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DEVELOPMENT OF STRATEGIES FOR PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS IN GAUTENG PROVINCE

by

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DECLARATION

I, Munyadziwa Jane Dzebu,

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declare that:

"DEVELOPMENT OF STRATEGIES FOR PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE**"**

is my own unaided work and has not been previously submitted by me or anyone at any other university. All efforts to acknowledge sources used in this study were taken.

_____ _____

Signed **Date**

DEDICATION

This work is affectionately dedicated to:

- My late Mawe, Mrs FJ Rasengane, who taught me perseverance but was not fortunate enough to live and witness the final product for which she has been an unflinching pillar of strength.

- To all the women and girl-children in South Africa.

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ABSTRACT

TITLE:

DEVELOPMENT OF STRATEGIES FOR PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

INTRODUCTION AND BACKGROUND:

Traditionally, patient referral occurs from a primary healthcare facility to a secondary or tertiary healthcare facility. Despite these formalised procedures in place, it has been reported within the global context that patients often circumvent these procedures and apply various forms of self-referral to tertiary hospitals. Through self –referral to the high level of care, patients' diagnoses and care are interrupted and get lost along the way.

AIM/ OBJECTIVES:

The overall aim of this study was to develop strategies for patients' self-referral in tertiary hospitals in Gauteng. In order to achieve this aim, the specific objectives of the study were:

Phase 1

Objective 1: To explore and describe current patients' self-referral patterns from patients and healthcare professionals' perspectives in tertiary hospitals in Gauteng Province.

Phase 2

Objective 2: To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

METHODOLOGY:

A qualitative research approach using critical ethnography was used. Purposive or judgment sampling was used as the researcher considers the participants to have a profound knowledge and in-depth information on the phenomenon. Data was generated through three phases: in-depth interviews with patients and healthcare professionals (registered nurses and doctors) rendering

services to self-referred patients in Gauteng Chronic clinics based in tertiary hospitals; reviewing of relevant site documents; and *imbizo* as policy discussion forum between the service providers and users of the services were held for the development of patient self-referral strategies. Data was analysed through the analytic five steps framework as advocated by the nurse ethnographers Roper and Shapira (2000: 98).

FINDINGS:

From the analysis of data five themes emerged as the pathways.. These pathways are emergency admissions, word of mouth, admissions in disguise, enabling patients to pay for admission, human rights, and sense of belonging.

CONCLUSION:

This study provided a baseline data on self –referral of chronic disease patients in tertiary hospitals in Gauteng Province. Given the epidemiology of chronic disease in South Africa, there is a need for innovative ways of bending the costs for treatment of such. The implementation of National Health Insurance (NHI) will address this problem as NHI has to have a self –referral scheme. The use of the hybrid (new technology and traditional) strategies will facilitate access to care and empowerment of patients to initiate self –referral.

KEY WORDS: patients' self-referral, referral policy, tertiary hospital, critical ethnography.

LIST OF ABBREVIATIONS

ABBREVIATION	MEANING
ANC	African National Congress
CE	Critical Ethnography
CR	Critical Realism
DOH	Department of Health
HPCSA	Health Professional Council of South Africa
PHC	Primary Health Centre
RSA	Republic of South Africa
SANC	South African Nursing Council
SLA	Sustainable Livelihoods Approach
WHO	World Health Organization

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CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The healthcare system in South Africa is under severe pressure. On the one hand, the Constitution of South Africa (Act 108 of 1996) entrenches the right to access to healthcare, based on the values of respect for human dignity, equality, human rights and freedom. On the other hand, there is an ever-increasing demand for healthcare on all levels. Tertiary or specialised healthcare centres in urban areas experience an over-demand for services, which is exacerbated by patients' self-referral. This phenomenon has major financial, human resource and supply implications (Beck & DuMoulin, 2013:34-35), as reflected in current proposals for health reform and nationalising healthcare (Hon. Zweli Mkhize, 25 June 2019).

Patient self-referral is a global phenomenon whereby patients refer themselves to specialised healthcare centres without obtaining the appropriate referral documents from a healthcare provider (O'Malley & Taylor, 2004: 2406; Seidenwurm, 2012:3; Gaakeer, van den Brand, Veugelers, & Patka, 2014:158; Kraaijvanger, Rijpsma, van Leeuwen, van Dijk & Edwards, 2016). Despite formalised referral processes to manage and fund cost-effective healthcare provision at different levels of specialisation, patients often circumvent these pathways or processes and apply various forms of self-referral. Healthcare referral processes are usually formalised as an integral part of continuity of care, as advocated by the World Health Organisation (Gulliford, Naithani & Morgan, 2006:1).

Usually, formalised patient referral occurs from a primary healthcare facility to a secondary or tertiary healthcare facility where specialised levels of care are needed. Furthermore, referral may include that a healthcare practitioner from one speciality refers a patient to another member of the healthcare team Van Der Heijde, Sieper, Elewaut, Deodhar, Pangan & Dorr, 2014: 411). Referrals may also occur between countries where specific specialised facilities are provided by another country with the necessary facilities (South Africa, 2008: 20). However, informal referral processes have been observed where patients refer themselves to a higher level of care without following the formal referral process.

Gauteng is the most densely populated province in South Africa. In addition to the needs of its own residents, large numbers of patients are transferred from district hospitals in Limpopo, Mpumalanga and KwaZulu-Natal Provinces to tertiary hospitals and specialised healthcare centres in Gauteng. There is an urgent need to explore ways to efficiently and effectively manage the phenomenon of 'self-referral' by patients in Gauteng Province, South Africa.

This chapter provides an overview of the current study and it will introduce the research process that was followed to develop strategies for patient self-referral in tertiary hospitals in Gauteng Province.

1.2 BACKGROUND AND RATIONALE

In many countries, healthcare models have strict referral policies for managing patient access from primary to secondary and tertiary healthcare levels (Atkinson, Ngwenwe, Macwan'gi, Ngulube, Harpham, & O'Connell, 1991; South Africa, 2008; Dickie, Ellwood & Robertson, 2011:11; Read, Varughese & Cameron,2014; Koce, Randhawa & Ochieng,2019). A well-coordinated referral system serves as a directive and promotional strategy for decisions on patient management at different levels of care (Luxenburg, Shelly & Margalit, 2014:149). It is further argued that during the self-referral process there is an interruption of healthcare provision as patients may be lost along the way (South Africa, 2008:3). For example, the researcher has observed patients who were previously diagnosed with chronic and debilitating diseases repeatedly undergoing unnecessary, expensive and painful procedures. This is done in order to confirm their diagnoses in urban tertiary hospitals during their self-referral process. Any form of referral process, except patient self-referral, ensures continuity of patient care whilst promoting the achievement of optimal health for all (Luxenburg, Shelly & Margalit, 2014:150). From patients' perspectives, however, these referral policies are seen as stop-signs and gatekeeping mechanisms (Atkinson, et al 1991: 38; Ang, Ho, Mimi, Salmah, Salmiah, & Noridah, 2014:2-16) that delay the effective management of their conditions.

1. The process and nature of patient self-referral have been observed in developed and developing countries. In developed countries such as Canada, Germany and Australia, where universal health coverage is provided, the debate around patient self-referral raises two important concerns which focus on financial and accountability issues (Beck & DuMoulin, 2013:34). Financially, patient self-referral is seen as a contributor to escalating costs within the healthcare system, especially in terms of diagnostic testing which uses a large amount of public health funds (Beck & DuMoulin, 2013:34). With regard to accountability, patient self-referral articulates the issue

of patients being accountable for their own health by seeking a second opinion on their own without being referred through proper established channels (Land & Meredith, 2013; Lega & Mengoni, 2008). These issues are also relevant in developing countries where self-referrals can result in long unplanned queues, lack of supplies and overburdened health professionals, which in turn impacts on the delivery of cost effective and high quality health care as stated by Mojaki, Basu, Letshokgola and Govender, (2011:109).

Analyses on self-referral relating to healthcare can be approached from both a public policy and an ethico-legal perspective (Beck & DuMoulin, 2013:33; Levin & Rao, 2010:848). From a public policy perspective, self-referral viewed around the costs that are incurred by the public healthcare system (Beck & DuMoulin, 2013:33). An example is when a patient is diagnosed and managed at one healthcare facility, and then goes to another facility for a second opinion without the necessary background information. This impacts on effective and efficient healthcare delivery, especially when expensive diagnostic procedures have to be repeated, or when treatment is duplicated unnecessarily. Self-referral from an ethico-legal perspective is often viewed by patients as a consequence of mismanagement of their conditions (Beck & DuMoulin, 2013: 32; Dickie, Ellwood & Robertson, 2011: 13). In this study, self-referral was viewed both from an ethical and legal perspective where its denial is seen as an infringement of someone's right to a second opinion (HPSCA National Patients' Rights Charter 2008).

According to Beck and DuMoulin ,(2013:34) within the Canadian healthcare system, patient self-referral is classified in two types: a) an in-office self-referral, where the specialist performs a test requested by the patient on-site which is not indicated in the diagnosis, and b) a self-referral where the patient requests tests or diagnostic measures not indicated in the diagnosis and the physician orders those diagnostic measures to be performed at another site where the physician has a direct or indirect financial interest. The two types are also applicable in Houston, Texas (Levin & Rao, 2010:848-852). In Australia, patient self-referral is reported as the bypassing of local primary healthcare services in rural counties, to facilities and professionals that are located further away from the patient's residence (Liu, Bellamy, Bannet & Weng, 2008:124). The patients provided reasons for self-referral as poor quality of local healthcare and the reputation of poor care delivered in healthcare facilities where they live (Read et al, 2014; Yaffee, Whiteside, Oteng, Carter, Donkor, Rominski, Kruk, & Cunningham, 2012;17).

In developing countries, for example Zambia, the health authorities established 'Reference Centres'. The aim of these centres is to reform and upgrade urban health centres at different levels of care. The intention was to relieve the congestion in the outpatient departments (OPD) which was

caused by self-referred patients who had bypassed the primary healthcare facilities (Conrad, 2013:25).

When expounding on patient self-referral, Mojaki, et al (2011:109) indicates that bypass in South Africa implies that the patients present themselves at a higher level of care for management and care without being referred by general practitioners. The situation in South Africa is made worse by the fact that different hospitals use different policies on patient referral (Mahinda, 2013; Gina, 2011:2). The current referral–processes for healthcare in South Africa are obscured and institutionally based (Gina, 2011:3; South Africa, 2008:3). There is no uniformity throughout the country on referral systems. A typical example is that the tertiary academic public hospitals do not use same policy on referral; despite the fact that these hospitals are within the same circuit and province.

There is an exodus of self-referred patients with chronic debilitating diseases such as cancer, diabetes and cardiac diseases, from Limpopo, Mpumalanga and Kwazulu-Natal provinces, who migrate for management to more urban hospitals; bypassing tertiary hospitals in their provinces. It is unclear as to what the pull factors to these hospitals are, despite their geographical location (urban) (Mahinda, 2013; Mojaki, et al 2011:109). The findings from Mahinda, (2013) and Mojaki et al, (2011) studies exposed that self-referral happened because of lack of high level diagnostic health care equipment that are needed and not available in Primary Healthcare centres.

In essence, the tertiary hospitals provide tertiary patient care; in other words, they are supposed to admit patients who are referred from provincial district hospitals, not by patients themselves, for continuity of care. One may consider the question as to what is taken into account in order to admit a self-referral patient in these tertiary hospitals.

In South Africa, the right to have access to healthcare is enshrined in the Bill of Rights in the Constitution of South Africa, (Act 108 of 1996) and reflected in the National Patients' Rights Charter of 2008, which specifically provides for the right to request a referral for a second opinion to a health provider of the patient's choice and the South Africa, (2008:3) indirectly endorses measures for patients to conduct self-referral. The endorsement is through various clauses such as the right to self-determination and autonomy, right to second opinion and the right to choose where to be treated within these policies. However, against the existing structures, powers and mechanisms within the referral policies of the National Department of Health the endorsed rights are compromised and impeded upon. Despite the deterrence by the referral policies in South

Africa, many patients continue to seek second opinions at tertiary level (South Africa, 1996; Dickie, Ellwood & Robertson, 2011: 13).

South Africa is in the process of implementing National Health Insurance (NHI) and patient referral is one of the processes embedded within the National Health Insurance (Matsoso & Fryatt, 2013:154). In reality what is known is that, within patient referrals, there will always be self-referred patients. From a national healthcare debate, self-referred patients might be a way to *"bend the cost curve*" (Levin & Rao,2010:848). However, from a patient's perspective, self-referral is considered a human right in terms of healthcare access. The implementation of National Health Insurance and its other processes, of which patient self-referral is included, warrants in-depth research within the South African healthcare system. The current study was aimed at developing strategies for patients' self-referral patterns/pathways in tertiary hospitals in Gauteng Province in South Africa.
This work is embedded with women's health as one of the pillars within the National Health Plan of South Africa. In essence the health status of women provides a true reflection of a country's sustainability. Hence the focus of the entire study was on women with chronic conditions and on how they can be empowered to navigate management of their condition from a human rights perspective.

1.3 STATEMENT OF RESEARCH PROBLEM

In South Africa, each tertiary facility in the different provinces has its own policy on patient referral (Gina 2011:2). Patients are expected to follow the prescribed channels guided by these policies when entering the healthcare system. The correct channel is starting from primary level, which is regarded as the first point of entry, to then, if appropriate, being referred by a healthcare professional to specialised healthcare services (South Africa, 2008:3; Liu, et al., 2008:124). However, patients are bypassing the first point of entry which includes primary healthcare facilities and district hospitals, and referring themselves to tertiary hospitals. A case example is from a specific tertiary hospital in Gauteng, where statistics on self-referral patients from June 2017 to June 2018 indicate that a total of 17 850 patients referred themselves to the tertiary hospital (Hospital D statistics 2018). Self-referral leads to overcrowding and overload of work for the healthcare professionals (based on comments by nurses and medical doctors). The effect of self-referral on patients is that their health history is lost and therefore their healthcare interrupted (South Africa, 2008:3; Dickie, Ellwood & Robertson 2011: 13). From a public policy perspective, self-referral is viewed in relation to the costs that are incurred by the public healthcare system (Beck, 2013:33) in paying repeatedly for the patients' diagnosis and management. Self-referral

from an ethico-legal perspective is associated with misdiagnosis and misinterpretation of the patients' condition (Beck & DuMoulin, 2013:33; South Africa, (2008:3).

Chapter 2 of the Constitution of Republic of South Africa 1996 endorses the right to life and access to healthcare. Patients who are referring themselves to the tertiary hospitals are exercising their human rights. These rights are recognised within the health sector through policies and guidelines such as the Patients' Rights (HPCSA 2008) and Batho Pele principles (South Africa, 1997) in which unfair discrimination against patients is prohibited and the right of patients to second opinions and self-determination is protected. A referral policy (South Africa, 2008) has been drafted, but has not been implemented and in the midst of this confusion, patients continue to refer themselves to tertiary hospitals. Self-referral in South Africa is a common phenomenon and should be managed in an appropriate and feasible manner. Through this study, strategies to manage patients' self-referral were developed in the tertiary hospitals in Gauteng Province.

1.4 SIGNIFICANCE OF THE PROPOSED STUDY

Findings from this study might be of importance to self-referred patients, healthcare practices and national policy development:

Patients care: The outcomes of this study might be significant for patients who will be allowed to refer themselves to another level of care. The endorsement of self-referral will give patients the right to seek multiple opinions related to their diagnosis.

Healthcare practices: The results might change traditional referral practices where letters of referral will be given or files transferred, as is done with pregnant women in the whole of South Africa. This will promote and ensure continuity of patient care whilst promoting achievement of optimal health for all.

National policy development: The study findings might lead to the incorporation of current patterns/pathways relating to patient self-referral in future reviews of the South Africa, (2008:3) and other relevant legislation.

1.5 RESEARCH QUESTION

The central research question that guided this study was:
What are the patients' self-referral patterns/pathways in tertiary hospitals in Gauteng Province?

1.6 AIM AND OBJECTIVES OF THE STUDY

The overall aim of this study was to develop strategies to manage patients' self-referral to tertiary hospitals in Gauteng Province.

In order to achieve the aim of the study, the objectives of the research were:

Phase 1
Objective 1: To explore and describe patients' self-referral patterns and healthcare professionals' perspectives on the current patient self-referral patterns/pathways in tertiary hospitals in Gauteng.

Phase 2
Objective 2: To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

1.7 CONCEPT CLARIFICATION

According to (Mogale, 2013:4), concept clarification is to define key concepts appropriately in research in order to avoid ambiguous research constructs. Concept clarity is essential for instrument development and validity of research findings. (Albashayreh, Al-Rawajfah, Al-Awaisi, Karkada, & Al Sabe, 2019: 1-9; Eriksen 1995:59). Some of the terms and concepts used in the study are presented below:

1.7.1 Culture

In contemporary ethnographic studies culture is viewed as the day to day activities of the people. In this study, culture was framed as workplace culture, which is influenced by the patient and healthcare professionals. Workplace culture is about the characteristics of work and its influencing factors, which embrace values, and beliefs of providers and users. Wilson, McCormack, Henderson, Wilson & Wright, (2007: 3) describe workplace culture as "the way things are done around here". Similarly, McCormack, Kitson, Harvey, Rycroft-Malone, Titchen and Seers, (2002) supported by Eskola, Roos and McCormack,Slater, Hahtela, & Suominen (2016:9), enhance the

description by stating that workplace culture ensues at individual, team and organizational levels in order to create the context for practice. Ethnographers in institutions, however, argue that workplace culture is about work processes, texts and discourses of various sorts, taken as the fundamental grounding of social life in the specific organization, which usually ensues without conscious awareness (Devault, 2006:29). In this study, the term workplace culture implies how the healthcare professionals provide health care services as enacted in policies, values and beliefs of the tertiary hospitals on patients' self-referral.

1.7.2 Imbizo

Traditionally, *imbizo* in Nguni, *pitso* in Sotho, and *tshivhidzo* in Tshivenda dialectics refers to a gathering summoned by the King, Chief or any leader in the community. However, the word has been used interchangeably for conferences, workplace workshops and consensus meetings (Pretorius, 2006:754) since 1994 in South Africa. In the public and community terrain *imbizo* is a term used to describe public debates and dialogues. Hence, Mathagu, (2010:4) defines *imbizo* as a gathering of the subjects of the King; while Mfene, (2013: 18) describes *imbizo* as a preferred policy discussion forum that enhances dialogue and interaction between the service providers and users of services. In this study, *imbizo* refers to the consensus meeting that was held in order to develop the strategies on self-referral for patients at tertiary hospitals.

1.7.3 Patient

A patient is a sick person (Tulloch, 1996: 1114). According to the South Africa, (2008:11) a patient is a person receiving medical treatment. In this study, a patient was a person who looks for treatment through self-referral to a tertiary hospital in Gauteng province.

1.7.4 Patterns

"Patterns are regular and intelligible forms or sequences discernible of certain actions or situations" (Johnson & Smitha, 2015). In this study, patterns were used interchangeably with pathways as these were the ways that patients used to refer themselves to obtain management of their diseases at a tertiary hospital.

1.7.5 Pathway

Pathways are means of planning through thinking of ways or routes to reach a goal (Parashar, 2015:565-568). In this study, pathways are used interchangeably with patterns as these were the ways that patients refer themselves to obtain management of their diseases at a tertiary hospital.

1.7.6 Self-referral

This is the process followed when a person refers himself or herself to specialised healthcare centres, without the proper referral letters (Seidenwurm, 2012:109; South Africa, 2008:3). In this study, self-referral was the processes / practices that the patients used to refer themselves to tertiary hospitals without following the prescribed referral system used in those tertiary hospitals in Gauteng Province.

1.7.7 Tertiary hospital

A tertiary hospital is a designated hospital set aside by the specific province in South Africa to manage specialised cases and simultaneously is assigned to train vast categories of healthcare professionals (Cullinan, 2006: 11-20; South Africa, 2008: 11). In this study, a tertiary hospital was an academic hospital where patients from the district and regional levels of care are referred for specialised treatment and interventions.

1.7.8. Strategy

Strategy refers to a plan or tactic of action or policy in business or politics (Long, Zhang, Deng, & Zhang, 2014: 494). In ethnographic studies, strategy can be framed as the cultural schema which is charted by the researcher and the participants (Agar, 2006: 18). In this study the strategy was an action/s that was developed from the self-referral patterns/pathways of patients in tertiary hospitals.

1.7.9 (e)-Strategy

From the above definition of strategy which refers to a plan or tactic of action or policy in business or politics (Long, Zhang, Deng, & Zhang, 2014:494), a normal strategy can be done manually. The term (e)-strategy in this study means that the plan of action has a vehicle through to be achieved, which is electronics. An (e)-strategy is defined as a plan of action which is designed to achieve a particular goal electronically, that is using the computer. Sondhi, (2018) advocates that for an (e)-strategy to work the person to use it must know the people who are to use the strategy, recognise their role, comprehend the work or business, be technologically savvy and widen the skillset. In this study the researcher and the people to use this (e)-strategy must have these characteristics.

1.8 RESEARCH METHODOLOGY

A qualitative research approach using a critical ethnography design was used. Purposive sampling was used as the researcher considers the participants to have a profound knowledge and in-depth information on the phenomenon. Data was generated through: in-depth interviews with patients and healthcare providers rendering services to self-referred patients in Gauteng chronic co-

morbidities clinics based in tertiary hospitals. Additionally, relevant site documents were reviewed. Data was analysed through the analytic five steps framework as advocated by the nurse ethnographers Roper and Shapira, (2000:98). Research methodology will be discussed in detail in Chapter three. Ultimately, an imbizo as a consensus meeting was held with the policy makers, service providers, community members and patients for the development of the self-referral strategies. The development of the strategies will be discussed in Chapter 7.

1.9 ORGANISATION OF THE STUDY

This thesis is summarised in Table 1.1 below.

Table 1.1: Summary of layout of thesis

CHAPTERS	TITLE	FOCUS
Chapter 1	Orientation to the study	Orientates the reader relating the background to the study, problem statement, research questions, design and methodology was discussed
Chapter 2	Context	Explains healthcare provision in South Africa and the health-seeking behaviours of patients in different healthcare settings
Chapter 3	Paradigmatic and theoretical perspectives	Provides a detailed description of the paradigmatic and theoretical perspectives used
Chapter 4	Phase1: Research methodology: Critical ethnography	Phase 1 which is the empirical phase discusses critical ethnography as research design and the methodology used.
Chapter 5	Data analysis and interpretation	Provides the detailed processes that were followed to analyse the data and the interpretation thereof.
Chapter 6	Insights and literature control	Discusses the insights and provides a synthesis on the findings to related literature.
Chapter 7	*Phase 2: Imbizo* Development of patients' self –referral strategies	Phase 2: Description on how the strategies for self-referral of patients to tertiary hospitals were developed through the Imbizo.
Chapter 8	Conclusions, claims, recommendations and limitations	Provides the conclusions, recommendations and limitations of the study.

1.10 SUMMARY

This chapter provided an overview of the study where the background, aim and objectives, research design, methodology and the layout of the study were discussed. Chapter 2 will discuss the context of the study in relation to the healthcare provision in South Africa and the health-seeking behaviours of patients to different healthcare settings.

CHAPTER 2
THE CONTEXT OF THE STUDY

2.1 INTRODUCTION

Chapter 1 presented an introduction and overview of the study. This chapter will outline the context of the study. The chapter will provide the reader with an understanding of what the study is all about aims and objectives, background to Gauteng Province where the study was done, the common health-seeking behaviours and points of referrals of patients.

2.2 AIMS AND OBJECTIVES

The overall aim of this study was to develop strategies for patients' self-referral in tertiary hospitals in Gauteng Province.

In order to achieve the aim of the study, the objectives of the research were:

Phase 1

- **Objective 1:** To explore and describe patients' self-referral patterns and health care professionals' perspectives on the current patient self-referral patterns/pathways in tertiary hospitals in Gauteng.

Phase 2

- **Objective 2:** To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

2.2.1 National Context

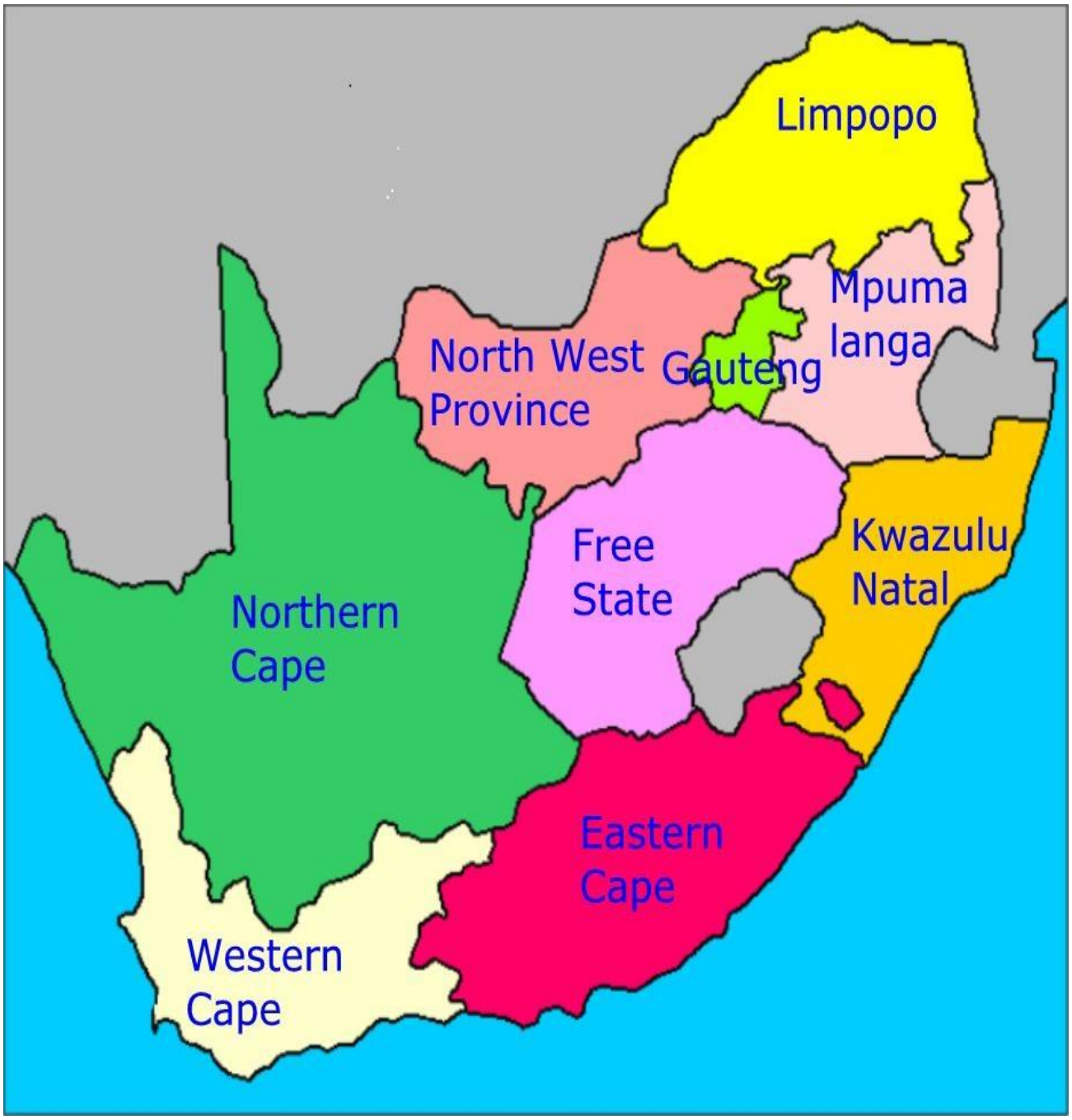


Figure 2.1 Map of South Africa showing the nine provinces

The study was conducted in South Africa. South Africa is a country at the Southern tip of the African continent. The country obtained its democracy in 1994 after decades of apartheid rule. Ultimately, post-1994 the country is made of nine provinces, with Gauteng being the province where the current study was conducted (refer to Figure 2.1). The healthcare system in South Africa before 1994 was fragmented, as was the government of the day (Kautzy & Tollman, 2008:20). Through apartheid policies, the healthcare system was affected by racist legislation, which set up

political and statutory bodies to control the professions and the facilities where healthcare was rendered (Kautzy & Tollman, 2008:20). Discrimination and racial segregation fragmented the health system in the facilities and institutions (ANC, 1994:1). Centrally there were four health departments with one for each race group. In 1993 when rationalisation occurred, the health department was unified, but with the ten homelands' additional department of health, South Africa remained with eleven separate departments of health. This resulted in a fragmented system, mostly biased towards curative caring and a private sector which was not sufficiently accessible, inefficient and inequitable. No team work was emphasised; only medical care was recognised (ANC, 1994:1, 30; Kautzy & Tollman, 2008:20).

A must for the healthcare system of South Africa, was to develop a comprehensive programme to redress social and economic injustices, eradicate poverty, promote efficiency, reduce waste, and promote greater control of individuals and communities over all aspects of their lives (ANC, 1994:1).

From 1994, there has been the establishment of a unified healthcare system that resorts under one National Department of Health with one Ministry. Currently, the healthcare system is considered to be comprehensive as it offers Primary Health Care (PHC) clinics and Community Health Care centres, as well as Secondary or District and Tertiary HealthCare facilities (Mojaki, Basu, Letshokgola & Govender ,2011:109; ANC 1994:1).

According to the National Health Act, (2003), Regulation 185 of 2012, the public health system of South Africa is divided into five categories, the PHC, district, regional, tertiary, central and specialised hospitals or facilities. The PHC is where patients procedurally ought to start seeking healthcare, as the first point of contact with health facilities. The district is the second tier for patients to be referred to from PHC. The regional is regarded as secondary healthcare where the patients from the district are referred to, according to the need of each patient, and the regional or secondary institutions refer patients to the tertiary hospitals. Tertiary hospitals provide specialised medical care usually over an extended period that involves advanced and complex procedures and treatments performed by medical specialists using state-of-the-art equipment.

