of the free care policy in the media (Walker & Gilson, 2004).

b) Good policy design. A well-designed policy may result in effective implementation, especially if actors understand it better. A technically sound design of policy is the primary requirement to effect policy change (Gilson et al., 2003) Therefore, a policy which is poorly designed, including a free health care policy, may not be well adopted and implemented effectively by health service personnel and beneficiaries.

c) Availability of a policy implementation strategy for free health care. Lack of a standard implementation strategy to be used by actors may affect the implementation and utilization of services. A qualitative study conducted in Australia with government policy officers, agencies and policy developers revealed that no uniform strategy was used, apart from mailing and posting the policy on the web which may have affected policy implementation (Gargliard et al., 2009).

d) Consultation with relevant stakeholders involved in the planning and implementation of policy. Limited consultation with hospital staff in planning and implementation of health policies may influence implementation of the free health care policy. A comparative study conducted in South Africa and Zambia in 2003 on the implementation of health financing reform found that although input was obtained from districts and hospital officials during the development of the policy, the common experience for both countries was of inadequate consultation and communication with implementers and the public (Gilson et al., 2003). However, analysts observed that few studies have examined the influence of implementers over policy change (Marion-Aitken, 1994; Atkinson, 1997).

e) Perfect communication and coordination of policy to key stake holders such as actors at implementation level. Hogwood and Gunn (1984) described that poor or inappropriate mode of communication and coordination may result in breakdown of communication and difficulties in coordination of policies for implementation. Further, a study conducted in South Africa and Zambia on implementing health financing reforms also revealed that inadequate communication and consultation with the actors affected the effective implementation of the policies (Gilson et al., 2003).

f) Knowledge about policy implementation. Lack of knowledge about the implementation process by the actors may affect policy change. Interviews conducted with individuals from 33 international funding agencies revealed a need for knowledge about the implementation and practise of implementation (Gagliard et al., 2009).

g) Adequate capacity of actors for effective policy implementation. Lack of skills and training of implementers may affect implementation of policy. Training of policy implementers has been identified as the most influencing factor for adoption and implementation of policy (Gagliard et al., 2009).

(h) Availability of resources. Lack of financial, human and infrastructure resources at operational level may affect implementation of policy. In a study conducted in South Africa

in 2004 on the perceptions of nurses on implementation of free health care at primary health care level, limited availability of certain key resources such as drugs was cited repeatedly as a major problem (Walker & Gilson, 2004).

i) Response of actors towards the policy. Poor response of actors to the free health care may affect the implementation of policy. According to Gilson et al. (1999) & Lake et al. (2000), the negative responses of health workers to the removal of user fees contributed to the deterioration of quality of public health services in South Africa and Zambia.

j) Availability of clear implementation criteria including the eligibility criteria for free health care policy for disabled persons. A policy without clear and practical instruction on implementation may be doomed for failure (Reich, 1996).

2.8.2 DECENTRALIZATION and HEALTH SERVICES

The UNDP (2002) defines decentralization as transfer power of responsibility for planning, management and resource raising and allocation from the central government and its agencies to the lower levels of government with the purpose of increasing the overall quality and effectiveness of system governance, while increasing the authority and capabilities of sub-national levels. In the last two decades, health sector decentralization policies have been implemented on broader scale throughout the developing world, usually as part of a broader process of political, economic and technical reform (Bossert & Beauvais, 2002). In South Africa, the health system has been undergoing reform since 1994, with a national vision of primary health care (PHC) through a decentralised, municipal –based, district health system (DHS) (Local Government & Health Consortium, 2004). The roles and responsibilities of the three government spheres – national, provincial and local are defined in the Constitution of 1996 (Local Government & Health Consortium, 2004).

2.8.2.1 MODELS OF DECENTRALIZATION

According to Bossert & Beauvais (2002), a commonly used typology to functional decentralization is that pioneered by Rondinelli (1981) and applied to health sector by Mills (1994) which viewed decentralization as one event that transferred power at one time and in one quantity to the new institutional location. This typology categorizes decentralization as: deconcentration, when the shift in authority is to regional or district offices within the structure of Ministry of Health; devolution, when the shift is to state, provincial or municipal governments; delegation, when semi-autonomous agencies are granted new powers; and privatization, when ownership is granted to private entities.

These forms of decentralization can stand alone or work together (Kumar, 2004). For implementation of the FHCP for persons with disabilities in KZN, health sector decentralization includes devolution of powers to the provincial sphere of government to provider resources and put the policy into operation.

2.9. CONCEPTUAL FRAMEWORK OF THE STUDY

Buse et al. (2005) describe a health policy system as embracing “courses of action (and inaction) that affect the set of institutions, services and funding arrangements of the health systems”. According to Ostrom (2007) and Schlager (2007), “frameworks organize inquiry by identifying elements and relationships among elements that need to be considered for theory generation and they do not, of themselves explain or predict behaviour and outcomes”. There are a number of widely used frameworks and theories of public health policy. For this study, the Walt & Gilson (1994) “Policy Triangle Framework” was adopted. This policy analysis model has been classified as an overarching framework specifically for health although its relevance extends beyond health. As shown in Figure 1, the Policy Triangle Framework is grounded in a political and economic perspective and it consists of four main elements including context, process, content and actors, which interact to shape policy-making (Walt et al., 2008).

Policy context refers to systematic factors that affect policy and these include: situational factors such as change of leadership, events or new evidence (Buse & Young, 2006). The Free Health Care Policy for disabled persons in South Africa was introduced in the following context: as part of the African National Congress health plan, for the government to deliver on its promise of a better life for all (ANC Health Plan, 1994; NDOH, 2003). For implementation of the Free Health Care Policy for disabled persons to occur, actors responsible for implementation must understand the contextual rationale that motivated the FHCP for persons with disability.

Policy process refers to the way the policy is initiated, developed, negotiated, communicated and implemented. It involves agenda setting, formulation of policy alternatives or evidence, identifying policy implementers and specifying an evaluation process (Buse & Young, 2006). For implementation of the Free Health Care Policy for disabled persons, actors are expected to have knowledge of the operationalization of the FHCP for persons with disability and how its implementation will be evaluated.

Policy actors are individuals, members of interest groups or professional associations who have some role in policymaking or implementation, are affected by policy decision (Walt & Gilson, 1994; Buse & Young, 2006). The actors for implementation of a free health care policy for disabled persons include: the disability movement, government policy makers and hospital staff. The disability movement comprises of organisations of persons with disabilities. Government policy makers consists of national minster of Health, National Deputy Minister of Health, Provincial MECs for Health, national Director for Health, provincial Heads of Department of Health and other Senior General Managers (National Health Council). Hospital personnel include: Hospital Managers; Administrators; Nurses; Rehabilitation Therapists; and frontline service providers such as the Admin clerks

Policy content is the substance of the policy, which details the aims and strategies; empirical basis; underlying values; technical content and administrative feasibility of the policy (Buse & Young, 2006). For implementation of the Free Health Care Policy for

persons with disabilities, actors are expected to understand the meaning of the policy, who qualifies to receive free health care as disabled persons and what they qualify for.

Figure 1 below shows the Policy Triangle Framework

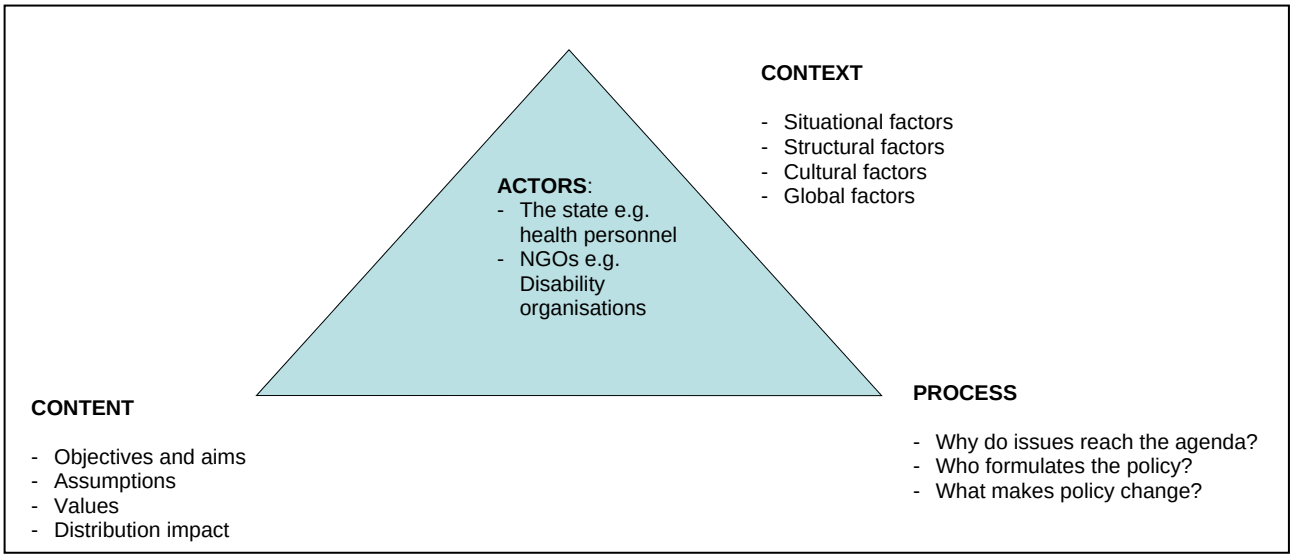

Figure 1: A model for health policy analysis (Adapted from Walt & Gilson 1994)

