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THE INTERACTIONS OF PUBLIC HEALTH ORGANISATIONAL LEADERSHIP WITH ITS ENVIRONMENT: A CASE STUDY OF THE PARIRENYATWA GROUP OF HOSPITALS IN HARARE, ZIMBABWE

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ABSTRACT

***Introduction*: This is a case study of the Parirenyatwa Group of Hospitals. It analyses interactions of public health organisational leadership with its environment, within the context of Zimbabwe's unique social, economic and political circumstances.**

***Objective*: To investigate how the local contextual environment of Zimbabwe's unique social, economic and political situation interacted with leadership of the Parirenyatwa Group of Hospitals; within Zimbabwe's public health setting.**

***Methods (Design, Setting, Participants and Interventions):* The research design was of a case study of a central government hospital. Semi-structured interviews and document analysis were used to conduct the research. An interview guide was used to give direction to interviews, but the questions and interviewing style were open-ended and exploratory. Purposive sampling and expert sampling were used to select respondents for interviews. Content analysis of administrative and management documents kept at the participating institution was carried out. This research is located within the theoretical framework of Health Policy and Systems Research (HPSR); and examines the institutional or meso-level of the healthcare system.**

***Results and Discussion*: Research findings are discussed under subheadings that correspond to the interactions of social, economic and political factors with public health institutional leadership.**

***Conclusions and Recommendations*: Based on the research findings, recommendations are made on relevant and effective changes to practice and policy, for the leadership of Zimbabwean public health institutions, recommendations that may have some applicability elsewhere as well, on the basis of lessons learnt.**

INTRODUCTION

The Parirenyatwa Group of Hospitals Hospital (PGH) is a public health institution that is one of six central government hospitals in Zimbabwe[1]. Zimbabwe, since the turn of the millennium, has experienced immense social, economic and political setbacks[2-4]. These included: international isolation; political polarization; hyperinflation; liquidity constraints; deflation; high inflation; and socio-economic desolation[5,6]. These challenges have been felt in all aspects of Zimbabwean life with the public health sector not being an exception[7]. This is a case study of the Parirenyatwa Group of Hospitals; that examines interactions of public health organisational leadership with its environment, within the context of Zimbabwe's unique social, economic and political predicament. This case study investigates how the local contextual environment of Zimbabwe's unique social, economic and political situation have interacted with the leadership of PGH as a public health institution. This case study makes recommendations on relevant and effective changes to practice, for the leadership of Zimbabwean public health institutions; that may have some applicability elsewhere as well, on the basis of lessons learnt.

The Hospital (PGH) was built by the colonial Rhodesian government in order for it to serve as the hospital to cater for the needs of the white minority settler population[8]. PGH is located north of the Central Business District (CBD) of Zimbabwe's capital city, Harare, since the northern suburbs of the city were previously reserved for the white minority population in accordance with the colonial government's segregationist laws[9]. The hospital was formerly known as the Andrew Fleming Hospital and was named after the principal medical officer to the British South Africa Company[10]. After Zimbabwe became independent in 1980, the hospital was renamed in honour of Dr Tichafa Samuel Parirenyatwa who was the first black person in the country to qualify as a medical doctor[11]. In keeping with the segregationist policies of the colonial government, a section of the hospital was, during colonial times, set aside to be the hospital for the mixed-race (or coloured) population and was named Princess Margaret Hospital[12]. PGH is the largest hospital in Zimbabwe having an inpatient bed capacity of 1800 beds.

METHODS

The research design is that of conducting a case study. In academia there is a well-established history and practice of using the case study method as an investigative tool when conducting research into public health institutional leadership[13,14]. Case studies are useful in elucidating multifaceted contextual factors and in interpreting complex phenomena[15]. This research is located within the theoretical framework of Health Policy and Systems Research (HPSR)[16]. This research examines the institutional level or meso-level of the healthcare system[17,18], by interrogating the leadership of a public health institution that is key to Zimbabwe's public health sector, being a central government hospital.

Semi-structured interviews and document analysis were used to conduct the research. An interview guide was used to give direction to interviews. The interviewing style was open ended and exploratory. Content analysis of documents kept at the institution under study was undertaken to corroborate data obtained from interviews. Documents analysed included administrative and management records, spanning the period from the year 2000 to the present. Medical records of individual patients at the participating institution were

not studied, as they were not part of the inclusion criteria for this study.

Purposive sampling and expert sampling of respondents for interviews were used because the study examined institutional leadership; so the target rich sources of data were concentrated amongst the leadership echelons of the institution.