2.2.2 Background to Gauteng province

This study was conducted in Gauteng Province's three tertiary hospitals. The three tertiary hospitals are found in different parts of the province, but are all located within the two main metropolitan municipalities of the province (**Refer to Figure 2.2).**

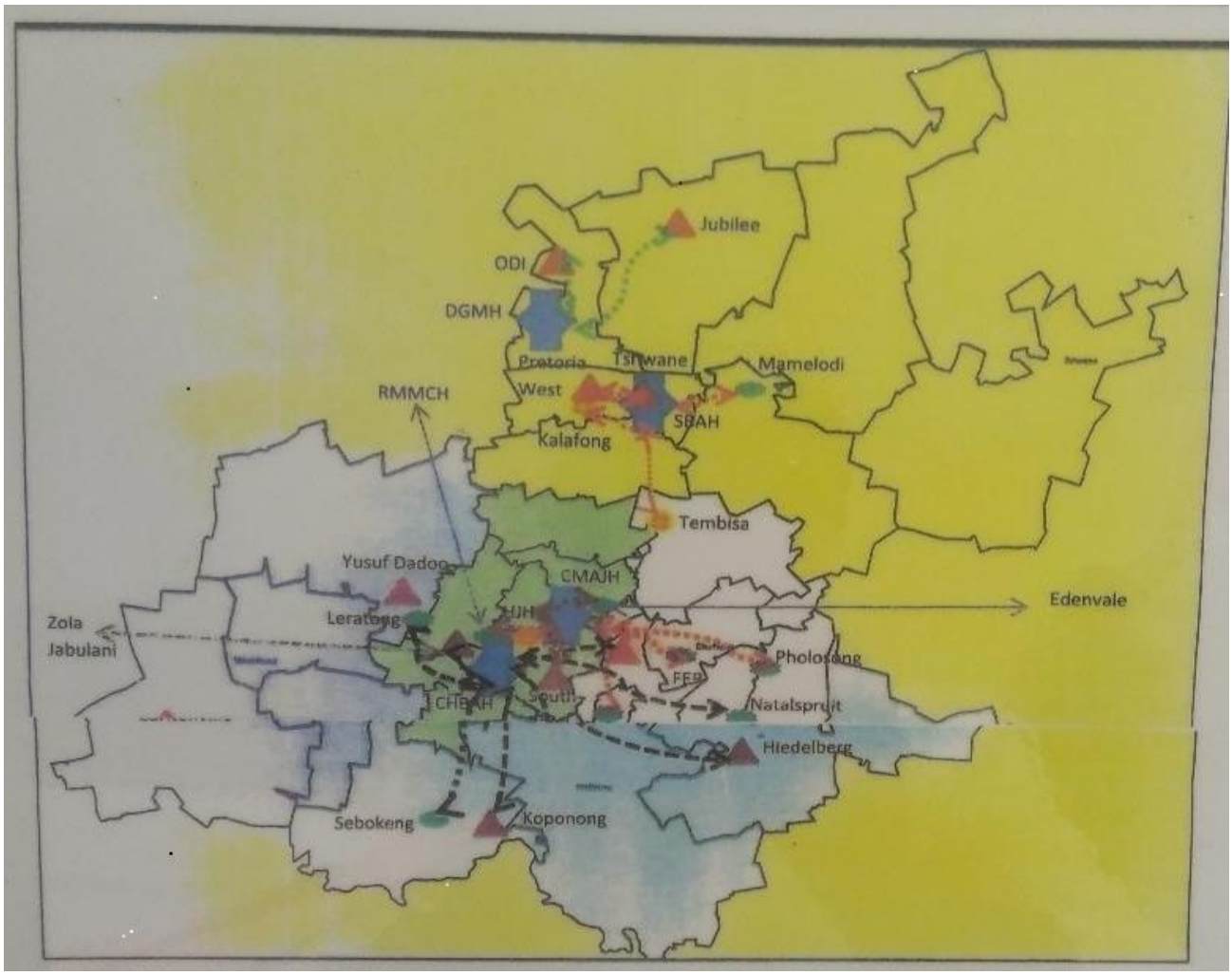


Figure 2.2 Map of primary, district and tertiary hospitals in Gauteng province

In this map, the tertiary hospitals are indicated in blue, and the district hospitals in red.

As indicated before Gauteng is one of the nine provinces of South Africa. It is the smallest province, and stretches about 120km from east to west and 55km from north to South with 18 176 km² surface area. Despite being the smallest it has a population of 12.67 million (Gauteng Growth and Development Agency, 2013).

This is a migratory province and it was established during the discovery of a gold reef in 1886 by two prospectors on a farm in Langlaagte. This became a turning point in South African history, as South Africa changed from an agricultural society to become the largest gold producer in the world. This shift attracted a lot of people seeking their fortune. Some came from England with shipments

of products, to meet the demands of the mines and the communities that were developing along the curve of the underground gold reef named as the Witwatersrand (Durand, 2012:29).
Currently, the Gauteng province is made of five metro cities: City of Tshwane, City of Johannesburg, West Rand, Ekurhuleni and Sedibeng. Tshwane is the administrative capital while Johannesburg is the economic hub, hosting the Johannesburg Stock Exchange (Gauteng Province 2019). Gauteng consists of different human settlements in which people live, including suburbs, peri-urban and informal settlements or squatter camps areas. The suburbs are where middle class people live in modernised houses. Peri-urban areas are those areas resulting from the process of peri-urbanisation, the landscape interface between town and country, or a rural-urban transition zone where urban and rural uses mix and often clash. Informal settlements or squatter camps are shanty towns where people who are poor or seeking jobs in urban areas live. This accommodation is often made of corrugated metal, sheets of plastic, cardboard and planks.

Gauteng Province hosts six public universities and 27 public hospitals. It has a highly educated population who know more about their rights-related education and health than the average citizen, although there are also those who do not have a clue about their rights. According to the literature, (Cutler, Lleras-Muney, 2014:232; Baum, Ma & Payea, 2013; Braveman, Egerter & Williams, 2011; Goldman & Smith, 2011:72; 1728) education can be a predictor of good health, hence in both groups the interpretation of health issues is at the two extremes of the continuum of health literacy. Due to the two extremes, self-referral to tertiary hospitals becomes a practice by both groups, but for different reasons.

The three tertiary hospitals where the study took place, each have specialised outpatient clinics with patients procedurally referred or self-referred from all over South Africa, particularly Limpopo, Mpumalanga and Kwazulu-Natal. Despite the three tertiary hospitals being in the same province, their referral policies differ.

In hospital A, patients are referred from a secondary or district hospital to the tertiary hospital. If a patient self-refers, they re-direct the patient back to the nearby district hospital for care to follow the correct channels of referral. In hospital B, patients are referred from PHC clinics to the tertiary and patients from the nearest district hospital. There is only one district hospital attached to this tertiary hospital and it is very far for the people it serves with many PHC clinics around it. The tertiary hospital has a triage area which is served continuously by a nursing team led by a registered nurse and medical doctors for triaging all patients who arrive in the tertiary hospital for care. Hospital C is fed by patients referred from secondary hospitals around it, and from its own specialist clinics.

The compelling issue becomes that the policy for referral in South Africa is still in a draft form, and has been since 2008. Hence all these tertiary hospitals have their own referral policies. Bed occupancy in these tertiary hospitals differs according to capacity and the assigned specialisation as well as human resources. (Refer to Table 2.1.).

In a tertiary hospital where the study was piloted, it was found that patients referred themselves from Soweto, DRC, Botswana, Zimbabwe, and Mozambique and in fact further north in Africa. One difficult issue was that some do not speak English, and some do not have papers for identification as they entered the country illegally. According to an anecdotal trend, some patients disguised themselves as coming to study or work in the country, and then self-referred to hospital with no referral letters as they did not have identification to go to the PHC with.

Table 2.1 Research Settings

	HUMAN RESOURCES	NUMBER OF BEDS	SPECIALISED SERVICES	POPULATION SERVED
Hospital A	6764	3200	Foetal medicine, uterine artery embolization, radiology, obstetrics and gynaecology, oncology, etc.	4 949 347
Hospital B	4080	1650	Burns care, specialised clinics	957 528
Hospital C	Not provided	832	Infertility, ear nose and throat, oncology and nephrology specialisations	3 275 152

Hospital A is the third biggest hospital in the world and it has an obstetric and gynecological unit, a radiology unit in which uterine artery embolization is done, and a big burns unit as well as a massive outpatient department for different co-morbidities. It is also responsible for the continuation of chemotherapy for patients with cancer. Hospital B specialises in oncology and has a burns unit. Hospital C specializes in infertility, nephrology and dialysis, and this is the only hospital which accommodates a university and a hospital clinical department in one building.

2.2.3 Health-seeking behaviour and points of referrals

In South Africa, there are various paths that patients might follow to seek healthcare. The first option might be to stay at their homes without seeking medical help. Another option might be to ignore the sickness until they are in a complicated state, then instead of following the correct

approved channels of seeking healthcare they self-refer themselves to tertiary hospitals as outlined in Figure 2.3.

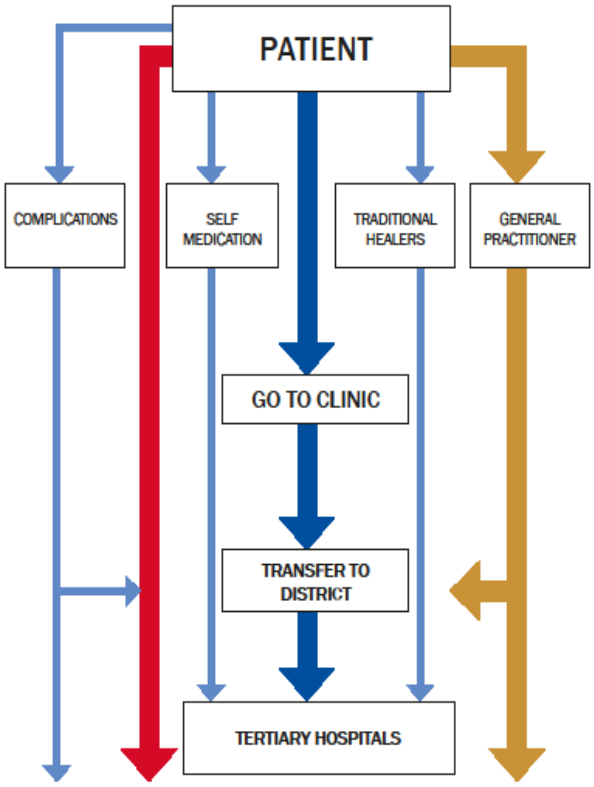
According to the National Health Act (South Africa 2003, 2008) the recommended option of seeking healthcare is by those persons who will feel sick and will follow the correct processes for seeking healthcare services. The processes will ensue: 1) going to the local clinic, 2) referred to district hospitals and 3) referred to a tertiary hospital if the need arises as outlined in Figure 2.3.

That said, another option might be to visit the traditional healers who are practicing within communities. Patients from the traditional healers might refer themselves to local clinics, district and tertiary hospitals when help was not found from the traditional healers (see Figure 2.3). Of importance is that there is no referral system between the traditional healthcare system and biomedical system, hence the patients might opt for self-referral.

A concurrent option is that of seeking healthcare from general practitioners. The general practitioners will provide healthcare and if after a while the patient is not improving they are firstly referred to the district clinics then to the tertiary hospitals. Some of these patients are referred directly to the tertiary hospital as outlined in Figure 2.3.

The last option might be to self-medicate themselves, and on observing that there is no improvement, they will self-refer themselves to local clinics, district or tertiary hospitals as outlined in Figure 2.3.

Figure 2.3 Flowchart on health seeking options



The tertiary hospitals in metropolitan provinces such as Gauteng are challenged with issues such as overcrowding from patients from nearby clinics and other rural provinces, and patients from other African states, and even overseas. According to Land and Meredith (2013) overcrowding is caused by patients migrating for the purpose of healthcare and causing a strain on the available resources in those tertiary hospitals which end up with self-referrals. The other patients are those coming to work in Gauteng illegally. This study was intended to explore those patterns that the patients used to refer themselves to tertiary hospitals in Gauteng province.

2.3 SUMMARY

This chapter is about the context of the study. The context discussed the healthcare delivery system from the apartheid era to the current status quo. Additionally, the chapter provided the pragmatic health seeking patterns/ pathways that people might follow when ill. Chapter 3 will discuss the **paradigmatic** and **theoretical perspectives** of the study that led to the development of the strategies for patient self-referral in tertiary hospitals in Gauteng Province.

CHAPTER 3
PARADIGMATIC AND THEORETICAL PERSPECTIVES

3.1 INTRODUCTION

Chapter 2 presented to the reader the whole context of the study. Chapter 3 will explain the **paradigmatic** and **theoretical perspectives** of the study with emancipatory knowledge as the framework that guided the results of the study and the development of the patient self-referral strategies. The objectives of this study were:

Phase 1

Objective 1: To explore and describe current patients' self-referral patterns from patients and healthcare professionals' perspectives in tertiary hospitals in Gauteng Province.

Phase 2

Objective 2: To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

3.2 RESEARCH PARADIGM

A research paradigm is an accepted set of values and/or beliefs that guides the research and the paradigm determines what is to be studied and what/how questions should be asked (Krauss, 2005:758). Put simply, a paradigm is a way of looking critically at something, a world view, a lens, a standard, a perspective or a set of ideas, which guides the decisions as to how to carry out the proposed research. Critical realism was selected as a research paradigm for this study and will be discussed below in terms of origin, rationale for the choice, relationship (similarities and differences) of critical realism with other paradigms, theories, methodologies, characterisation and application in this study.

3.3 ORIGIN OF CRITICAL REALISM

The origin of critical realism philosophy lies with Roy Bhaskar who is also considered the father of critical realism (Bhaskar, 1975; 1978; 1979; Mingers & Willcocks, 2004; Parpio, Malik, Purijani & Farooq, 2013:490).

3.3.1 Rationale for choosing the paradigm

Critical realism is applied in different disciplines and also the health fraternity, including in nursing research. As nursing research has advanced, wide breadths of nursing issues are being addressed through the critical realism paradigm, and there is research published that uses critical realism to frame nursing inquiry philosophically. A few examples include the following: In Africa, Nigeria, in 2013 Oladele, Richter, Clark and Lang, used critical realism to conduct a study on smoking and tobacco control amongst adolescents and youth. In 2012, Sword, Clark, Hegadoren, Brooks and Kingston, from Canada, did research on the complexity of postpartum mental disease and illness through a critical realism frame. Harwood and Clark from Canada in 2014 did a research study on kidney dialysis decision-making. Also from Canada, Kontos, Miller, Mitchell and Cott did a study on dementia care in 2011.

As a lens through which research can be conducted, critical realism defends the critical and emancipatory potential of scientific and philosophical enquiry against both positivist and postmodernism challenges. The emancipatory nature of knowledge in critical realism is intended to free society from the modification of earlier structures of science (Wikgren, 2004: 11). Related to this study, scientific studies have shown that a structured referral system is suitable for the continuity of patient care (Wikgren, 2004: 11). However, this was not the case in this study as patients referred themselves to tertiary hospitals in South Africa. Critical realism in this study provided an emancipatory platform to explore self-referral as a phenomenon from a human rights perspective (South Africa, 1996; South Africa, 2008:3).

Despite critical realism as the base for freeing people from oppressive social arrangements, critical realism rejects the monistic theory of scientific development and its deductive theory of scientific structure (Hammersley,2002:39; Parpio, Malik, Punjani & Farooq, 2013:491). In this study, the researcher considered various accounts such as personal, cognitive, discursive or socio-cultural, for the development of strategies for patient's self-referral to Gauteng tertiary hospitals.

3.3.2 Relationship of critical realism with other paradigms, theories, methodologies

Critical realism is a philosophical theory of reality and human knowledge, and it falls under the social constructivism interpretive paradigm in which the reality of the world, events and discourses is interpreted by social actors (Bhaskar ,1989; Polit & Beck, 2012:12). Critical realism emphasises the importance of distinguishing between epistemological and ontological questions and the significance of objectivity properly understood for a critical project (Bhaskar, 1989). Unlike modernism, neomodernism (critical realism) doesn't detach itself from a humanistic approach and critical realism allows for a more diverse range of human experiences and caring for people during illnesses.

The assumptions of the positivist world view have been crushed without being able to resolve the phenomenon of discontinuity with the seemingly progressive, cumulative character of scientific development capable of growth and change (Hammersly, 2002:1). According to Wilson and McCormack, (2006:1), a purely positivist approach will not be able to capture most of the unobservable, non-measurable and unexplainable concepts related to the practice component. On the contrary, critical realism is able to acknowledge the role of the study context as it recognises the complexity of social situations (Bhaskar, 1989).

The stratified ontology in the critical realism paradigm, differs from the ontologies of other philosophical frameworks such as post-positivism, as they only engage with and seek to recognise the actual or the empirical domains of the world without proper consideration of an independent reality (Schiller, 2016:91).

Through this stratified view, as alluded to by Schiller, (2016:91), critical realism enabled the researcher in this study to unpack patients' self-referral as one of the difficult social phenomena and articulate the many potential patterns that are used to access emergency departments in tertiary hospitals by the self-referred patients.

3.3.3 Characterisation of critical realism

The tenets of critical realism and its influence on the development and the application of knowledge and research in the nursing profession have been addressed by Parpio, Malik, Punjani and Farooq, (2013: 492). These authors presented essential arguments in support of the critical realism of science as the fundamental paradigm or lens for the pursuit and development of nursing knowledge. According to Reed, (2006:36) and Parpio, et al, (2013:492), critical realism has six tenets which reflect a philosophy of science that is aggressively engaged within the clinical constituent.

Tenet 1: Use of innovative tools, methodology and technologies

As a lens, critical realism accommodates multiple ways of knowing and data collection methods to get some pluralistic perspectives of a phenomenon (Parpio et al, 2013:492). Pluralistic perspective is the belief that no single explanatory system or view of reality can account for all the phenomena of life (Parpio et al, 2013:492). In this study, a pluralistic perspective of phenomena referred to the different methods which were used to collect the data (view Sections 4.4.1.4 and 4.4.2.4) in order to validate the insights of the study. In this study the researcher could have used traditional methods of member checking. Instead, the Google+ platform was used to share data with the participants for the validation of the patterns and pathways to self-referral as discussed in Chapter 5.

The multiple methods of collecting data were used to optimise knowledge production in this study. The methods employed were in-depth interviews with the participants who were patients and healthcare professionals (nurses and doctors) from the tertiary hospitals in Gauteng Province, and a review of patients' documents as well as the referral policies of the different tertiary hospitals. Additionally, an imbizo was also conducted to capture different multiple perspectives. These different data sets provided a multidimensional stance which is a tenet of critical realism.

Tenet 2: The use of new epistemology to educate healthcare professionals about the use of all the ways of knowing

Critical realism can be used in all the ways of knowing in nursing that include empirics which is about the science of knowing; ethics as a moral component of knowing in nursing, and aesthetics as the art of knowing (Carper, 1978:1; Meleis, 2007:1). In addition, critical realism includes socio-political knowing as mentioned by White, (1995), which is about understanding the status quo of the participants in the caring process and the unknowing stance as a condition of openness to knowing (Munhall, 1993); personal knowing (Tarlier, 2005) is based on experiential knowing. Relevant to this study the participants who in this study were the patients, were the ones that referred themselves to the tertiary hospitals thus having experiential knowledge of self-referral. Equally, the healthcare professionals as the other population in the study have personal and experiential knowledge on managing self-referral patients in tertiary hospitals.

Tenet 3: Capacity for self-organisation, agency, humanism, spirituality and potential for empowerment

The critical realist paradigm acknowledges the underlying pattern, a capacity for self-organisation, agency, humanism, and spirituality for potential empowerment (Parpio et al, 2013:492). A more diverse range of human experiences and caring for people during illnesses are core issues in

critical realism. In this study, participants portrayed a sense of empowerment as they were referring themselves when a health need arose (Vannini, 2015:12). Through self-referral, patients were showing one of the endorsements of Batho Pele Principles (South Africa, 1997) and the Patients' Right Charter (South Africa, 1996) which states that all people in South Africa must have access to health and a better life from all services by putting people first. Additionally, the Charter indicates that the patients are allowed to consult freely, have best quality of service standard, be able to access care freely, not accept inferior service, and be informed of everything done on them, while the administration must be open and transparent, if there are complaints it must be addressed and must spark positive action afterward to be done, and patients should see the value of money that should be spent wisely (South Africa, 1997:1).

Tenet 4: Valuing the difference and continuous analysis of oppression

In critical realism, there is continuous analysis of oppression and value of differences where social injustice is the core (Chinn & Kramer, 2008:77). As a lens critical realism interrogates oppressive social arrangements in society (Parpio et al, 2013:492). Specifically, in this study critical realism uncovered gatekeeping mechanisms through the referral policies that are used in tertiary hospitals for patients with chronic conditions to access quality and advance healthcare in these hospitals.

In reality referral policies are in place to cut the costs in the healthcare system, subsequently denying access to those in need of such care. From a social justice perspective, such policies are seen as oppressive social measures (Parpio et al, 2013:492).

Tenet 5: Universal and shared principles

The fifth tenet of critical realism underscores the assumption of universal/shared principles as well as individual uniqueness and local truths (Reed, 2006:1; Parpio et al, 2013:492). This allows for access to diverse models of explanation of phenomena, thereby accepting the multiple interpretations of knowledge (Reed, 2006:1) in the nursing fraternities. For this study the researcher collected various forms of data in three tertiary hospitals in Gauteng Province. The researcher's own analysis of data and sharing the analysis with the expert team in preparation for the imbizo as well the imbizo forum were in line with the shared principles of critical realism where the underlying principle was an understanding of what self-referral entails in tertiary hospitals.

Tenet 6: On-going appraisal in nursing fraternity

Critical realism emphasises on-going appraisal approaches in knowledge construction. Critical realism is equated with critical awareness of history, context, and freedom for the knowledge generation. This is a result of open, dynamic and contextually relevant meta-narratives, theories and philosophies (Reed, 2006:1; Parpio et al, 2013:492).

Throughout the study, the researcher continuously sought validation from the participants and supervisory team. Much as transcription of the data was done individually, consultation meetings were held for guidance. On completion of the analysis the analysis trailers were shared with a team of experts for their appraisal. This continuous appraisal in this study was done in preparation for the Imbizo which was also a strategy for validation in knowledge creation.

3.4 APPLICATION OF CRITICAL REALISM IN THE STUDY

Critical realism guided the entire study on the development of the strategies for patient self-referral in Gauteng province. Through critical realism the unobservable structures (realities) as reasons for the observable event (self-referral) (Krauss, 2005; Morton, 2006; Polit & Beck, 2012: 506) were explored. As a philosophical theory of reality and human knowledge, critical realism falls under the social constructivism paradigm whereby reality of the world, events and discourses are interpreted by different social actors. In this study, self-referral is interpreted differently by the patients who practise it and the healthcare professionals who are managing such patients. Additionally, the records that the researcher reviewed endorsed self-referral from a different perspective.

Consequently, the realists refer to this as a multi-dimensional and stratified social construction of the phenomenon under the study. For the researcher to know the world of the self-referred patients she learned and then reflected critically on what was learnt (Bhaskar & Lawson, 1998: 19; Bhaskar, 1989; Polit & Beck, 2012: 506; Oladele, Clark, Richter & Laing, 2012:1). From the learning consequently the researcher represented the reality independently, shared with the team of experts who were purposively selected before developing the strategies with the participants during the Imbizo.

Critical realism was the relevant paradigm for this study as the researcher employed the voices of self-referred patients and healthcare professionals as reality is multi-dimensional and stratified; as well as open and different (Bhaskar & Lawson, 1998: 19). Through critical realism the researcher understood the description of the current and past situations of patients' self-referral in tertiary hospitals in Gauteng Province. Numerous factors in policy development lead to effective policy/ interventions/ outcomes (Oladele et al, 2012) hence the researcher is hopeful that the strategies will benefit the healthcare system. Different people and their different perspectives on self-referral were incorporated in this study. The aim was to obtain various accounts such as personal, cognitive, discursive or socio-cultural, for the development of strategies as the form of new knowledge.

As a paradigm for this study, critical realism is based on philosophical assumptions as a set of beliefs relating to a particular field or activity (Botma, Greef, Mulaudzi, & Wright, 2010:39). The ontological, epistemological and methodological assumptions are discussed below. Assumptions are discussed as ontological, epistemological and methodological.

3.4.1. Ontological assumptions

Ontology focuses on what exists and is how one views the nature of reality and other people on what is to be studied (Guba & Lincholn 1989). For Wikgren, (2005:15) the ontological assumptions are the underlying beliefs for reality that the researcher will follow in the research process. Hence what is to be researched is of primary concern (Bhaskar, 1989). The classic work of Bhaskar and Lawson, (1998:23) urges that each account of a generative mechanism has 'gaps' or black 'boxes'. As such reality is not only constituted by experiences and the course of events but by also the existing structure, powers and mechanisms (Bhaskar & Lawson, 1998: 23; Schiller, 2016:89).

Critical realism is coined as an intransitive dimension, an attempt to understand the things and not beliefs, experiences or current knowledge according to the critical realist (Bhaskar, 2008:1). As such the critical realists hold that ontological assumptions of the world are capable of changing, and the structures that create the world cannot be directly observed, however, theories can be formulated to make the observations possible. In this study, self-referral is seen as a reality that will continuously happen in tertiary hospitals. The patients are bypassing the primary and secondary healthcare facilities and referring themselves for healthcare at tertiary level without following the prescribed channels put in place by the powers, structures and mechanisms of the Department of Health in its draft referral policy (South Africa, 2008).

3.4.2 Epistemological assumptions

Epistemology refers to the theory of knowledge that is concerned with how we know and what we know (Botma et al, 2010: 40, 287). Epistemology (transitive) as stated by Bhaskar and Lawson, (1998: 23-24, in Oladele et al. 2012; Schiller, 2016:92), is about the relationship between the researcher and what is to be known (knowledge).

Epistemologically, critical realism is about the relationship between the researcher and what is to be known. In critical realism, epistemological factors are based on the fact that human behaviours and interactions are emergent in the production of knowledge (Schiller, 2016:92). In this study the researcher interacted with the patients who are referring themselves to tertiary hospitals in order to come up with knowledge as a social product of such interactions. Additionally, the researcher

interacted with the healthcare professionals who were providing healthcare to the self-referred patients as an attempt to produce knowledge from the interactions.

In this study, knowledge is seen as a social product of human beings (patients) and their activities (self-referral patterns), which is consistent with the views of Bhaskar and Lawson, (1998:16). The critical realists hold an epistemological assumption that knowledge can be acquired independently through a subjective human mind (Parpio et al, 2013: 490). In this study, the researcher used the participants who were patients and healthcare professionals to unpack what self-referral in tertiary hospitals is. The researcher interacted with the patients who are referring themselves to tertiary hospitals in order to come up with knowledge as a social product of such interactions. Additionally, the development of strategies to manage patient self-referral was done with social actors who are involved in self-referral. These strategies were open to critique and were constructively communicated with the team of experts and also with Imbizo participants as alluded by critical realists.

3.4.3 Methodological assumptions

Methodological assumptions are the methods that are used to conduct the study through a scientific process (Botma et al, 2010: 40-41, 47). In research the methodological assumptions propose a trajectory which has to be pursued by the researcher in order to shape the research methodology (Botma et al, 2010: 287). Through methodological assumptions the researcher finds out the knowledge and carries out the research (Burns & Grove, 2009: 287).

Through critical realism as a lens the real mechanisms and structures underlying the research question and objectives were uncovered. In this study critical ethnography was the research design. Bhaskar, (1989) indicates that the intransitive (ontological) dimension is the most important driver for the decisions on methodological approach in a study. Epistemology dimension according to Bhaskar and Lawson, (1998: 23-24, in Oladele et al. 2012) is about the relationship between the researcher and what is to be known (knowledge). Epistemology modifies the methodology and justifies the knowledge produced. In this study, the methodological assumption describes and explains the justification of the method used in the research. Ethnographic studies are among others characterised by the ability to explain phenomena in the context in which they occur (natural setting); together with an understanding of the culture of a group which produces valid explanations of phenomena of interest. A qualitative critical ethnographic design was used to generate data (Botma et al, 2010:289), in order to understand the contributing factors and patterns relating to patients' self-referral. Additionally, critical ethnography assisted on how to develop the strategies from patient self-referral patterns.

3.5 EMANCIPATORY KNOWLEDGE FRAMEWORK

The framework of emancipatory knowledge originates from the four fundamentals of knowing as expounded by Carper, (1978), namely: empirics (science of nursing), aesthetics (art of nursing), personal knowing, and ethics (moral component of knowledge in nursing). Chinn and Kramer, (2008:15) added a fifth pattern of knowing and termed it emancipatory.

This pattern of emancipatory knowing critiques the existing social and political circumstances under which knowledge in nursing has been developed and embraced, and recommends a vision for the future (Chinn & Kramer, 2008:15; 77). As the fifth pattern in knowledge creation in nursing, emancipatory knowing surrounds and connects the four patterns of knowing (Chinn & Kramer, 2008:15). In its inception, emancipatory knowing was intended to ask critical questions such as: who benefits, what are the barriers to freedom, and what is invisible? (Chinn & Kramer, 2008:15). In this study, such questions were the rudiments of the inquiry where self-referred patients were asked about the patterns that they follow in referring themselves to tertiary hospitals. Secondly, who was benefiting during self-referral processes and the invisibility factors that are imposed by the referral policies of the different tertiary hospitals such as gatekeeping mechanisms and injustices for chronic patients. The reasons for choosing the emancipatory framework was that the framework requires people to extensively analyze the existing social and political circumstances under which knowledge has been developed and embraced, and recommends an idea or change for the future.

According to Chinn and Kramer, (2008: 103) an emancipatory knowledge framework consists of four ideals which are used as a benchmark to determine the worth and validity of knowledge. These ideals are*: critical reflections/ actions, sustainability, empowerment, social equity and demystification* as indicated in Figure 3.1.

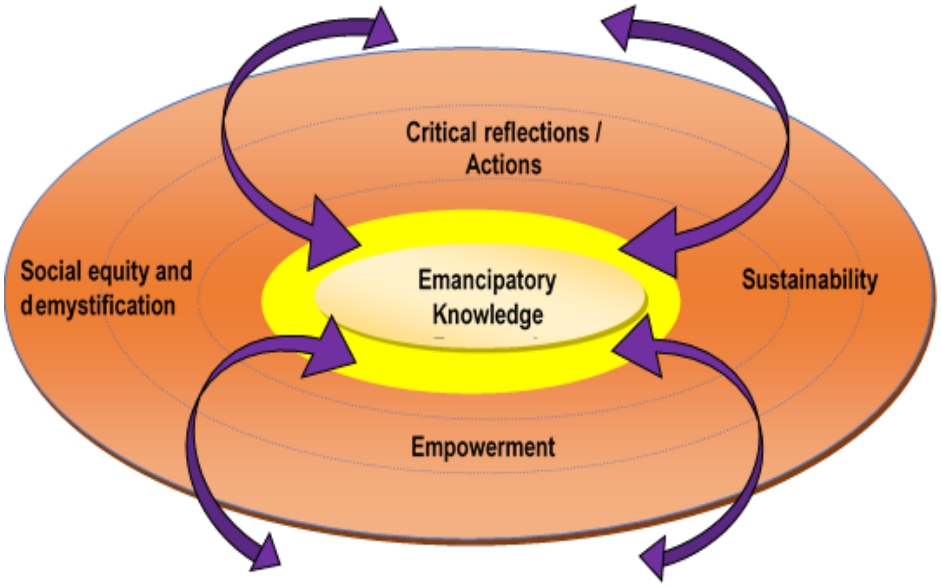


Figure 3.1: Emancipatory Knowledge Framework (adapted from Chinn & Kramer, 2008: 10)

3.5.1 Characterisation of emancipatory knowledge framework

Emancipatory knowing forms the core of the four patterns of knowing. However, according to Chinn and Kramer, (2008:102), the emancipatory knowledge framework consists of four tenets: critical reflection or action, sustainability, empowerment and social equity and demystification **(Refer Figure 3.1),** which will be discussed below.

3.5 1.1 Critical reflections or actions

Emancipatory knowledge calls to people to critically reflect or act on situations when experiencing unjust situations and capacities. Through their reflections and actions, they realise that the situations could be different and embark on actions that can change the situations. This is done through in-depth reflection on the situations and seeks emergent actions as the ways of undoing unjust social practices (Chinn & Kramer, 2008:6). In this study one of the patients' roles was justifying their self-referral. In order for them to deconstruct and reconstruct unjust social practices they referred themselves to tertiary hospitals despite the existing referral policies. When reflecting on self-referral as a phenomenon, both the participants, healthcare professionals and patients, understood it very well as a right to access care and an endorsement of WHO and principles of PHC.

3.5.1.2 Sustainability

Sustainability of the health and care system depends on internal and external factors and public and political acceptability and support as stated by Crisp, (2017:1-3).

When people understand and have knowledge of the origin of the social, cultural and political status quo, they can seek freedom (Chinn & Kramer, 2008:6) as such knowledge contributes to social problems. The freedom is sought from the institutionalised political and social contexts that sustain the unjust status quo for the few, while the rest remain disadvantaged (Chinn & Kramer, 2008:6). The new acquired knowledge from freedom is then shaped to influence knowledge and knowing from the people's collective struggles. As everyone has shared their individual insights into the experiences to make future directed change that led to sustainable empowerment (Chinn & Kramer, 2008:5), the proposed strategies are seen as sustainable innovative measures that could be used in the management of self-referral.

3.5.1.3 Empowerment

Empowerment is when an individual has access to information, self -esteem, ability to make choices and assertiveness, which can be in an individual or group dimension (Chaudhuri, 2016:121). The patients as participants were part of the entire process of developing the strategies for patient self-referral in tertiary hospitals in Gauteng Province. Scientific evidence has shown that active participation and involvement of patients in their care optimises the response to patients' needs, as well as ensuring better and faster processes that will increase opportunities for new interventions (Evans, Bird, Gibson, Grier, Li Chin; Stoddart, & MacGowan, 2017:1). The collaborative participation of patients and healthcare professionals in this study was a concrete empowerment strategy to redress the injustices in healthcare settings.