Gilson & Raphaely (2007) stated that this policy framework has influenced health policy research in many countries and has been used to analyse a large number of health issues including mental health, health sector reform, tuberculosis, reproductive health and antenatal syphilis control. Walt & Gilson (1994) have noted that health policy research has focused attention on the content of policies and has neglected actors, context and processes. In the figure illustrated above, the focus on policy content diverts attention from understanding policy processes, which explains why often desired policy outcomes fail to emerge. According to Walt & Gilson (1994), although this model looks simplified and gives the impression that each factor can be considered separately, it is a complex set of interrelationships of the abovementioned four factors. In reality, actors are influenced by the context within which they live or work both at macro–governmental level and/or at micro-institutional level; while context is affected by many factors such as instability or uncertainty created by changes in a political regime or war. The process of policy making is in turn affected by the actor's position in power structures and their expectations. The content

reflects some or all of the above dimensions (Walt & Gilson, 1994). Reich (1994) argues that policy reform is a political process, affecting the origins, formulation and implementation of policy. In this study, the current understanding of the content of the national Free Health Care Policy for disabled persons has been analysed by looking at the understanding of its aims and objectives; underlying assumptions; values; and distribution impact. Limitation in or lack of clear policy guidelines on implementation may result in ineffective or poor policy implementation (Reich, 1996). For example, with regard to the Free Health Care Policy for Disabled Persons, it has been found that there is no nationally agreed criterion to determine when a patient qualifies for free health care services (NDOH, 2007). Further, Deputy Manager: Disability and Rehabilitation Programme, Ms. NB. Khan confirmed that the KwaZulu-Natal Department of Health has also no provincial priorities and implementation strategy for this policy (Khan, 2009) and according to Ms. NB. Khan, this may result in ineffective implementation of the policy. This study aims to inform provincial priorities and implementation strategies.

2.10. CONCLUSION OF CHAPTER 2

The chapter made an attempt to critically review literature from relevant studies previously conducted both in developed and undeveloped countries, including South Africa, pertaining to the provision of health services to vulnerable groups such as disabled persons. Studies conducted internationally and locally on free health care services revealed an increased utilization of services after the introduction of the free health care policy. However, the studies showed some policy implementation gaps. To address these policy implementation gaps, the factors that may influence implementation of the free health care policy in KwaZulu-Natal and the appropriate conceptual frame that underpin this process have been highlighted and explained.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The research methodology is discussed in this chapter. The discussion includes the study setting, study period, study design, source population, sample strategy and size sampling, data collection and analysis, and measures undertaken to ensure the trustworthiness of the study. Furthermore, the ethical considerations of the study are presented.

3.2 STUDY SETTING

The study was conducted in KwaZulu-Natal, at provincial, district and health facility level, in both urban and rural areas. The study area was divided as follows:

1) Provincial Office, which included the Disability and Rehabilitation Programme
2) The Health Cluster for Area 2 of the KwaZulu-Natal Department of Health, which is situated in the western side of the Province of KwaZulu-Natal, and consists of five (5) health districts namely Sisonke and Umgungundlovu in the South, Uthukela, Umzinyathi and Amajuba Districts in the north.
3) The health facilities in both urban and rural areas of UMgungundlovu District were used and these included: Edendale, Grey's, Northdale and Appelsbosh Hospitals as well as the Pietermaritzburg Assessment and Therapy Centre.
4) The Office on the Status of Disabled Persons in the Office of the Premier
5) Disabled groups with in Pietermaritzburg and eThekwini

3.3 STUDY DESIGN

An exploratory qualitative study design was implemented for this study.

3.4 STUDY PERIOD

Full ethics approval was obtained on the 30 July 2010 (BE161/09). The pilot study was conducted on the 20th of August 2010 and the actual data collection commenced on the 3rd September 2010.

3.5 SOURCE POPULATION

The source population for this study included all relevant actors in the public health sector in KwaZulu-Natal and disabled persons using public sector health services in the province.

3.6 STUDY POPULATION

Participants for the study comprised the health service personnel working at provincial, district and hospital levels, as mangers and providers of care, as well as disabled persons, as beneficiaries of the free health care policy. Health service workers included: the Provincial Disability and Rehabilitation Manager, Provincial Disability Advisors, District Disability and Rehabilitation Coordinators, Hospital Managers, Hospital Admission Clerks, Rehabilitation Therapists. Disabled persons included representatives from the disability movement such as Magaye Visually Impaired Association of Imbali in Pietermaritzburg, Quad-Para Association in KwaZulu-Natal and a representative (disabled person) from the Office on the Status of Disabled Persons in the Office of the Premier KwaZulu-Natal.

3.7 SAMPLING STRATEGY AND SIZE

Since the study is looking at free health care policy for persons with disabilities, which involves different stakeholders (participants), a purposive heterogeneous sampling was used. According to Ulin et al (2002), heterogeneous sampling is useful for studying issues that cut across individuals or programs. Purposive sampling is a strategic approach to sampling, where participants are selected for their ability to provide rich information. There is no optimal sample size in qualitative studies (Ulin et al. 2002): an appropriate sample size is one that adequately answers the research question (Marshall, 1996). According to Ulin et al (2002), qualitative data must be collected from as many groups or individuals as necessary to answer the research question. However, Ulin et al (2002) and Patton (1990) indicate that an estimated minimum sample size, which will give a reasonable coverage of the issues, can be proposed and a decision to expand can be taken if needed during data collection, based on the principles of saturation and redundancy. For this study, 24 individual interviews and three focus group discussions were implemented.

3.8 DATA SOURCE

3.8.1 DATA COLLECTION METHODS AND INSTRUMENTS

The three primary methods of data collection in qualitative research are: observation, in-depth interviews and focus group discussions. The data collection method is distinguished from the data collection technique. The data collection method refers to a systematic approach to data collection while the technique of collecting data refers to the art of asking, listening and interpreting (Ulin et al., 2002). Qualitative data is collected using a variety of instruments including: questioning by an interviewer; documentary reviews or by direct observation (Joubert & Ehrlich, 2007). For this study, data was collected using the following methods and instruments: interviews with key informants, focus group discussions and through documentary reviews.

3.8.1.1 INTERVIEWS

Ackroyd and Hughes 1983 (in May, 1993) define interviews as encounters between a researcher and a respondent in which the latter is asked a series of questions relevant to the subject of research. The respondent's answers constitute the raw data analysed at a later point in time by a researcher. Gilchrist (1992) describes key informants as individuals with special knowledge, and skills in communication who are willing to share what they know with a researcher.

Key informant interviews utilising the general interview guide approach were conducted to collect data from the following participants:

a) Three representatives of disability groups including: Magaye Visually Impaired Association, Quadpara Association KwaZulu-Natal and the Office on the Status Disabled Persons in the Premier's Office.

b) The health service personnel working in the KwaZulu-Natal Department of Health at provincial, district and hospital / facility level. These included: the Provincial Disability Rehabilitation Manager (Speech Therapist); five District Disability and Rehabilitation Coordinators from five Districts (including: one Professional Nurse, one Audiologist, one Occupational Therapist and two Physiotherapists); five Rehabilitation Therapists (who included: three Physiotherapists, one Occupational Therapist and one Audiologist) from two hospitals; two Hospital Managers; two Medical Managers; one Nursing Manager; and six Admission Clerks from four hospitals and Assessment and Therapy Centre. As stated above, the Clinical Managers as key informants included two Medical Managers, one Nursing Manager, the Provincial Disability and Rehabilitation Manager, five District Disability and Coordinators. The Administrators as additional key informants included the two Hospital Managers and one administrative Officer; however the Provincial Disability and Rehabilitation Managers, the two Medical Managers, the Nursing Manager and the five District Disability and Rehabilitation Coordinators performed both administrative and clinical functions. The representatives of disability movements as key informants were only three disabled persons. An interview guide for conducting the interviews was used (Annexure 2).

3.8.1.2 FOCUS GROUP DISCUSSIONS

Focus group discussions promote interactions between participants and enhance the quality of data. A diversity of views among participants can easily be assessed (Patton, 2002). Three focus group discussions were arranged with Rehabilitation Therapists who included physiotherapists, occupational therapists, speech therapists and audiologists (with six to twelve therapists per focus group discussion) at three hospitals. Rehabilitation Therapists who participated in the focus group discussions had different levels of experience and responsibility, and included: Therapy Managers; Chief Therapists; Senior Therapists; Junior Therapists including Community Service Officers. A discussion guide for focus group for facilitation of discussions was used (Annexure 2).