Ethical approval for the study was obtained from the Africa University Research Ethics Committee (AUREC), the Medical Research Council of Zimbabwe (MRCZ) and from the participating institution. Participation in the research was voluntary and subject to the granting of informed consent.

RESULTS AND DISCUSSION

General Observations:

Challenges experienced at PGH included unstable economic conditions; inflation induced price distortions; high staff turnover; high patient volumes amidst a collapsed referral system; and water cuts.

There were shortages of staff and material resources. There were high levels of staff attrition. A desirable nurse-patient ratio; which does not exceed 1:6 for general wards, as a matter of international best practice; is something the hospital has failed to achieve. In a best-case scenario, the hospital found itself with a nurse patient ratio of 1:8; and sometimes things got as bad as a nurse patient ratio of 1:15. Ideally, each ward is supposed to have 15 Registered General Nurses (RGNs), but the average was 8 RGNs per ward. The total establishment for nurses at PGH stands at 1000 nurses. This is no longer adequate given the increased population, increased patient volumes and increased disease burden. The establishment needs to be increased to at least 1220 in order to meet current requirements. At the time of conducting this study, PGH had 925 nurses, after having recently received 20 resignations.

The Interaction of Social Factors with Public Health Leadership:

Economic challenges in Zimbabwe manifested as social problems for PGH's staff. There were high levels of absenteeism and demotivation among staff; and low productivity.

A topical social issue was that the hospital's psychiatric unit had seen an increase in the numbers for substance abuse cases. This was perceived by research participants to be related to increasing social and economic problems in the community.

The Interaction of Economic Factors with Public Health Leadership:

Low salaries and poor remuneration for PGH employees resulted in many staff leaving the organisation for greener pastures. The economic environment has had a negative impact on the welfare of PGH's employees. Salaries at PGH were so much eroded by inflation and economic instability that ordinary employees found themselves unable to afford to pay for transport to come to work. Inflation caused loss of purchasing power and basic goods were priced out of reach. Resultantly, work performance and staff morale declined.

PGH has not been efficient in replacing with new recruitments the staff that left. Since 2010, the central government has imposed a recruitment freeze. After death, retirement, resignation or termination; treasury concurrence has been required in order to fill the vacant post; this being something that has been notoriously difficult to obtain within a reasonable amount of time. There are shortages of doctors and nurses.

There have been numerous doctors' strikes at PGH, causing disruption to hospital operations. Long term solutions to the causes of the strikes have never come from the central government, no matter how many times these strikes have happened over the years.

The central government introduced a policy of allowing nurses to have flexible working hours. Research participants were unanimously in agreement that the three-day work week that was introduced compromised the quality of services at PGH. Maintenance of adequate nurse-patient ratios was compromised. PGH was already short of 224 nurses; so the reduction in working hours for those nurses that were available exacerbated this problem.

Most medical doctors at PGH have been focussing most of their time and energy on private practice work, at the expense of their government work, because of poor remuneration from the government.

National economic challenges manifested as foreign currency shortages. This meant that the PGH was unable to pay for imported medical equipment, medicines and consumables. US$ 1.7 million is urgently required for procurement of immediately needed medical equipment. Challenges related to foreign currency shortages include getting spare parts for medical equipment that has already been acquired by PGH. Two radiotherapy oncology machines were not working, due to inability to procure spare parts. Badly needed is foreign currency for procurement of orthopaedic prostheses, laboratory reagents and equipment for cardiac catheterization. US$108 000.00 is needed every six months for importation of orthopaedic prostheses. US$2.2 million is needed in order to procure cardiac catheterisation equipment. US$2.1 million is required in order to fulfil the conditions of the service contract with a Swiss company for the equipment in the radiotherapy centre at PGH. The lift (elevator) at PGH's maternity unit was not working; US$57 000.00 was required to repair it.

Research participants stated that inconsistent and incoherent national monetary policies had a negative impact on hospital operations. There has been constant reactive shifting in policy positions at national level, with a lack of clear policy direction, and this has bred economic uncertainty. The national monetary policy statement issued by the Reserve Bank of Zimbabwe in February of 2019 threw all of the hospital's contracts with its suppliers into disarray. It was problematic for the hospital because it established the inter-bank foreign exchange platform; and it was in direct conflict with previous national monetary policy statements; it effectively declared the Real Time Gross Settlement (RTGS) dollar as the local currency of Zimbabwe. The negative effects experienced at PGH because of this were that, for example, a service which the hospital had been paying $10.00 for just a few months earlier was now costing $90.00 using the interbank foreign exchange rate, and yet the budget of the hospital and its revenue had not increased. The result was that the hospital started failing to meet its suppliers' requirements.