3.5.1.4 Social equity and demystification

For the people to achieve social equity and demystification of the cultural beliefs and values they need to be changed agents (Chinn & Kramer, 2008:7). A demystification process for equitable and fair conditions will clarify the myths that are held against the people. This process will result in the establishment of socio-cultural structures and practices that are equitable in addressing human health and wellbeing (Chinn & Kramer, 2008: 7).

In this study, it was found that self-referral is perceived as a myth in tertiary hospitals, yet it still exists and will continue to take place in tertiary hospitals. The overall aim of the developed strategies was to demystify self-referral as a phenomenon in order to redress social equity in health care.

3.5.2 How emancipatory knowing has been used in nursing research

Chinn & Kramer, (2008:102) mentioned that emancipatory knowing has long-standing roots in nursing that have not been recognised for nurses and nursing as essential and inherent. But there were expressions which were written previously where nurses were involved through emancipatory knowing as a lens (Chinn & Kramer, 2008:100).

Some of the expressions which have been written, for example the Challenge in Action in Chinn & Kramer, (2008), represented a personal experience of a nurse where a call for action for a future in nursing was done through emancipatory insights. The *Nurse Manifest Project* by Cowling & Taliaferro, (2004) and Jarrin, (2006), was an alliance between grassroots nurses and academic nurses who discussed issues on nursing healthcare around the globe. In 2005, Giddings interviewed nurses as active advocates for the disadvantaged. The findings provided insights into the explanations of nurses' own challenges and barriers or injustices in health (Chinn & Kramer, 2008:100). From these findings, a model of social consciousness was developed.

3.5.3 Application of emancipatory knowledge framework in the current study

Emancipatory knowing brings possibilities of social and structural changes. This framework afforded the researcher a space and position to develop strategies. The strategies could enable self-referred patients to be given optimal healthcare in tertiary hospitals. These strategies might be incorporated into the referral policy of the Gauteng tertiary hospitals.

In this study, the patients with chronic or oncological conditions reflected deeply about their conditions and decided to take reflective actions through self-referral pathways. The self-referral pathways are sustainable for the patients as the organisational policies and the social contexts allow only a few to attain expensive interventions in the tertiary healthcare setup.

The strategies are intended to address health equity and demystify self-referral as a phenomenon which is inexcusable in tertiary hospitals as outlined by the various referral policies. Both the self-referred patients and healthcare professionals managing self-referral acted as the change agents for the development of strategies as the socio-cultural structures and practices.

3.6 SUMMARY

This chapter provided a detailed discussion of critical realism as a paradigm of the study and emancipatory knowledge as the framework that guided the results of the study and the development of the strategies for managing patient self-referral in tertiary hospitals in Gauteng

Province. Chapter 4 addresses the method used in this research that is research approach, research design, research methods, data analysis, data management and data storage and ethical considerations, to be able to develop the strategies for managing patient self-referral in the tertiary hospitals in Gauteng Province.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

Chapter 3 discussed the paradigmatic and theoretical perspectives of the study. The paradigm that underpinned the study paradigm was critical realism while the theoretical framework was the emancipatory knowledge framework which guided the study and the development of the patient self-referral strategies. This chapter will discuss the research methodology specifically referring to the research approach, design and methods used to address the aim and objectives of the study.
The aim of this study was to develop strategies for managing self-referred patients in tertiary hospitals in Gauteng Province.

The objectives were:

Phase 1

- Objective 1: To explore and describe patients' self-referral patterns and healthcare professionals' perspectives on the current patient self-referral patterns/pathways in tertiary hospitals in Gauteng.

Phase 2

- Objective 2: To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

4.2 RESEARCH METHODOLOGY

Research methodology refers to all the processes that the researcher will follow in order to conduct the research (Polit & Beck, 2017:463-464). In this study methodological processes will relate to the fundamental steps of conducting an ethnographic study. The processes include: the research approach and the research design which narrate ethnography as a whole, purpose of ethnographic

research designs, researcher's reflexivity, and contextualization of the study, gaining entry, selection and recruitment of participants, data generation, analysis and ethics encompassed.

4.3 RESEARCH APPROACH

A qualitative research approach was used, which entails the in-depth description of the characteristics and qualities of the phenomenon, and data is produced in the form of words (Silverman, 2014:3-14; Botma et al, 2010:182). In qualitative research the data is expressed through feelings, actions, thoughts, behaviours and insights instead of numbers (Silverman, 2014:6-11; Botma et al, 2010:182). Such data is placed in an array, larger whole or a dense description, drawn from many sources to avoid loss of the meaning of the research (Silverman, 2014:6-11; Silverman, 2014:24; Botma et al, 2010:191; Brink, 2010:11).

Using a qualitative approach in this study revealed the meanings related to the phenomenon of patients' self-referral patterns (Silverman, 2014:6-11; Botma et al, 2010: 182), as the phenomenon of interest. The researcher, with the participants, explored self-referral from the perspectives of the patients to develop strategies that may be used in future in the management of self-referred patients to tertiary hospitals in Gauteng province. Through qualitative research, the researcher was able to explore and describe the patients' self-referral as a phenomenon from the viewpoints of the research participants in the context where self-referral was taking place. There was a continuous approach that permitted the uninterrupted interaction of the researcher with the participants in their own environment and in their own language (Polit & Beck, 2017:503; Botma et al, 2010:194; Brink, 2010:11, 113) on patients' self-referral. A qualitative approach was the suitable research approach for this study as the self-referred patients were the ones that have first-hand information of self-referral and the healthcare professionals were the ones that were managing the self-referral patients.

The researcher situated the participants' viewpoints on self-referral within a pluralistic stance as alluded to by qualitative research (Polit & Beck, 2017:456; Brink, 2010:10; Botma et al, 2010:181). The researcher entered the study not knowing what was known or unknown (Polit & Beck, 2017:463; Botma et al, 2010:182) about patient self-referral to tertiary hospitals. The qualitative research approach has various forms of designs, which is supported by the work by Polit and Beck, (2017) and Botma et al, (2010:183). In this study, critical ethnography was used.

4.4 RESEARCH DESIGN

Research design is the guide of the researcher on how, where and when to have the data generation and its analysis. According to Brink et al, 2006:92, it is the overall approach to research in order to achieve the aims of the study.

In this study, critical ethnography was used as the research design. In order for the researcher to have an in-depth understanding of critical ethnography, the researcher first opted to unpack ethnography as a research design, as discussed below.

4.4.1 Ethnography as a whole

Ethnography is a research design that evolved from anthropology and its interest is on studying of individuals, artifacts, and documents in a real or natural setting (de Chesnay, 2015:121; Speziale & Carpenter, 2011:196). The intent in ethnographic studies is to understand the ways, the beliefs systems and values of people (de Chesnay, 2015:121). According to the classic work of Fetterman, (1998:1) ethnography is the art and science of describing a group of people or the culture of the group. The description may vary from for example a small tribal group in an exotic land, to a classroom in middle-class suburbia (Roper & Shapira, 2000:2) or even patients' practices in different health settings as in this case (Oladele et al, 2013: 1).

Ethnography originated from anthropology as a mechanism to study the cultures of people, although now more recently it also includes their lifestyles (de Chesnay, 2015:96). Anthropologists such as Franz Boas, (1948) signalled the beginning of ethnography with his studies on the Eskimo culture. Margaret Mead, (1928) also ushered in the beginning of ethnography with her studies of Coming of Age where she was exploring nature versus nurture among the adolescents in Samoa. Consequently, the design was introduced in healthcare service in order to have a better understanding of different health practices that underpin healthcare provision (Polit & Beck, 2017:10).

In healthcare, ethnographic studies usually assist in the development of services that are culturally-specific to the service users and providers (de Chesnay, 2015:95). In addition, Roper and Shapira, (2000: 3) as well as Speziale and Carpenter, (2007: 196) emphasized that ethnography in contemporary societies is about describing and interpreting the daily activities of the people in their context. This implies how people live their daily lives or how they execute their daily work (Roper & Shapira, 2000:3; Speziale & Carpenter, 2007:196). The ethnographic intent focuses on learning about people by learning from them (Dewi,2014:39-55; Greef, 2009:135).

For the researcher to learn through ethnography there is a need to be in the setting in order to gain awareness through personal experience (Dewi, 2014:39-55); Greef, 2009:135) of the practice under study. This personal experience is made clear through observing in order to avoid errors based on preconceived notions (de Chesnay, 2015:127). In the current study, the researcher engaged with the patients who were referring themselves to tertiary hospitals and the healthcare professionals managing self-referral patients in tertiary hospitals in order to learn about this phenomenon and its current management.

The research questions that ethnographic designs ask, seek to: 1) explore the nature of the phenomenon, i.e. seek to understand why and what people do, and 2) describe the values, beliefs or cultural practices (Dewi, 2014:39-55; Roper & Shapira, 2000:12). Unlike phenomenology, which addresses specifically the experiences, and grounded theory pertaining to the process and how the process occurs, ethnographic studies address and primarily want to know what is happening (De Forge & Shaw,2011: 90; Roper & Shapira, 2000: 12) in the context. The current study aimed to explore and describe the current phenomenon of self-referral patterns amongst chronic patients to tertiary hospitals in Gauteng province. That is why the patients were self -referring themselves and what were the patterns they were using to do self -referral? The cultural practices of the self -referring patients pertaining to seeking healthcare services from the displayed patterns were explained. From these patterns the self-referral pathways were charted and self-referral strategies were developed for future use in tertiary hospitals where they might be formalised.

Agar, (2006: 16) and Madison, (2012:18) posit that in ethnographic research, the ethnographers immersed into the natural setting to learn the culture of the group. This process is called cultural immersion. Dewi, (2014:39-55) and Fouche, (2005: 271) state that a good ethnographic study will give one an intimate 'feel' of the way of life under study through the establishment of rapport, credibility and trust with the people involved. For this study the researcher was reporting at each of the three tertiary hospitals for a period of 16 weeks on a daily basis from Monday to Friday to find out about and understand patient self-referral and the management thereof. This prolonged engagement with participants assisted the researcher with the knowledge and management of self-referral as required by the study.

4.4.2 Purpose of ethnographic research designs

According to Warrell, Walshe and Molassiotis, (2017:8); and Streubert-Speziale and Carpenter, (2007:196), ethnographic designs are classified in relation to their purposes. These purposes are: classic ethnography (Enriquez, 2015; Whitehead, 2005:1); systematic ethnography (Pritchard, 2012:1365); interpretive or hermeneutic ethnography (Landu, 2014:1); ethno-nursing (de Chesnay,

2015); auto-ethnography (Adams, Ellis & Jones, 2017:2; Madison, 2012:10); visual ethnography (de Chesnay, 2015:8; Pink, 2008:1) as well as sensory ethnography (Pink, 2015:1); and focused ethnography (de Chesnay, 2015:9). Additionally, there is critical ethnography (de Chesnay, 2015:7; Roper & Shapiro, 2000:20). Examples of the types of ethnographic research designs are summarised in Table 4.1.

Table 4.1: Examples of different types of ethnographic designs used in Health / Nursing

TYPE OF ETHNOGRAPHY	TITLE OF MANUSCRIPT	PURPOSE	REFERENCES
Classic ethnography	Ethnographic study of self-management by people with diabetes	To understand how people live with diabetes and why self-management is challenging for some	Enriquez, (2015)
Systematic ethnography	Systematic ethnography of school-age children with bleeding disorders and other chronic illnesses: exploring children's perceptions of partnership roles in family-centred care of their chronic illness	To investigate how children, living with bleeding disorders or other chronic illness, understand family-centred care and their inherent role in this approach of care being centred on the family as a whole	Pritchard, (2012)
Interpretive /hermeneutic ethnography	Connecting the Dots: A Review of Norman K. Denzin's Interpretive Autoethnography	To study the biographical life experiences and performance of a person. Using exemplars, the author tried to connect the dots between lives, performance, the epiphany and its' interpretation.	Landu, (2014)
Ethno-nursing	The Experiences of Mexican Americans Receiving Professional Nursing Care: An Ethnonursing Study	To explore the care experiences, views, patterns, and meanings of Mexican Americans who have received professional nursing care.	Zoucha,, (1998)

Auto-ethnography	Critical auto-ethnography, education, and a call for forgiveness	To describe and identify and attempt to remedy personal/cultural offenses.	Adams, (2017)
Visual ethnography	Mobilising Visual Ethnography: Making Routes, Making Place and Making Images	To examine what visual ethnographers might learn from an analysis of how routes and mobilities are represented in local visual culture	Pink, (2008)
Sensory ethnography	What does it feel like to live here? Exploring sensory ethnography as a collaborative methodology for investigating social determinants of health in place	To introduce sensory ethnography as an innovative methodology for studying the lived experience of place based SDOH.	Sunderland, Bristed, Gudes, Boddy, & Da Silva, (2012)
Focused ethnography	The use of focused ethnography in nursing research	To provide an overview of the relevance and strengths of focused ethnography in nursing research.	Cruz & Higginbottom, (2013) .
Critical ethnography	Moral distress among Ugandan nurses providing HIV care: A critical ethnography	To describe the manifestation and impact of moral distress as it was experienced by Ugandan nurses who provided care to HIV-infected or -affected people	Harrowing & Mill, (2010).

Each of the ethnography research designs are briefly introduced:

- **Classic ethnography** is the study of the whole culture or behaviour from the standpoint of its members or insiders (Enriquez, 2015:1). This is the ethnography which was traditionally used by anthropologists. It consists of classic and basic classical ethnography. Classic ethnography refers to the study of populations or communities whereas basic classical ethnography refers to communities or populations including their settings e.g. meetings, organisations where human or populations interact, and also the use of technology in assessing the cultural domains of cultural meanings, through the analysis of language (Whitehead, 2005:3; Enriquez, 2015:1).
- **Systematic ethnography** defines the structure of culture rather than social interaction, emotion and material (Pritchard,2012:863-869). This type of ethnography design originated from

the Brazilian anthropologist Parker, (2009) and he originally published his work in the early 1990s, which quickly became a classic ethnographic study of the social, cultural and historical.

- **Interpretive or hermeneutic ethnography** which is about discovering meanings of social interactions. Hermeneutics is a science or branch of knowing that deals with interpretation so that the researchers can be able to have a shared horizon in their work to be able to work together or collaborate (Hannaford, 2018). Interpretive or hermeneutic ethnography originated from Denzin, (2014) who wanted to study the biography of a person's life experience and the performance of a person (Landu,2014:1)
- **Ethno-nursing** was first used by Leininger who studied explicit nursing phenomena from a cross-cultural perspective, after she had studied nursing and anthropology; she decided to merge cultural studies within her nursing profession in 1997. Leininger advocated, , longer time in the field will be good (de Chesnay ,2015: 6, 15; Brink , 2010:115).
- **Auto-ethnography** is based on personal experience of the researcher; the self is overtly and centrally positioned in the study; the subjective experience is located culturally and theoretically according to Adams, Ellis and Jones, (2017:2). Madison, (2012:10) mentioned that auto-ethnography is about human beings meeting and having a dialogue and challenges that make a difference in other worlds.
- Now of late, as ethnographic designs evolve, there is **visual ethnography** in which photos and films are used to study a culture (de Chesnay, 2015:8). Doing visual ethnography is a milestone in ethnographic and visual research. The design consists of web-based practices for visual ethnography and the issues surrounding the representation, interpretation and authoring of knowledge with the rise of digital media (Pink, 2013:1).
- **Sensory ethnography** is a research design that uses the senses concurrently with other methods of data collection to create knowledge (Pink, 2015:1). Pink provided an important framework for thinking about sensory ethnography stressing the numerous ways that smell, taste, touch and vision can be interconnected and interrelated within research. This article focuses on practical advice on how to effectively conduct and share sensory ethnography (Pink, 2015:1).
- **Focused ethnography** as a design, the researcher looks at cultural factors within a narrower scope of enquiry, rather than the whole (de Chesnay, 2015:9; Knoblauch, 2005:10). According to Venzon Cruz and Higginbottom, 2013:36, focused ethnography has emerged as a promising method for applying ethnography to a distinct issue or shared experience in cultures or sub-cultures and in specific settings, rather than throughout entire communities. There is limited guidance on using focused ethnography, particularly as applied to nursing research. More recently, focused ethnography offers an opportunity to gain a better understanding and appreciation of nursing as a profession, and the role of nursing in society.

- **Critical ethnography** wherein the researcher and members of culture together create a cultural schema to discern the absolute truth of a culture (de Chesnay, 2015:7; Roper & Shapiro, 2000:20). Herein the researcher invites the participants to be aware of the imbalance of power segregating marginalised people and to create change so that the oppressed are given a voice (Oladele et al, 2012: 25).

For the purpose of this study, the researcher chose critical ethnography based on the observations and experiences that are faced by the self-referred patients with chronic conditions or co-morbidity. Located within a post-positivist view, critical ethnography is defined as a qualitative research design that helps the researcher to not only study, explore and understand the culture of the society, but also to critique and change the society (De Forge & Shaw, 2011: 90; Roper & Shapiro, 2000:20). This design was opted for in order to interrogate the impact of the current referral policies on the chronic illnesses of patients and in particular women seeking healthcare services in tertiary hospitals. The intention was to challenge the procedural referral systems in place in tertiary hospitals. Chronic patients wait too long to be referred for management and treatment of their conditions. The researcher used critical ethnography with the chronic participants who were self-referring themselves to tertiary hospitals in Gauteng Province. The participants together with the researcher developed strategies for patients' self-referral.

According to Harrowing, Mill, Spiers, Kullig and Kipp, (2010:243) critical ethnography can be used as a pedagogical and political method of research. As indicated before, the aim of critical ethnography is about raising awareness in the group or culture under study in the hope of effecting social change (Botma et al, 2010:2; De Forge & Shaw, 2011: 86; Roper & Shapira, 2000: 20; Polit & Beck, 2008: 720). Critical ethnography aims not to describe, but to explain, by identifying the influence and relationship between structural factors and human agency. The emphasis in critical ethnography is on culture and change. Then critical realism becomes an appropriate lens to be implored concurrently with critical ethnography to use in understanding and redressing healthcare practices (De Forge & Shaw, 2011: 90), which in this study includes self-referral, in healthcare settings in Gauteng Province.

The most important character of critical ethnography is the researcher as an instrument of research who adequately and accurately represents the voices of the participants. The domains in critical ethnography include emancipatory, illusion-destroying and self-creation (Madison, 2012:1-16; Botma et al, 2010:183). In this study, the researcher inquired into the self-referral patterns of patients to tertiary care hospitals despite the different existing policies on referrals processes in different tertiary hospitals in Gauteng. The researcher, together with the participants, examined the

cultural practices or phenomena of interest from the participants' viewpoints, with the researcher representing the voices of participants as accounts. Representation, in this regard, was about the voices that desired to be heard but is otherwise out of reach or affected by various constraints such as set policies and protocols within the healthcare system (Oladele et al, 2012:25).

4.4.3 Hallmarks of critical ethnography

According to Brink, (2006:120) every research design has what is referred to as the signature or methodological features. In this case the hallmarks of critical ethnography are: the nexus of method and theory, positionality as well as the never-ending dialogues. The hallmarks are such features that create change (Madison, 2012:91).

- **The Nexus of Method and Theory**

In an ideal research world, theory is linked to the research methods (Madison, 2012:13). This notion is clarified by Madison, (2012:13) when indicating that the way in which a theory is, may at times be the same as methods. he notion is supported by Oladele et al, (2012:24) on studying smoking practices and patterns in Nigeria when emphasising the nexus of critical ethnography and critical realism. Likewise, in this study, critical realism as the lens informed critical ethnography as a research design. In the literature, critical ethnography is referred to as doing or the performance of critical theory (Madison, 2012:13). In both critical ethnography and critical realism, the intention is to identify hidden forces and ambiguities that operate beneath appearances. When the duo (nexus of theory and method) is used in research they provide insight and inspire acts of justice (Madison, 2012:91).

In this study, the self-referral policies are seen as unjust as the process involved in the referral processes are seen as gatekeeping mechanisms (Ang, Ho, Mimi, Salmah & Nondah, 2014:2; Atkison et al, 1991:38) that widen the gap in health provision. The two (critical ethnography and critical realism) in this study were used as partners to explore the patients' self-referral patterns in order to develop strategies for self-referral in tertiary hospitals in Gauteng Province.

Through the use of critical ethnography and critical realism as the paradigm, the existence of inequalities became understandable between those who have and those who do not have. Oladele et al, (2012:26) indicated the discrepancies even between more and less developed countries. In this study, the researcher used critical ethnography and critical realism to gain an understanding on how the participants were referring themselves to tertiary institutions as a method of rebellion against the existing referral practices. Through both critical ethnography and critical realism, the

researcher was attempting to challenge the long-standing tradition of referral processes to tertiary hospitals through radical ideas such as strategies for self-referral (see chapter 1).

- **Positionality /Reflexivity**

Critical ethnographers need to be cognisant as researchers about their own acts and how they represent people and situations (Madison 2012:220). In counteracting the representation, it becomes very important for the ethnographers in critical ethnography to go through the process of "*turning back on the self*", which is called reflexivity (de Chesnay 2015:159; Salzman 2002:815). Reflexivity is the main important hallmark of critical ethnographic design. Critical ethnographers need to address how the subjectivity of their perceptions, experiences, personal, and cultural understanding influences reality and informs or is informed by their engagement and representation of others (Madison 2012: 8).

***Researcher's Reflexivity in this* study**

Upon reflection in the proposed study, the researcher has been working in one of the tertiary care hospitals in Gauteng Province since 1990, with chronic patients. The ward had twenty beds. In the researcher's daily activities, the researcher came across patients who referred themselves to the tertiary hospital. These patients then voiced their frustrations and concerns about the way in which they themselves ought to search for optimal standardised quality treatment. The researcher noticed with concern how the patients were subjected to painful and expensive procedures despite being diagnosed where they came from. All these repetitions of the investigations contributed to delays and discontinuity in the care and management of the patients' conditions. These were some of the reasons that compelled the researcher to conduct this study with the intention of forging change in terms of referral processes and procedures to tertiary hospitals in the province.

Madison, (2012:113) clarifies that critical ethnography begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain. Related to the current study, from the human rights perspective the self-referred patients have enshrined rights to seek treatment in any health facility without being questioned by the healthcare professionals. Hence the researcher remained cognisant of an ethical responsibility particularly towards the self-referred patients as part of her sense of duty and commitment based on moral principles of human freedom as stated in the Bill of Rights in the Constitution of Republic of South Africa (South Africa,1996) and supported by the Batho Pele Principles (South Africa, 1997). Taylor et al, (2015:95) underscore the importance of ethics while in the field.

Reflexivity is about starting from where you are as the researcher/s (Madison, 2012: 19).
Throughout the research process the researcher was deliberately aware of herself and her responses, while simultaneously attempting to understand the self-referred patients and the situation they found themselves in (Roper and Shapira ,2000: 26) as required by reflexivity through self-examination against the occurring injustice (Madison ,2012: 10).

On many occasions even before data collection, the researcher had to put up front her reflexivity, self-awareness and self-reflection as a way to acknowledge potential areas of subjectivity during the entire research process as suggested by Streubert-Speziale and Carpenter, (2007: 257) as well as Roper and Shapira, (2000: 26). This was an attempt to take off her own belonging to the research setting (Madison,2012: 19). These elaborations assist the researcher to be more self-knowledgeable as a being (de Chesnay ,2015:159)

According to Roper and Shapira, (2000: 26) reflexivity involves "being deliberately aware of oneself, one's responses, and one's internal state in relation to a specific situation and at the same time attempting to understand the patient and the situation". In order to begin data collection in ethnographic studies, the researcher needs to put up front her/his state of reflexivity, and self-awareness and self-reflection must occur in order to acknowledge potential areas of subjectivity during the entire research process (Streubert-Speziale & Carpenter, 2007:257; Roper & Shapira ,2000:26). 2.

- **Never-ending dialogue with the participants**

In health and social research, dialogue is seen as a living communion between researcher and participants (Madison 2012:10, 142). This living communion entails reciprocal giving and receiving rather than a timeless resolution (Madison 2012:11,114). Dialogue in critical ethnography is an important hallmark as it is intensely committed to keeping the meanings between and the conversations with the researcher and the participants open and ongoing. The researcher in this study, did not only end up by collecting data from the participants but engaged them in analysis and even in the development of the strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

The essence in critical ethnography is to bring self (researcher) and other (participants) together so they may question, debate, and challenge one another (Madison 2012:10). Importantly, the dialogical stance is situated in multiple ways of transgression, collision and elaborations of meaning for the common good (Madison 2012:11). A vital challenge in critical ethnography is not only self-knowledge; concurrently the researcher opens to know the participants more fully. This is

the relationship emphasised by Taylor et al (2015:128), between the participants and the researcher, for in-depth understanding of the culture under study. Likewise, the researcher engaged the participants from the beginning of research up to the final second phase of this study, the development of the strategies during the Imbizo.

4.4.4 Gaining ethical approval to conduct the study

The researcher obtained ethical approval for the study from University of Pretoria, Faculty of Health Sciences Ethics Committee (Refer Annexure D1). The researcher applied for permission to conduct research through the Department of Health, Gauteng Province and also for permission from the three tertiary hospitals (Refer Annexures D2, D3, D4 and D5).

4.4.5 Gaining access to the research setting and participants

In every research project, there are gatekeepers. The gatekeeper in research is the person who can arbitrate access to the research setting or structure (Kulu-Glasgow, Delnoij & Bakker, 1998:221).This gatekeeping is done to protect the patients from people – including researchers – who might come and infringe on their rights to confidentiality and to the Batho Pele Principles, which also emphasise confidentiality, transparency and consultation as part of the functions of gatekeepers in qualitative studies.

Gaining access to the research setting in most ethnographic studies is multi-layered and involves convincing various gatekeepers as well as key informants and best informants to allow and participate in the study.

In this study, the Chief Executive Officers, superintendents and Directors of Nursing in different research settings were the gatekeepers. Also of importance were the unit managers who were able to identify the potential participants for the study (Lee, 2005:36). In other words, the management of the different hospitals became the gatekeepers with the staff from outpatient clinics as the key informants (Taylor, Bogdan and Devault,2015:64)._The self-referred patients in chronic co-morbidity clinics were the best informants about self-referral as the phenomenon of interest. To expedite the access process, the researcher used her insider stance as a professional nurse in one of the tertiary hospitals.

After obtaining ethical approval to conduct the study, the researcher sent the proposal and information leaflets to the training sections of the tertiary hospitals for perusal. Then appointments were secured with the management teams especially in the training sections of the tertiary hospitals and the outpatients' clinics. During these visits the researcher conducted a presentation about the aims and objectives of the study. After the presentation an opportunity was provided to

ask questions about the study and the researcher then answered these questions to clarify concerns.

This initial presentation enabled the researcher to build rapport with the training section staff as well as the members of the staff from the outpatients' clinics. These presentations assisted the researcher in identifying key informants, those individuals who possessed "insider knowledge" and who had the most knowledge on the exploration of self-referral of chronic patients as cited by Taylor et al, (2015:64). The initial presentations provided the researcher with an idea as to which days the outpatient clinics were operating in the three tertiary hospitals around Gauteng Province. During these presentations, key informants, participants and gatekeepers were present.

For this study gaining access extended from February to April 2017. With the exception of hospital C, gaining access in two settings (A & B) was easy and quick. In hospital C the training officer did not have buy-in to the study. As the gatekeeper she was reluctant to give access for the study. The researcher had to wait for three months (as endorsed in the letter) before access was given due to reasons unknown to the researcher.

4.4.6 Recruitment and selection of participants

The participants of this study were chosen from the population which consisted of the patients, the nurses and the doctors from the three tertiary hospitals in Gauteng Province.

Several strategies such as the use of flyers, the use of key informants and word of mouth are used to recruit participants in ethnographic studies. The researcher used word of mouth to recruit participants in the different research settings. The researcher visited various clinics in the three tertiary hospitals to recruit participants who met the inclusion criteria for the interviews. Below are the processes that were followed to recruit the participants.

- The researcher contacted the management of the different settings.
- The management in turn referred the researcher to the managers in chronic clinics.
- Lastly, the researcher was allowed to recruit participants in a purposive manner (Roper & Shapiro, 2000:62).
- The researcher recruited participants individually in the different settings.

Participants are people who participated in the research (Roper & Shapira, 2000: 34; Burns & Groove, 2009:713). In this study these were patients who initiated self-referral to the tertiary hospitals in Gauteng Province, and health professionals (nurses and doctors) who were working in clinics for chronic co-morbidity or similar conditions (Botma et al, 2010: 6). The selection was based on the inclusion and exclusion criteria of this study.

Participants in this study were patients as well as healthcare professionals and were selected purposively based on reasons related to the research and not because people were available or accessible to be used in this study (Etikan, Musa & Alkassim, 2016: 3 Botma et al, 2010: 202). As a qualitative study, purposive sampling helped to achieve the depth of understanding required for the study, in this case study on the self-referral of women with chronic conditions to tertiary hospitals in Gauteng Province. Purposive sampling, according to Etikan et al, (2016:3) and Polit and Beck, (2012: 343), is often used when researchers desire to systematically construct a sample of representative thoughts, views, or experiences in a particular subject or field of study. Purposive or judgment sampling was the preferred sampling technique in this study as the researcher considered the self-referred patients who were women patients and health professionals to have profound knowledge and in-depth information (Etikan et al, 2016: 4; Polit & Beck, 2012: 343).

The number of self-referred patients and health professionals to be interviewed was determined by data saturation (Polit & Beck, 2012:62). This means that if the information being given by the patients and the health professionals is repeated or is the same, data saturation would have been reached. A total of 45 participants were interviewed, with fifteen self-referred patients and thirty healthcare professionals. **(Refer to Figure 4.1)**.

- **Inclusion criteria for the participants**

Inclusion criteria are the characteristics which determined the participants to be used in the research. The inclusion criteria relate to factors that justified the research participants' involvement in the study. Accordingly, the following inclusion criteria were applicable for self-referred patients:

- Adult women who self-referred themselves to tertiary hospitals in Gauteng province
- 18 years and above
- Able to communicate in English
- Attending outpatient clinics or admitted in the wards in tertiary care hospitals in Gauteng province
- Willing to participate in the study and be digitally recorded.

The inclusion criteria for health professionals were:

- Registered with different health professional organisations in South Africa and working in outpatient clinics in the tertiary hospitals in Gauteng Province.
- Registered with the health professions organisations in South Africa, namely the South Africa Nursing Council or Health Professional Council of South Africa
- Have five years or more experience working in the chronic co-morbidity clinics in one of the three tertiary hospitals in Gauteng Province

- **Exclusion criteria**

Exclusion criteria are those characteristics that disqualify prospective participants from inclusion in the study (Botma et al, 2010: 287). In this research, the exclusion criteria were:

- Those patients referred to the hospital by members of the multi-disciplinary team as they had referral letters.