Table 1: TABULAR PRESENTATION OF PARTCIPANTS

Data Collection Method	Respondents
Interviews	• Admin Clerks • Hospital Managers • Medical Managers • Nursing Managers • Representatives Disability Groups • District Rehabilitation Coordinators • Individual Rehabilitation Therapists
Focus Group Discussions	• Rehabilitation Therapists: Physiotherapists, Occupational Therapists, Speech Therapists and Audiologists

3.8.1.3 DOCUMENTARY REVIEW

Documentary review or analysis is beneficial in comparative studies of policy implementation (Abbot et al., 2004). Documentary review also provides supplementary data that may be used to contextualize or clarify other methods of data collection (Abbot et al., 2004). In this study, national documents such as the Free Health Care Policy for disabled, assessment tool and training manual were analysed to supplement data that was collected using interviews and focus group discussions. Copies of these official documents were obtained from Department of Health officials at provincial level. Permission on the use of relevant information was obtained from the relevant officials before these documents were analysed. For analysis of documents in policy implementation, this study used the approach: “What Ideology or Discourse Underpins the Document” (Abbot et al., 2004:262). According to Mason (1996 in Abbott et al., 2004), a data extraction sheet is devised which asks questions underlying the reasons for

documents as follows: “why were the documents prepared; by whom; for whom; under what conditions; and according to what rules and conventions?” (Annexure 4)

3.8.2 DATA COLLECTION PROCESS

The researcher identified respondents and arranged appointments for interviews and focus group discussions in writing. Confirmation of appointments was made telephonically, well in advance. Interviews and focus group discussions were conducted at the workplace and at a suitable time for the respondents. The study information document was either circulated by email or hand delivered to all participants prior to the interview or focus group discussion (Annexure 5). The interviews lasted between 30 to 40 minutes, and the focus group discussions took about one hour. Interviews with key informants were conducted in their offices whereas focus group discussions with therapists were conducted in a venue within the hospital premises which was booked by the researcher. The researcher and the assistant ensured that they arrived at the venue for interviews early enough to have ample time to inspect and prepare the venue, arrange and test tape recorders and to arrange snacks to eat before or after the interview session.

Each session of interviews and focus group discussions was started by the researcher with formal introductions. At each focus group discussion session, names of participants were printed on pieces of paper and given to each person as a name tag for easy identification during the facilitation of the discussion. At the onset, the researcher explained to the participants the purpose of the study and why participants were selected to be part of the study, and assured them that the information that they would provide would remain confidential to the researcher. Further, the researcher assured participants that their personal details and the information they conveyed would remain confidential. Participants were informed in advance that the interview session would be recorded using a tape recorder and that it was important that unnecessary noises or sounds were avoided during the interviews.

The interviewees were informed of their rights to withdraw as participants at any stage of the process with no negative consequences ensuing. Their willingness to participate in the

interview or focus group discussion was sought both in writing and orally, by requesting respondents to sign informed consent (Annexure 6).

Prior to starting to ask questions, participants were asked to confirm which language would be suitable for them, and explained to participants that they were free to demonstrate their answers in any suitable and acceptable method e.g. by drawing a picture should they wish to do so. Participants were reminded that they would be contacted in person or telephonically should there be need for clarification of their responses or should there be any missing information during the transcribing of recorded data.

Participants were informed in advance that, should they feel unable to continue talking in the course of an interview due to body discomfort or being sick or for use of the bathroom, the interview could be discontinued and resumed immediately. Depending on the reason, interview could be rescheduled for another suitable time.

For the focus group discussions the following were added: the agenda for the session was explained, and participants were requested to switch off their cellular phones. Facilitation of the focus group discussion and interviews was conducted by the researcher.

All participants, both for interviews and focus group discussions, were informed and assured that the feedback will be provided in the form of a report, maintaining the confidentiality of informants.

In the interviews and focus group discussions, participants were asked to describe their “understanding of the free health care policy for persons with disabilities at public hospitals; the context within which the policy was developed, the content of the policy; implementers of the policy and their respective roles and responsibilities in the operationalization of the policy; and finally its implementation process at public hospitals in KwaZulu-Natal” (Annexure 2 and 3).

Two assistants were trained and used for recording and transcription. Assistants helped with language translation during the interviews with respondents from the disability sector.

3.9 DATA ANALYSIS

Ulin et al. (2002) state that qualitative data analysis begins during the first field activities which leads to the refinement of the research questions as the study proceeds. There are several approaches used in qualitative data analysis. A thematic analysis approach was used for this study. Boyatzis (1998) describes thematic analysis as a process for encoding qualitative information using codes or themes. All pieces of information that relate to a common theme are grouped, which enables the researcher to explore this data in further depth and discover new sub-themes (Ulin et al., 2002).

Qualitative data analysis follows a sequence of interrelated steps which include: reading, coding, displaying, reducing and interpreting (Ulin et al., 2002). Figure 2 below shows a step-by-step approach to data analysis.

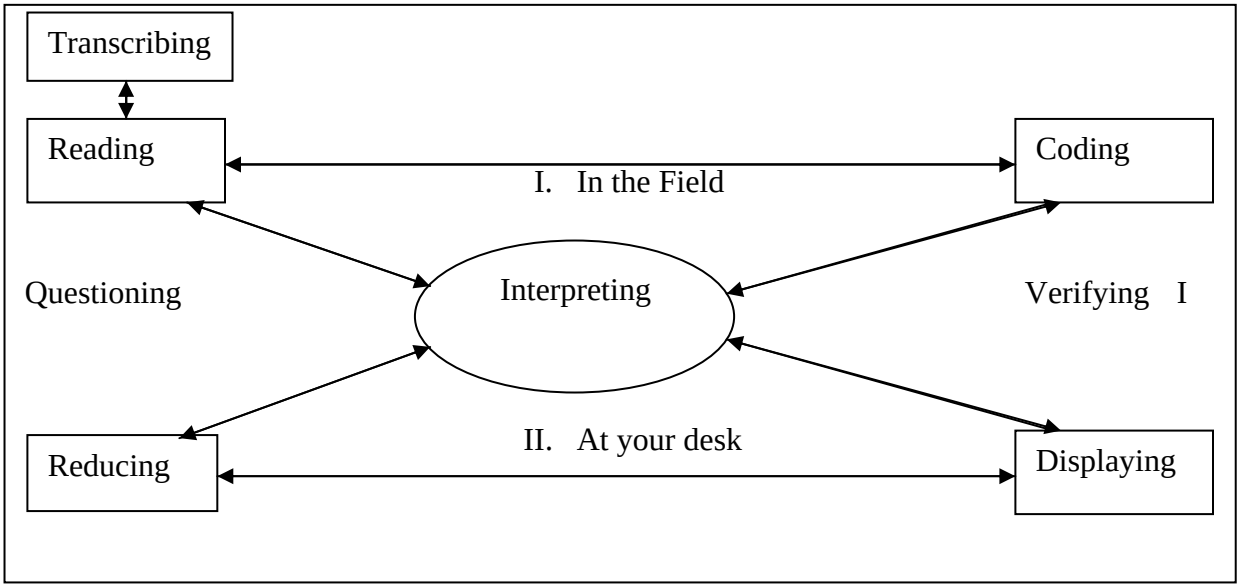

Figure 2: Qualitative analysis Step-by-step (Adapted from Huberman and Miles 1994)

All data analysis for this study was done manually.

In this study, the first step of data analysis involved a careful reading of the transcribed data obtained through the interviews and focus group discussions.

The second step was coding the transcribed data. Codes were used to flag ideas that were discovered in the transcript. The ideas were subsequently grouped into categories or key themes. A deductive approach to the theme identification was initially implemented, guided by the objectives of the study. An inductive approach was used to identify further themes. All data pertaining to one theme was grouped into a theme file. The data in each theme file was further read and re-read to identify sub-themes through further inductive analysis.

The third and fourth steps included displaying and subsequently reducing and summarising the data. Key illustrative quotes were identified to give representation to the findings.

3.10 DATA MANAGEMENT AND STORAGE

According to Ulin et al. (2002), it is the researcher's job to facilitate a well-articulated plan for handling data as it is collected. Thus, the researcher was responsible for data management and storage and ensured that identification codes were assigned to all individual records, including tape recording, transcripts, and demographic information sheets. Data collected was checked for completeness, consistency and correctness at the end of each day before storage. All gathered data and information was kept strictly confidential. Documents were stored in a secured location with access only by the researcher. A filing system was set up with a place for each component of the study, for example, a component for the original proposal, protocols for data collection, transcripts theme files to ensure that important documents were not lost and were readily available for analysis and writing up the results. A back-up system was set up off-site.

3.11 PILOT STUDY

A pilot study refers to a mini-version of the full-scale study or to a feasibility study, as well as specific pre-testing of a particular research instrument such as a questionnaire or interview schedule (van Teijlingen & Hundley, 2001). A pilot study for this study was conducted at the Pietermaritzburg Assessment and Therapy Centre with therapists and administrators. The pilot study was done to ensure that interview and focus group guides used for data collection were pre-tested in a group of trial participants similar to the participants that were used in the main study.

3.12 LIMITATIONS OF STUDY

Ulin et al. (2002) cautioned that there are limits to the information that key informants can provide in both qualitative and quantitative studies. Key informants may be reluctant to admit knowing something, or may try to please the researcher/interviewer by giving what he/she thinks the interviewer wants to hear. Further, key informants may also have their own biased interpretations especially if they come from different ethnic, religious, or social-economical groups (Ulin et al., 2002). To minimize this limitation, triangulation of data sources was implemented in this study. The sources included representatives of disability movements including: Magaye Visual Impairment Association, Quad Para Association of KwaZulu-Natal and the Office on the Status Disabled Persons in the Premier's Office.

Deliberate selection of participants by the researcher can introduce selection bias (Collier & Mahoney, 1996). To minimize this limitation, the researcher attempted to select appropriate and heterogeneous stakeholders/participants that may have been involved in the policy implementation of free health care for disabled persons in KwaZulu-Natal. These included relevant representatives of disability sectors, clinical service providers as well as managers of disability and rehabilitation services.

A search for information on Free Health Care Policy for persons with disabilities in South Africa, and research conducted locally and internationally, revealed minimal literature on provision of free health care for persons with disabilities.

3.13 ENSURING CREDIBILITY AND TRUSTWORTHINESS

Patton (2002) states that “the criteria you choose to emphasize in your work will depend on the purpose of your inquiry, the values, the perspectives of the audiences of your work and your own philosophical and methodological orientation”. There are different approaches used to ensure the quality, credibility and trustworthiness of data and these may include: Triangulation, member checking, reflexivity, and attention to negative cases.