Cost recovery mechanisms at PGH have been inefficient; monies owed to PGH by debtors have increased without adequate corrective action being taken. From December 2018 to May 2019, despite cash payments being received by PGH every month, the total owed to PGH by cash paying patients rose from $57 595 049.75 to $59 743 340.92; due to new business that was not fully compensated for. Figure 1 presents, schematically, the variation in the total owed to PGH by all medical aid societies (medical insurance entities), from December 2018 to May 2019. For this period, for every month, new business was received from medical aid patients; and there were payments received by the hospital from medical aid societies. However, despite payments being received every month, it can be seen from Figure 1 that the total owed to PGH kept increasing. This indicates and confirms that cost recovery mechanisms at PGH have been inefficient; and that monies owed to PGH by debtors have increased without adequate corrective action being taken.

On superficial examination therefore, it appears that the private sector, in the form of private medical insurance schemes, is not giving adequate financial support to PGH; until one realises that the lion's share of the money owed to PGH by private medical insurance schemes is owed by the Premier Medical Aid Society (PSMAS); a medical aid society that provides medical aid cover to the country's civil service and whose main source of funding is the Government of Zimbabwe, through contributions made by deducting civil servants' medical aid contributions from their salaries. 93% of money owed to PGH by private medical insurance schemes was owed by PSMAS. Thus, there are complexities when considering this issue; namely that this central government hospital's (PGH's) inability to recover what it is owed by private sector players is not just only attributable to the economic problem of private sector market failure, but is more importantly and predominantly a result of a lack of political will from the central government to address and resolve health sector funding gaps.

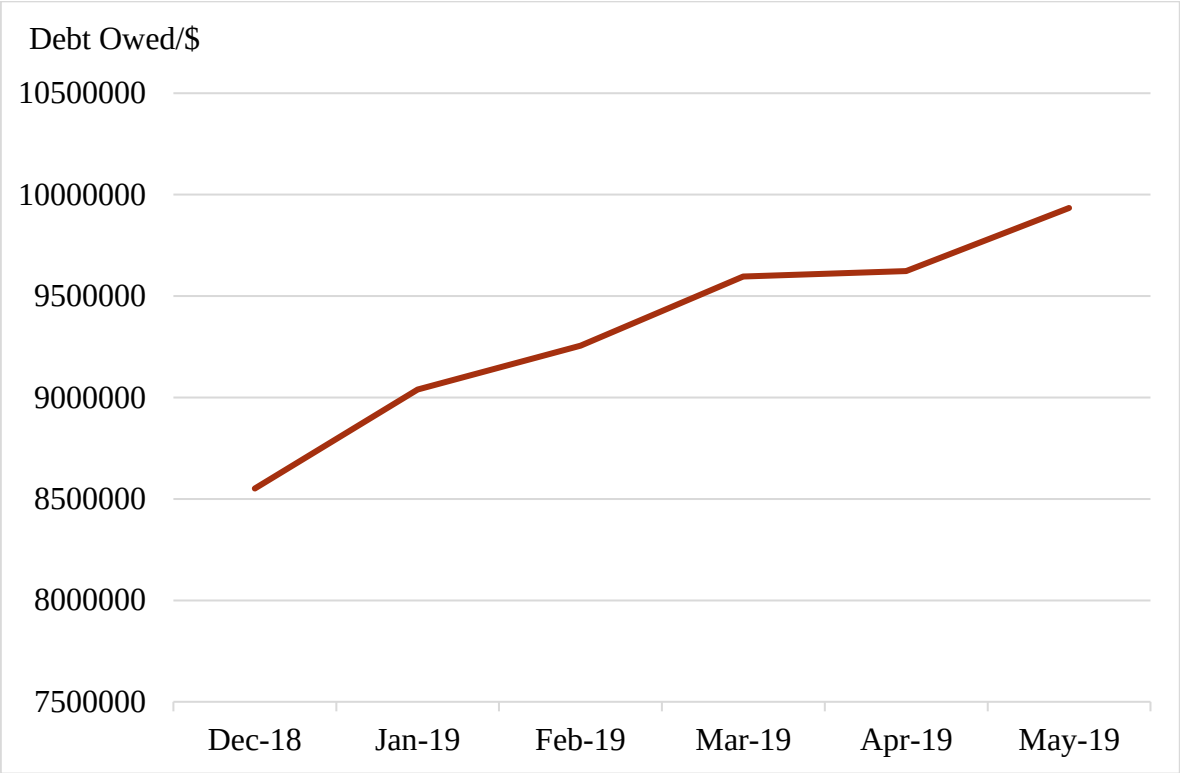

Figure 1. Variation in the Total Amount Owed to the Parirenyatwa Group of Hospitals by all Medical Aid Societies (Medical Insurance Entities) for the Period from December 2018 to May 2019

Figure 2 presents a comparison of the total owed to PGH by PSMAS and the amount owed by all other medical aid societies put together, from December 2018 to May 2019.