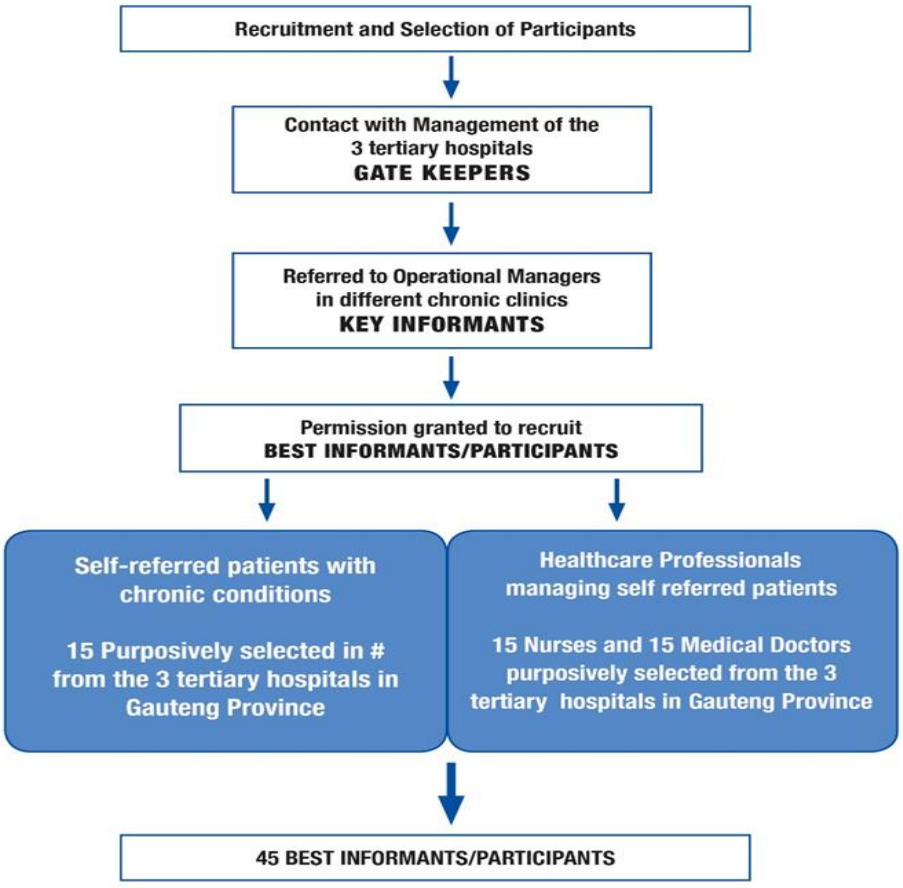


Figure 4.1 Flowchart on recruitment and selection of participants

4.4.7 Data generation

Data generation is the reproduction of the information based on the subject matter concerned to give a clear indication of its impact within the study concerned (Silverman, 2014:82; Botma et al, 2010:285). In ethnographic research, data is generated through (Refer Table 4.4),diverse techniques: interviews, participant observations, field notes, maps, life histories, diaries, photographs, letters, personal documents, and official documents (Higginbottom & Liamputtong, 2015; Botma et al, 2010:189) . Although there are no hard and fast rules in collecting data in ethnographic research, the current research used three phases to generate data:1) interviews with patients who initiated self-referral and healthcare providers rendering services to self-referred patients;2) review of relevant tertiary care hospital (site) documents, where self-referral is taking place; and 3) an imbizo which is a forum that is preferred in South Africa for policy discussion (Mfene, 2013:18).

4.4.7.1 Developing and Piloting the interview guide

The researcher with the aid of the literature and the discussions and consultations with the supervisor developed the interview guide.

An interview pilot is a simulation of the interview which the researcher does before the true interview is done. There may be a lack of consistency in the way the research questions are asked as the researcher can interchange the ways of posing the questions. Through the pilot the researcher was able to find and learn the best way of interviewing the participants and got in-depth experience in interviewing (Taylor et al, 2015:122; Turner, 2010:760).

The researcher conducted a trial of the interview guides at the hospital where she works. This was to see if the interview guides would work in the three research settings. It was confirmed with the participants that the sessions would serve as a trial session for non-research purposes only. The researcher attempted to simulate the session as closely as possible to the topic guides. All the processes were simulated as a replica of the processes to be followed in the research settings. During the trial of the interview guide no new information was added, findings of the pilot were not used.

4.4.7.2 In-depth interviews

In-depth interviews are considered to be interactions with participants where the researcher attempts to understand their living world (Silverman, 2014:56; Botma et al. 2010:207). The researcher aimed to understand the participants' responses in a wider context. Hence, the researcher began with a broad open-ended question, as suggested by Botma et al, (2010: 205), on patients' self-referral. Although the aim of the inquiry took the approach of what ought to be

happening, many participants started the interview by describing what was happening instead of answering the question raised, and the participants gave honest and frank answers. The researcher during the interview kept on bringing back the participants to the subject as suggested by Gielen et al, (2016:466). This was deemed to be important within the context as an illustration of respect to the participants. Additionally, this enabled the participants to answer research questions from participants' views (Gielen et al, 2016:466).

Before the commencement of the interviews participants signed an informed consent document after the researcher had explained the aim of the study as well as the benefits (Refer **Annexure C**). Following agreement between the participants and researcher, the interviews were conducted in consulting room or office for the healthcare professionals, in the three hospitals, which ensured that noise levels were limited, there were no interruptions and privacy could be maintained. The patients were interviewed in the empty consulting rooms. In addition, confidentiality of the participants was maintained and the researcher was able to record the interview and the participants could thus communicate freely with the researcher (Surmiak, 2018:1).

Among the participants, four patients were provided with interpreters for IsiXhoza and Seswati.

The main question that was asked during in-depth interviews with patients was: What are the self-referral patterns that you are currently using to come to this tertiary hospital? Whilst the main question that was asked during in-depth interviews with the healthcare professionals was: What are your perspectives on patients' self-referral to this tertiary hospital?

Based on the participants' answers, follow-up probing questions were asked to understand exactly what they meant and to get a thick description of self-referral (Taylor et al, 2015:123; Roper & Shapiro, 2000:74).

The questioning with the patients evolved over the course of the study, continually developing as the researcher immersed herself in the context (Jarvis, 2016: 79). The interviews took about 30-45 minutes. All the participants agreed upon the digital recording of the interviews. (Refer to Appendix L for the interview guide for the participants).

4.5 RESEARCH METHODS

A research method is all the processes which are used in order to conduct the research (Polit & Beck, 2012:68)

Objective 1: Exploration of patients and healthcare professionals' perspectives on the current patient self-referral patterns/pathways in tertiary hospitals in Gauteng Province

A detailed description of the research methods to address the objective is provided.

4.5.1 Phase 1: Selection of Participants

Selection of participants was based on reasons related to the research and not because people are available or accessible (Botma et al, 2010:199). Purposive sampling was used, which is according to Polit and Beck, (2012:343) often used when researchers desire to systematically construct a sample of representative thoughts, views, or experiences of participants relating to a subject or field of study. There were patients who did not want to be chosen for the study despite the thorough explanation being done and chosen purposively; thus, the researcher agreed with the decision of such participants and they were not used for the study. The researcher purposively selected the self-referred patients who had profound knowledge and in-depth information (Polit & Beck, 2012:343) about self-referral.

Data collection

A total of 15 participants were interviewed from the three tertiary hospitals. These were five patients, five nurses and five doctors from each tertiary hospital (Refer Table 4.2). Later sections will provide an overview of the demographic information of all the participants interviewed.

Table 4.2 Summary of the sample

PARTICIPANTS	Hospital A	Hospital B	Hospital C
Patients	5	5	5
Nurses	5	5	5
Doctors	5	5	5
Sub-total	15	15	15

A total of forty-five participants (n = 45) was the sample size to address objective 1 and 2. The number of participants interviewed was determined by data saturation (Polit & Beck, 2012:62). Data saturation implies that there was repetition in what the participants were saying about the phenomenon.

Field notes

The researcher compiled the field notes. after each participant's interview or observed episode to capture nonverbal cues and the social situation or context in which the event occurred. in this study. The notes were captured both interview and observation notes as advocated by de Chesnay, (2015:99). In observation notes body language, feelings and other facial expressions seen were recorded in support of what the participants were saying verbally. **Refer Table 4.3 for an example of field notes**. The field notes were created and described by the researcher to remember and be reminded about the behaviours, activities, events and other features of what was observed during the interview. Below are the steps that the researcher followed to prepare and create the field notes (Phillipi & Lauderdale, 2017:381).

Steps for preparing field notes

The researcher established a consistent time to write up field notes. In this study, it was always which was immediately after each interview with each participant. Field notes were written in the room where the interview took place, for confidentiality. During the interviews the researcher wrote field notes from what the researcher heard and what the researcher observed. Participants were informed about field notes to avoid disturbing the concentration of the participant during the interview.

Process of creating field notes

The researcher scratched or jotted down notes while in the field as advocated by Phillipi and Lauderdale, (2017:381; Roper & Shapira, 2000:84).

- The participant was informed about field notes to be taken.
- Each participant was assigned a code number.
- The interview is done
- Recording of the interview as field notes and exact quotes done (Refer Box4.1) which helped to clarify some recorded information, during transcription, enhancing data and provided rich context during analysis (Holloway & Wheeler, 2010:95; Flick, 2018:340-342).
- The researcher decides the mode of taking field notes,

Table 4.3: Example of field notes

Researcher do observations on patient after greeting the patient The researcher approaches the patient and relative to ask for permission to interview.	Patient talks very softly and looks away from researcher. Relative asks the researcher to see the doctor for the patient.

Researcher sits next to patient. Researcher speaks to both patient and relatives to explain the setup of the hospital and what she was doing	Patient asks if there was no doctor as she was in pain. Both patient and relative calm and allow the researcher to interview the patient.

In this study, an example of field notes is shown in Table 4.3, with the researcher's intervention on the left –hand side and the actions and response of the patient and relative on the right-hand side.

4.5.2 Phase 2: Review of relevant site documents

One of the popular techniques for data generation in ethnographic study is the review of site documents (Roper & Shapira, 2000: 13; Bowen, 2009:28). The site documents in ethnographic studies are examined to identify dominant discourses on the culture being studied and in this study on patients' self-referral. The documents are used to supplement the in-depth interviews. Depending on the study the documents may comprise public or private documents. The site documents that were reviewed in this study were: admission registers, patient files and referral policies of the tertiary hospitals, other policies like Batho Pele and the Patients' Rights Charter, triaging papers, job descriptions for the nurses and of doctors' and statistics for patients who were self-referral and patients who were re-directed to district or to PHC clinics. **Refer Table 4.2** on the data set for this study. The researcher asked permission to access such documents when seeking ethical approval from Department of Health in Gauteng Province.

The process of reviewing the site documents

The researcher reviewed relevant site documents using the developed review worksheet **(Refer Annexure E)**. The documents were reviewed under the following headings:

Category: The researcher in this part of the review of document wanted to establish if the document was for public, patient, personal or other use. The name or title of the document; was also needed. Documents used in hospitals have types, either a memo or the patients' records, or results of test done on the patient, the healthcare professionals' type of record. The identification of the different. type of the document: memo, patient record, patient's results and even the healthcare provider's record. helped the researcher to find out how far do the healthcare professionals stretch to render care to the self –referral patients.

The unique physical characteristics of the document: The researcher was able to see type of papers used for the patients by healthcare professionals as letterheads or notations, the authenticity of the documents used to review the patients and whatever document is with the

patient does it have a seals or received stamp and others like barcodes of specimen, bloods taken for results on going or patient is hopping from one healthcare facility to the other.

Date on document if available; creator of the document and position, the title of the creator.
The researcher on checking the dates wanted to verify if the patient was seen there at the tertiary hospital that day or came with a note from other tertiary hospital. The researcher was able to identify who consulted the patient and what was written or the result and identification of healthcare professionals.

The purpose of the document: In this study, the researcher found out who the audience the document was written for was; and the content in the document. From the patients records the researcher was focusing on: result from the investigations such as blood, sonar and even radiological results. The date and the time when the investigations were done or still to be done. From the healthcare professionals the researcher's focus was on their descriptions with the aim of exploring their expected duties for patients after being consulted. and to see if there is health education and also when the patient is expected to return if need be or be referred. Documents were reviewed by the researcher to check if treatment was prescribed or given to the patient seen.

Additionally, the statistics for the self-referred patients and statistics for patients directed from tertiary to PHC or district hospitals were also reviewed as well as admission registers in the clinics about the self-referred patients. The researcher checked the admission files as some were admitted and to see the types of patients admitted and the disease profile of such patients who self –refer themselves and the severity of the diseases.

Vitally, the Charter for Patients' Rights and Responsibilities as well as the Batho Pele principles were reviewed by the researcher as the documents addresses issues such as how patients might seek second opinions regarding their condition and for patients to be informed.
The researcher checked on the different Acts of the healthcare professionals attending to the self-referred patients in this study, and the referral system policy of each tertiary hospital where this research was conducted. The researcher wanted to find out if the policies are the same or different in these three tertiary hospitals.

TABLE 4.4 Data set of the entire study

TYPE OF DATA	NUMBER	FORMAT
Interviews	45 15 patients recorded interviews 15 nurses recorded interviews 15 Medical Doctors recorded interviews	Audios
Site Documents	15 patient's records - document review worksheet 2 Job Descriptions (1 for medical doctors, 1 for registered nurses) 3 registers for patients from three tertiary hospitals 3 books for statistics about self-referral patients and patients re-directed to PHC or to district 3 referral policies for the three tertiary hospitals 1 Batho Pele Principles 1 Patients' Rights Charter	Texts

4.6 DATA ANALYSIS

Data analysis is the process of making sense of texts and image of data (Burns & Grove, 2009:534). In ethnographic study, data analysis always occurs together with data collection. The analytic five steps framework as advocated by Roper and Shapira, (2000: 98) was used to analyze all the acquired data from the participants (patients and healthcare professionals), site documents as well the field notes. The researcher opted for the analytic framework of Roper and Shapira as this was an ethnographic study. Roper and Shapira's analytic framework consists of five steps which are: (a) coding for descriptive labels, (b) sorting for patterns, (c) identification of outliers or negative cases, (d) generalizing with constructs and theories, and (e) memoing that occurs

continually as the researcher is moving back and forth among the steps as reflective remarks. **Refer to Chapter 5** for the detailed data analysis.

4.7 STRATEGIES TO ENSURE TRUSTWORTHINESS

Polit and Beck, (2012:394) define trustworthiness as the degree of confidence researchers have in their data and measures to ensure accuracy and confidence in the study (Roper & Shapira, 2000: 82). Polit and Beck (2017:747), delineate trustworthiness through the five criteria as: the criteria of credibility, transferability, dependability, conformability and authenticity. In this ethnographic study trustworthiness was achieved by strategies such as: the use of multiple techniques for data collection, purposive sampling, the construction of open-ended questions framed in neutral language, spending a long time with participants, and reflexivity to ensure trustworthiness.

4.7.1 The use of multiple strategies for data collection

Multiple methods to collect and interpret data about a phenomenon were used in this study in order to realize a truthful representation of reality (Polit & Beck, 2012:745). According to Kulkami, (2013:1) and Brink, (1989:159) by definition in qualitative research, ethnography triangulates information from the main activities of observations, interviews and data sources; what is learnt from one method is checked against other data collection strategy (Roper & Shapira, 2000:83). This is to capture diverse dimensions of the same phenomenon. In this study, triangulation was enhanced by the use of data from in-depth interviews and relevant site documents as well as field notes.

4.7.2 Purposive sampling

The process of selecting events, observing participants and obtaining information from knowledgeable people are some of the most common strategies that are used by ethnographers to increase the relevance and meaning of the research results (Roper and Shapira, 2000:82). In this study the researcher purposively selected knowledgeable participants, and these were patients who had referred themselves to chronic clinics in tertiary hospitals in Gauteng province. Additionally, the sample included healthcare professionals who were managing self-referred patients to these tertiary hospitals and were nurses and doctors in the three tertiary hospitals.
Additionally, the site documents were selected purposively for the review.

4.7.3 Construction of open-ended questions

Ethnographers ask open-ended question/s in engaging key informants and participants when collecting data. Research questions in ethnography are guided by the topic of interest; however,

these questions are subject to change as the study progress (Morse, Barret, Mayan & Olson & Spiers, 2002). In this study the researcher asked the same questions of each population over the extended course of field work (Roper & Shapira, 2000:83). The question/s in this study were on the patterns of patients' self-referral and the perspectives of the healthcare professionals on patients' self-referral to tertiary hospitals in Gauteng Province. These open-ended questions were followed by relevant probes based on the answers the participants were giving.

4.7.4 Prolonged engagement with participants in the field

Spending extended time in the field in ethnographic research increased the opportunity to obtain accurate information from both informants and participants (Roper & Shapira, 2000:83). However, the duration of fieldwork depends on the type of ethnography. The type might either be classic / conventional or focused / contemporary (Knoblauch, 2005:9). In contemporary ethnographies the time frame for data gathering is short-range and not continual, and research settings are visited at various intervals (Knoblauch 2005:9). Thi, study falls under such short-range ethnographic studies. Hence the researcher stayed six months in the field for the entire study Unlike with long. -range ethnography the researcher can stay for a long time within the culture being studied.

4.7.5 Reflexivity

As criterion, reflexivity involved being deliberately aware of oneself, one's responses, and one's internal state in relation to a specific situation and at the same time attempting to understand the patient and the situation as stated by Roper and Shapira, (2000: 26). In this study, self-awareness and self-reflection of the researcher is discussed in detail under the characteristics of critical ethnography (see section 4.3).

4.8 DATA MANAGEMENT AND DATA STORAGE

The researcher ensured that the data was managed under the following categories: protection, confidentiality, data storage, record keeping, data ownership and data sharing, as suggested by Lin, (2009:132) and required by the University of Pretoria (www.up.co.za).

- **Protection:** The participants were made aware of how their information would be used and were also informed that their information would not be used for any other purposes. The data was kept safe and secure from unauthorized access, loss, damage or destruction.

- **Confidentiality:** Participants were reassured that their identity would be kept confidential as well as the information they have provided. Each participant was assigned a code that was linked to his/her data.

- **Data storage:** Data transcribed was stored in the computer of the researcher and the supervisory team. An external drive was used to store or capture the audio recorded findings of this study and also the typed work on this study and the printed data after transcription was pasted on the poster sheaths and are stored.

- **Record keeping**: The researcher's records, including transcribed interviews, the researcher's field notes and the audio recorded interviews, were kept safely by the researcher with no names attached but only with assigned code numbers and the names only known by the researcher. The records consist of the book with field notes, the transcribed interviews pasted on poster sheaths and audio recorded data, stored by the researcher.

- **Data ownership:** The researcher has full ownership of the data together with the supervisor and co-supervisor. The research will be kept for a period of fifteen years after the study has been completed as required by the Ethics committee of the Faculty of Health Sciences.

4.9 ETHICAL CONSIDERATIONS

Ethics refers to the body of moral guidelines that are used to justify healthcare or research practices that promote quality of life (Jooste, 2009: 265). In this study the following ethical considerations were adhered to:

The study received approval from the research ethics committee, Faculty of Health Sciences, at the University of Pretoria. The Department of Health's Permission was sought for the three tertiary hospitals in Gauteng Province, one being the piloting hospital.

Voluntary **informed consent** was obtained from all the participants in the three tertiary hospitals and if the participants decided to stop being involved or to participate in this research, they were told that they were free to do so. Additionally, the following four ethnographic ethical principles were followed as stated by Madison, (2012:113):

Accountability

In ethnography the researcher has to be accountable for participants and the research work as ethnography is about the representation of people's voices. This means being responsible for something or being able to account or to tell a story. In ethics, it is important not just to tell a story but to be accountable for the story one is telling. With this study the researcher tells us the story of how the strategies for patients' self-referral are being developed through critical ethnography.

Truthfulness

Truthfulness is to check how honest one is to the work that has been done. Example: how truthful is the researcher with the data collected, transcribed and analysed? Is there openness in this study? In this study truthfulness was maintained when data collected was not exposed to anyone except to the researcher and the supervisor when discussing about the study and way forward. The expert team of 8 helped by validating the findings after data was analysed.

Community

When presenting the results and the conclusion of this ethnographic story, the researcher must be prepared to respond to anyone in the community who asks a question about the results. The researcher must not disappear but be truthful and correct about what has been discovered and be accountable (Taylor, Bogdan & Devault, 2015:122). This study's findings have been sent to the supervisors and the team of 8 experts for verification of the themes found immediately after the analysis. On development of the strategies, the supervisors were involved with the 13 participants during the Imbizo forum.

Maintenance of participants' confidentiality was considered. According to Polit and Beck, (2012: 156) participants have the right to expect that their data will be kept in strictest confidence. In this study the participants' information was kept confidential by allocating numbers identifying the participants and not names. Names were known by the researcher only.

Justice was ensured by the principle of justice included the right to fair treatment and the right to privacy. Interviews were done in a private place and the respondents' information was not divulged, including the participants' names. The right to fair treatment indicates the equal distribution of information in research and fair selection (Polit & Beck, 2012: 156). In this study the participants were treated fairly and they were given sufficient information. There was equal distribution of information amongst the participants. There was fair treatment of the participants.

The principle of **autonomy** was considered. According to Jooste, (2009: 272) autonomy provides the privilege of self-determination in deciding what happens to one's body in the healthcare

situation. In this study, the participants were given adequate information about the study and about what was expected from them to be able to voluntarily give informed consent.

Authenticity is the extent to which researchers fairly and faithfully display a variety of realities (Polit & Beck, 2012:585). The researcher's findings were verified by the supervisor and the team of 8 experts first after analysis and the participators in the Imbizo forum **(Refer to Chapters 5 and 7 consecutively)**.

Beneficence was also considered. This is the right for the participants to be protected from harm in all aspects of their lives (Botma et al, 2010:20-21). In this study beneficence was maintained through upholding the confidentiality of the data collected.

4.10 SUMMARY

In Chapter 4 the research methodology was discussed, which entailed the research approach, design and methods used to address the aim and objectives of the study. Chapter 5 focuses on the data analysis process and interpretation of the findings on patients' self-referral Themes and Sub Themes, Data sharing with the purpose of developing self-referral management strategies in the tertiary hospitals in Gauteng province.

CHAPTER 5
DATA ANALYSIS AND PRESENTATION OF THE THEMES

5.1 INTRODUCTION

Chapter 4 discussed *the research methodology specifically referring to the research approach, design and methods used, as well as the data collection and techniques that were used in this study to address the aim and objectives of the study.* Chapter 5 will discuss the data analysis process that was used in this study.

Like other qualitative research designs, data analysis in ethnographic designs commences concurrently with the data collection process (Cresswell and Poth, 2017:118; de Chesnay, 2015:57). In this study the data analysis followed Roper and Shapira's, (2000:98) framework of analysis. The analysis was guided by critical realism. Critical realism aided the researcher to critically examine the socio-cultural political status quo and understand why and how patients *(*Bhaskar, 1989; Polit & Beck, 2017:12) were referring themselves to tertiary hospitals in Gauteng Province.

5.2 AIM AND OBJECTIVES

The aim of this study was to develop strategies for the self-referred patients in tertiary hospitals in Gauteng Province with the following objectives:

Phase 1

- To explore and describe current patient self-referral patterns and the healthcare system's perspectives of patient self-referral patterns in tertiary hospitals in Gauteng Province

Phase 2f

- To develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

5.3 PREPARATION FOR DATA ANALYSIS

The researcher transcribed all the recorded data in their different formats (audio, field notes and results from the reviewed documents) in order to prepare them for data analysis. **Refer to Table 4.2 for the full Data Set of the Study.**

During data collection and transcription, the first impressions from the data emerged and were written down. In this regard, the first impressions of data in research were what the data was telling the researcher relating to the aim of the study. This involved sense making from the interviews with the participants as well the reviewed documents and field notes. Some of the first impressions from the patients' data were issues such as: Sense of ownership of the tertiary hospital in their area, staff attitudes compel the patients to tell lies in order to be treated in the hospitals, lack of trust of local clinics' staff members or healthcare providers, need of help, no doctors in clinics, poor communication, having money to pay for care, fear of death, nurses do not care.

The first impressions from the healthcare professionals among others were: overworked staff resulting in burnout, resource depletion, empowerment of patients, ignorance of patients, denial of referral policies by the patients, confidentiality need by patients resulting in relocation, triaging issue, ignorance, tardiness of staff in both primary healthcare and secondary healthcare settings, expense reduction, accountability of patients, seeking of second opinion, attitudes of patients/ public and future suggestions from both participants.

5.4 DATA ANALYSIS PROCESS

Data analysis is the process of making sense of texts and images in the data (Burns & Grove, 2009: 534). As indicated, in this study data emerged from the review of relevant site documents and the transcribed verbatim data from the in-depth interviews of the patients and the healthcare professionals from the three tertiary hospitals.

The five analytic steps by Roper and Shapira, (2000: 98) were used to analyse all the acquired data. This analytic framework is not linear but iterative in nature (**Refer to Figure 5.1).** The researcher opted for the analytic framework of Roper and Shapira, (2000: 94) as this was an ethnography study and the duo are well known ethnographic nurse researchers (Higginbottom & Liamputtong, 2015:60).

The five analytic steps are: (a) coding for descriptive labels, (b) sorting for patterns, (c) identification of outliers or negative cases, (d) generalizing with constructs and theories, and (e) memoing that

occurred continually as the researcher was moving back and forth among the steps as reflective remarks (**Refer to Figure 5.1).** The five steps are discussed further below.

Throughout the analysis the researcher was using critical realism as the vantage point. This vantage point ensured that the researcher was cognisant of the process and consequences of knowledge production (Jarvis 2016:68) throughout the entire analysis.

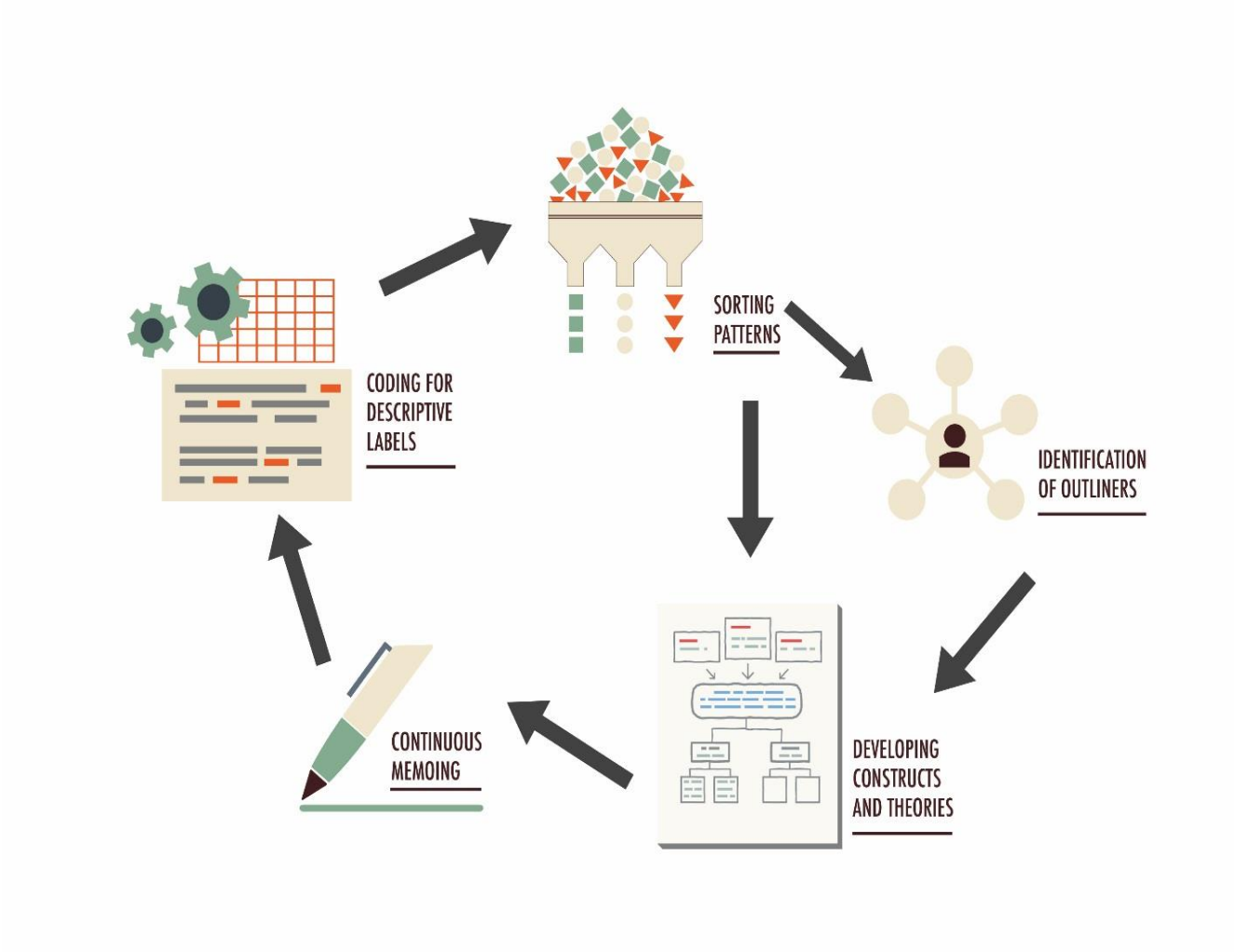


FIGURE 5.1: Summary of the analytical framework used (Roper & Shapira, 2000)

Step 1: Coding for descriptive labels

The first step within the Roper and Shapiro, (2000:94) analytic framework is coding for descriptive labels. Neuman, (2011: 510) describes the codes as the names or labels assigned to specific units or segments of related meaning identified within the field notes and transcripts. In qualitative inquiry a code is most often a word or a short phrase that is symbolically assigned summative, salient, essence-capturing and/or evocative attribute for a portion of language-based or visual data (Saldana, 2008:3).

In this study, from the transcription of the interviews, field notes as well as the review of the relevant site documents the researcher was able to presume the data analysis process.

In this step, the researcher firstly examined the segments or chunks of words, sentences or paragraphs individually. The researcher used different pens to highlight the words and sentences that referred to the same trait. This was done in order to combine sentences and the words in order to generate broader and more abstract categories. Consequently, labels were assigned to the broader categories as labels (Roper & Shapira, 2000: 94; Higginbottom & Liamputtong, 2015:61) A total of 1 323 codes were yielded from the 45 transcriptions, document reviews and field notes. The highlighting assisted the researcher to move to the second step of analysis by Roper and Shapiro, (2000: 94) for the sorting of patterns.

Step 2: Sorting for patterns

The second step was sorting for patterns whereby the highlighted sentences and words were grouped together and patterns were formulated. These patterns according to Roper and Shapira, (2009:98) are formulated by different or discrete codes. The patterns in ethnographic study become general and abstract as they explain regularities in behaviour and beliefs.

In this study, these patterns developed an explanation of why patients are doing self-referral and explained the recurring relationship within the participants' voices in the study which eventually developed into the themes. These themes are: emergency admissions, admission through disguise, financial standing, word of mouth, and human rights and ethico-legal considerations**. Refer to Table 5.5** for the identified themes and sub-themes of the study.

Step 3: Identification of outliers or negative cases

Outliers in data analysis are cases, situations, events, or settings that did not fit the rest of the findings (Roper & Shapira, 2000:99: Higginbottom & Liamputtong, 2015:63). In this study, the researcher did not discard the identified outliers; however, they were put aside and used to test the rest by comparing and contrasting when not sure about others in the study, for a better understanding of the findings (Roper & Shapira, 2000:99; Higginbottom & Liamputtong, 2015:63). Examples of outliers in this step were: 'I am doing this to oppose apartheid practised'; 'This is racial discrimination or segregation in hospitals'; 'The Minister of Health is treated here, so why not me?'

This study was on patient self -referral not about these three examples of negative cases or outliers.

Step 4: Generalization of constructs and theories

This step is about the linkages of the participants' meanings and worldviews from the researcher's emic stance and interpretations of the meanings from the data (Roper & Shapira, 2000:100; Higginbottom & Liamputtong, 2015:63) as an outsider to the phenomenon under inquiry.

The researcher constructed better understandings of the self-referral patterns from both the emic stance and the world view of the participants, as well as the etic perspective of the 'self'. In relation to this study, the researcher is of the belief that self-referral is a paradoxical process as whether patients are allowed to do self -referral or not, they will refer themselves to the tertiary hospitals as they are informed on the healthcare that is provided in tertiary hospitals.

Step 5: Memoing

Memoing in data analysis started from the onset of data collection. The memos are the notations that highlight commonalities and permit connections between pieces of data collected (Roper & Shapira, 2000: 101; Higginbottom & Liamputtong, 2015:63). In this study the researcher jotted down memos and reflective remarks from the interviews, reviewed documents and field notes. These were jotted on the sides of the pages which later provided direction for further exploration and literature support.