Strauss and Corbin (1998) as well as Denzin and Lincoln (2000), stress the importance of triangulating data from multiple sources and techniques. In this study, triangulation of methods was done by using different data collection methods such as document analysis, key informant interviews and focus group discussions. Triangulating of sources was achieved by including study participants from different sectors including: the Department of Health, the Office of the Premier and Disability Movements as beneficiaries of the free health care policy. Further, analyst triangulation was done with use of my research supervisor to independently analyse and compare a selection of the findings. This increased credibility as the strength of one approach compensates for weakness of another approach (Mays & Pope, 2005).

Member checking (Baptiste, 2001) was used to improve credibility and quality of the research by making participants check the researcher’s interpretations of their comments or behaviour. This was done by the researcher by sending a draft transcript to participants for verification of their responses.

Confidentiality and active participation was promoted by conducting interviews or focus group discussions in an environment where respondents felt comfortable to express themselves (i.e. in the absence of their superiors or clients). Precautionary measures were taken by the researcher to ensure that data collected with the help of the research assistants was treated with confidentiality. The importance of confidentiality was stressed during the training of assistants, who assisted with translation, recording and transcription of data.

3.14 ETHICAL APROVAL

The researcher obtained approval to conduct the study towards the Master of Public Health from the University of KwaZulu-Natal Postgraduate Education Committee on 1st June 2010 (206521430) (Refer to Annexure 8). The Biomedical Research Ethics Committee (BREC) granted ethics approval on 30 July 2010 (BE 188/09) (Refer to Annexure 9). The Head Office of the KwaZulu-Natal Provincial Department of Health granted permission for the study to be conducted on 15 February 2010 (HRKM 11/10) (Refer to Annexure 7). District Managers for Sisonke, UMgungundlovu, UThukela, Amajuba and UMzinyathi districts as well as Management of Edendale, Grey's, Northdale and Appelsbosch hospitals granted permission for the study to be conducted in their districts and at their institutions.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

The first part of the research process comprised of establishing what the Free Health Care Policy for persons with disabilities actually stated, as described in chapter one. This served as a backdrop to exploring what respondents knew about the policy. This chapter describes firstly, the understanding by participants of: the policy context; the policy content, including the purpose of the policy and the understanding of the criteria for eligibility. Secondly, the chapter describes understanding of the policy implementers or actors and their roles. The chapter also covers how the free health care policy for disabled persons has been implemented. Results have been organised according to the major themes suggested by the conceptual framework and further sub-themes identified through thematic analysis. The results are summarised, where there was consensus, with an illustrative quote. Where there was disagreement between sources, this has been stated.

4.2 UNDERSTANDING OF POLICY CONTEXT

This section reports on the understanding by the participants of the contextual factors underpinning the development of the Free Health Care Policy for persons with disabilities in South Africa. Respondents reported a variety of understandings with regard to policy context and presented challenges they experienced in understanding the contextual factors in the development of the Free Health Care Policy for persons with disabilities.

4.2.1 UNDERSTANDING CONTEXTUAL FACTORS INFLUENCING THE POLICY

Health service personnel, especially those at management level, articulated factors that may have contributed to the development of the policy. The respondents cited as contextual factors that contributed to the development of the Free Health Care Policy for persons with disabilities: advocacy and marketing from pressure groups such as the disability sector; discrimination and marginalization of disabled people; media awareness

on the suffering of disabled people; affordability and cost of health services; and the intention of the new government to provide free health care services to previously disadvantaged groups such as the disabled population.

"*There may have had agitations and advocacy and marketing from the disability sector as well as the pressure groups to actually form this policy, and this is one of those enabling policies that the government would have decided on."* (Manager 0)

"*Maybe when they were doing a White Paper on people with disability they found a gap, and with our new democracy that may be one of the things that they had to define*." (District Rehabilitation Manager 5)

"There might have been an out-cry from the disabled people." (Therapists FGD 2)

"Before the policy was in action, there was so much discrimination to these people. They used to be abandoned; there was so much neglect to these people." (Nursing Manager 4)

"It was developed for persons who could prove unemployment status and could not afford to pay for health." (Admission Clerk 3)

Some disabled persons also cited advocacy by Therapists and affordability as contextual factors that led to introduction of the Free Health Care Policy for persons with disability.

"*It was introduced by professionals working with disabled persons like therapists who spoke for them; and maybe from disabled people who were not able to pay for services at hospitals and clinics."* (Disabled Group Rep 1)

4.2.2 BARRIERS TO UNDERSTANDING CONTEXUAL FACTORS

Respondents did not articulate contextual factors underpinning the development of the Free Health Care Policy for persons with disabilities. Respondents cited the following as reasons for lack of knowledge of the contextual factors of the policy: lack of knowledge of the policy, lack of consultation during the policy development process, inadequate information about the policy, and being new employees or juniors in the Department of Health when the policy was developed and introduced.

"Because one was not part and parcel, it is difficult for us to know the process that was used or how they constructed this policy." (Disability Group Rep 2)

"I haven't seen the policy; I won't be able to know." (Manager 5)

*"We don't know, it is my first time to hear that it is a policy. It was just decided I don't know by whom?" (*Therapists FGD 1)

"I'm not sure, but I think when I came into public sector it was already there." (District Rehabilitation Manager 5)

4.3 UNDERSTANDING OF POLICY CONTENT

This section reports on the understanding by participants of the content of the Free Health Care Policy for persons with disabilities, including their understanding of the purpose and the eligibility criteria of this policy. Respondents reported a variety of understandings with regard to policy content and highlighted their challenges in understanding the policy content. However, participants did present factors that would facilitate understanding of the policy content

4.3.1 OBJECTIVES OF FREE HEALTH CARE POLICY FOR DISABLED PERSONS

The National Department of Health laid out the following objectives of the free health care policy for people with disabilities (NDOH, 2003):

- "To improve the health status and quality of life of disabled persons
- To obtain greater equity – to get health status, independence, social participation on par with that of the general population
- Attempt to minimise external stresses and vulnerability
- Attempt to improve social heritage e.g. to decrease the possibility of adverse health effects on children of parents with disabilities or disabled children in adulthood
- Improve consumer satisfaction
- Lower costs that would have been incurred in absence of this action and
- Contribute to a positive relationship between health and development."

4.3.1.1 ELIGIBILITY CRITERIA CONTAINED IN THE FREE HEALTH CARE POLICY FOR DISABLED PERSONS

According to the policy, persons with disabilities are eligible to benefit if: after undergoing an income-based assessment, are classified at entry into the health system to have a minimum annual income of R36 000 or less; they have an impairment which causes moderate to severe difficulties with one or more of the following functions or activities, as assessed by a therapist or trained service provider: mobility, self-care, activities of daily living, communication, seeing and hearing; major psychosocial life situations and specific mental disabilities; **or** frail older persons as classified by the Department of Social Development DQ 98. Furthermore, any person on a waiting list for longer than 6 months for maximum correction will be classified as "permanently" disabled and would receive free services to the point where maximum correction changes the disability status" (NDOH, 2003).

The national policy states that “free services refer to Personal Medical Services only and not to non-personal and inter-sectoral services” (NDOH, 2003). Personal Medical Services comprise health services that are directly provided to individual patients; whereas Non-personal Medical Services comprise health activities provided to groups or communities such as public health campaigns (Deputy Director: National Directorate Disability and Rehabilitation, 2011). However personal medical services is described as services where the provider negotiate a local agreement with their Primary Care Trust (PCT) for the services they will provide and payments they will receive, taking into account specific local healthcare needs (NHS, 2008). The free health services include: all in and outpatient hospital services, (day admissions included), and specialised medical interventions for prevention, correction or rehabilitation of a disability that requires a motivation from the treating specialist and approval by a committee appointed by the Head of Health. A motivation is not required for emergency care, and all assistive devices needed for the prevention of complications and for corrections of a disability (NDOH, 2003:4).

Highly specialised devices or technology e.g. implants excluding intraocular lenses implants (IOL) and others, need a motivation by the prescribing specialist and approval by the Head of Health or a committee appointed by the Head of Health. Beneficiaries of free services referred by the public health sector to private practitioners for services not available at public hospitals, will have their services paid for by the Department of Health. Those that do not meet these criteria are excluded, as well as disabled persons covered by health insurance, the Road Accident Fund (RAF), and Workman’s Compensation, and those people with temporary disabilities (NDOH, 2003:4). Refer to the full policy in Annexure 1.

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4.3.2 CURRENT UNDERSTANDINGS OF POLICY CONTENT

Health service respondents reported that the Free Health Care Policy entailed free health care for the poor and indigent and for persons with disabilities who are unemployed or are in receipt of a disability grant.

Respondents reported that the Free Health Care Policy entitled persons with disability to free consultation, medical check-ups, medication, assessments for assistive devices and acquisition of assistive devices.

> "*People with disabilities or those who haven't got or who is unemployed and getting a pension (social grant) from government, we are taking them free here*." (Admission Clerk 2)

> "*People with disability should not be charged for services they receive at the hospital and these include consultation, medication, procedures, food and admission in to the hospital."* (Manager 2)

Therapists reported on further services that would be free to eligible persons with disability: admission, functional assessment, therapy or treatment.