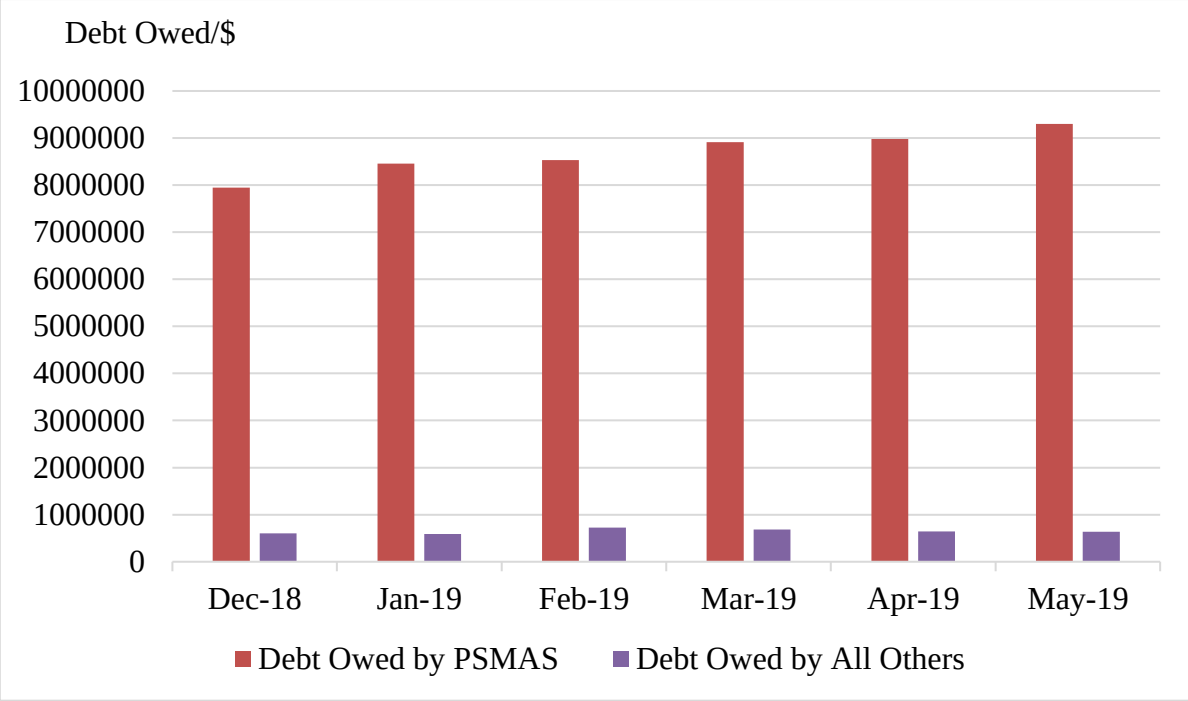

Figure 2. Comparison of the Total Amount Owed to the Parirenyatwa Group of Hospitals by PSMAS, as Compared to the total Amount Owed to the Hospital by All Other Medical Aid Societies Put Together for the Period from December 2018 to May 2019

Research participants reported that sanctions imposed on Zimbabwe by members of the international community translated into PGH facing challenges in making foreign payments for the supply of hospital equipment. The hospital intended to procure, from outside Zimbabwe, laparoscopy equipment; but the transaction collapsed because PGH was obstructed from making the foreign payment as result of prevailing sanctions. The laparoscopy equipment that PGH intended to procure was valued at US$30 000.00.

The Interaction of Political Factors with Public Health Leadership:

PGH has been plagued by a lack of political will to review its staff establishment. PGH was designed for a small white minority community, the staff establishment became too small when PGH was desegregated at Zimbabwe's independence. Disease patterns and disease burden have changed necessitating an increase in staffing levels.

The flexible working hours system was an inappropriate political strategy that was professionally unworkable. It meant nurses were only working three days a week; when work load was higher than what has been provided for by the current staff establishment. The main obstacle to PGH right-sizing its staff is the Ministry of Finance and Economic Development; since treasury concurrence is required whenever there is any recruitment at the hospital. This is a political problem that requires political will and action from political actors in order to solve the problem. The Ministry of Finance has too much power and control, when it comes to determining outcomes for human resources in the public health sector.