5.5 CHARACTERISTICS OF PARTICIPANTS

Participants are people who participated in the research (Roper & Shapira, 2000:34; Burns & Groove: 2009:713). In this study, the participants were patients who initiated self-referral to the tertiary hospitals, and health professionals (nurses and doctors) who were working in outpatient clinics at the three tertiary hospitals in Gauteng province.

Table 5.1: Characteristics of the participants (patients)

		NUMBER OF PARTICIPANTS
Gender	*Male*	*None*
	Female	*15*
Hospital	*A*	*5*
	B	*5*
	C	*5*
Age	*18-20*	*2*
	21-30	*3*
	31-40	*8*
	41-50	*2*
Condition	*Gynaecological Cancer*	*9*
	Other Chronic conditions	*6*

N=15

A total of 15 female patients were interviewed, which included five participants from each tertiary hospital. The participants' age ranged from 18 to 50 years; nine participants were suffering from gynaecological cancer while six were suffering from other chronic morbidities **(Refer Table 5.1).**

Table 5.2: Characteristics of participants (healthcare professionals)

		NUMBER OF PARTICIPANTS
Gender	*Male*	*9 (all doctors)*
	Female	*21(6 doctors and 15 nurses)*
Profession	*Nurses*	*15*
	Medical Doctors	*15*
Hospital	*A*	*10*
	B	*10*
	C	*10*

		NUMBER OF PARTICIPANTS
Age	*21-30*	*5*
	31-40	*10*
	41-50	*11*
	51-60	*4*
Years of Experience	*5 years*	*12*
	6 – 10 years	*10*
	11-20 years	*8*

N=30

A total of thirty participants took part, with 21 being female (6 doctors and 15 nurses) and nine being male doctors who worked in the three hospitals and participated in this study. From each tertiary hospital, five registered nurses and five doctors were interviewed. The participants ages ranged from 21 to 60 years (**Refer Table 5.2).** The years of experience ranged between five to twenty years, with twelve healthcare professionals having five years' service, ten with six to ten years 'service and eight with eleven to twenty years' service **(Refer Table 5.2).**

Several site documents were reviewed in Phase 2 of the study. **Table 5.3** indicates the types of documents that were reviewed**.**

Table 5.3 Types of documents reviewed

TYPE OF DATA	***NUMBER***	***FORMAT***
Site documents	*15 patients' files* *15 Review worksheet forms* *3 Admission registers* *3 OPD triage area registration books* *6 Job descriptions* *3 Batho Pele Principles Charter* *3 Patients' Rights Charter* *3 Hospital referral policies*	*Texts*

A total of 51 documents were reviewed, from the three tertiary hospitals in Gauteng Province for this study. The reviewed documents included fifteen files relating to the participants (patients), with five

files from each tertiary hospital. From each tertiary hospital an admission register, a policy and a triage booklet from the Outpatient department was examined, resulting in nine documents. In addition, each hospital provided a job description for each healthcare professional, amongst which one was for the doctors and the other was for the nurses. The other documents which were reviewed was the Batho Pele principles charter and the Patients' Rights Charter of each hospital.

5.6 SUMMARY OF THE THEMES AND SUBTHEMES

The analysis of the data yielded five themes, with thirteen subthemes. The themes were: Emergency Admissions, Admission through Disguise, Financial Standing, *Word of mouth,* Human Rights and Ethico-legal considerations as in Table 5.4.

Table 5.4 Summary of themes and sub-themes

THEMES	***SUB-THEMES***
Emergency Admissions	*Responsiveness to the pain* *Sudden recurrence of the intensity of the condition* *Needing urgent assurance and help*
Admission through Disguise	*Fabricated information on the condition to the EMS* *Hopeful for better investigations and resources with management of the condition under one roof* *Fraudulent residential addresses*
Financial Standing	*Against all costs and price of the service* *Ability to pay*
Word of mouth	*Referral* *Advertisements and media*
Human Rights and Ethico-legal considerations	*Accessibility and availability* *Sense of belonging* *Equitable quality health service*

5.7 THEMES AND SUB-THEMES

The analysis of data in this study yielded five themes. These themes emerged from the interviews, reviewed documents and field notes **(Refer to Table 5.2, 5.3. 4.3 respectively)**. The following are the themes yielded by the analysis: Emergency *Admissions, Admission through Disguise, Financial*

Standing, Word of mouth**,** *Human Rights and Ethico-legal considerations. The themes each have* three to four sub-themes with a total of thirteen sub-themes **(Refer to Table 5.4)**.

Theme 1: Emergency Admissions

Emergency admissions are one of the themes that came out of the analysis of data. The theme emerged when the participants indicated how they were ending up in emergency departments(ED) despite having chronic conditions which are manageable at primary healthcare centres and district hospitals. This theme has three sub-themes: *responsiveness to pain,* sudden intensity of the condition, and needing *urgent assurance and help.*

- **Responsiveness to pain**

Based on the interviews with patients and healthcare professionals, it was evident that the patients were reactively responding to the pain that they were enduring. The pain compelled the participants to end up in emergency departments.

The participants reflected as follows:

"…sometimes it might be because is an emergency to (end up) here and you do not have time to pass through the clinic because maybe the person is very sick and there is no time to pass through the clinic for consultations or referral so you just refer yourself to the hospital without any referral letter…" [Patient G062]

"…this word emergency is a complicated word, (if) you really need help now, and you are (in) need of help now and maybe I can't stand that pain; you have to bypass the clinic (and go) straight to the hospital…" [Patient G062]

The participants were supported by healthcare professional who said:

''…Women are very much tolerating and endures a lot of hardship, but to see a woman rolling like how they do and also not being able to walk because of the chronic disease they are suffering from, one understands when they rush to this emergency area for help and seeking relief... [Healthcare Professional S055].

- **Sudden recurrence of the intensity of the condition**

The recurrence of the intensity of pain in chronic conditions is usually unexpected and unpredictable. The participants clarified how they were experiencing the sudden recurrence of such pain. One participant indicates this when stating that:

"This is [how] I come to this hospital during the night, because I am sick! I have pains and could not sleep, and my pelvis feels like swollen and private part and I could not pass stools. I used a taxi to come here during the night with my grandson because of the pains." [Patient G037].

This participant further explained that:

"[The pain] can start at any time and the abruptness causes apprehension which forced me [to] end up in the emergency department."

The other participants supported the statement above by saying:

"Because it was an emergency let me say that I was pouring… blood was coming out with something like grapes and I could not even use sanitary pads but towels! The pains were horrible…I needed help and I was weak! Emergency or no emergency you cannot go to the clinic for this! If you are really having something like this, you have to come straight to the hospital and because the process will be shorter than going to the clinic and then having referral letters and consultations because sometimes you might not have help, they can only give you pills not knowing that you have inside bleeding". [Patient C013].

- **Needing *urgent assurance and help***

Living with chronic conditions is always stressful especially when it is incurable. Patients who participated in this study expressed this uncertainty with fear and sadness. This was emphasised during the interviews. Not only the patient participants said this but also healthcare professionals echoed this when stating:

"There is no need to chase them if they are really sick! They (outpatient triaging staff) can just send them (patients) straight to us, we don't mind! We don't really mind if patient is really sick! But there is a need for an official process that will guide us in order to treat them quickly as they are now in an alarming state!" [Healthcare Professional 011C].

The other healthcare professional supported this by saying:

"Self -referral is increasing day in and day out. I have seen younger people coming a lot nowadays and a lot of foreigner patients too with no papers and their state of disease being very advanced and with poor hygiene, self-care and in need of emergency care and operation… Advanced cancer patients are from other provinces (Limpopo, Kwazulu Natal – due to collapsed health system, Mpumalanga, DRC, Zimbabwe). This results in the collapse of proper consultations where the patients will be seen in a hurry method of saying next! next!, to finish the long queues." [Healthcare Professional G057]

Alluding to the need for assurance and help, one patient participant said:

"Pain caused me to come to this hospital. I know they won't be able to help me at the local clinic. Yesterday evening before 21h00 I called an ambulance and it took me to the clinic and I was not helped... Hence I end up in this emergency department [for help of the pain]" [Patient G037].

Theme 2: Admission through Disguise

Admission through 'disguise' was another theme that came out of the data analysis. The participants were coming to tertiary hospitals using various pretexts. This theme consists of three sub-themes: fabricated information on the condition to the emergency medical services staff (emergency care practitioners), hopeful for better investigations and resources with management of the condition under one roof and fraudulent residential addresses.

- **Fabricated information on the condition to the Emergency Medical Services (EMS)**

The patients indicated their desperation in seeking management of their chronic conditions. In some cases, the severity of their conditions compelled them to fabricate information on their chronic conditions to the EMS staff in order to get help.

The participants highlighted this when saying:
"I told the ambulance attendant to (bring) me to this hospital early this morning, as I was rolling with pains. I told them I was pregnant, whereas I knew that the private doctor told me that it was dirt in my womb {had miscarriage} and I was to go to hospital for admission. The doctor referred me to that small hospital. So the (ambulance) attendant bought my story and brought me here and I got the best care! I was checked and operated." [Patient G040].

The healthcare professionals were aware of the fabrications. One participant stated that:
"The patient [will present] with complaint or they will come saying that they have got headache, because of high blood pressure, some will say they have chest pain they can't even breathe, they try to hyperventilate but when you put on the monitor you find that everything is normal. Ja, so others will come and say I have abdominal pains and you know they will behave as if they are very sick, they are distressed but once you send them for the diagnostic test, everything comes [back] normal. So this was an act just for them to be seen and be accepted at the hospital. Ja, this is what they will do." [Healthcare Professional G054G].

- ***Hopeful for better investigations and resources with management of the condition under one roof***

Through desperation, for quality care regarding their conditions, the participants visit the ED in tertiary hospitals with the hope of getting better examinations and management of their conditions. The participants supported each other on this sub-theme by stating:

"I told the ambulance attendant to (bring) me to this hospital early this morning, as I was rolling with pains. I told them I was pregnant, where as I knew that the private doctor told me that it was dirt in my womb and I was to go to hospital for admission. The doctor referred me to that small hospital. So the (ambulance) attendant bought my story and brought me here and I got the best care. I was checked and operated." [Patient G040].

Another participant added that:
"I am still waiting but I know what they are going to do [operate] on me, it will be of good quality for my complaint. I have heard people talking here when we were sitting outside that the nurses here and doctors are [helpful] and I even saw the people who are coming here for check-up and who have been helped from here and they are healed." [Patient G037].

Tertiary hospitals are specialized entities with the availability of both human and material resources. Self-referred patients visit tertiary hospitals with the hope of getting specialized comprehensive care. One of the participants said:
"We come on our own using public transport or own cars and it is because this hospital is No 1. The doctor sees you well and nurses and sisters see you well too. We get our help here and that is why it is No 1." [Patient P062S].

The other patient alluded to the comprehensiveness of tertiary hospitals when indicating that:
"[In district hospitals] … wherever you are seen and for whatever investigation you are done or whatever test you are done and if it is not in same facility, you have a burden of transport, money. It is so expensive to be treated not in one location as you need to pay for everything." [Patient C013].

- **Fraudulent residential addresses**

Self-referred patients used various tricks to access care in tertiary hospitals. Tertiary hospitals are in the cities and poaching of residential addresses of acquaintances is rife. Poached fraudulent residential addresses are used in order to get treatment and admission in tertiary hospitals. One healthcare professional clarified this by saying:
"The patients tend to think that we do not know what is happening outside the hospital. Procedurally, everybody is to come with water and lights receipts of where they are staying. Out of desperation, the patient will come with a number of the street and with unknown flat name around this place, and when we checked on our areas' addresses it's not there." *[Healthcare professional G054].*

From the reviewed documents, the researcher found that there was a discrepancy with some participants' residential addresses. The excerpts from the field notes attest to this:

This address given on the bed letter on opening the OPD file is different from residential address given by patient (self).

The participant's date of the biopsy done is 2016 January, Limpopo, with a different name, not in the Identity book with the patient.

Theme 3: Financial Standing

The financial standing of patients is another theme that emerged from the analysis of data. Throughout the globe it is well known that healthcare is costly, especially specialized care. However, when one is ill she/he will go all out to access healthcare. This theme consists of two sub-themes, against all costs and *price for the service, and ability to pay.*

- ***Against all costs and p*rice for the service**

Globally, health and healthy life are commodities, hence the participants in this study went all out to acquire quality care. Despite the tertiary hospitals being public entities, they are very costly due to specialized treatment. However, the cost did not deter the participants in this study. One of the patient-participants echoed this by saying*:*

"I am from the administration section [Arrangement is done with the patients on how the patient will pay the needed money for the care and the duration of payment and the patient signs], my heart is not well. I am to be in High Care, for treatment I do not have money, but I agreed to pay by instalments for my care." [Patient C099].

Another patient-participant said:

"*A lot of us come like me. [If] you come with money and pay for the care as they charge you are helped…. Any way what is R 5000 against your health?" [Patient S037].*

This was attested by the current RSA Gazette Uniform Patient Fees Schedule (2019). This protocol classifies foreign nationals without proper documentation in public hospitals as private paying patients under Annexure 3 Schedule B. For example, admission of a patient and all procedures costs approximately R5 000 (**Refer Annexure H).**

- **Ability to pay**

Public healthcare service in the Republic of South Africa where the study was conducted is free of charge if the correct referral processes are followed. That said, patients continue to bypass the systems and indicate that they can pay for their own care. This notion was supported by the participants when stating that:

"It made me think of home. At home where I come from there is no such rule, all are seen anywhere as long as you pay for your care." [Patient G037].

"We are desperate that I must get good care and I have been in different places for care, with no help. Can I be saved please I am suffering, we will pay we can pay no..w[now]" [Patient S001].

***Theme 4:* Word of Mouth**

The use of word of mouth also emerged as one of the themes from the analysis of data. Through social contacts and other forms of communication, information about services in tertiary hospitals filters to patients and families. Those that are keen like chronic patients will embrace the information use when time comes. This theme consists of two sub-themes: *referral by previous satisfied patients as well as staff members, and advertisements and media.*

- **Referral**

A satisfied patient will share her/his positive experiences with others especially with those who are suffering from the same condition. Such positive encounters in healthcare act as the push factors for other patients. This was supported by one of the participants who said:

"*I myself, with severe pains and my grandson who valued this hospital, encouraged me not to go back to the clinic as they are not helpful. As at the clinic they didn't help yesterday when I was very ill. My neighbours this morning told me that I was not supposed to go there, as they just come to this hospital as this is the only big hospital here and the other one is very far from our place, that is why clinic staff give us hassle". [Patient G037].*

Not only were the patient participants referred by other patients, the previous healthcare professionals were also referring some patients to tertiary hospitals. This was attested by the participant who said:

"They … presume is like this hospital is the best hospital. Instead of all these which I have said they do say it openly that they have been told by a doctor in private who used to work here that it is the best place for their illness and again they have observed that the place is the best and it has best doctors and nurses and it is clean." [Healthcare Professional C07].

Another participant said this in support:

"And at any time in the process they (patients) snap and they hear from somebody of good soul, that they (patients) actually can come here directly they will not be returned because this is an open access for the last more than ten years. The reason that we are an open access tertiary clinic is that we think we must react to this environment and that we must do something in a situation that the majority of our patients initially were largely disadvantaged." [Healthcare Professional C07].

Due to desperation and being tired of suffering from their chronic health conditions, the participants visit or seek advice from healthcare professionals. Information from people, who are working in health facilities, is also very valuable. One participant said:

"There are some patients who come to the tertiary set-up because of informal arrangements where a doctor arranges with another in that facility to let the patient jump the queue and come and be treated there or the patient is advised by the doctor who once worked there or who is working in the tertiary to go to that tertiary hospital." [Healthcare Professional 085C].

To attest to this, another participant said*:*

"The nurse just told us when you have this … just run to the hospital, and we were also told that at night the waiting time is less than during the day." [Patient S013].

- **Advertisements and media**

Today is an era of information and public knowledge hence the participants in this study acquired information about the services in tertiary hospitals from various sources. One participant said:

"As patients we communicate better with each other especially with social media. In fact, we spread the message that it is not impossible to get service in tertiary hospitals." [Patient S030].

And another participant said:

"I am a cardiac patient and with a very bad chest problem. After my operation, I started to check on the medical web which became of more value to me and is a phenomenon of positive network effects. Some of us refer to the web communication as connecting collective intelligence. When we patients are managing the same chronic condition, share observations with each other, collective wisdom produce clinical insights well beyond the understanding of any single patient or our doctors*" [Patient S061].*

The healthcare professionals also echoed that the media was a strong tool for patient's self-referral by saying:

"Today what is improving is really that patients are better informed, patients are communicating better. Obviously social media is working better and also that the information is spreading that it is not impossible to get the service here". [Healthcare Professional C07].

The healthcare professional emphasized the spread of the access of care through self-referral by patients by saying:

"And I think … whoever … she [a patient who was treated] speaks to, about her own health she advises them not to fall in that trap also. She verbalized that she was going to advertise in all media route she can manage to. These are the factors for spreading HELP." [Healthcare Professional C07].

"Patients rate the health information they get through social media…" *[Healthcare professional G10].*

Theme 5: Human Rights and Ethico-legal Considerations

The Human Rights and Ethico-legal Considerations are a theme that also emerged from the analysis of the data. Health is embedded within the treaties of the United Nations and many countries have adopted such treaties through various protocols. This theme has three sub-themes: accessibility and availability, *sense of belonging, as well as* equitable and equal health services.

- ***Accessibility and availability of healthcare***

Accessibility and availability are key aspects of appropriate healthcare provision. The two aspects are endorsed in various healthcare provision policies and standards.

An excerpt from the Patients' Right Charter, it is clearly indicated that access to care is a right (South Africa, 1996):

> *"Individuals shall be afforded impartial access to treatment that is available and medically indicated regardless of race, creed, national origin, religion, gender, sexual orientation, disability or source of payment." (Patients' Rights Charter, South Africa 1996)*

Excerpts from Batho-Pele Principles (1997) that ratifies access to healthcare in South Africa is which state that:

> *"You and all citizens should have equal **access** to the services to which you are entitled." (Batho-Pele Principles, South Africa, 1997).*
> *"You should be given full and accurate service about the public services you are entitled to receive (**availability)**." (Batho-Pele Principles, South Africa, 1997).*

In addition, to support these excerpts a participant said*:*
"I think it is good as I am helped already through it, by following Batho Pele principle for seeking second opinion of my health problem and my right to access treatment." [Patient C017].

- **Sense of belonging**

Sense of belonging is when one feels that by right, she/he has the right to belong at a place. Vicinity matters a lot especially when someone is ill. As close vicinity helps in the management of chronically sick patients. A familiar environment is also a therapeutic agent for recuperation. The participants in this study supported this when stating that:
"I think according to the Patients' Rights and of late in the Batho Pele principles, I am to be here. In fact, I belong to (hospital B), I was born here and I bore my kids here, I have a (hospital B) file from long time ago. Hence I regard myself as a '(hospital B) rian', why can I not be helped here when I am sick?" [Patient C012].

Another participant said:
"Lots of patients are emergencies in Obstetrics and Gynaecology with chronic conditions, and they are staying near the hospital vicinity and according to the Primary Healthcare notation they are allowed to bring themselves or seek healthcare services at this hospital as the distance covers them when it comes to accessibility and availability of care and their rights of healthcare and also the Batho Pele principles." [Healthcare Professional S085].

- **Equitable and Equal Health Services**

Equality and equitable treatment are important variables for comprehensive quality healthcare provision. According to an extract from "OUR VALUES, I CARE 4 U Charter," patients must be treated the same way, equally, with the same treatment, and their rights respected with no discrimination. In turn, equity means care should be representative, reasonable, realistic, and just for the patient. The value of the treatment must be worthy, fair, just and equal. The participants in this study echoed this by saying:

*"*We're creating ways for people to get what they need (equitable and equal healthcare services) in a different way than they have been previously." *[Healthcare Professional S005].*

One participant supported said

"The treatment I am getting from this hospital is great and we are treated equally and I know that where ever I come from such care is not there we starve, we cannot complain, we do not have medication and a lot of our leaders do not consult for help there, but comes here or go over the sea to get help. Where is fairness, justice and where is the practice of the Primary Healthcare principles?"[Patient G001].

And in terms of the Batho Pele Principles access to healthcare is endorsed as a right and entitlement as follows:

> *"You and all citizens should have **equal access** to the services to which you are entitled." (Batho Pele Principles Charter, South Africa 1997)*

5.8 DATA SHARING

Data Sharing is when the researcher shares the findings from the research with some or other members of the population of the studies, the participants and also with the experts chosen **(Refer Table 5.5)**. It is necessary to share in order to get validation of the findings, to reduce the errors and also to meet the study objectives set.

In this study, data sharing was necessary as the participants were many participants and huge information was collected, which needed validation and trail review and reduction of errors.

Data was shared with only the supervisor and co-supervisor to strengthen the research. This was done through discussions held from the start of the research with the supervisor and co- supervisor and it continued until the completion of the study. During the data collection from the three tertiary hospitals, there were very many parties interested in the researcher's study and they gave advice and availed themselves for future help in case a need arose with the study.

To validate the themes, a team of eight experts was purposively selected from the total number of participants whom the researcher had interviewed for this study. This team of eight also helped the researcher with the reduction of errors in interpretation of the collected data.

Inclusion Criteria for experts in the validation of the sharing process

The researcher selected the team of eight experts based on the following inclusion criteria:

- The participants who elaborated on the strategies that could be used for self-referral during the interviews.
- Those who elaborated on the use of technology during the interviews.
- Those who showed an interest in the development of strategies**. (Refer to Table 5.5 for the profile of the experts**.

The profile of the group of experts is summarized in table 5.6 below:

Table 5.5 Profile of group of experts

HOSPITAL	*SEX*	*RACE*	*STATUS*
B	*F*	*Black*	*Patient 1*
A	*F*	*Black*	*Patient 1*
A	*M*	*Black*	*Doctor 2*
A	*F*	*White*	*Doctor 2*
A	*M*	*Black*	*Nurse 1*
B	*M*	*Black*	*Doctor 1*
C	*F*	*Black*	*Doctor 1*
C	*F*	*White*	*Nurse 1*

In Table 5.6, the profile of the team of eight experts is shown, and it consisted of four doctors, two nurses and two patients. Only two were white and six were black.

Data Sharing Process

As a way to validate the themes, the researcher saw it as necessary to share some of the essential trailers of the patterns with the eight experts in the advisory group. In preparation for the sharing of the trailers of the patterns on self-referral to tertiary hospitals, the researcher underwent training on how to use the Google platform, conducted by a computer training co-ordinator. The researcher prepared a package (**Refer Box 5.1).**

Box 5.1: Data Sharing Package: The package has the following:

*Information leaflet on the aim of data sharing process was provided to the group of experts or advisory group. (**Refer Annexure F)* *Trailers of the identified patterns on patient self-referral to tertiary hospitals highlighted and identified. For experts to validate as mentioned in information leaflet.* *Informed Consent Forms which had a section on information disclosure (**Refer Annexure C2)**.* *The consent form was requested despite the previous one that was signed.* *All these were sent virtually to the experts through google plus to the experts.*

The advisory group or eight experts were given two weeks to provide feedback on the trailers. However, the researcher was continuously offering virtual support to the members on how to access the trailers. The researcher received feedback validating the trailers of the patterns on patient self-referral to tertiary hospital in Gauteng Province, through the Google platform. The advisory group or eight experts confirmed the trailers of the patterns about patient self-referral to tertiary hospitals in Gauteng Province. **(Refer Annexure G** for an example of a validated trailer.)

5.9 SUMMARY

This chapter 5 discussed the data analysis process and interpretation of the findings from interviews, field notes and site document review on patient self-referral to tertiary hospitals in Gauteng Province. Chapter Six will be on discussion of the insights from the study with the control of the literature.

CHAPTER 6
DISCUSSION OF INSIGHTS AND LITERATURE CONTROL

6.1 INTRODUCTION

In Chapter 5 the analysis and interpretation of the data was discussed. Chapter 6 will discuss the insights of the study in relation to available literature relating to the themes and sub-themes identified in Chapter 5. The discussion in this chapter was guided by the Critical Realism framework, which was used as the over-arching paradigm (**Refer Section 3.2**) and the Emancipatory Knowledge Framework.

6.2 OVERVIEW OF EMANCIPATORY KNOWLEDGE FRAMEWORK

The Emancipatory Knowledge Framework developed by Chinn and Kramer, (2008:10; 76) is a framework that critiques the existing social and political circumstances under which knowledge is developed and embraced (Chinn & Kramer, 2008:15). Consequently, the framework explores the reasons and processes of the political, social and cultural stances of knowledge development. According to Chinn and Kramer, (2008:15), the Emancipatory Knowledge Framework has four tenets or stances about knowledge development (Chinn & Kramer, 2008:15), namely critical reflection or action, sustainability, empowerment and social equity, as well as demystification. The insights of the study were derived from the themes identified in Chapter 5, which are: emergency admissions, admission in disguise, word of mouth, financial standing, as well as the human rights and ethico-legal considerations. In this study, the insights will be interwoven within the four tenets of the Emancipatory Knowledge Framework (**Refer Figure 6.1**).

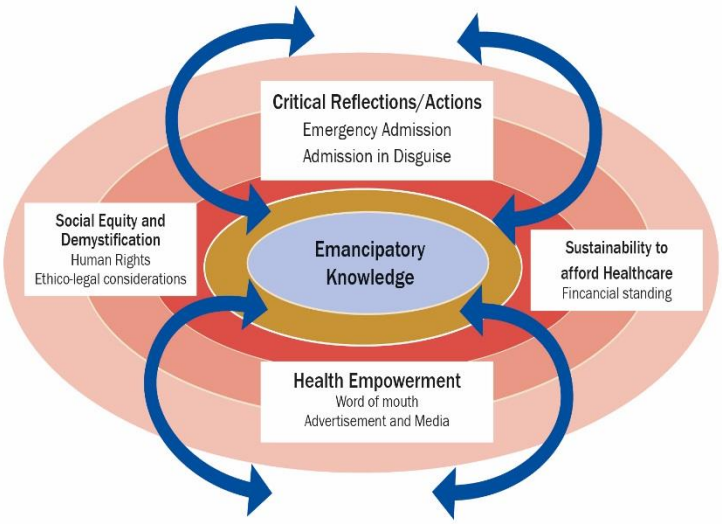


Figure 6.1: Depiction of the four tenets of the Emancipatory Knowledge Framework with the insights of the study (Chinn & Kramer, 2008:10)

Within the Emancipatory Knowledge Framework, emergency admissions and admission in disguise as insights are viewed as Critical Reflections/Actions that the self-referred patients take for the management of their conditions. Word of mouth as an insight is linked to the empowerment tenet of the emancipatory knowledge framework. In this regard word of mouth is seen as an emancipatory process to seek a second opinion regarding health care provision.

The patients' financial standing as a theme from the insights is linked to the sustainability tenet of the emancipatory knowledge framework. Human rights and ethico-legal considerations fall under the social equity and demystification tenet of the emancipatory knowledge framework. **(Refer Figure**

6.1) for the insights woven within the emancipatory knowledge framework. A detailed discussion of these insights is given below.

6.2.1 Tenet 1: Critical reflections / actions

According to Contractor and Qudsiya (2018) critical reflection is an extension of 'critical thinking'. Through critical thinking one is implored to think critically on the practices and ideas to be undertaken. The action required one to step back and examine one's thinking by asking probing questions (Essays, 2018:1). Critical reflections ask one not only to explore into the past and look at the present but importantly to venture into the future and act (Mitchell, 2017:165). Based on the current study, critical reflections are the actions taken by the participants, who were self-referring themselves to tertiary hospitals. The insights indicate that on realizing the deterioration of their conditions the participants embarked on actions that could change their situations (Vannini ,2015:12) by seeking admission and care for their health conditions in emergency departments and tertiary hospitals. The actions were taken knowing that they (patients) were not supposed to go there, but to go to Primary level of care.

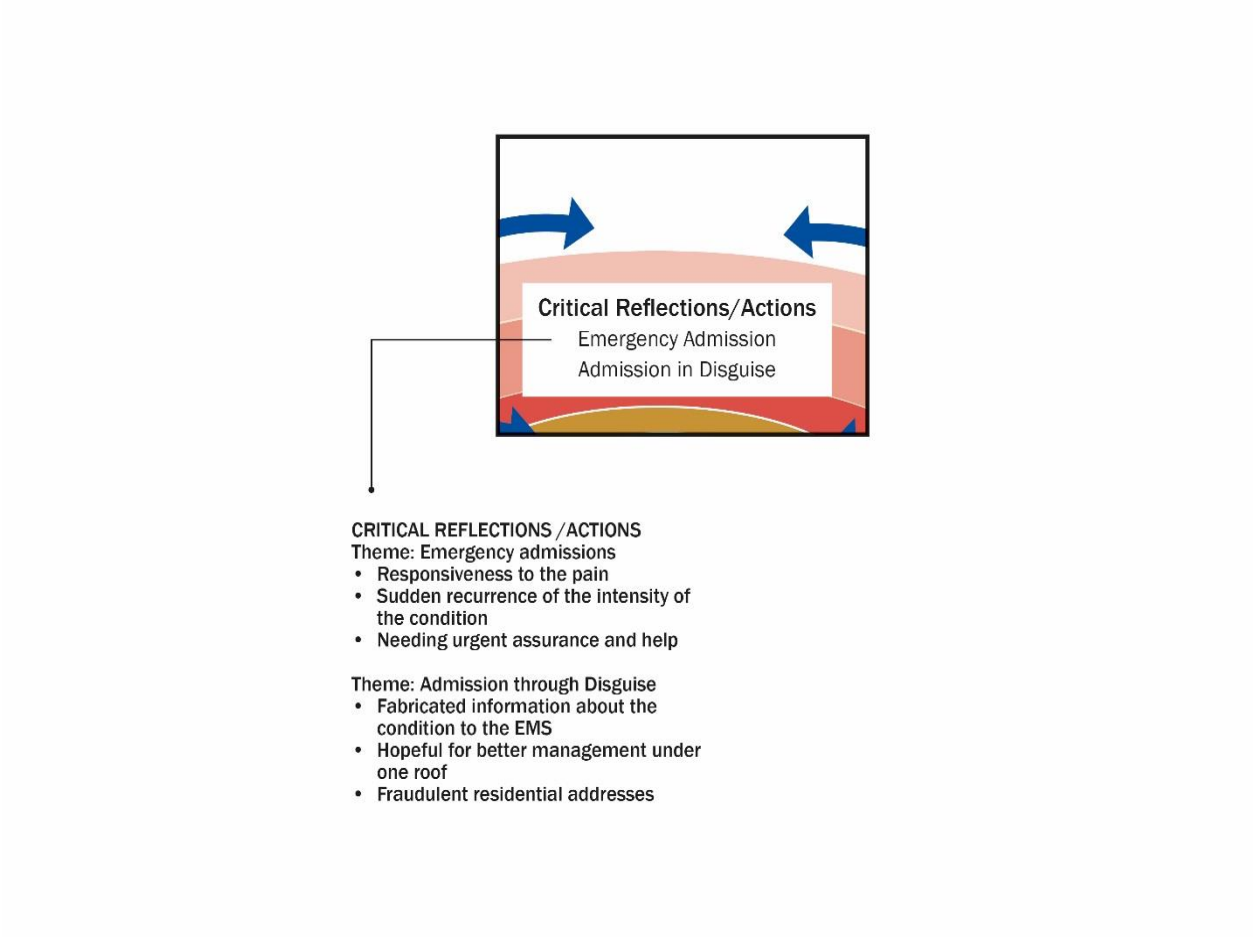


Figure 6.2: Tenet 2: Critical reflections / actions

The critical reflections or actions that were derived from the data as indicated in Chapter 5 were: emergency admissions and admissions in disguise (**Refer Figure 6.2**). Each of these critical reflections' sub-themes is discussed in-depth below.