> "*Persons with disability would not have to pay and would attend the health care facilities free of charge."* (Therapist 1)

> "*Functional assessment or any other therapy or treatment that they require will be offered free of charge to them*." (Therapists FGD 3)

4.3.3 UNDERSTANDING OF PURPOSE OF THE POLICY

Respondents presented different views with regard to understanding the purpose of the Free Health Care Policy. Health service respondents identified the purpose of the Free

Health Care Policy to be: enhancing affordability; helping disadvantaged or poor people; rendering a quality service and equal service; and to improve health and well-being of disabled persons.

> *"To help people that is disadvantaged to have access to medical care."* (Admission Clerk 1)

> "*To entitle them* (persons with disabilities) *to services and not to discriminate them; to prevent further disability and illness as well; affordability and to empower disabled people*." (Therapists FGD 3)

The managers added another dimension to the purpose of the policy: for the empowerment of disabled persons; addressing inequality and discrimination; ensuring equity and care.

> *"This policy should address the inequalities of people such as people with disabilities; to make sure that health services are accessible to them; to make sure that persons with disability don't feel the burden they have to pay so much to receive health care services."* (District Rehabilitation Manager 5)

Health service respondents, in articulating their understanding of the content of the Free Health Care Policy for persons with disabilities, reported on the purpose of the policy, as follows:

> *"All patients have rights and they come to an institution to be assisted without being judged or being seen as people who are not able to."* (Admission Clerk 5)

> "*It's an opportunity for disabled people to have a say in their health care needs rather than able-bodied people making decisions for them."* (Manager 1)

Disabled persons cited poverty and high cost of having disability as some reasons for introducing the policy.

> "*It is to give some relief to persons with disabilities; you know the cost of having a disability is extraordinary high*." (Disabled Group Rep. 3)

> "*It was meant to make life easier for disabled people."* (Disabled Group Rep. 2)

4.3.4 UNDERSTANDING OF THE ELIGIBILITY CRITERIA

Respondents reported a variety of understandings with regard to the eligibility criteria contained in the Free Health Care Policy. Health service respondents were able to identify the criteria to qualify for free health care by disabled persons and linked the criteria to the requirements of the patient's fees manual (Unified Patient Fees Structure). Respondents explained that recipients of free health care were required to have proof of: receiving a disability grant or any social grant; or being a resident in KwaZulu-Natal; or proof of unemployment from the Department of Labour; and being in possession of other supporting documents such as the South African identity document.

> *"We are guided by the patient's fees manual (UPFS). Patients have to show proof that they are receiving a grant (disability or pension grant), their physical address, identity card, and of course their physical appearance."* (Admission Clerk 1)

> "*Proof that you provide a disability card because the fee's manual is clear; should you be unemployed you need to provide us with the letter from Department of Labour confirming your employment*." (Admission Clerk 3)

> "*Free health care for disabilities at the moment in KwaZulu-Natal is that you have to have a disability grant. So people who are not receiving grants who are disabled don't get free health care*." (District Rehabilitation Manager 3)

Some therapists reported that the criterion to qualify for free health care is dependent on the income of the client.

> "*It depends on the income; it is according to government gazette classification and fees structure*." (Therapists FGD 3)

Some therapists related the understanding of eligibility by stating that:

> *"It depends on the degree of impairment of each patient."* (Therapists FGD 1)

Disabled persons appeared to be aware of the disability card as the requirement for a disabled person to qualify for free health care services at State hospitals.

> "*The services* (Health services) *will not be provided freely if you don't bring along the disability card*." (Disabled Group Rep 1)

4.3.5 BARRIERS TO THE UNDERSTANDING OF POLICY CONTENT

Many participants reported the following as barriers to understanding policy content and provided explanation for their limited understanding as: lack of information and awareness of the policy provided to the health service personnel and the disability population as beneficiaries; lack of consultation of role players; non-availability of the policy document; lack of translation of the policy to an appropriate medium e.g. Braille for the blind and in local languages.

> *"I have no knowledge about the content of this policy*; the *problem with this policy is that it was introduced but I don't remember having workshops on it. We as beneficiaries, nobody came to us to introduce the policy; nobody came to us and explained the policy fully."* (Disability Group Rep 1)

> *"Even if it is there, it is not accessible for me in terms of not being in Braille and for our illiterate people who don't know English if there is one (policy) in Nguni or siSotho languages."* (Disabled Group Rep1)

"*We don't know! It's my first time even to hear that it is a policy. It was just decided I don't know by whom*?" (Disability Group Rep 1)

"I have never seen this policy, I don't remember! Most of the people are not aware of this policy for people with disabilities." (Therapist 3)

"I haven't seen the policy; I wouldn't be able to know." (Hospital Manager 5)

4.3.6 FACTORS FACILITATING THE UNDERSTANDING OF POLICY CONTENT

Participants reported on factors that would facilitate access to free health care for persons with disabilities including: increasing awareness of the policy and educating persons with disabilities and health service personnel about the policy; make the policy document available to all at hospital level; translation of the policy into an appropriate medium and format; training of admission clerks on the assessment of patients for eligibility to free health care; involvement of therapists in the assessment of patients for eligibility, incorporation of the Free Health Care Policy into the Uniform Patients Fees Structure, and revision of the policy at national level.

"They should ensure that everything they have printed about the policy is brailled or put at information desk where they can explain to us all." (Disability Group Rep 1)

"Members of the community need to be made aware about the Free Health Care Policy and they need to know what they are entitled to get; and health care teams need to be aware of what is included and not included; who qualifies and who doesn't; and what they can expect to receive." (Therapist 4)

4.4 UNDERSTANDING OF POLICY IMPLEMENTERS (ACTORS)

Actors for implementation the Free Health Care Policy for persons with disabilities include: the hospital managers, systems and finance managers, medical managers and

administration officers as administrators; rehabilitation therapists, nurses and admission clerks as frontline service providers.This section reports on the understanding by participants of who is responsible for implementing the Free Health Care Policy for persons with disabilities. Participants reported a variety of understandings with regard to who is involved in the implementation of the policy, and different understandings of the roles of implementers.

4.4.1 KNOWLEDGE OF IMPLEMENTERS

Health service respondents identified a full range of actors responsible for implementing the Free Health Care Policy, including: patient administration, therapists, nurses, doctors, finance and the hospital CEO.

> "*It should be the administrator, the clinical staff, the patient, the family, the caregiver*." (Admission Clerk 1)

> *"It is the Heads of Department and the Hospital CEO*." (Admission Clerk 2)

> "*It is the administration, patient's administration department. We are responsible for registering patients*." (Admission Clerk 3)

> "*It is the Head of Revenue Department, clerks, medical records, patient administration and also different clinics*." (Admission Clerk 4)

> "*It is every one of us as workers in the institution, Finance, Hospital CEO, Administration, Nurses and Human Resource*." (Admission Clerk 5)

In each category of health service personnel there were respondents that did not perceive themselves as responsible for implementing the policy.

"*I have not yet actually read this policy (Free Health Care Policy for persons with disability). I'm not very much involved in the implementation of this policy."* (Medical Manager 2)

"*Having heard all these questions, I feel I'm also involved and I should be the one who is facilitating this*." (Hospital Manager 5)

"*We have no role in assessing patients for financial status, we just treat. We assess patients and treat."* (Therapists FGD 1)

Disabled people, as beneficiaries of the policy, on the whole seemed unaware of who should be responsible for implementing the policy but only assumed that persons with disabilities and government officials should be involved.

"*I don't know who is involved, may be it is disabled people, government officials and the government itself."* (Disabled Group Rep. 1)

4.4.2 ROLES IN IMPLEMENTING THE POLICY

Respondents provided different understandings of their roles in implementing the Free Health Care Policy for disabled persons. Admission clerks identified their specific role in the implementation of the policy in terms of determining the eligibility of persons with disability receiving free health care. Admission clerks however were not able to identify their specific role:

"*I wouldn't say I have a specific involvement but only assist those who are in front of me*." (Admission Clerk 5)

Health managers reported wide responsibilities: ensuring implementation; raising policy awareness among hospital personnel and persons with disabilities and disabled people organizations, coordination; monitoring and evaluation; provision of resources; marketing and advocacy for the disability sector.

"*Monitoring to see if our people (disabled persons) are accessing service, what challenges, and if people are not accessing the services. If training is needed, to coordinate training*." (Manager 0)

"*To make sure that the staff is aware of the policy internally; provide resources for implementation of policy; identify the budget; ensure training of staff and communication with persons with disabilities."* (Manager 1)

"To ensure in–service training to the service providers (clinicians and non-clinicians) about the policy and monitor and evaluate whether the policy is properly implemented." (Manager 5)

"*Marketing and fight for rights of the patient (disabled people); ensure that people providing free health care are aware of the policy; to ensure services are accessible to disabled persons; to educate clerks so that it is implemented properly."* (District Disability & Rehabilitation Manager 5)

However health managers identified a more limited scope with regard to their responsibility in the implementation of the policy.

"*Firstly from the Department of Health side, is to know the policy which I don't think I know very well."* (District Disability & Rehabilitation Manager 2)

All therapists identified their responsibilities as: assessment for treatment; assessment for disability grant and issuing of assistive devices; and ensuring awareness of the policy by disabled persons and the community.

"Therapists, doctors; we all have our roles to play so everyone does what they need to do; To improve a patient's functional ability; to ensure assessments; make sure they get referred to people for disability card, to provide assistive devices." (Therapists FGD 2)

Some disabled persons demonstrated lack of knowledge of their role in the implementation of the policy. Others identified their advocacy role in implementation of the Free Health Care Policy, by disseminating information about the policy among the disability sector and ensuring that the policy was accessible to all disabled persons.