Scrapping of user fees for maternity fees in public hospitals was a sensitive political issue. It is now national policy. It has cost the hospital $12 million from January 2018 to June 2019 to fund services for free patients.

Clinician (medically trained) managers at PGH were in favour of free user fees policies; they perceived these policies as being

positive developments that increased access to health care services to vulnerable populations; and that contributed to a reduction in Maternal Mortality. Non-clinician (non-medically trained) managers were against the free maternity fees policy; they complained that it meant that productive working age people with capacity to pay were being exempted from paying for hospital services; something they perceived as being financially unsustainable as it left the hospital unable to fund these services. Clinician managers argued for a model under which everybody wouldn't pay anything; but then there would be full funding from the national government; in other words, a model similar to England's National Health Service (NHS).

There was unanimous agreement among research participants that the central government needs to find the political will to adequately fund the hospital and the whole public health sector. The government needs to find political will to abide by the Abuja Declaration; given that the central government has been falling short of dedicating at least 15% of the national budget to the health sector.

CONCLUSIONS AND RECOMMENDATIONS

There should be construction of a district hospital for the Harare urban area so as to decongest PGH, since PGH is currently congested and overwhelmed with cases that should be seen at a lower level of care.

Unworkable, unsound policies such as the flexible-working-hours system should not be imposed on the public health system through a top-to-bottom approach, as was the case.

The establishment for nurses at PGH should be increased from 1000 to 1220 in order to meet current requirements.

The Zimbabwean Government should increase taxes on alcohol and tobacco, in order to inhibit drug use and for the greater social good of society.

Zimbabwean Government policies should encourage Foreign Direct Investment and stimulate local industrial production; to produce an increase in local employment; and an improvement in socio-economic conditions.

The Zimbabwean Government should expand social protection programmes, so as to protect vulnerable groups.

Government medical doctors should be remunerated enough so they do not feel a need to do private practice work; because public work with good employment benefits is preferable to self-employment without employment benefits in the private sector.

Long term sustainable solutions to the causes of strikes by health professionals should come from the central government; there should be a paradigm shift in attitude and approach of government; with more sincere seriousness towards addressing and resolving this problem.

The Zimbabwean Government should have prudent monetary and fiscal policies that ensure macroeconomic stability and that contain inflation within low, narrow and acceptable limits; so that central government hospitals are able to adequately remunerate their staff and do not face impractical and unreasonable challenges when conducting procurement and tender processes.

The Zimbabwe Government should achieve consistency, coherence and predictability in its policy pronouncements on monetary and fiscal matters.

There should be policy interventions targeted at increasing the productivity of public sector health professionals; through incentivising and properly remunerating them; and through improving funding of public hospitals.

At the national economic level, there should be macro-economic and currency stability; so as to create the conditions under which PGH

would be more easily able to procure equipment for its operating theatres.

Macro-economic and currency stability would jump-start industry; thereby creating employment and wealth to spread around for the benefit of social services sectors, namely health and education.

Consideration can be given to a health financing model under which everybody pay nothing; but then there would be full funding from the national government; a model similar to England's National Health Service (NHS).

The PGH maternity unit should be expanded for it to be able to cope with the larger numbers of patients, population growth, and the hospital's larger catchment area. The numbers for maternity beds and operating theatres need to be doubled; and numbers for operating theatre nurses and midwives should be increased.

In institutional strategic planning, public health institutions need to establish effective strategies for achieving acceptable levels of cost recovery, and need to become adept at debtor management. The central government needs to assist government hospitals recover monies owed to them (hospitals) by fulfilling its (government's) responsibility to adequately fund PSMAS, an entity that owes large amounts of monies to health institutions in both the public and private sectors.

The Zimbabwean Government should make all efforts to mend relations with members of the international community that have imposed sanctions on Zimbabwe. Being able to freely interact without constraints with all nation states would be beneficial in enabling the equipping of Zimbabwe's public health sector, and in attracting Foreign Direct Investment.

The free maternity services policy, can be used as effectively to ensure equitable access to healthcare; and as a means to reduce morbidity and mortality; but the central government must ensure provision of adequate funding for this from general taxation, in order to guarantee long term sustainability.

Zimbabwe's government should find the political will to adequately fund PGH and the whole public health sector. The central government should find the political will to abide by the Abuja Declaration; given that the central government has been falling short of dedicating at least 15% of the national budget to the health sector.

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