6.2.1.1 Emergency admissions

Globally, emergency departments are meant for the management of acute and inevitable conditions of patients in a hospital set-up (Henshall, Innes & Morrison ,2018:39; Kraaijvanger et al, 2016:6). Emergency admission to an emergency department can be considered to be the pull and push factor for self-referred patients in this study. From the insights of this study, it was revealed that the patients end up in emergency departments while they are chronic patients who could be managed in Primary Healthcare clinics (Van der Straten, van Stel, Spee, Vreeburg, Schrijvers & Sturms,2014:877; Kraaijvanger, van Leeuwen, Rijpsma & Edwards, 2016:1).The findings from Van der Straten et al, (2014) and Kraaijvanger et al, (2016) were to the benefit of the patients with chronic conditions but not emergency, as they referred themselves and got care as a way to prevent further complications of their conditions. Additionally, the study insights point out various ways used by patients with chronic conditions to be admitted and managed in Emergency Departments. The patients might use the Emergency Department as a way to address their responsiveness to pain or due to the sudden recurrence or intensification of their chronic conditions (Mitchell, 2017:165; van der Linden et al, 2014:1). The insights revealed that patients needed an urgent assurance and admission as part of the management of their conditions.

Responsiveness to pain

Pain is defined as a multidimensional entity with the equal involvement of central nervous system, cognitions, and emotions (Kumar & Elavarasi, 2016:87). The research insights indicate that the self-referred patients end up as emergency admissions as they seek relief for pain for their chronic conditions. Affirming the insights of the study, van der Linden et al, (2014:1) stated that self-referred patients bypassed their General Practitioners as they believed that care at tertiary hospital Emergency Departments was suitable for their illnesses.

According to Kumar and Elavarasi, (2016:87), pain is a subjective phenomenon which is experienced by the sufferer, and the sufferers respond in different ways when pain strikes (Lehti, Fjellman-Wiklund, Stalnacke, Hammarstrom & Wiklund, 2017:48). From the insights of the study, it was noted that patients were using the subjectivity of the nature of pain to their advantage by coming to the Emergency Department as self-referrals. This is supported by Kumar and Elavarasi, (2016:87) who indicate that measuring pain is paradoxical and complex as what is felt by an individual cannot be verified by another person and it cannot be proved scientifically.

According to the insights some of the self-referred patients knew or had heard about the endorsed referral policies in the tertiary hospitals. However, they bypassed the appropriate health facilities as a responsive measure to pain that was persistent. From the insights, chronic pains prompted the patients' self-referral to the Emergency Department because they could not get help for their chronic conditions from the first level of contact. Hecke, Torrance and Smith, (2018:13) supported the insights by citing that the care of chronic pain remains sub-standard, perhaps because of the absence of evidence for real interventions in the Primary health facilities.

Krishnan, Anderson, Chan, Kim, Reistetter, Sood, Mortera, Heesakker and Heyn, (2018:2393) supported the responsiveness to chronic pains among chronic patients. These authors indicated that if chronic pain is not addressed positively the patients might end up being depressed and even lose functionality (Krishnan et al, 2018:2393). The insights reveal that the Emergency Department was usually the first option for the patients despite suffering from chronic conditions. Van der Linden et al, (2014:1) also supported this trend by stating that chronic patients refer themselves to the emergency department due to the perceived severity or acuity of their conditions.

Sudden recurrence of the condition

Literature differentiates the stance of pain either as acute or chronic pain (Slater, Greenberg, Wahlgren, Williams, Carter, Patterson, Grant, Garfin, Webster & Atkinson, 2009:546). The acuteness and chronicity is determined by type of condition and the duration of such (Slater et al, 2009:550). Slater et al, (2009:548) indicate that variables such as beliefs or moods can impact the transition from acute to chronic and vice versa.

From the insights of this study, the self-referred patients used the sudden recurrence of their condition as another way of seeking management and admission at the Emergency Departments. Kumar and Elavarasi (2016:87) mention that pain is multifactorial and complex, and produces emotional and physical unappealing experiences for patients. In this study, the stated experiences generate a sudden recurrence of the condition in chronic patients. Van der Linden (2014:1) indicates that in cases where chronic pain becomes unbearable and sudden, self-referral becomes an option for the patients to the Emergency Departments. Likewise, in this study, the insights indicate that on experiencing the suddenness of the pain chronic patients end up in Emergency Departments as emergency admissions.

The sudden recurrence of chronic conditions into acute progression of the condition in most cases poses a concern to the patients (Kraaijvanger et al 2016:3; van der Linden, Lindeboom, van der Linden, van den Brand, Lam, Lucas, de Haan & Goslings 2014:1; Lega & Mengoni 2008:327).

Patient with chronic disease then perceive the recurrence of their chronic symptoms as a deterioration of their condition (Lega & Mengoni, 2008:327). Similarly, in this study, the insights showed that self-referred patients were compelled by the abruptness of the recurrence in their conditions to end up as self-referrals and emergency admissions any time of the day. Detollenaere, Boucherie and Willems, (2018:246) supported the insights when stating that chronic self-referred patients might seek Emergency Departments in tertiary hospitals any time of the day for the management of their chronic conditions due to an acute episode. A common trend that the insights revealed was that chronic patients usually have interrelated multiple chronic conditions and during the progression of the diseases they (the conditions) become acute (Schellinger, Anderson, Schmitz Fraser & Cain, 2018:160). As such those patients will use self-referral as their own self-care strategy to be admitted to the Emergency Department.

Needing assurance and help

Chronically ill patients are inclined to seek assurance and help continuously (Schellinger et al, 2018:160; Kraaijvanger et al, 2016:5). Equally in this study, the insights indicate that due to the progression of the chronic conditions the patients were rushing to tertiary hospitals. In some cases, the patients might not even need treatment but only reassurance or counselling from the healthcare professionals (Detollenaere et al, 2018:246; Diserens et al,. 2015:4). This was revealed by the findings in this study where the self-referred patients went to Emergency Departments to seek professional assurance about their conditions. Diserens et al, (2015:5) mentioned that patients with chronic conditions refer themselves to the emergency department as a means of validating their conditions (LeMay, Wilson, Buenger Jarvis, Fitzgibbon, Bhimji & Dobkin, 2011:116).

The insights in this study revealed that professional assurance is an important aspect in the management of chronic conditions and chronicity is linked with signs of depression (Krishnan et al, 2018:2393). These authors indicate that chronic patients are in need of continuous assurance and help. From the insights the same was noted and the tendency was that if the emergency admission was denied the patients turned to the use of alternative medicines such as traditional and spiritual healers (Krishnan et al, 2018:2393). Most of the alternative healthcare providers do not focus on symptoms but consider a holistic approach to healing with professional assurance as the core of management of the conditions.

6.2.1.2. Admission in disguise

Admission in disguise is one of the insights of this study and is packaged as part of the critical reflections or actions of the Emancipatory Knowledge Framework as indicated in Figure 6.2. The insights from the participants indicated that patients were seeking treatment for their chronic

conditions through disguise. Westaby, De Silva, Petro, Bond and Taggart, (2015:1) define disguise as hiding the true form of that thing or person; put simply disguise is deception. The insights in this study, indicate that deceptions were used by the patients to be able to enter as self-referral cases and be managed in tertiary hospitals. The insights revealed that self-referred patients critically acted about their chronic conditions after thorough reflection on their health needs.

Lehti et al, (2017:45) supported the insights of the current study when citing that patients with chronic conditions use various strategies to be taken seriously in Emergency Departments. Some of these strategies that self-referred patients used include: fabricating information about their conditions to the healthcare providers especially to Emergency Medical Staff, and giving fraudulent residential addresses and names with the hope of getting better examinations and management of their conditions under one roof.

Fraudulent residential addresses and names

According to the insights from referral policies and documents of the three tertiary hospitals, the referral policies of the tertiary hospitals and draft referral policy of South Africa (South Africa, 2008:3) indicate that a person has to go to the first level of healthcare closest to where they reside. The contents of these policies were among the factors that drive patient with chronic disease to use fraudulent residential addresses to access tertiary hospitals as self-referrals. Fraudulent residential addresses of the patients were found during a review of the documents in the three tertiary hospitals. The insights revealed that the addresses given at the registration area to the administration personnel were different from the addresses which the self-referred patients gave at the triage before consultation.

Mordini, (2016:2), supported the insights when asserting that identification of the person's details as well as residential address is challenging unless biometrics systems are used. The insights pointed out that some of the participants in the study were foreigners whose proof of personal identity was questionable. Diserens et al, (2015:5), in their study, mentioned that many foreigners seek access to the Emergency Departments of tertiary hospitals for their health conditions. These people do not seek healthcare services from General Practitioners or Primary Healthcare as they do not have the needed identification documents.

The insights reveal that in some cases the identification name on the identification document was not the same as the one on the laboratory results which the patient came with to seek help. Mordini, (2016:2) affirms that identification for refugees and asylum seekers is very difficult through personal identification as writing systems are different from country to country. Most importantly, the challenge

is that there is a possibility of lost identification documents when refugees are fleeing their countries of birth. Mordini, (2016:3) mentions that the worst case scenario becomes where the refugees and asylum seekers throw away their documents to avoid disclosure as part of protecting themselves and relatives.

Additionally, the insights in this study, indicated that self-referred patients were often coming from rural areas to seek help for their chronic conditions, regardless of the availability of tertiary hospitals in different provinces in South Africa. Concurrently, from the reviewed documents it was evident that some of the self-referred patients were from the neighbouring states of South Africa. Accordingly, the draft referral policy of South Africa (South Africa 2008) clarifies the referral processes between South Africa and neighbouring countries. However, from the insights it was evident that patients from neighbouring states such as Mozambique, Zimbabwe, Lesotho, Swaziland and Nigeria, were referring themselves to South Africa despite the country to country referral processes. South Africa, (2008) stipulates that the country of origin would have communicated through the National Department of Health, which in turn would have notified the hospital depending on the patient's disease.

Fabricated conditions to Emergency Medical Services

The insights indicated that most of the self-referred patients come to Emergency Departments through emergency ambulances wherein they have fabricated their conditions to be transported as emergencies. The insights revealed that the self-referred patients hold back accurate or complete information about their illnesses. In support of these insights, van Hyssteen, (2017:83) indicated that self-referred patients feel that they can only tell the truth about their conditions to the doctors, rather than the emergency medical staff. Not only were the patients referring themselves to emergency departments, relatives also play a part in self-referral (van Hyssteen, 2017:83) as they compel Emergency Medical Services, **(**EMS) personnel to transport patient with chronic disease as emergencies.

It was revealed from the insights that patients knowingly summon the EMS for conditions that are not life-threatening. This is supported by van der Linden et al, (2014:1) and Gentile, Vignally and Durand, (2010:2) who found that self-referred patients come to emergency departments with non-urgent conditions. In the current study, patients were coming to the emergency department with problems with their limbs, abdominal problems, nose bleeds, stomach aches, gastroenteritis and normal pregnancies as conditions that are manageable at primary healthcare level.

From the insights it is noted with concern that communities tend to abuse or misuse EMS as a mode of transport to hospitals, tertiary included. Van Hyssteen ,(2017:46) cites that in South Africa the rights of patients in accordance with EMS have become dominant over the patients' responsibilities as the community demands the services even if they do not fall under the emergency category.

The insights in this study further indicated that patients are aware in self-referral that the continuity of care is disrupted; however, their need to be seen by specialists in tertiary hospitals (Luxenburg et al, 2014:150) compels them to fabricate their conditions. The draft referral policy (South Africa, 2008:3) outlines exactly the processes that need to be followed by patients in order to end up in tertiary hospitals **(Refer Annexure K).**

Hope for comprehensive management

The structure of tertiary hospitals in South Africa allows for management and treatment of patients under one roof. The insights in this study further indicated that patients are aware that in tertiary hospitals they are managed seamlessly and comprehensively. Kraaijvanger et al, (2016:3); and Atenstaedt, Gregory, Price-Jones, et al, (2015:370) supported the insights of this study when indicating that self-referral patients feel comfortable when the management of their condition is handled comprehensively in one visit to the hospital.

From the study, it was evident that during self-referral the results of the investigations such as blood tests and x-rays among others are repeated as there is no communication about the patients. The repetition of all these tests sometimes exposes patients to pain and has major financial, human resource and supply implications, as alluded by Beck and DuMoulin, (2013:34). This is supported by Lega and Mengoni, (2008:3260) who noted the financial implications that are incurred through self-referral of patients. From the insights, it was revealed that chronic patients prefer a single location for the management of their care. This is supported by Haley, Richards, Becker and Richardson, (2005:1163); and Lowthian, Smith, Stoelwinder, Smit, McNeil and Cameron, (2013:63) who alluded to the comprehensive management of chronic conditions to avoid non-compliance. Additionally, Ragin, Hwang, Cydulka and Holson, (2017:4) indicated that self-referred patients reject multiple visits to different locations for investigations, for their conditions.

The insights in this study revealed that patients who referred themselves to higher levels of healthcare expect further research of their conditions to get second opinions. Detollenaere et al, (2018:246) and Van der Linden et al, (2014:1) supported this when mentioning that the self-referred patients choose the Emergency Departments as a second opinion for advanced diagnostic laboratory and/or radiological testing and diagnoses.

From the insights, we can see that self-referral patients use various form of disguise in order to be seen in Emergency Departments and tertiary hospitals. The Constitution of South Africa states that all citizens should be allowed to have access to healthcare and the care should be equitable and equal in every healthcare facility that the patient found himself/herself in (South Africa, 1996).

6.2.2 Tenet 2: Sustainability of Healthcare

Sustainability is one of the tenets of the Emancipatory Knowledge Framework. For the purpose of this study, this tenet is linked to financial standing in the insights as represented in Figure 6.3.

According to Buffoli, Capolongo, Bottero, Cavagliato, Speranza and Volpatti, (2013:411) sustainability:

"… is a broad and debated subject, often difficult to be understood, however sustainable structure is a structure that can be easily maintained and that can be functional from the environmental, social and economic point of view, in order to comply with the diverse interests and needs of all the stakeholders."

In health, sustainability is Sustainable Livelihoods Approach (Allison & Horemans,2006:605-842).

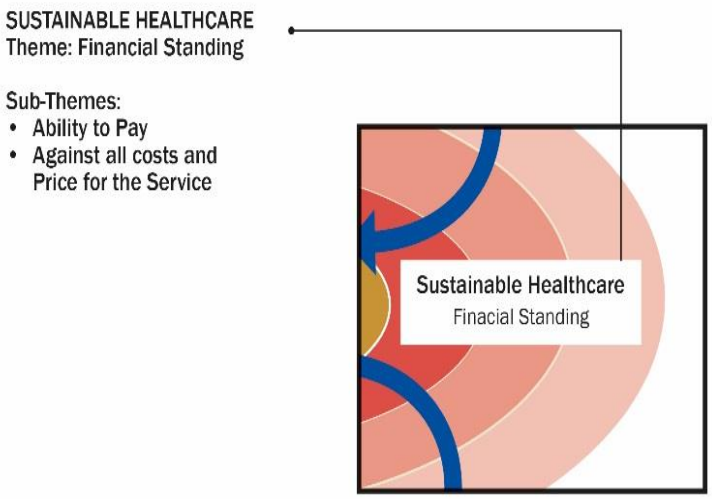


Figure 6.3: Tenet 2: Sustainability of healthcare

In relation to the insights of the study, sustainability in this study refers and implies positive financial standing, with payment against all costs and the price for the service as the sub-themes. The insights will be discussed below.

6.2.2.1 Financial Standing of the Patients

The insights of this study revealed that the self-referred patients used their financial standing as one of the vehicles for admission to the Emergency Departments of the tertiary hospitals. From the study insights, the participants indicated that they were prepared to pay the price for the service which tertiary hospitals charged for the management of their chronic conditions, against all costs.

The financial standing of the self-referred patients became a sustainable way that the patients with the chronic conditions could rely on to be able to visit or be admitted to the Emergency Department of the tertiary hospitals. The insight is supported by Buffoli et al, (2013:411) who mention that a sustainable structure must be functional from different points of view including the financial point of view, to comply with the various needs and interests. In this study, stakeholders being the self-referred patients and their needs and interests, for tertiary healthcare Van der Linden et al, (2014:1), appointed this insight when citing that the needs and interests of the self-referred patients are for good health which, according to Humphreys, Wakerman, Perkins, Lisle and McGrail, (2011:11), is seen as a basic right.

Against all costs for the Healthcare service

The insights from this study illustrate that the self-referred patients were prepared to pay the high prices that were charged for Health service despite these hospitals being public hospitals. Van der Linden et al, (2014:1) and Kraaijvanger et al, (2016: 6) attest to this insight when stating that Emergency Department visits are more expensive than Primary Healthcare visits. The high price tag attached to tertiary hospitals and Emergency Departments visits is due to unnecessary investigations and the advanced quality of the technological equipment used by the specialists in these departments.

Inasmuch as the insights indicated the high costs in self-referral, the participants were making payment arrangements with the Registry of the tertiary hospitals for instalments. According to Kraaijvanger et al, (2016:6) and Markenm, (2016:1), the Registry is where financial considerations for the self-referred patients in healthcare are usually sorted out through `payment flexibility. The insights of the study were also supported by Ragin, Hwang, Cydulka, Holson, Haley, Richards, Becker and Richardson, (2005:1163), who cited that self-referred patients were keen to pay for their healthcare even when they were underinsured. To put it clearly, the limits on health insurance do not deter self-referred patients from visiting Emergency Departments and obtaining specialized care.

Different countries charge consultation fees for the PHC and visits to Emergency Departments. In South Africa such tariffs arise from the policy regarding the classification of patients for the determination of fees (National Department of Health Policy, 2002:1), depending on the level of care. The insights of this study indicated that the Department of Health in the Republic of South Africa has stipulated ways in which patients ought to pay for the care they receive at the different levels of the provision of care. The payments are set through policies, from 1994 to date, and some prices are adjusted according to the financial stability of the country**. (Refer Annexure H** for policies for

healthcare payments and the Republic of South Africa's Regulation for Healthcare Provision and Consultation.)

According to Kraaijvanger et al (2016:6), in countries such as Australia and the United Kingdom, self-referred patients, on visiting private and public hospitals, do not pay for services delivered. The Emergency Departments and General Practitioners are regarded as gatekeepers to the healthcare system of these two countries due to national health insurance (NHI). As of now in South Africa, the self-referred patients are willing to pay for their healthcare services while awaiting the implementation of NHI.

Price of service

In this study, the insights showed that the self-referred patients were prepared to pay for the care they were to receive on visiting the tertiary hospitals. According to Diserens et al, (2015:5) and Mordini, (2016:2), the patients (with acute or chronic conditions) usually were not worried about the amount of money which was needed for them to receive healthcare. Kraaijvanger et al, (2016:8) supported this insight in the USA and Netherlands where citizens pay a certain amount if they self-refer themselves and bypass General Practitioners.

Though this study was not about frequent visits to Emergency Departments, the insights revealed that foreigners, and people with lower education and lower income pay more frequent visits to Emergency Departments. This was also seen in a study by Van der Berg, van Loenen and Westert, (2016:42) where it was noted that such groups frequent Emergency Departments as they do not like extended waiting times (Kaaijvanger et al, 2016:5). In line with the insights of this study, in Ethopia, a study by Wolkite, Waju and Gebeyehu, (2015:87) stated that patients incurred unnecessary costs from referring themselves to distant and more expensive healthcare centres. This citation was mentioned also by Beck and DuMoulin, (2013:34), who said that repetition of tests was costly but patients were ready to pay.

From the insights of this study, it was clearly indicated that patients with chronic disease who are referring themselves are aware that there is a great difference between the resources in the tertiary hospitals and at the first level of care. Levin and Rao, (2011:848) supported this notion when indicating that specialized diagnostic imaging resources such as specialist radiographers are very scarce in the first level of care. Gentile, Vignally and Durand, (2010:1) are in consensus with this notion when citing that specialized hospitals are well-equipped with both human and material resources. The insights pointed out that most facilities at Primary Healthcare facilities and district levels of care have a scarcity of resources. In the current study, the lack and scarcity of resources

compel the patients to refer themselves to tertiary hospitals which are based in urban areas, and their consultation and admission fees are high.

The insights also point out that not only are tertiary hospitals well-equipped, but care provision in these hospitals is rated as the best and of higher quality as supported by Kraaijvanger et al, (2016:3) and Haley, Richards, Becker and Richardson, (2005:1163). The insights reveal that tertiary hospitals in this regard becomes one of the pull and push factors for internal migration. Internal migration refers to a change of residence within national boundaries, such as between states, provinces, cities, or municipalities (Skeldon, 2017:4; Rees, Bell, Kupiszewski, Kupiszewska, Ueffing, Bernard, Charles-Edwards & Stillwell, 2016:1). According to Thet, (2014:4) there are five pull and push factors for migration: economic, demographic, socio-cultural, political and miscellaneous factors. Self-referral fits under miscellaneous factors as the self-referral patients leave their original homes and come to urban areas where the tertiary hospitals are situated for the management of their conditions.

Thus, the insights point out that the self-referred patients pay extensive amount of fees to be seen in Emergency Departments in tertiary hospitals. Various methods of payments are sought to cater for those costs, despite healthcare being a state responsibility. From the South African health perspective, financial considerations for healthcare provision are endorsed by the Batho Pele Principles, Notice 1459 of 1997, which state that public services are to be delivered efficiently and economically and be of the value of money paid by the patients.

6.2.3 Tenet 3: Health Empowerment

The third tenet of empowerment in this study refers to health empowerment. Health Empowerment is a central component of health promotion and disease prevention (Fung, Yum Guo et al, 2016: 2). This aspect of health empowerment refers to the process through which people gain greater control and make decisions affecting their lives and health (Fung, Yum Guo et al, 2016: 2). Empowerment is “to give power to”, with power in turn being “the ability to do or act, or the capability of doing or accomplishing” (Chaudhuri, 2016:122). In addition, McGuigan, (2017:1137) explains that there is something which needs to be accomplished or done, by somebody who needs to be given power to be able to do so. According to Chaudihuri, (2016:140), power can be negative or positive in its context depending on the context within which the person with power uses it. In this study self-referred patients were using power positively as they needed to be empowered in order to understand and have knowledge as well as have positive health outcomes for their conditions.

Empowerment is one of the tenets of the Emancipatory Knowledge Framework. Related to this study this theme covers word of mouth as insight, referral by previous satisfied patients, staff members

and other community members, as well as advertisement and media as sub-themes. A detailed discussion on this insight is below as represented in Figure 6.4.

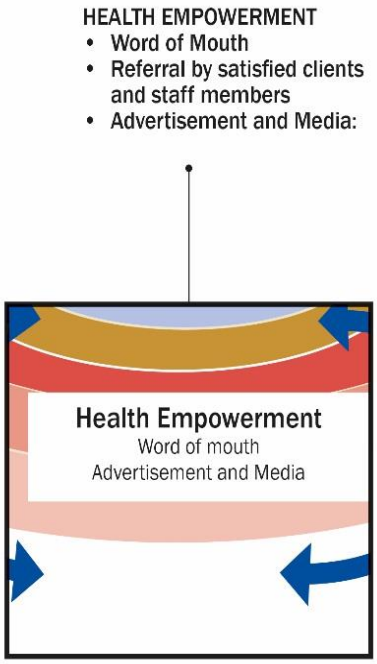


Figure 6.4: Tenet 3: Health Empowerment

6.2.3.1 Word of mouth

According to Chaniotakis, (2009:229) word of mouth is the method of speaking where positive or negative statements are made by consumers about their experiences with the service. Word of mouth plays a noteworthy role in making decisions in healthcare as it does anywhere in the realm of patients' behaviour as cited by Gelb and Johnson, (2015:57). The insights stipulated that through word of mouth, available services in different tertiary hospitals are publicized. Hence patients in need of such healthcare services refer themselves for second opinions or as part of their responsibility towards their health (McGuigan, 2017:1137).

In the healthcare setup according to Chaniotakis, (2009:240), word of mouth releases empathy that radiates responsiveness, assurance and intangibles. Additionally, through word of mouth, service

improvement and client satisfaction is anticipated. The insights expound clearly on this aspect as the previously satisfied patients and community members including own families, friends and healthcare professionals, are seen as informants for the self-referred patients. Additionally, in this digital era, various forms of media (Hinz, Drevs, & Wehner, 2017: 17) were used by the self-referred patients to tertiary hospitals.

Referral by previous satisfied patients, staff members and other community members

From the insights of the study the self-referred patients with chronic conditions mentioned that they were given knowledge about the services in the tertiary hospitals through word of mouth, from healthcare professionals and other community members. The insights of the study revealed that patient with chronic conditions need knowledge and help for the treatment of their chronic conditions. According to Gelb and Johnson, (2015:56), word of mouth through referral by previously satisfied patients, broadens cognizance and knowledge of the healthcare services which patients can leverage. Additionally, the insights of the study revealed that there were self-referred informants who had previously managed to do self-referral and obtained healthcare services in the Emergency Departments of the tertiary hospitals. The insights of this study were supported by Kraaijvanger et al, (2016:5); Wolkite, Waju and Gebeyehu, (2015:89); Van der Linden et al, (2014:1); and Stanislaw, Kasi and Sidney, (2013:246), who found in their studies that previously satisfied patients will recommend care to other patients who had the same conditions.

The insights revealed that previous patients were not the only ones who were referring patients to tertiary hospitals; there were also staff members who have knowledge on the referral procedures to Emergency Departments and tertiary hospitals. Kraaijvanger et al, (2016:5); Van der Linden et al, (2014:1) and Lowthian et al, (2013:62), in support of the insights stated that advice from others such as General Practitioners, nursing staff, clinics and doctors was cited as among the reasons for self-referral to hospitals especially Emergency Departments.

Furthermore, from the insights of this study, it was found that the healthcare professionals who were not directly going to render care on the patients were the ones that were referring them. And they were often those who had previously worked in tertiary hospitals (Kraaijvanger et al, 2016:6; Lowthian et al, 2013:62; Ragin, Hwang, Cydulka, Holson, Haley, Richards, Bruce, Becker & Richardson, 2005:1).

According to the insights of the study, the self-referred patients were also told by other people including family members and friends, that they could go straight to tertiary hospitals where they would be treated or get help for their conditions as cited by Stanislaw, Kasi and Sidney, (2013:246). From the insights it was evident that the Emergency Departments are viewed as a normal

Departments for care by the self-referred patients, the families, relatives and friends of patients with chronic conditions as they tend to demand such care (Detollenaer et al, 2017:246; Dorah, Colucci, Wall, Williams, Hessler, Goldfrank & Raven, 2014:506).

6.2.3.2 Advertisements and media

Advertisement as defined by Brueck, Owen, Bye, Edwards and Brueck, (2014:1) is publicizing something and media is the biggest method of providing knowledge through either audio or reading materials. In the Republic of South Africa in Gauteng Province where this research was done, the media plays a very important role in advertising and expounding on healthcare around the province. In this study, advertisement and media fall under word of mouth.

The insights of the study also emphasized that patient with chronic conditions and community members listened to advertisements on television and other audios as well as print media to make a choice for the facility to visit for treatment of their chronic conditions. The insights revealed that self-referral was worth doing as some of the patients were able to be recorded by the doctors, on the waiting list for operations. However, through self-referral and advertisement their operations were expedited. Deuze, (2016:326) explains how the media's activities are found everywhere. Gelb and Johnson, (2015:57) emphasize that advertising and media stimulated self-referral by previously satisfied patients and staff members and other community members including the family.

The insights of the study revealed that the patients were enlightened about their health needs through advertisement and media. Deuze, (2016:330) explained this clearly when stating that: "…*Media is a key to our chances for survival in today's world, therefore, is not a far-fetched notion, as media are most certainly continuously mediating our lived experience…."*

The insights indicated that participants portrayed a sense of empowerment as they were self-referring themselves when a health need arose based on the information from advertisements and the media. Through self-referral the patients were implementing one of the endorsements of the Batho Pele Principles and Patients' Right Charter, which state that all patients must be allowed to consult freely, have the best quality of service standard, be able to access care freely, be informed of everything done on them, and seek a second opinion on their conditions (South Africa, 1997). Furthermore, the two mentioned policies uphold equity in health amongst the South African population.

6.2.4 Tenet 4: Social Equity and Demystification in the Healthcare System

Social equity and demystification are one of the tenets of the Emancipatory Knowledge Framework (Chinn & Kramer,2008). Social equity emphasizes social, political and economic justice, fairness in pursuing sustainable policies and development. Additionally, social equity requires an efficient, fair and just healthcare system. The emphasis in equity is on social, political and economic factors that determine who gets sick and who gets good care as stated by Brothers, To, Van Zoost and Turnbull, (2015:758).

Concurrently, the demystification process in this study clarifies the myths that are held against the self-referred patients. The process of demystifying ultimately results in the establishment of socio-cultural structures and practices that are equitable, fair and just in addressing human health and wellbeing (Chinn & Kramer, 2008:7).

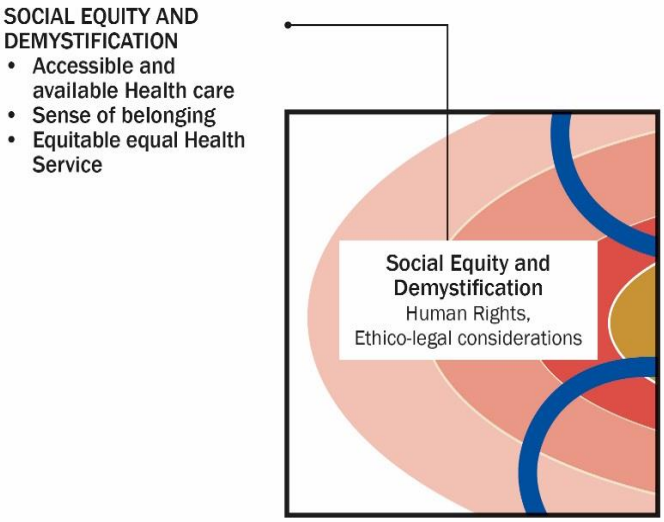


Figure 6.5 Tenet 4: Social equity and demystification

The insights of this study that are interwoven within the social equity and demystification tenet are human rights and ethico-legal considerations as **represented in Figure 6.5**.

6.2.4.1 Human Rights and Ethico-legal Considerations

Globally, healthcare is endorsed as a human right and ethical issue; for example, in Australia good healthcare is a basic right according to (Humphreys et al, 2011:11); Nunes & Rego,2017; WHO, 2017). In South Africa an endorsement of this is found in Chapter 2 on the Bill of Rights of the Constitution of the Republic of South Africa (South Africa, 1997). Related to health, this endorsement provides for each person in the Republic of South Africa to seek healthcare wherever (s)he wants.

In this study, self-referral was viewed as a problem despite it being endorsed in the Bill of Rights as the right to access healthcare. Both the Bill of Rights and the Batho Pele principles in South Africa allow patients the right to seek multiple opinions related to their diagnoses (Dickie, Elkwood & Robertson, 2011:13). Ethically and legally patients can go wherever they wish to obtain healthcare without gatekeeping policies. From the insights the patients were very much aware of their rights, as outlined by the Batho Pele Principles, in the White Paper (South Africa, 1997).

The insights indicate that self-referral is often associated with missed diagnoses and missed interpretations of the patient's conditions. This is supported by Dickie, Elkwood and Robertson, (2011:13) as mentioned previously, who argue that most patients who refer themselves are dissatisfied with their diagnosis or management of their conditions and they are likely to be missed or mismanaged at the new level of healthcare or setting and have to deal with lost information. From the insights of the study, participants echoed their right to healthcare in Emergency Departments in tertiary hospitals where the care is accessible and available as well as equitable, therefore optimising their sense of belonging to those tertiary hospitals.

Accessibility and Availability of Healthcare

Accessibility and availability are the main principles of Primary Healthcare (South Africa, 1997). In the current healthcare situation, the National Health Insurance Plan (Sithole, 2015:2) is underpinned by the Batho Pele Principles (South Africa, 1997) and the Constitution's Bill of Rights (South Africa, 1996). The Patients' Right Charter reiterates these principles (Gulliford, 2017:532) as far as health is concerned.