> *"The disability sector can just go around and inform their colleagues that there is this policy; the disability sector is the only sector which can say this policy needs to be in Braille, that this policy must have somebody to explain it in sign language."* (Disabled Group Rep 1)

4.3 UNDERSTANDING OF POLICY IMPLEMENTATION PROCESS

This section reports on the understanding by participants of the implementation process of the Free Health Care Policy for persons with disabilities in public hospitals in KwaZulu-Natal. Respondents identified barriers to implementation, and presented factors to facilitate implementation.

4.5.1 DESCRIPTION OF THE IMPLEMENTATION PROCESS

Health service personnel reported that implementation of the Free Health Care Policy for persons with disability began at the patient's administration department or out-patient department) of the State hospital. Respondents explained that implementation of the policy required an assessment of patients to determine or confirm eligibility for free health care services.

> *"Firstly we assess the patient when they are in; even when they are disabled persons we need to make sure that we assess them accordingly, and also have a proof if it is something critical."* (Admission Clerk 1)
>
> *"When a person arrives, they need first to get their card."* (District Rehab Manager 2)

Respondents reported further that assessment was done using the fees manual (UPFS) guidelines to confirm eligibility and these included: proof of a disability grant or social grant; or proof of unemployment from the Department of Labour; the South African Identity card and proof of physical address.

> "*We have a signage in the institution advising people that if they are in possession of a disability grant or pension that they are to produce proof, they will be entitled to free services. Should they be unemployed, you need to provide us with the letter from the Department of Labour confirming your unemployment."* (Admission Clerk 3)

Therapists reported that they were sometimes consulted to assess disability for confirmation of eligibility for free health care services.

> "*It has been implemented because from time to time when they (doctors) are doing most of the things they consult us*." (Therapists FGD 2)

Participants however acknowledged that the implementation of the Free Health Care Policy for the disabled persons was not fully implemented or standardized at State hospitals.

> "*In terms of implementation, it is very erratic, no standardized format, there's lack of understanding of the criteria and of definition of disability*." (Manager 0)

> *"It is implemented but I don't see it, there is no consistency. The information was not well disseminated to disabled people."* (Disabled Group Rep 1)

> *They are implementing but I don't think it is to the fullest. I would give KwaZulu-Natal may be 40% of the quality of health care that is being provided for people with disabilities."* (Disabled Group Rep 2)

4.5.2 BARRIERS TO THE IMPLEMENTATION OF THE FREE HEALTH CARE POLICY FOR DISABLED PERSONS

Participants demonstrated lack of knowledge or awareness of the policy implementation process and identified the following as barriers to the implementation of the Free Heath Care Policy for persons with disabilities at public hospitals in KwaZulu-Natal:

1) Lack of involvement or consultation of therapists in the assessment of disability to determine eligibility for free health care services as stipulated by the policy.

> "We *have never been required to fill out a form that says: in my experience/opinion (that) this person is disabled*." (Therapist 1)
> *"Us as therapists are rarely involved in this policy, we see one or two patients. There is this policy that they have at the Revenue Office that we shouldn't be writing as Physiotherapists any notes regarding disability of a patient."* (Therapist 2)

2) Inadequate understanding of the policy by implementers and poor definition of disability in the policy.

> *"The definition of disability in the policy is not clear, like who is disabled and who is not: because everyone thinks that they are disabled."* (Hospital /Medical Manager 3)

3) The limited resources including sufficient budget for recruiting staff, for conducting training, obtaining assistive devices, adequate physical space and drugs and others contribute to ineffective implementation of the Free Health Care Policy for persons with disabilities at state hospitals in KwaZulu-Natal.

> "*It is all clear and well to have a Free Health Care Policy but if there is no funding to give everybody for example hearing aids, and if patients are on waiting list and*

there is no funds, the policy cannot be embraced and if you cannot implement it with actual funds available then the policy is just a piece of paper." (FGD 2)

4) Lack of training of actors such as admission clerks, therapists, nurses and doctors on the implementation of the policy:

I can vouch that none of us had any training or none of us have done training on this. Nobody has ever been trained in my district." (District Rehabilitation Manager 1)

5) Lack of knowledge and awareness of the policy by some health service workers and the disability community as beneficiaries of policy.

Nothing is done in terms of implementing this policy at hospitals; some of the hospital staff is not aware about the policy and therefore it becomes difficult for them to implement something that they don't know. These people (health workers) don't even bother to read these policies; they don't understand why it is there. People are ignorant especially when it comes to disability!" (Disability Group Rep 2)

6) The negative attitude of health workers towards persons with disabilities.

"People with disabilities are not receiving free health care services at public hospitals in KwaZulu-Natal; actually they receive harassment rather than free health care at facilities because they are not given right information at the right time." (Disability Group Rep 2)

7) Conflict or misunderstanding of the eligibility criteria between the Uniform Patient Fees Structure and the national Free Health Care Policy for disabled persons. According to the respondents, the eligibility criteria used for implementation of the Free Health Care Policy for disabled persons at public hospitals in KwaZulu-Natal is in line with the Uniform Patients Fee Structure (UPFS).

"We are guided by the patient's fees manual (UPFS). Patients have to show proof that they are receiving a grant (disability or pension grant), their physical address, identity card, and of course their physical appearance." (Admission Clerk 1)

"We got a guide on how to classify patients for free health care but we are unable to do that at hospital level because at hospital level, the revenue people (officers) said that the only people that get free care are those that have disability grant." (District Rehabilitation Manager 4)

"We don't know the policy, we haven't used it. What we know is they just use it to screen patients. We don't know what criteria is there." (FGD 1)

"I think the shortfall of this policy is the fact that you have to use the disability grant as the criteria and some of the persons with disabilities don't have the disability grant." (District Rehabilitation Manager 3)

"*The policy looks very good on paper. I think it just needs to be sorted out at national level on why it clashes with the fees manual (UPFS)."* (District Rehabilitation Manager 3)

"I think it should go hand-in-hand with the fees manual because Rehabilitation Therapists have problems with fees manual. The Admission Clerks also don't know what to charge and not to charge." (District Rehabilitation Manager 5)

8) Non availability of an implementation strategy for the policy.

"*An implementation strategy is not in place."* (Manager 0)

9) Lack of monitoring and evaluation mechanism/system for implementation of the Free Health Care Policy for persons with disabilities in KwaZulu-Natal.

"It is implemented in certain institutions but how far it is implemented we don't know. Monitoring is not as often. It is just done when the national audit does come down, then we would administer the audit but not regularly. We know that it is not working, and then to constantly monitoring and evaluating something that is challenging, we will just frustrate people." (Manager 0)

10) Unclear definition of disability and lack of understanding of the criteria.

"There's lack of understanding of the criteria and of definition of disability." (Manager 0)

"*I use my own criteria or my own intellectual ability."* (Admission Clerk 5)

11) People with physical disability being able to more easily access free health care services than people with other types of disability. For example, patients with hearing impairment, partial visual impairment or psychiatric condition/s are less likely to access free health care.

"The problem arises where there are people with disabilities whose disability is invisible (not physical). For instance, hearing loss where the Admission Clerk cannot see that this person has a disability." (District Rehabilitation Manager 2)

12) Lack of harmonisation of an assessment tool used by the South African Social Security Agency and the Department of Health.

"There is need to use a harmonised tool that South Africa Security Agency (SASSA) and the Department of Health have proposed since the same criteria is used by both Departments." (Manager 0)

Health managers associated the implementation of the Free Health Care Policy for disabled persons either to the fast queue policy or physical accessibility of buildings to persons with disabilities and the elderly.

"*We have facilities like toilet facilities that they are actually use user-friendly to people with disabilities*." (Hospital Manager1)

4.5.3 FACTORS FACILITATING POLICY IMPLEMENTATION

Participants presented the following as factors facilitating implementation of the Free Health Care Policy for persons with disabilities: Adequate awareness of the policy by hospital staff and members of the community including disability movements; in-service training and induction to the policy for new staff; translation of policy into appropriate formats (Braille) and local languages (isiZulu); training of health workers (Admission Clerks, Therapists, Doctors and Nurses) on the Free Health Care Policy for persons with disabilities; provision of sufficient funds for Free Health Care Policy; recruitment of more staff especially therapists; effective communication of the policy; availability of adequate assistive devices and equipment; involvement of all staff; incorporation of the Free Health Care Policy for disabled persons into the UPFS; sufficient support from management; a monitoring and evaluation system for checking implementation of the policy; strong supervision from higher management and political will to enforce implementation; provision of transport for disabled persons attending hospital services; revision of the policy; redefinition of disability; making the policy clear.

"KwaZulu-Natal was one of the provinces that the National Department of Health chose to conduct training, but again due to budgetary constraints we couldn't pull the training together." (Manager 0)

"Members of the community need to be made aware of the policy and they need to know they are entitled to get; and health care team need to be made aware of what is included and what is not included; who qualifies and who doesn't." (Therapist 2)

"With Department of Health, I have noticed that if they employ an Admission Clerk today, tomorrow they start working. They don't get training. Admission Clerks need

to be given clarity on what they are expected to do! So training and support is needed." (Admission Clerk 1)

"The policy is out from national level and we are policy implementers at operational level, we need somebody at higher level to crack a whip and say this shall be done!" (Hospital Manager 1)

"Looking at the policy alone, I feel the policy is good but there are other things that factor in when you are looking at policy implementation. For example you need to look at the accessibility of health services to people with disability: availability of HR, equipment, infrastructure. These people also spend money travelling to hospitals. To me, it is more than just producing the disability grant." (Disability Rehabilitation Manager 5)

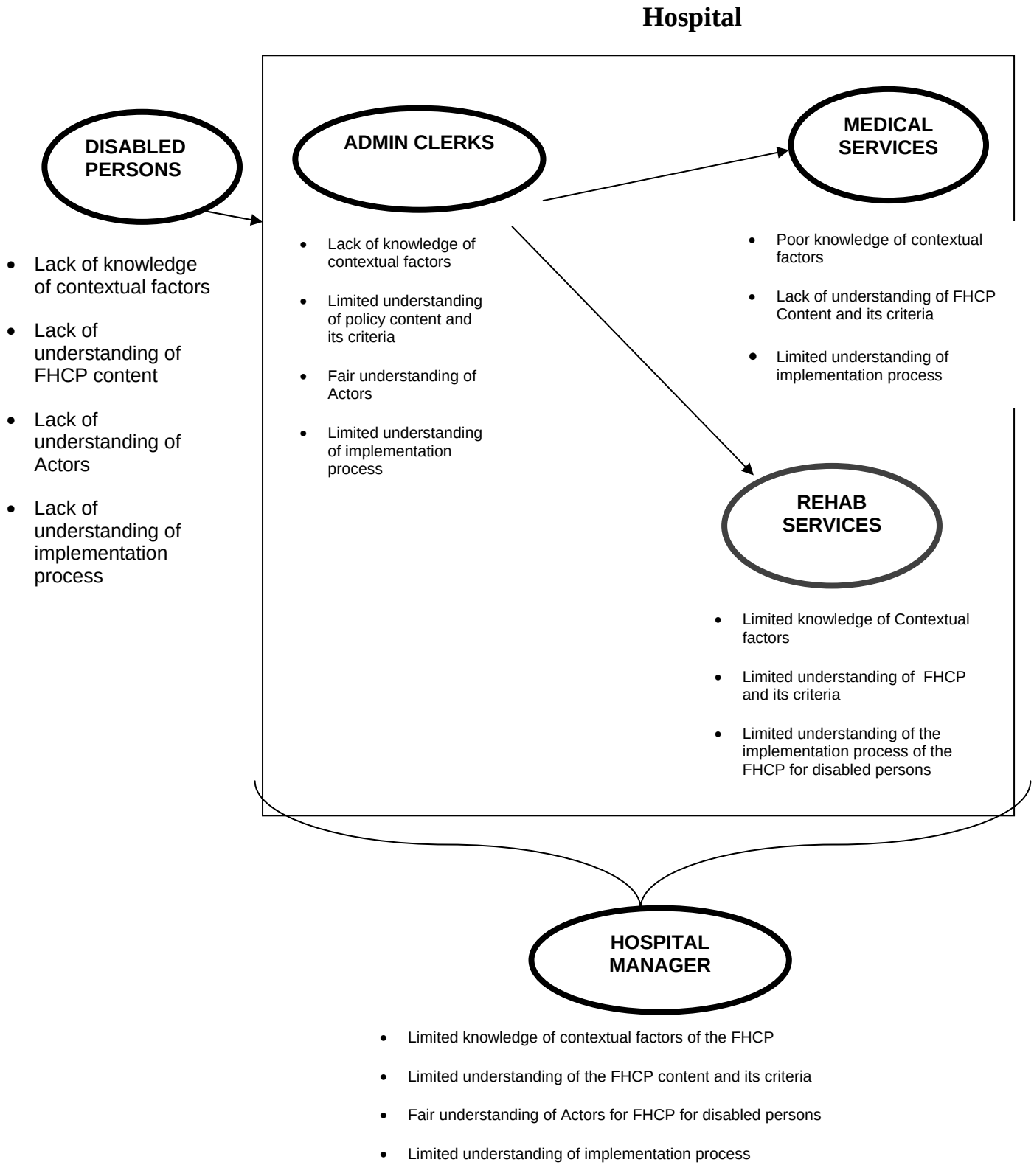
"They should make sure that everything they have printed about the policy is also brailed or put the policy at information desk of the hospital where they can explain to us all these policies especially for persons with disabilities." (Disability Group Rep 1)

CONCLUSION OF CHAPTER 4

This chapter has highlighted the general understanding of the Free Health Care Policy for disabled persons by participants, who included health services personnel, and the representatives from the disability community. There were mixed responses with regard to the understanding of the policy in terms of the context, content, actors involved as well as its implementation process at public hospitals of KwaZulu-Natal. Some categories of health service personnel demonstrated good understanding of policy in different aspects of the policy implementation at different levels while other health service participants reported complete lack of understanding of the policy in different areas and levels of

operation. Some representatives of the disability community reported lack of understanding of the policy with regard to context, content and implementers of the policy. Some of the disability movement representatives reported that they have only heard about it and they have never seen the policy document.

Figure 3. DIAGRAMATIC SUMMARY OF BARRIERS TO IMPLEMENTATION OF THE FREE HEALTH CARE POLICY FOR PERSONS WITH DISABILITIES IN KWAZULU-NATAL IN 2010



CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

This chapter discusses the results of this research. Here, the findings are outlined in reference to the aim and objectives of the study and in relation to other similar studies. As stated previously, the objectives of this study include: to describe the contextual factors influencing the development of the Free Health Care Policy for disabled persons in the Republic of South Africa; describe the current knowledge in KwaZulu-Natal with regard to the content of the Free Health Care Policy for disabled persons; and to describe the process factors influencing the current implementation in KwaZulu-Natal of the free health policy for disabled persons. The respondents' understanding of these factors would inform the development of an implementation strategy for the Free Health Care Policy for persons with disabilities at state hospitals of KwaZulu-Natal.

5.2 UNDERSTANDING OF THE POLICY CONTEXT, CONTENT, ACTORS AND IMPLEMENTATION PROCESS OF THE FREE HEALTH CARE POLICY FOR DISABLED PERSONS

In reference to the conceptual framework adapted from the Walt and Gilson (1994), the context within which the policy needs to be implemented is similar to the context for which the policy was developed. i.e. Poverty, exclusion of people with disabilities, poor access of health services to people with disabilities. The younger rehabilitation therapists, admission clerks, managers and other health workers may not be familiar with the vision of the ANC at the time of formulating the FHCP for persons with disabilities.

The study has revealed: the limited knowledge among health service personnel and among disability groups about the rationale of the Free Health Care Policy for disabled persons; varied understanding about the content of the policy, including the purpose of the policy and the eligibility criteria to access free health care, and inadequate knowledge on the

specific roles of implementers. The study respondents reported erratic implementation of the Free Health Care Policy for persons with disabilities in KwaZulu-Natal.

As stated in chapter four, participants presented barriers to their understanding of the policy rationale, content, actors involved and their responsibilities as well as barriers to effective implementation of the Free Health Care Policy for disabled persons. Some of the barriers highlighted by some participants to understanding of the policy include: lack of awareness of the existence of policy by some health service personnel and some disability groups; lack of consultation during the developmental process of the policy of the implementers and organisations of disabled people; inadequate information about the policy to health service personnel and disability groups; lack of translation of the policy document into appropriate formats; non-availability of the policy documents at operational level; and the young age of some implementers particularly some therapists in the Department of Health when the policy was introduced.

For the policy implementation process, there is very little happening regarding the implementation, and monitoring and evaluation of the Free Health Care Policy for persons with disabilities at public hospitals in KwaZulu-Natal. Participants presented the following as barriers to implementation: non-availability of an implementation strategy; lack of involvement of therapists in the assessment of disability to determine eligibility; limited resources such as budget, human resource and assistive devices; lack of training of implementers such as admission clerks, nurses and therapists; the conflict of the eligibility criteria between the UPFS and the Free Health Care Policy for disabled persons; unclear definition of disability; and lack of a monitoring and evaluation system. Nevertheless, participants demonstrated knowledge of the aims and objectives of the Free Health Care Policy for disabled persons however lack of resources to support the achievement of the intended purpose of policy was identified as the main barrier. This study revealed a general lack of understanding of the policy by some participants due to poor communication of policy.

Lack of a communication strategy may result in poor and incomplete understanding of the rationale for the policy, the content of the policy, and the responsibility of each of the actors in ensuring its implementation. For instance, persons with disability as beneficiaries of the FHCP reported that they knew nothing about the existence of the Free Health Care Policy for persons with disability at public hospitals as they were not informed about the policy and its implications. In fact some disabled persons claimed that they had not even seen the policy document. Similarly some therapists, as key implementers of the policy, were not aware of the existence of the Free Health Care Policy for disabled persons. The international philosophy on disability "nothing about us without us" lobbies for active involvement of the disabled persons in any activity, procedures, decision or policies that affect disabled persons (Rowland, 2004).

Limited knowledge about the policy by participants including the disabled persons themselves and health service personnel in KwaZulu-Natal, has confirmed the findings of the national review (NDOH, 2007) of the implementation of Free Health Care Policy for disabled person in five provinces, excluding KwaZulu-Natal, how no communication strategy was in place when the policy was introduced. Literature on health policy implementation emphasises the need to communicate new policies (Gilson et al., 2003; Walker & Gilson 2004). It is important to communicate each aspect of a policy including the rationale, content, implementation strategy and the actors who should be involved in the policy implementation. Good communication of these elements of policy would allow for relevant stakeholders and beneficiaries of the policy to understand, own and participate actively in the policy implementation. For instance, the study by Walker and Gilson (2004) found that implementers of the free health care policy at primary health care clinics were frustrated with the implementation of the policy as they were not properly informed about the policy, or consulted in planning the implementation, or given the explanation about the policy by the higher health authorities and this was identified as barrier to implementation of the policy. A study by Sookdin (2005) identified a need for significance planning and implementation of appropriate strategies for awareness and understanding of the Free Health Policy for disabled persons. A communication strategy is recommended to facilitate

good understanding of the Free Health Care Policy for disabled persons by implementers and its beneficiaries.