From the insights of the study, the self-referred patients visited the Emergency Departments of the tertiary hospitals for their chronic conditions to access the available healthcare services which they could not receive from their first level of contact. Ideally, Primary healthcare is the first level of care

(van der Straten et al, 2014:877) which is at community level. However, the insights indicate that the care received at this level was not satisfactory hence patients end up referring themselves to tertiary hospitals. Reliability and trust of tertiary hospitals were amongst the echoed virtues from the insights. Of importance was that the patients were going to tertiary hospitals to seek second opinions on their conditions (Detollenaere et al, 2018:246); van der Linden et al, 2014:1). Furthermore, Kraaijvanger et al, (2016:6) are in consensus with the insights of this study by stating that patients who usually self-referred themselves to the tertiary hospitals need convenience of access.

According to Chase, Cleverland, Beatson and Rousseauw, (2017:251-258), accessibility and availability of healthcare are in line with the utilisation of services. This supports the notion stated above on Primary Healthcare services that are within reach (accessible) and having the resources needing to be used and also human resources and buildings (available), but these are not always appropriate for the management of patients' chronic conditions. To put it clearly, accessibility and availability do not guarantee utilisation (Chase et al, 2017:251-258).

Lack of access to and availability of effective and sustainable Primary Healthcare services as cited by Humphreys et al, (2011:12-38), promotes self-referral by patients, as services will be used less, care will become less affordable, which will affect all the human and physical resources needed and continuity of care will be affected. Coster, Turner, Bradbury and Cantrell, 2017:1137 supported the insights of the study too by stating that patients had very limited access to the PHC clinics resulting in the patients visiting the Emergency Departments of referral hospitals.

Dorah, Colucci, Wall, Williams, Hessler, Goldfrank and Raven, (2014:89) also alluded to the accessibility and availability of healthcare for chronic conditions, citing that many patients with psychiatric conditions, which is a chronic condition, found themselves passing through the doors of the Emergency Departments each year because of unmet needs. This happens because of a lack of access and availability of healthcare needed by the self-referral patients with chronic conditions in tertiary hospitals near the residential areas where they belong.

A Sense of Belonging to the Tertiary Hospital

According to Maslow's hierarchy of needs a sense of belonging is seen as a human need in the same way as food and shelter, though it is at a higher level. According to Brar-Josan, 2015:93-95) as human beings we all have a yearning for a sense of belonging.

The insights revealed that the self-referred patients declared that they belonged to the tertiary hospitals and in fact they felt attached to those tertiary hospitals as they were located within their

communities. Brar-Josan, (2015:73-95) cited that when a person has a sense of belonging, the person feels free and confident, accepted, comfortable, with a sense of purpose and integration. These attributes were mentioned by the self-referred patients as they felt free and confident because the Patients' Rights and the White Paper on Batho Pele Principles embraced the Constitution (South Africa,1996), which enabled them (self-referred patients) to be legally treated in tertiary hospitals.

The insights revealed the self-referred patients reported feeling accepted and with confidence and that they felt a sense of purpose in tertiary hospitals when they were in the Emergency Department. Thus, when the healthcare professionals were interested to know more about their conditions, they felt valued and accepted, and when given the treatments. Some of the healthcare professionals even asked them to tell others to visit those tertiary hospitals for care, especially those with debilitating conditions like cancer (Brar-Josan, 2015:73-95).

The insights illustrated how the self-referred patients felt integration in the tertiary hospitals because they were given Hospital files to take home and they also saw positive progress after immediate treatment (Brar-Josan, 2015:73-95). According to Block, (2009:131) in his book The *Structure of Belonging,* human beings become better when connected to the local level, which supports the sense of belonging of the self-referred patients with their chronic conditions to the tertiary hospitals, in close proximity to their place of stay. The insights expound on how the self-referred patients were adamant about being connected to their localities from birth; and even envisaged dying in those tertiary hospitals. However, the current referral policies of these tertiary hospitals were not patient-friendly. The policies compel the patients to detour from their residential areas which are nearby to tertiary hospitals and go to a first point of care in faraway places before they can get access to be treated which is not justifiable.

Equitable equal health services

According to Braveman and Gruskin, (2003: 255) equity is an ethical principle related to human tights principles. In healthcare, equity refers to the absence of organized inequalities, where social, environmental, economic and political issues determining health are fair, just, even-handed or equitable (Braveman & Gruskin, 2003:254). The insights revealed that patients were referring themselves to tertiary hospitals as a way to redress inequalities in healthcare settings (PHC facilities and tertiary hospitals).

Additionally, these insights revealed that among healthcare facilities, despite being in Gauteng province and within the same circuit, there were many inequities and they were not equal. This was echoed by the patients who visited the tertiary hospitals where this research was done. Some

of the inequalities that were echoed from insights stem from: a shortage of medication, extended waiting times, poor communication with patients, doctors not working full time, staff-patient attitudes, and vice-versa.

According to Lehti et al, (2016:450; Ragin et al, (2005:1158); and Disirense et al, (2015:5), healthcare professionals struggle to offer equitable healthcare to patients with chronic conditions in most cases. In addition, a poor quality of healthcare service at primary healthcare level underscored low patient satisfaction scores (Wolkite, Waju & Gebeyehu ,2015:91). These factors compel patients with chronic conditions to practise self-referral.

The insights indicate that patients with conditions practise self-referral to tertiary hospitals where the care is rendered 24 hours. During the day and night, services in tertiary hospitals are available. The insights indicate that chronic conditions require equitable and equal healthcare like other conditions. The insights indicate that the current referral policies displace patient with chronic conditions far from their place of residence. Ultimately, the patients refer themselves to their nearest tertiary hospitals in order to claim their sense of belonging and their rights enshrined in the Bill of Rights from the Constitution of South Africa (South Africa, 1996).

6.3 SUMMARY

Chapter six discussed the insights of self-referred patients, who in this study were women with chronic conditions, as well as the perspectives by healthcare professionals managing them in tertiary hospitals in Gauteng Province. The chapter highlighted how chronic patients access care from emergency departments and tertiary hospitals through various strategies that include emergency admissions and admissions through disguise. Additionally, the chapter discussed how the participants in the study go to the extent of using fraudulent names and residential addresses in order to be treated for their chronic conditions in tertiary hospitals.

Furthermore, insights indicate how the participants fabricated details of their conditions to get access to the care in tertiary hospitals with the hope of getting comprehensive management for their conditions. The insights indicate how the participants **referred to Chapter 2** of the Constitution, the Bill of Rights, which provides a detailed account of the ethical, legal and moral responsibility of healthcare provision towards patients despite their location, condition, race and social or financial standing.

Chapter 7 will discuss the development of strategies for patient self-referral in tertiary hospitals in Gauteng Province.

CHAPTER 7
PHASE 2: DEVELOPMENT OF THE PATIENT SELF-REFERRAL STRATEGIES FOR TERTIARY HOSPITALS IN GAUTENG

7.1 INTRODUCTION

Chapter 6 discussed the insights relating to patient self-referral to tertiary hospitals in Gauteng Province. The insights revealed some of the ways through which the participants managed to gain access to healthcare in the tertiary hospitals using self-referral. These ways involve emergency admissions, admission in disguise, ability to pay for admissions, word of mouth and human rights, as well as sense of ownership of the tertiary hospitals.

Chapter 7 focuses on the development of strategies for patients' self-referral in tertiary hospitals in Gauteng from the critique and adoption of the preliminary strategies. This chapter fulfils objective 2 of this study, which was the development of strategies for managing patient self-referral which occurred mostly in emergency departments.

The aim of this chapter is twofold. First the chapter will briefly discuss the literature relating to strategies in healthcare. Secondly, the chapter will then discuss the processes that were followed to develop the strategies. The processes are based on the insights from Phase 1 (Chapter 6) and also a broad review of the literature. The processes were also guided by the Emancipatory Knowing framework and Critical Realism theory (Chinn & Kramer, 2008) that was used as the lens of this study. Below is a discussion on the processes that were followed to develop the strategies.

7.2 STRATEGIES IN THE DELIVERY OF HEALTHCARE

The World Health Organisation (WHO, 2018:11) describe health strategies as the actions or activities that might be used to achieve health policies and programmes. Additionally, Campbell and Graham, (2006: 1284) elaborate further by stating that strategies are a package of specific interventions as well as the detailed means of distributing such interventions. According to these descriptions, quality health strategies become the bridges that help the healthcare system to accelerate the achievement

of healthcare goals and priorities, through quality management principles that incorporate quality planning, control and improvement (WHO, 2018:11). Combrinck, (2018:137) when citing Hiller, (2011:503) and Martin, (2014:79) explains that strategies are the important routes that assist the organisations to move into the future. Additionally, in business strategies are used by executives to improve healthcare services (Hiller, 2011:503; Martin, 2014:79). Related to the current study, the self-referral strategies will address problems of bottlenecking and gatekeeping at the tertiary hospitals.

The development of strategies in healthcare builds a sense of ownership among those implementing them. Additionally, as the process is collaborative with service providers it ensures the outcomes that are grounded in the realities of service delivery and patients and community experience (WHO, 2018:11). The WHO, (2018:11) specifies that the development of strategies requires sustained and meaningful public engagement especially with the patients, healthcare professionals, DOH representatives, unions and legal representatives of the community, across the healthcare system and throughout the process, to get buy-in and improve quality care provision. Hence, in this study the Imbizo was planned. There are two acute choices that produce successful results in the development of strategies. These are: “where-to-play” and “how to win” choices in organisations (Martin, 2014: 80; Hiller, 2011: 503). The “where-to-play” choice in this study refers to an understanding of the patients’ experiences while seeking healthcare services and causes of self-referral to tertiary hospitals in Gauteng Province. The “how to win” choice in this study refers to the implementation of the self-referral strategies to tertiary hospitals for the positive financial and health implications in Gauteng Province.

The insights from the empirical phase, Phase 1, of the study were analysed and interpreted into six main statements which were used to guide the development of strategies that might be used for patients’ self-referral in tertiary hospitals in Gauteng Province in the future. The insights as the body of evidence were obtained from participants, of whom 15 were patients and 30 were healthcare professionals who were managing the self-referred patients in tertiary hospitals for more than five years, as well as from the relevant site documents.

7.2.1 Drafting of the strategies

During the data collection and transcription, first impressions from data emerged. The researcher then analysed the data in this study using analytic framework of Roper and Shapira which yielded five themes. These themes emerged from the interviews, reviewed documents and field notes The five themes were shared with the supervisors. Again the researcher shared the **trailers of the five themes <u>with</u>** the eight group of experts who were considered to be advisory group through google+

platform. The researcher saw a need for data sharing in this regard as the collected data was massive. The aim of sharing was to validate and the reduction of errors The researcher linked the findings through participants' voices (self–referred patients and healthcare professionals) and the use of literature, with the discussions between the supervisors and he reports from the group of eight experts and the researcher's findings. This assisted the researcher to identify the six declarative statements, for the formulation of the strategies.

From the obtained evidence, an imbizo was conducted where the six statements were broadly critiqued to self -referral strategies through the process that will be discussed below.7.2.1 Overview of imbizo participants.

A total of 13 participants participated in the Imbizo. These participants will be represented by means of table 7.1 below which explains the characteristics of the participants as follows:

TABLE 7.1: Summary of Imbizo participants

PARTICIPANT #	SEX	RACE	POSITION
#1	M	B	Medical Doctor
# 2	F	B	Medical Doctor
# 3	F	B	Medical Doctor
# 4	F	B	Patient
# 5	F	B	Patient
# 6	F	W	Patient
#7	F	B	Union Representative
# 8	M	B	Union Representative
# 9	F	W	Lawyer from the Community
# 10	F	B	Nurse
# 11	F	B	Nurse
# 12	F	B	Nurse
# 13	M	B	Instructional Designer

From the empirical phase (Phase 1), participants were recruited to be part of the Imbizo. The aim of the Imbizo was to develop strategies for patient self -referral in tertiary hospitals around Gauteng Province.

The13 Imbizo participants illustrated in table 7.1 were three medical doctors, three patients as well as two union representatives, one lawyer from the community, three nurses and an instructional designer. The participants represented each tertiary hospital as patient, nurse or doctor. There were representatives of the community, the nurses' union, South African Nursing Council and Council of Doctors. Amongst the nurse's representatives, there was one from the National Department of Health; all of the needed voices were there to represent the unheard voices (Oladele et al, 2012:25) regarding patients' self-referral.

7.2.2 Inclusion and Exclusion Criteria of Participants in the Imbizo

The participants who took part in the Imbizo for the development of the self-referral strategies were those who:

- Participated in the first phase of the study
- We're willing to participate in the second phase and provided the researcher with their contact details during the first phase
- Indicated the use of technology as a communication strategy during the interviews, and
- Were invited specifically by the researcher as experts based on knowledge and expertise in public healthcare system in South Africa.

7.2.3 Sampling and sample size

Purposive sampling was used to select the participants and the experts. A total of thirteen participants formed part of the imbizo to develop patients' self-referral strategies. These included patients, healthcare professionals and the invited experts. **Refer to Table 7.1** for the characterisation of the participants for the imbizo.

7.3 IMBIZO AS METHOD TO DEVELOP THE STRATEGIES FOR SELF-REFERRAL

An *imbizo* is a Nguni word, *pitso* in Sotho and *tshivhidzo* in Tshivenda (Mathagu, 2010:4). All these terms refer to a gathering that is summoned by the King, Chief or any leader in the community (Mathagu, 2010:4-10). Currently, the word is used interchangeably for conferences, workplace workshops and consensus meetings (Pretorius, 2006:754) since 1994 in South Africa. In public and community, an *imbizo* is called around public debates and dialogues. Hence Mathagu, (2010:4) defines imbizo as a gathering of the subjects of the King; while Mfene, (2013: 18) describes imbizo as a preferred policy discussion forum that enhances dialogue and interaction between the service providers and users of the services. In this phase, imbizo was used to facilitate discussions and to

reach consensus about the strategies on self-referral for patients to tertiary hospitals in Gauteng Province.

The current study was underpinned by a critical realism and emancipation knowledge framework. Critically, imbizo allows people to gather and discuss important difficult situations or things in the presence of a high authority person (Mathagu, 2010:7). As critical realism is about setting people free from oppressive social injustice (Hammersley, 2002:39), an imbizo forum in this study, allowed discussions to take place, addressing the denial of access to healthcare as one of the oppressive social injustices. Imbizo in this study provided an emancipatory platform to critique the six statements and then develop the strategies on patients' self -referral in tertiary hospitals in Gauteng Province. Furthermore, as critical realism rejects a monolithic theory of the scientific development structure (Hammersley, 2002:39; Parpio, Malik, Punjani & Farooq, 2013:491) not only were the healthcare providers and policymaker's participants in the imbizo, the patients were also invited. Collaboratively patients, healthcare providers and experts on the Public Health system in South Africa engaged in dialogues on patients' self-referral as a human rights phenomenon (South Africa, 1996; South Africa, 2008:3) **(Annexure K).**

7.3.1 Preparation for the imbizo

An invitation letter was written to twenty potential participants by the researcher to attend an Imbizo which took place on the 31st of August 2018 (**Refer to Annexure J).** The letter provided the aim of the Imbizo as to critique and develop strategies for patient self-referral to tertiary hospitals in Gauteng Province. The potential participants were urged to reply and send an acknowledgement indicating whether the participant would come or not, to make the logistical preparations such as the venue easy. Out of twenty potential participants only thirteen came for the Imbizo (**Refer to Table 7 on summary of Imbizo participants**).

The venue for the Imbizo was secured within the University without any cost as the researcher was a registered student. Secondly the venue was convenient to some of the participants as it was located close to two tertiary hospitals and centrally situated for the experts from Department of Health and other organisations. However, for those participants who were from the other two tertiary hospitals, transport was arranged, especially for the patients. The researcher prepared an infographic presentation of the study that was presented on the day of the imbizo (**Refer to Annexure I**).

An Imbizo package was prepared by the researcher and the supervisory team. The package included: a programme for the day, a document with the steps on participants' produced drawing

activity. writing materials as well as informed consent forms. Snacks and drinks were also organized. Seating arrangements were made with four round tables and on each a table was a common brochure on **participants' produced drawing activity** that invited the participants *to imagine an optimal patient self-referral policy* (**Refer to Annexure K**). Additionally, individual words related to self-referral were prepared as ice breakers for the Imbizo. Among others the words were: time, referral, health, participation, access, care, rights, policy (**Refer to Figure 7.1: Collage of Words)**. The researcher placed posters of different colours about each statement on the walls. The Imbizo was set to last for two hours (10.00 am to 12.00).

7.3.2 Opening activities during the imbizo

Registration started at 9.30 am. On registration participants were given the Imbizo package and offered a seat on any table in the venue. At 10.00 am the program started with a welcome address by one member of the facilitator group, who was one of the supervisory team. Ground rules were set. The rules included: aiming to be equal, cell phones to be switched off, participants to have a non-judgemental attitude, active participation, to respect each other, give others a chance and have fun.

The information leaflet about the Imbizo was read by the facilitator to the participants. Thereafter, the participants were asked to sign the informed consent form **(Refer to Annexure C**). The facilitator then invited the participants to a table where different words (icebreakers) were spread on the table (Refer to Figure 7.1). The participants were requested to choose one word which they thought talks to self-referral. On picking the word the participants were to introduce themselves and explain their understanding of the word to the group. The following were the words that were picked, and explanations given by the participants of the Imbizo.

Figure 7.1: Collage of Words

TABLE 7.2 Words that talk to self-referral

WORD	EXPLANATION OF THE TERM RELATED TO THE STUDY BY PARTICIPANTS
Access	A patient must be able to have access to resources for his/her ailment or sickness. The health systems regulation says that the place of care or hospitals must be accessible. Check patients' Bill of Rights.
Care	The healthcare fraternity do not care for the patients as they send patients too far away from where one is residing when sick, for treatment and some patients have complications.
Cell phones	These gadgets can be used in healthcare centres as it is handy and is able to make services faster for patients and explain what must be done to patients, if there is an emergency or patients just need an appointment or advice. Hence there is a need for patients'

	phones to be registered as this will lessen or eliminate overcrowding in tertiary hospitals and depletion of resources.
Communication	There are a lot of problems we experience as patients during emergencies. Time is consumed due to improper communication about our (patients') records and information needed at the healthcare centres. If an e-health card can be created for each individual, it will be easy for us (patients) as the doctor will be given an e-card by the patient to download and this will be easy for the healthcare professional to know about and care for the patient.
Inclusion	Patients must be included in making decisions concerning their healthcare needs
Money	Money, status and social standings must not be used to discriminate against one's access to any point of healthcare delivery. Health for all must be available, with access of patients to wherever and to whatever facility one desires. Patients must not be neglected due to lack of money. Emergency care must be rendered.
People-centred	As a self-referral patient I prefer tertiary hospital care rather than primary healthcare as it is reliable as I perceive care rendered there. PHC says healthcare must be for all.
Policy	The SA policy of referral is still in draft form – it must be sorted out for patients to have knowledge of how referrals are done in the hospital when one is sick.
Referral	The patient referral must be done correctly from the ground or PHC route to the tertiary place and best patient care must emanate from healthcare facilities if we want to curb self-referral.
Rights	It is the right for any human being to do self-referral anywhere and it must be sorted out as this is abusing patients' rights including the cost needed for care of patients.
Self-referral	Sick patients want help then and there. They go to hospital in emergency situations to the Emergency Department, even if it is a chronic condition as they know resources are there. These patients will preferably go to nearest place, hence self-referral.
Tertiary hospitals	People from different hospitals in different provinces than Gauteng refer them self or are referred by special doctors to one of the

	tertiary hospitals. A tertiary hospital is a specialized healthcare facility for special cases.
Time	Waiting times for patients in PHC areas are lagging and must be improved to stop delaying the consultation of patients. A lot of people go to tertiary hospitals because of long waiting times for ill patients and self-referral prevents are experiencing suffering even if their condition is chronic at the place where one must get help.
Trust	Patients need to trust that healthcare services are the same in the private and the public healthcare centres and time delays must be eliminated through filters used on access to healthcare services.

This activity on picking up and explaining the words, served as an ice-breaker for the imbizo which was held on the 31st of August 2018. Ice-breaking in workshops and consensus groups according to A-Ghamdi, Ali- Khalifa, Al-Onaizy and Al- Rhajhi, (2016: 383) is a method which is used to check the knowledge or information which the participants have concerning the topic or investigation or discussion.

The ice breaking was followed by presentation that familiarizes the participants with the study. The researcher presented infographics on the process of the study up to the time of Imbizo, together with the six recommended statements for the strategies to the participants **(Refer Annexure I).** The participants were informed about their freedom to withdraw during the Imbizo if they wanted to stop. They were also assured of confidentiality **(Refer to Annexure C**).

7.3.3 The use of participant-produced drawings in ethnographic studies

Ethnographic studies are known for their emergent nature as in most qualitative research designs (Pink, 2015:5-24; Pink, 2009:112). According to Pink, (2009:112) in ethnography a range of participatory techniques are often developed and adapted in the context for a specific research project (Pink, 2009:112). One such technique is the use of participant-produced drawings. In participant-produced drawings the participants are asked to produce the drawings or images themselves as a way to create connections between the participants' judgements and accounts (Pink, 2009:112). The drawings in ethnography might be used to elicit unspoken categories of physical practices and activities (Pink, 2009: 112).

In this study, the researcher decided to use participant-produced drawings in order to critique the six statements draft and develop the strategies. The researcher decided not to use the nominal group techniques. A drawing is regarded as a two-dimensional art form characterized by 1) an element

which produces signs used in a direct way, 2) the colour which is often one or two tones, and 3) the paper that serves as support (Stefanescu, 2017:200). There was a need to clarify the purpose and the role that the drawing played in the creator(s)' visual activity, for those researchers who wanted to understand a drawing. According to Stefanescu, (2017:200), participant-produced drawings are done to clarify the creator(s)' own ideas and acted as metaphors and expressions that created a safety net for the participants (Cheung, Saini & Smith ,2016:1).

Related to the current study, drawings were employed in this phase for the participants individually and in different groups to clarify their own ideas about patients' self-referral to tertiary hospitals in Gauteng Province. Simultaneously, the drawings were used to critique the six statement themes as the insights with the intention of developing strategies for managing patients' self-referral in tertiary hospitals around Gauteng Province. The researcher opted for the use of drawings in this phase as they usually produce better evidence than linguistic modes of responses (Puglionesi, 2016:359). Additionally, drawings provide for participatory possibilities in knowledge creation and translation (Cheung, Saini & Smith, 2016:1).

In order to start the drawing activity, the facilitator (one of the supervisors) arranged the participants into three heterogeneous groups. The heterogenic arrangement was aimed at having representation for the patients, healthcare professionals and the experts in all the groups for diversified deliberations (Hebert, 2018:101-108). In groups the participants were provided with flip charts and A4 blank papers with drawing pencils of different colours to draw a visual representation of the strategies from the insights (preliminary statements and/or new). Individually, in the groups the participants were asked to write their own ideas first, on how they envisage patients' self-referral to tertiary hospitals in Gauteng Province. Thereafter, the participants were asked to share their individual ideas to each other in their small groups. Lastly in groups they were to represent their ideas collectively by means of a drawing.

The deliberations during the activities were audio recorded (**Refer to video clip 1, 2 and 3),** by the moderator who was moving from table to table. As a form of reaching agreement the deliberations around the tables were focused on: the *actions* that should be considered to manage self-referred patients and *ideas about each recommended strategy.* The emphasis during this activity was that there is no right or wrong answer. The participants were given 45 minutes to work on the drawings. The participants were to choose people who would present their drawings thereafter.

URL OF *3 Video Clips*

Video of Figure 1

WIN_20180831_110 557 (4).MP4

Video of Figure 2

WIN_20180831_110 557 (6).MP4

Video of Figure 3

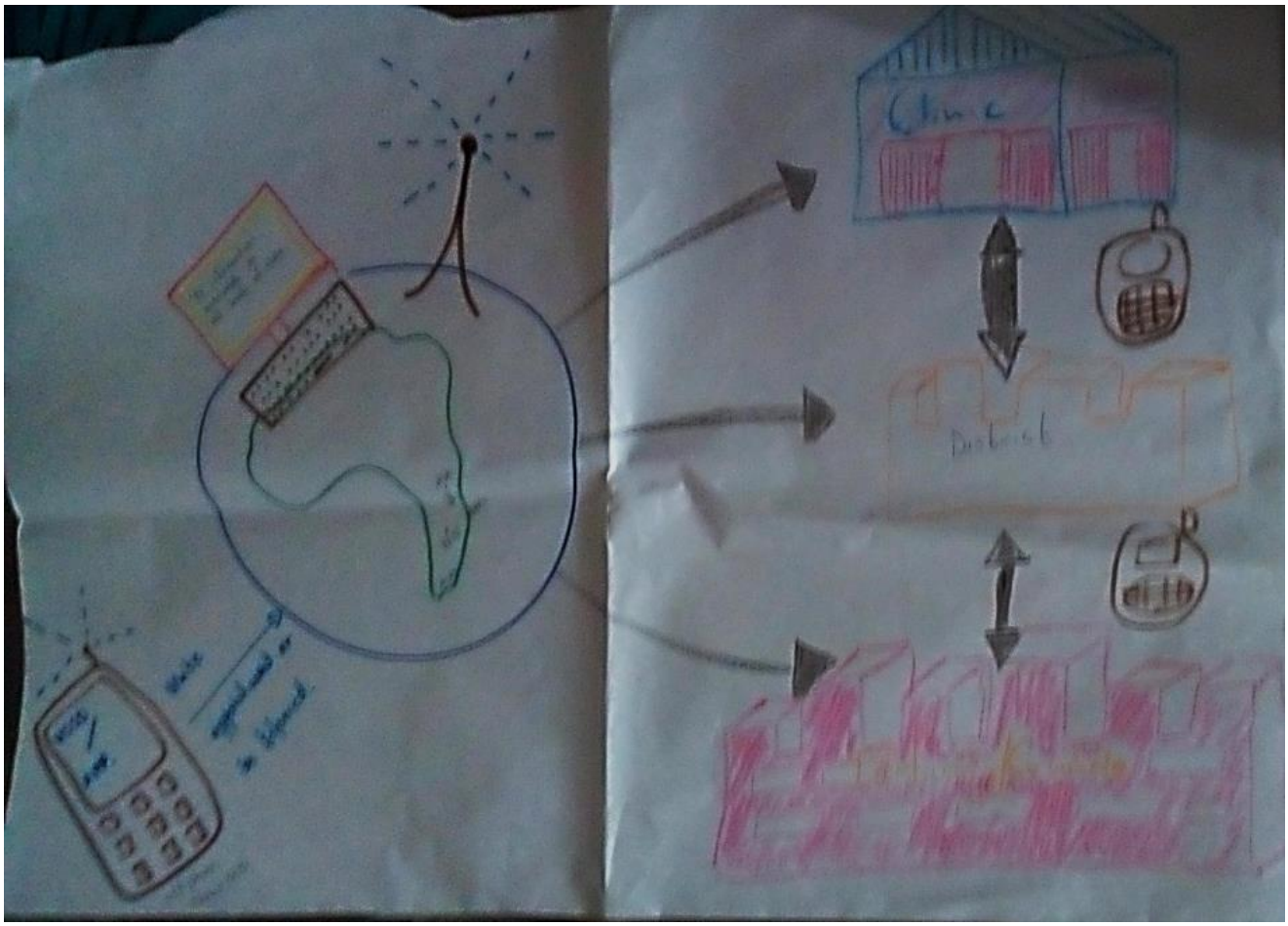
WIN_20180831_110 557 (3).MP4

7.3.4 Presentation of the drawings

The drawings were hung on the walls and each group was given a chance to present with the members of the group allowed to explain further what the drawings represented. The other participants could ask questions during the presentation and group members made inputs. The interpretations were audiotaped and transcribed verbatim by the researcher. These are presented below.

Interpretation and representation in critical ethnography play an important part. According Madison, (2012:147) representation is when the researcher describes the deeply layered and the sensual part of what has happened in the field without reservation, but mindful of what motivated the work done and own arguments and the commitment to social justice. In this phase the participants (re) presented their drawings on an optimal patient self-referral policy in tertiary hospitals around Gauteng Province. The presentations were transcribed verbatim and each drawing is attached as well as evidence of the transcription.

Drawing 7.1



Presentation and Interpretation of Drawing 7.1 # Group 1

Presenter 1:

Mary is a 55-year-old woman and she doesn't really have issues. She works as a labourer in a factory but she notices that she now has a swelling around her abdominal area and she is quite worried about it and doesn't know where to go and where to start. She lives right next to Johannesburg Academic Hospital and in her mind she is not thinking of going anywhere else because it is right across the road [**but to walk in**]. She is not medically trained, her kids don't talk to her that much, so the best that she can do is with her **cell phone**, trying to figure out where is best to go and get help. So using a cheap method, we are hoping by then that Gauteng has **free Wi-Fi**, Mary will be able to **punch in** 'these are my symptoms' because she wants to be seen. It's not an emergency of which most people think emergencies are the issue but it's also about the mundane things that can be handled effectively. So she **punches in info** and from there she is able to get feedback about her symptoms. A simple **application**

that asks 'what is the matter?' From there she should be able to type or reply that she has an abdominal swelling and it's been there for such a period of time and from there be asked important questions, whether it be associated with pain or not, and it would give her a whole list of options she would be able to choose from. If the **algorithm** feels that she needs further assessments, it would refer her to **her local clinic**.

What we had in mind is that all this information should be available to everyone and not just from the first point where you meet and referred on. But from the fact that she has been complaining about something for the past 4 months and from when she first complained about it, the clinic should also know, should also have an understanding from that. When she gets to the clinic, we would like that Mary make her information known to the rest of us as having **[e-card]** in the sense that we can track how these things have been progressing. Not only that we can help Mary, but also so that we can see as healthcare workers, how well we have achieved in terms of managing these patients. So she sees that she has a hernia, a hernia that can easily be repaired and is not an emergency at the moment. We know that what we are trying to move towards is district services that have specialised services. So in her mind she should have **walked across** the road to Johannesburg Academic Hospital. Unfortunately, there is a specialised hospital in Edenvale clinic that only does hernia. In fact, they call it a hernia excellent centre. It would actually have been a whole waste of time for Mary to come across the road. She would have gone to the clinic and they would have said it is not an emergency. Here is an appointment in 3 months to come to the same hospital that will tell you that you need to be treated at a different hospital. We have just wasted 3 months of time, energy and effort.

On top of that Mary works in a factory in which she has to take sick days off, which she has to take [from] leave [days], of which she has to think about as she has a child, how is she going to look after that child. So we would love that when this information is available, she has finally been assessed **at any facility**, that she has a hernia that needs to be helped, that she would be able to get help from that district centre and not have long queues with long waiting times. It also allows the healthcare system to actually plan in the future, saying to itself that this operation needs to take place and where it needs to take place, how can we plan our future where our theatres are better [equipped], our wards [beds] are available, our medication [is there] in the case that she is feeling a bit symptomatic of which sometimes they grow in size, the medication is [there that] can be given to Mary.

Summary of Drawing 7.1

The presenter of Group 1 reported about a lady who was 55years of age and was staying adjacent to the tertiary hospital and she discovered that she had an abdominal swelling which was painful and she was worried about the abdominal swelling. Mary wanted to just walk- in to the hospital but she first decided to open her cellphone trying to find what to do with her condition. The group perceived Mary opening the application on her cell phone through free Wi-Fi and found that she was to answer questions to be helped, like what her problem was, signs and symptoms and the duration of the problem. After answering those questions, Mary was advised to go to Edenvale district hospital, which was regarded as the specializing centre for the hernia she had.

This was to promote the clinics to be well furnished and well stocked with medication. According to the group, the information about the different types of facilities with different specialization ought to be available for any one and applications must be disseminated so that all people are informed. Mary could have walked in to her nearest tertiary hospital, where she would be told it was not emergency, she ought to go to the clinic where she would be given 3 months to be seen by the doctor and that will be a delaying technique and will result in Mary waiting for 4months since she discovered that she had abdominal swelling according to the group.