The implications for not putting in place a communication strategy for implementation of the Free Health Care Policy for disabled persons would negatively affect its implementation and may result: in poor understanding of the policy by both health service personnel and the disabled people; poor implementation of the policy, poor access of health services by disabled persons; and inadequate advocacy by disabled organisations.

Developing communications strategies of the policy, outlining the objectives and communication methods is important to allow relationships with audiences to be built over the course of the policy (South, 2011). A communication strategy must encompass: multi stakeholder partnerships including policy and practitioner communities, intermediaries, advocacy communities, traditional leaders to influence attitudes and reinforce power of knowledge to be applied to a given policy (Tulloch et al., 2011).

Disabled people as beneficiaries of this policy need to be given information on the specific kind of health services available for them. Disabled people have a right to know the content of the FHCP such as criteria for eligibility, where these services could found and who the service providers are. Information on the FHCP for persons with disability must be provided in accessible formats and types such as braille, DVDs, pamphlets, posters, community radios, and these must be translated into local languages.

For Admission clerks and Administrators as frontline services providers, need the following for implementation of this policy: General information about the Free Health Care Policy for persons with disability including policy document; regular training on the general content of the policy including the criteria for eligibility. Admission clerks and administrators must ensure that they assist people receiving hospital services to understand the Free Health Care Policy for persons with disabilities. They must assist to put posters and pamphlets on the Free Health services for persons with disabilities at appropriate points in the hospital for easy access of this.

Rehabilitation therapists, nurses and medical officers as health service providers need the following for implementation of the Health Care Policy for disabled persons: General information about the FHCP for persons with disability including policy document; regular training on the general content of the policy including the criteria for eligibility, and what

different kind of health services disabled persons as patients / clients qualify to receive for free. Clinicians must also assist disabled people to understand relevant health services that they must receive for free.

Hospital managers need to know Free Health Care Policy for persons with disabilities. Managers must have understanding of the cost implication of the policy and plan for resources for implementation of free health care services to disabled people. Institutional Managers must ensure that relevant health personnel are provided with training of staff on the Free Health Care Policy for persons with disabilities as well as provision of guidelines, posters, pamphlets and others for implementation of the Free Health Care Policy for persons with disabilities.

Participants of this study recommended the creation of awareness of the implementation of the Free Health Care Policy for disabled persons. Creation of awareness would include: the development of pamphlets and posters about the policy; translation of the policy as well as pamphlets and the posters into local languages such as isiZulu. Use of national and community radio stations, putting up posters and pamphlets at health facilities, as well as distribution of pamphlets at community events such as Izimbizo would facilitate awareness of the Free Health Care policy for disabled persons among the disabled people and members of public. Furthermore, a communication strategy for implementation of the Free Health Care Policy for disabled persons may include: conducting road shows, workshops with all relevant stake holders such as disability movements, traditional leaders, health service personnel and other NGOs and governments departments. Translation of the policy into accessible formats such as Braille for blind people must be considered in the communication strategy to enhance the understanding and awareness of the policy to all disability groups.

At hospital level, it is recommended that an in-service training programme for health service personnel on implementation of the free health care be included in the policy implementation strategy. An induction and orientation programme for all new hospital employees including community service officers must be put in place to increase awareness and education among health service workers as implementers of the Free Health Care Policy for disabled persons. The inclusion of the health policy implementation including the Free Health Care Policy for disabled persons in the training

curriculum for undergraduates would enhance education and awareness of the policy issues among the undergraduates and prepare for future implementation of policy in their practice.

Confusions raised by participants about the eligibility criteria and the responsibilities of actors for implementation of the Free Health Care Policy for disabled persons included: the use of the eligibility criteria in the Uniform patient Fees Structure instead of the national Free Health Care Policy for disabled persons; lack of training of admission clerks on the screening of disability for eligibility; and the non-involvement of therapists in the screening of disability to determine eligibility to receive free health care services. For example, it was reported that physical appearance of disabled persons was used in some instances by health service personnel to determine eligibility for free health care. This improper way of determining eligibility would obviously result in exclusion of disabled people with less visible disabilities from receiving free health care services. The national review (NDOH, 2007) identified the challenges faced by the admission clerks in the use of the UPFS guidelines and the eligibility criteria stated in the national policy. Harmonisation of the assessment tool to include both UPFS guidelines and the eligibility criteria in the national policy of free health care services for disabled persons is therefore recommended. Further, training of admission clerks, therapists and doctors on assessment may alleviate these problems and enhance the implementation of the Free Health Care Policy for disabled persons.

Finally, effective implementation of any policy requires a monitoring and evaluation strategy to be put in place. Careful monitoring and evaluation of a country's health policy and plan are vital: for assessing results of the policy decisions; for measuring the impact of the policy; for improving services, treatment and care and for guiding future policy directions (WHO, 2007; Segone et al., 2008). Participants of this study reported a lack of monitoring and evaluation systems for implementation of the policy and recommended a monitoring and evaluation strategy. The literature reports that there has been a shift in monitoring and evaluation of policy from implementation-based approaches to result-based strategies. This is based on the premise that it is not enough to implement

programmes or policies and assume successful implementation or improvements in health outcomes (World Bank, 2004). This study therefore recommends the use of the 10 steps of results-based monitoring and evaluation system for the implementation of the Free Health Care Policy for disabled persons. Figure 3 below shows 10 steps to Results-based monitoring and evaluation system.

Step 1. **Conduct readiness assessment:** determine capacity and willingness within organisation/s

Step 2. **Agree on out come to monitor and evaluate:** ensure outcomes to monitor and evaluate

Step 3. **Develop key indicators to develop outcomes:** assess the degree to which outcomes are being achieved.

Step 4. **Gather baseline data on indicators:** Assess initial conditions

Step 5. **Plan for improvements by setting realistic targets:** set intermediate goals since most outcomes are long term, complex and not quickly achieved

Step 6. **Monitor results:** establish data collection, analysis and reporting guidelines, establish mean of quality controls

Step 7. **Evaluate information to support decision making:** use evaluation studies throughout the process to assess results and movements towards the results

Step 8. **Analyse and report findings:** determine what findings are to be reported, in what format and intervals

Step 9**. Use findings:** get the information to the appropriate users in a timely way so that they can consider the findings in their management of a programme or policy

Step 10. **Sustain the monitoring and evaluation systems:** implement a long term process including building and maintaining elements of sustainable systems.

Figure 4. Ten steps to building a results-based Monitoring & Evaluation System. (Adapted from the World Bank, 2004.)

The main tool for monitoring the performance of hospitals in implementing the free healthcare policy for disabled persons may be through monthly and quarterly reports. Data can be submitted using the District Health Information System (DHIS) and from this, the indicators can be calculated from the minimum data set (RuDASA, 2006). Other recommended methods of evaluating and monitoring of the Free Health Care Policy for disabled persons include: periodic reviews of policy implementation; annual reports using policy implementation indicators; monitoring of health impacts of disabled persons (Meir & Kestenbaum, 2011). Furthermore, the establishment of registers for disabled persons being screened for free health care or those receiving free health care services at public hospitals, use of clients satisfaction surveys on the periodic basis and development of a data base of induction and in-service training workshops conducted at hospitals for implementation of the free health care to persons with disabilities could be used for monitoring and evaluation of this policy

Literature on monitoring and evaluation of policy implementation has noted that participation of policy stakeholders, national decision makers, local level implementers, and communities affected by the policy, in policy design, implementation, monitoring and evaluation, improves the programme and helps to address local development needs (UNFPA, 2004). Participation of stakeholders increases national and local ownership of policy activities and promotes the likelihood that the policy activities and their impact would be sustained (UNFPA, 2004). The involvement of disabled people organisations and health service personnel in monitoring and evaluation of the implementation of the Free Health Care Policy for disabled is thus crucial and vital for implementation of this policy. The key to any evaluation is an ongoing monitoring to ensure the policy is implemented as intended (WHO, 2007).

CHAPTER 6: CONCLUSION

The limited understanding of the Free Health Care Policy for Persons with disabilities by participants and the erratic or poor implementation of the policy at public hospitals in KwaZulu-Natal indicate that the policy has been implemented without relevant preparation. A communication strategy, guidelines for implementation, assessment of available resources, training of actors at operational level, and translation of the policy in appropriate format and language for persons with disabilities are all required for effective implementation. An effective communication strategy is necessary to inform and educate members of the public including the persons with disabilities about the policy and its implications. Furthermore, a monitoring and evaluation system is necessary to assess whether the policy is achieving its objectives as well as its intended purpose. It is however worth noting that the idea of introducing the Free Health Care Policy for persons with disabilities in KwaZulu-Natal has been appreciated by all stakeholders including the persons with disabilities. Nevertheless, the policy needs to be properly implemented for its intended purpose and objectives to be achieved. The findings of this study provide a platform for factors to consider in development of an implementation strategy of the Free Health Care Policy for persons with disabilities. However, further research is recommended in this area of free health care implementation especially with the introduction of National Health Insurance (NHI) in South Africa by 2012.

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