The group critically reflected with this delay of help and suggested that Mary must have an e-card which will show how the healthcare professionals treated Mary and what care was given to Mary on seeking healthcare in clinics for 4 months. The group suggested that as Mary was working and with a small child who was under the care of Mary, that the clinic ought to do all the checking and give the date for operation there as she was complaining, so that sick leave is sorted out there and there and for arrangement of baby sitter to be done by Mary. The group wanted Mary and the community to be empowered, so that when she is ill, she must not be delayed to get help and she must be ready for care at that time of consulting. Critical reflection is used by the group for Mary in this scenario, to find help who has children but not talking to Mary and Mary to use her cellphone to be helped.

Drawing 7.2


CLINIC
1
DISTRICT
TERTIARY
2018
2020
2022
2018
2018
2018
PRELIMINARY
E-STRATEGIES
TERTIARY
DISTRICT
2018
COLLABORATION

Presentation and Interpretation of the Drawing 7.2 # Group 2 Imbizo

On the top we have the current situation. We have a woman that has got fibroids or is diagnosed with fibroids, the current situation is that she would have to go to the clinic, and probably get referred to the district by 2020 having been diagnosed in 2018. By then she may have been advised to go to different clinics or districts, to only get where she is supposed to get treated in which we say may be 2022, or she would go directly to the tertiary [hospital] in 2018 and get lost in the system and still not get her treatment in time and still wait till 2022, so that's the current situation. We also notice because patients have to look for these places, a lot of time gets wasted, a lot of queuing, a lot of wrong district hospital allocations.

In the future, strategies, we have the same patient using a **laptop** or a **cellphone** or an **e-card**, with all the details that will be inside the records here and she then log in that she needs to be admitted and her fibroids taken out, and that immediately gets [admitted and] recorded in the hospital and hopefully it happens in the same year 2018. So here she has the option of going to the hospital and having her fibroids removed because of **the e-card** and doing it **electronically** as an on-site method, and what we thought was that tertiary [hospitals] might be overburdened, so it's very important to have **collaboration with district hospitals with tertiary hospitals** so they can suggest that maybe next door they have the same theatre and so for this type of operation, the patient can just be sent there.

Some people take the tertiary level as more resourced and that is why they undermine the primary healthcare and its specialists. So if they can also try [to have] resources at a district, they **may be resourced also at primary healthcare facilities.**

Summary of Drawing 7.2

The presenter for Group 2 discussed two scenarios. The first scenario was about what was happening now in the healthcare settings while the second scenario was about what is envisaged in future within the healthcare services. In the first scenario a woman who had fibroids went to a clinic where her care was delayed; she could only be transferred to the district hospital, and then to the tertiary hospital where an operation would be done either within a year or two years. Ultimately, the patient decides to refer herself to a tertiary hospital where she got lost within the system and she is again delayed in getting care. She has to restart her consultation as a new patient.

The second scenario is the group's perception of the future with the same patient in the same year 2018, using her laptop, cell phone and e-card with the entire patient's information which will reveal all the places of healthcare facilities visited and what was done and the group perceives prevention of repeating tests, and also patients' hop from one healthcare facility to the other through the e-card. As part of sustainable technological actions the patient log in her problem to the e-health system and she is triaged and directed on what to do and where to go in the same year, and her needs are met immediately.

The group envisaged the best future of healthcare system with cell phone making appointments when a person is sick and in need of help and advises of what to do and where to go for consultation with all healthcare issues.

Drawing 7.3

(Re) Presentation and Interpretation on Drawing 7.3 #Group 3 Imbizo

Our picture has 3 segments, which are the current situation, the middle phase is the interface or transition and then there is the last phase which is the idea of the world we want to see. The reason why it is in these phases and the bottom up way is as we are moving higher, so thus it begins at the bottom. So the lady gets turned away from healthcare representing mountains that people climb to **access a clinic**, which are like hurdles people cross over to get medical help, although there is grass, sometimes patients go through the thorny areas to **get access**, and these are the roads some patients drive through, where you have potholes, some are gravel roads etc. But if we are to change, it means everybody must face towards the **same direction which are the arrows taking us to the interface.** In the **interface area is the area of technology (e-tech**) which is a form of technology in the form of **e-health** or e-strategies which must be [adopted] and finally given access to everybody.

Now the format therefore would include the formalisation which would use **cellphones,** for example to assist the elderly such as my mum, who has a **cell phone** but only has receiving calls, making calls and sms(messages) services only. She cannot **use an app** and is not fluent in English and so on. This phase must include the ability to use any **form of technology**, including computers, tablets etc. Important to it is the **communication strategy** to achieve, which addresses communication issues itself. These may include television, radio and billboards so that there is a paradigm shift for everybody utilising technology [and those who do not]. But what is ideal to be achieved at that time is a happy face because of the **e-health system**. What additionally makes her smile is that it matters not where she stays or her socio-economic status, what matters most is that the **technology** is able to tell people in a clinic that the lady in village A, today is due to receive her chronic medication and that **e-tech message** pops up automatically without the lady having to do anything except have her **e-card** swiped, which is the power of **e-health**.

Furthermore, if I feel I am sick on my own, I can also book myself an appointment, or the patient is **able to walk** to a clinic from her residence, and within the clinic there is a **health information system** that is able to integrate all the information, **a biometric system idea**, where if she puts her finger, it says she was diagnosed with high blood pressure 2 years ago or she was diagnosed with a certain cancer and so on, and if she shows any form of symptoms the system should be able to tell them this person has such and such a condition, and this may suggest an emergency.

So this is the **power of technology** in a nutshell and one does not have to run around. Information must filter too through places like a church, or gym etc so that the delivery vehicle has everything integrated, where even in urban areas one can utilise drones, scooters and bikes etc to access and deliver the services to the people. It should matter not whether the person goes to the tertiary or smallest hospitals. If all [**the technology]** they are using has the information there, it should be able to say in this clinic we can't help but let us refer you to the next level, because your information as an individual says what the patient needs at the moment is not available here but we are taking you to the next level. We suggest that a patient should access a tertiary hospital as a self-referral, with the information pointing out that the patient can be managed like this but getting to that clinic [at tertiary level] and they should be able to assist.

What can you see, hear imagine and feel about the presentation and picture? I see taking power away from human referral and so if you go to a clinic and the lady is at the back, you won't get the referral, so if you take it to the facts based on your health history, this is where you should be going and here is a referral letter. The middle part seems to deal with **artificial intelligence** by **centralising data**, so if I want to book into a clinic, I can **log onto a system** and by stating the symptoms I have or what the problem is, using **artificial intelligence** to filter, I have a possible programme for me and that can take me to a **screen** based on the symptoms I have presented to the system, I can now refer to a certain clinic that can screen me and direct me to a specialist.

Summary of Drawing 7.3

The presenter of group 3 gave the three types of phases from where group 3 are observing the healthcare system (current situation, middle phase or transition phase) and also the desired for future, in healthcare system, this healthcare system could be in future which is the last phase of this group.

The first phase of the drawing, which is at the bottom, showed how a lady was suffering and failing to enter the healthcare facilities, the clinics when in need of health care service. There are so many obstacles today including bottlenecks through policies to seek healthcare.

The group's drawing also depicts the middle phase which they called interphase which is an upward move which the group perceive as a change phase, with technology introduced in the health care system from the state in which the healthcare system is today. All types of technology artificial

intelligence through introduction of centralization of records or data of patients, Biometrics through scanning of fingers is accepted as long as the patient will be able to get access to healthcare facilities or be provided with healthcare services and get treatment.

The last phase of the drawing shows a continuation of the middle phase. There is a lot of advertisements, schooters, billboards, vehicles, which can tell the patients about health and also take medicines to people and people be introduced and with e-cards which reveals all what they are suffering from when inserted in the computer without patients hindered by being asked a lot of questions when seeking healthcare for their chronic conditions.

7.3.5 Making sense of the data from the drawings

For this phase the three drawings were the source of data to be analysed. The researcher employed Rose's, (2007, 2012) critical visual analysis in making meaning of the drawings. For the researcher in this regard, the drawing itself were more important than how they were produced as well as the intended audience for the drawing (Rose, 2012). During the presentation of the drawings the presenters produced what is referred as story panels for each drawing (Ownby,2013: 3). The story panels assisted the researcher and the participants to understand various perspectives on how self-referral might be endorsed in tertiary hospitals. The main story panels that emerged were: innovation, technology and artificial intelligence.

STORY PANELS FROM THE DRAWINGS

The three drawings were the source of data for this phase. These story panels were on the following three main aspects:

1. The use of innovation and technology in Healthcare provision
2. Optimization of access to healthcare in different levels
3. Centralized Healthcare Management

Table 7.3 below is on story panel's main aspects: the story and its explanation

Table7.3: Story panel

STORY	EXPLANATION
Use of Innovation and Technology in Healthcare provision (Apps, e-health, e-card)	The dominant discourse in the presentation of the drawings indicated a move towards the use of Innovation and Technology. The participants in their presentation reiterated this aspect several e-tools such as applications were highlighted.
Optimization of Access to Healthcare in Different levels of Care (walk-ins)	The second story panel was on the best ways to optimize access to healthcare in tertiary hospitals. In these story panel walk-ins, porous referral system and again technology might be the best ways to make tertiary hospitals accessible.
Centralized Healthcare Management (innovations)	The third story panel was on Centralization of healthcare information in South Africa. This will allow for access of information on every patient within the South African health system, being at Primary, District and Tertiary levels. Centralization of health information will address the issue of lost health histories of patients within the health system.

As the presenters were presenting the drawings, the group members and the other participants from the other groups were afforded an opportunity to give the inputs and ask questions. This served as a way of further appraising the proposed strategies as alluded to by Hammersley, (2006:3-14). The adopted hybrid (traditional and electronic) strategies were then the following: 1) *tertiary hospitals to have call centres, 2) telephonic triaging system, 3) centralization of patients' records, 4) online platforms that chronic patients might use,5) national e-register for chronic conditions, and 6) walk-ins for chronic self-referral patients.*

7.3.6 Acknowledgement and closure of the imbizo

The facilitator called the participants for the closure of the forum and all participants were **happy to have been allowed to participate in this phase of the research and they were all keen to see this study published**. The researcher thanked everybody.

7.4 PRESENTATION OF: THE HYBRID STRATEGIES FOR PATIENTS' SELF-REFERRAL IN THE TERTIARY HOSPITALS IN GAUTENG PROVINCE

7.4.1 Purpose of the strategies

According to (WHO, 2018:11), quality health strategies become the bridges that help the healthcare system to accelerate the achievement of healthcare goals and priorities, through quality management principles that incorporate quality planning, control and improvement.

As mentioned above during the development of the strategies, there was an agreement that each strategy should have a rationale, the recommended actions and the suggested accounts about the strategy obtained from the participants during imbizo. The suggested accounts attest and affirm the choice of the strategy.

Strategy # 1: Tertiary hospitals to have Call Centres to provide advice and referral of chronic patients who are in need of urgent help.

Rationale:

Call centres as stated by Bogan and English, (1994) in Best Practices are places where people who are desperate for their needs to be met, especially those who are mobile, connected and impatient with slow services are helped. The call centres are exploring ways for increasing self-services to customers with the same queries for a reduction in payments or money. These self-referred patients already tend to bypass PHC due to various reasons such as long waiting times and lack of medications (Bogan and English, 1994; Kraaijvanger et al, 2016:6).

ACTION(S) TERTIARY HOSPITALS TO HAVE CALL CENTRES THAT:	SUGGESTED ACCOUNTS ABOUT THE STRATEGY OBTAINED FROM THE PARTICIPANTS
Have qualitatively trained staff that are emotionally mature to manage the Call Centres. Call Centres to be accessible for patients with different conditions Call Centres to be available and affordable resources to address myriad problems	"Call centre referrals for first time patients need to be addressed by somebody who will be of help to that patient" "The service of a call centre will reduce waiting times "Waiting times might be minimized and it will increase great satisfaction level of patients"

Strategy # 2: Introduction of telephonic triage requests to establish urgency and immediate referral to correct centres for chronic patients.

Rationale:

Telephone triaging is the service of categorizing the patients telephonically by healthcare professionals based on their state of health. The patients are assessed through a method of categorization based upon many apprehensions, which includes the extent of illness or injury, which results in less patient's consultations in the Emergency Department after prioritization of patients (Travers, Waller, Browling, Flowers & Tintinalli, 2002:395-400).

In case of using telephone triaging the patients will either have telephone consultations or even call for advice. The method can be used prior to a visit to the Emergency Department according to Kraaijvanger et al, (2016:7). Telephone triaging should be run by experienced and skilful professional personnel who will be able to provide telephonic health information and advice in order to reduce the influx to emergency departments in tertiary hospitals. Critically, the patients will take this action of phoning on their own when encountering illness related problems.

Action(s) Tertiary hospitals to establish a telephone triaging system. The system should:	Suggested accounts about the strategy obtained from the participants
Telephone triaging should operate 24 hours around the clock for the community The telephone triage should be managed by multilingual professionals with good telephone etiquette Knowledgeable and skillful healthcare professionals should work in the triaging area.	"Telephone triaging requests will help in case a patient is scheduled for December, but their medications are finished and mismanaged or for example tablets fell into a toilet, a patient is able to call and find out where they can go and get their next treatment". "It is better when you phone for help and you are helped by a person who understands one's language as you become free and say everything to get help and your money is used for the correct purpose" "Face to face follow-ups are reduced and few people are there as many people are helped through telephone triaging by people who know what to do"

Strategy # 3: Centralization of patients' records for continuity of chronic patient care.

Rationale:

Centralized patients' records are needed as a practical and secure on-demand system that can be used to collect the patients' information or medical histories with no risk of breach of privacy (Allaert, Quantin, Jaquet-Chiffelle, Coatrieux, Benzenine & Auverlot, 2011:1). The system is intended to prevent the loss of medical records of patients through standardization and centralization of all the

information about each patient in a single Medical Record system. Through a technological system the patient's records can be retrieved from different hospitals where the patient is to be hospitalized. In countries where the systems are centralized, the healthcare professionals who need the records will use a code to enter the Medical Record or Search Engine, with the permission of the patients. This is a sustainable method for patients' care continuity.

ACTION(S) TERTIARY HOSPITALS TO CENTRALIZE THE RECORDS OF PATIENTS BY:	SUGGESTED ACCOUNTS ABOUT THE STRATEGY OBTAINED FROM THE PARTICIPANTS
Piloting the centralization of patients' records with a few patients in few hospitals Standardization of the patients' medical records across the public healthcare facilities. Establishment of data backup for storage of patients 'records Availability of trained officers to centralize and retrieve with supervision Make available patients' health record	"I hope things change by having a main centre that keeps information for everyone. I'm certain life would be a lot easier." "I have seen a new file for our patients and all the needed documents are inside one booklet" "Centralization will help the healthcare professionals with recordkeeping." "When patients' records are needed by patients it is only through legal department that it comes out and the healthcare professionals sign with their identification for such." "Money is saved as fewer investigations will be done and when necessary as more previous medical information is available"

Strategy # 4: Establishment of online platforms for easy access to healthcare services for chronic patients. Leveraging on available and suitable on line platforms

Rationale:

Online platform is defined as a digital service that facilitates interaction between the two or more distinct interdepend users. Online platforms serve as a personalized data-driven service to patients or in medical research or health education where data is extracted and distributed and shared, opened and reused (Van Dijck and Poell, 2016:1). Further Van Dijck and Poell, (2016:1) cited that

the government has the duty to provide conceptual clarity in the description of healthcare and research in health about the use of different platforms.

ACTION(S) TERTIARY HOSPITALS TO INTRODUCE SUITABLE ONLINE PLATFORMS THAT WILL:	SUGGESTED IDEAS ABOUT THE STRATEGY OBTAINED FROM THE PARTICIPANTS
Availability of online platform to different groups of patients with different chronic diseases Ensure accurate suitable information for specific illnesses are updated frequently through evidence Provide the required support to the patients with array of chronic conditions	"Already in some provinces in South Africa we have the Mom Connect, which can be done for all patients and not only for the pregnant women." "Patients also have electronic referrals, Wi-Fi capabilities" "The middle part seems to deal with artificial intelligence by centralising data, so if I want to book into a clinic, I can log onto a system [and do it]" "[They] have a possible programme for me and that can take me to a screen based on the symptoms I have presented to the system, I can now refer to a certain clinic that can screen me and direct me to a specialist." "The whole country must have this service offered to all patients"

Strategy # 5: Establishment of a national e-register of chronic patients in Gauteng Province.

Rationale:

A national e-register is the detailed record of patients who are inside the hospitals and the patients who are discharged including their diagnoses and procedures done on them (Waithera, Muhia & Songole, 2017; Rose, Richter, Kapustin, 2014). The use of an electronic health record system reduces errors, and it ensures database integrity. The national e-register is supposed to be correct and be up to date always as this will reflect all the people's record in the health discipline.

ACTION(S) TERTIARY HOSPITALS TO INTRODUCE OR ADVOCATE THE NATIONAL-E HEALTH REGISTER WHICH WILL BE:	SUGGESTED IDEAS ABOUT THE STRATEGY OBTAINED FROM THE PARTICIPANTS
Available in all healthcare facilities Established and monitored by qualified officers Updated on daily basis	"When I am in the health facility, I would like to see and know the information of when I was seen previously in this facility. It is so bad to be asked for your history when you are very sick, while you have been providing it continuously on visiting the healthcare facility" "The Administrative officers must show the other multidisciplinary team members what to do with the established e-register for support purposes when the trained officer is not there, for continuity purposes" "This will be cost-effective and help with time management in terms of statistical error, as the e-register will be electronic instead of manually done"

Strategy # 6: Introduction of walk-ins for patients with chronic conditions.

Rationale:

Walk -in of patients is when the patients come into the emergency department without being referred but on their own, for healthcare services. These patients comes into the centre at their own time as the access to the walk-in is free and opening hours are extended (Labgaa, Locatelli, Gilgien, Staeger, Comuz, & Perdrix,2014:874).

ACTION(S) TERTIARY HOSPITALS TO INTRODUCE WALK-INS FOR CHRONIC PATIENTS WHICH NEED TO:	SUGGESTED IDEAS ABOUT THE STRATEGY OBTAINED FROM THE PARTICIPANTS
Be accessible, within a walking distance from the community.	"The patient is able to walk to a clinic from her residence"
Be fully equipped with medications for chronic conditions and qualified knowledgeable human resources	"I do not need anything more than to have my script re-written and be given my medication as I have been given a date for next year for my chronic condition"
Operate 24 hours around the clock	"It's convenient for me with its extended opening hours and its location" "We are free to go anytime as there is no need for an appointment"

In presenting the strategies, rationale, and actions the researcher used the deliberations and accounts from the participants when drawing and presenting the drawings. The deliberations and accounts enhanced and optimized the strategies in general.

7.5 SUMMARY

Chapter Seven discussed the development and presentation of the hybrid strategies for patient self-referral in tertiary hospitals in Gauteng Province as phase 2 of the study. The development of the strategies was to fulfil objective 2 of the study, which was to develop strategies for managing patients' self-referral in tertiary hospitals in Gauteng Province.

The chapter described the Imbizo forum, from its preparation to the development of the strategies. The Imbizo was used as a consensus forum where participant-produced drawings were used to collect data. These drawing represented the ideas and actions for optimal self-referral in Gauteng Province.

The activities in the imbizo ended up with the adoption of six strategies which are:

Strategy # 1: Tertiary hospitals to have Call Centres to provide advice and referral of chronic patients who are in need of urgent help.

Strategy # 2: Introduction of telephonic triage requests to establish urgency and immediate referral to correct centres for chronic patients.

Strategy # 3: Centralization of patients' records for continuity of chronic patient care.

Strategy # 4: Establishment of online platforms for easy access to healthcare services for chronic patients.

Strategy # 5: Establishment of a national e-register of chronic patients in Gauteng Province.

Strategy # 6: Introduction of walk-ins for patients with chronic conditions.

Each strategy has a rationale and the actions for implementation. Chapter 8 will be on the synopsis of the study implications, the final set of hybrid strategies developed, limitations, recommendations for future research and summary.

CHAPTER 8

IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS OF THE STUDY

8.1 INTRODUCTION

Chapter 7 discussed the development of the strategies for patient self-referral in tertiary hospitals in Gauteng Province as phase 2 of the study. The development of the strategies was intended to fulfil objective 2 of the study. The *Imbizo* was used as a consensus forum for the development of such strategies. Chapter 8 will provide the synopsis of the study, the final set of hybrid strategies for patient self-referral, implications for: health and nursing practices, patient care and policy development, limitations of the study as well as recommendations for future research.

8.2 SYNOPSIS OF THE STUDY

This study was intended for the development of strategies for patient self-referral in tertiary hospitals in Gauteng Province. This intention was accomplished through addressing the two objectives of this study.

The objectives of this study were:

- *To explore and describe patients' self-referral patterns and the healthcare professionals' perspectives on the current patient self-referral patterns/pathways in tertiary hospitals of Gauteng Province*
- To develop strategies for managing patients' self-referral to tertiary hospitals in Gauteng Province.

Chapter 1 of this study provided an overview where orientation of the study is outlined. From the scientific evidence and personal experience of the researcher the patients (with chronic and acute conditions) are bypassing the first point of entry which include primary healthcare facilities and district hospitals, and refer themselves to tertiary hospitals. Through self-referral patients are relegating the

approved referral process despite having knowledge of such in tertiary hospitals in Gauteng Province.

Chapter 2, explained the context of the study. This chapter provides, an understanding of the both the background to Gauteng Province where the study was done, and the common health-seeking practices of patients to different healthcare settings in South Africa in general.

Chapter 3 dwelled on the paradigmatic and theoretical perspectives that underpinned the study. The study was informed by critical realism as the paradigm of choice and Emancipatory knowledge framework as a theory for knowledge development. Given the emancipatory nature of knowledge in critical realism as indicated by (Wikgren 2005: 11), the intention in this study was to develop the self- referral strategies that the patients in Gauteng Province might be used to modify existing policies on referral processes.

Chapter 4 provided the in-depth discussion of critical ethnography as a buddy to critical realism and the preferred research design for the study. Critical ethnography, in this regard interrogates the current referral policies on chronically ill patients and specifically women in tertiary hospitals. The design used in-depth interviews with patients and healthcare providers to obtain knowledge on the patterns/pathways for self-referral in tertiary hospitals in Gauteng Province.

Chapter 5 of the thesis discussed data analysis and interpretation. The analysis followed Roper and Shapiro's analytical framework. The researcher shared the findings with a team of eight experts who were purposively selected to from the total number of participants whom the researcher has interviewed on this study. The aim here was to validate the findings as well as the reduction of errors in interpretation of the collected data. The sharing process was done virtually using Google+. This team of eight experts validated the patterns/ pathways from the analysed data.

Chapter 6 discussed the insights of the study in relation to available literature. The discussion is further guided by the emancipatory knowledge framework and critical realism as the paradigm. The insights from this study included: emergency admissions, admission in disguise, word of mouth, financial standing as well as human rights and ethico-legal considerations. These insights were interwoven within the four tenets of the Emancipatory Knowledge Framework with regard to the development of strategies for patient self-referral in Gauteng province.

Chapter 7 is phase two of this study which was on the processes that were followed to critique and adopt the strategies for self-referral in tertiary hospitals in Gauteng Province. The researcher decided to use *Imbizo* as a way to bring all the stakeholders to reach consensus. The stakeholders were

medical doctors, patients, nurses' union representatives, practising lawyer, nurses and an instructional designer from Education Innovation at the University. Together the participants reach consensus on the patient self-referral strategies through the use of participants'-produced drawings instead of using the nominal group techniques (Cheung, Saini & Smith 2016:1). Participants'-produced drawings are participatory techniques that might be used to create connections between the participants' judgements and accounts on the phenomena of interest (Pink 2009:112).

Hybrid strategies for patients' self-referral in Gauteng Province were developed. These were: introduction of call centres, triage telephonic requests, centralization of patients' records, establishment of online platforms, establishment of a national e-register, and the introduction of walk-in's. Each strategy was presented with rationale and actions which were suggested by the participants.

Chapter 8 presents the hybrid strategies, study implications, recommendations for future research and limitations of the study.

8.3 FINAL SET OF HYBRID STRATEGIES FOR PATIENT SELF-RFERRAL IN TERTIARY HOSPITALS IN GAUTENG PROVINCE

The six hybrid strategies that were developed are finally presented as:

- Strategy # 1: Tertiary hospitals to have call centres to provide advice and referral of chronic patients who are in need of urgent help.
- Strategy # 2: Introduction of telephonic triage requests to establish urgency and immediate referral to correct centres for chronic patients.
- Strategy # 3: Centralization of patients' records for continuity of chronic patient care.
- Strategy # 4: Establishment of online platforms for easy access to healthcare services for chronic patients.
- Strategy # 5: Establishment of a national e-register of chronic patients in Gauteng Province.
- Strategy # 6: Introduction of walk-ins for patients with chronic conditions.

8.4 IMPLICATIONS OF THE STUDY

8.4.1 Implications for health and nursing practices

These findings of this study have important implications for health and nursing. It is very essential for the healthcare professionals to be technologically informed, as these strategies indicated the move towards the use of innovation and technology. This is particularly important as the strategies recommended the use of innovation like the new e- applications, e-cards and centralization of healthcare information. Furthermore, the gatekeeping practices in the tertiary hospitals will be reduced as the strategies suggest and enable the patients to know what to do about their conditions through mechanisms such telephone triaging.

This study is about advocacy for the patients by the healthcare professionals. According to the International Council of Nurses; nurses are to be encouraged to advocate for the patients as one of the core values of nursing practice (Benton 2012:1). Therefore, it becomes imperative for the healthcare professionals especially the nurses to provide education as part of their advocacy practice for the patients and communities about the available strategies to use in order to access healthcare in tertiary hospitals. Through the findings of the study the nurses will have to optimized their knowledge on women chronic conditions in order to provide correct health and disease management practices that will advance women's health practices.

8.4.2 Implications for patient care

The findings of the study indicated that if self-referral is not legally endorsed, patients' files and information get lost along the way in the healthcare systems. As such the developed strategies will enhance and optimize the continuity of care in chronic patients in tertiary hospitals. Furthermore, the findings endorsed measures that will prompt the patients to understand the signs and symptoms of their chronic conditions especially when using telephone triaging and new applications. Additionally, the self-referred patients will receive quality care which is affordable, effective, efficient, and available according to the Bathopele Principles as endorsed by the Constitution of South Africa.

The quality care for the patient will be improved as the healthcare professionals will have to be knowledgeable and skilled on total patient care which involves educating the patients and their families on their conditions.

The findings of the study indicated that patients wanted to have control of their chronic conditions; the strategies that were developed in this study indicate such an opportunity. Relief from workload

is envisaged as the patients will decide on their own care and are able to do it from their own homes especially with the availability of technology.

8.4.3 Implications for policy development

Amongst other issues this study was intended for was to advance the referral policies of tertiary hospitals by incorporating the concept of self-referral within them. The findings and strategies developed might be useful to the various health departments in South Africa to develop responsive referral policies. Furthermore, those in health policy development might leverage on technology for the development of some of the policies. Most importantly, nurses still lack behind on issues of policy making and policy decisions. The study can provide the nurses with ways to facilitate policy making and policy decisions for optimal health outcomes

8.5 LIMITATIONS OF THE STUDY

First and foremost, the study was only conducted in one province (Gauteng) while South Africa has nine provinces. If the study was done in all the 9 provinces this could have yielded a bigger and clearer picture about patient self-referral in South Africa.

The researcher had challenges of obtaining access to the tertiary hospitals despite having approval from the Department of Health Ethics Committee. This limitation was a result of the new processes that were introduced recently by the National Department of Health for registering any research protocol in their database. This limitation had an impact on the duration of engagement with the participants in the research settings. However, the study employed several techniques (sharing of data with the participants, review of site documents and *imbizo* to optimize engagement with the participants

Additionally, the study only provides the landscape of self-referral amongst women with chronic conditions to tertiary hospitals in tertiary hospitals.

Only doctors and nurses were the healthcare professionals included in the study. The study could have been more advanced if other multidisciplinary team members such as radiologists and pharmacists were also included as they also manage the self-referrals.

8.6 RECOMMENDATIONS FOR FUTURE RESEARCH

Several recommendations for future research have been identified during the study: These will be discussed below'

Research for Men's Health

Men's health is one of the areas that are orphaned /deserted in research. There is a possibility of conducting similar study with men with chronic conditions not only in tertiary hospitals but in other hospitals. It will be very interesting to explore the men's perceptions on self-referral.

Epidemiological studies on chronic diseases

This study provided qualitative baseline data on the self-referral of female patients with chronic diseases to tertiary hospitals in Gauteng Province. Given the epidemiology of chronic illness in South Africa, there is a need to explore innovative ways of reducing the cost of treatment. Further exploration is needed to use of new technologies as well as the traditional strategies to facilitate to determination of the prevalence rates in communities with chronic diseases.

Blending and leveraging on the available technology in research

This study used collaborative research endeavours such as sharing of ideas through the Google platform with the participants. Further studies need to be done using available innovative collaborations that will increase researcher-participant participation in research.

Using collaborative research designs and techniques

This study used critical ethnographic design which has a focus on creating cultural schema for change with the participants. There is a need in future for studies to be done through such designs in order to improve practices in the healthcare sector. Furthermore, Imbizo forum was used as a technique to reach consensus. These are relevant context based techniques to encourage service users to collaborate with service providers within the South African context. Subsequently, the current study supplemented the inquiry with participant-produced drawings. Such artistic techniques are beseeched in research as they create and elicit unspoken voices from participants.

8.7 CONCLUSIONS ABOUT THE STUDY

This study was an ethnographic study that was intended to bring change on the current referral processes in tertiary hospitals. The study premised from the researcher personal experiences when providing care to the self-referred women with chronic gynaecological conditions. Prominently, it was

clear that patients both *acute and chronic* will continue to bypass primary healthcare facilities and go to district and tertiary hospitals for the management of their conditions. Some of the pushing and pulling factors for self-referral practices are lack of both human and material resources in primary healthcare settings.

South Africa is known for its diverse population groups. And different populations respond differently to illness, and have different health seeking practices. One of such practices is self-referral; which in is not endorsed in South African patient referral policies.

This study used critical ethnography in order to involve the self-referred patients and those managing self-referral in tertiary hospital to come up with knowledge that might create change and alter perceptions on the phenomenon of inquiry. Through critical ethnography as a research design and critical realism as a lens the participants indicated several patterns that they use to access tertiary hospitals especially emergency departments despite being chronically ill. High costs of healthcare in these tertiary hospitals did not deter them for referring themselves for management of their conditions. Participants showed that they were prepared to go all out to bypass lower levels of care and use disguise, pirating of physical addresses as some of the unacceptable ways that worked for them to get access to tertiary hospitals

That said, to some participants, self-referral was seen as the right to seek second opinion as endorsed by several protocols globally and nationally. These protocols among others include The Bill of Rights, BathoPele Principles. Most of the participants interrogated the practices of being referred to healthcare settings that were very far from where they reside. The findings of the study indicate that such practices were unfair and unjust to the management of patients with chronic conditions.

Uptake on new development is usually influenced by active participation of stakeholders during the developmental process. In this study, Imbizo was customized as a consensus forum rather than Nominal Group techniques or the Delphi techniques which are traditionally used in research. The imbizo allowed the patients, healthcare providers, members of professional bodies, as well as members of the community to come together and actively share their opinions on how self-referral can be endorsed in referral policies of tertiary hospitals in Gauteng Province. From the imbizo essential strategies were developed. Hopefully there might be a positive uptake of the developed strategies as the participants for the imbizo were from various sectors involved in provision and management of patients.

8.8 SUMMARY

This chapter provides the synopsis of the study, the final set of hybrid strategies for patient self - referral, implications for: health and nursing practices, patient care policy development,
limitations of the study as well as recommendations for future research as the end of this study. The develop strategies might enhance and optimize the continuity of care in chronic patients in tertiary hospitals and quality care. The patients wanted control of their chronic conditions, such an opportunity is envisaged through the strategies that were developed in this study. This will yield the relief from workload as the patients will decide on their own care and are able to do it from their own homes especially with the availability of technology. Concerning the policy development within the nursing fraternity, this study can provide the nurses with ways to facilitate policy making and policy decisions for optimal health outcomes. Like any other doctoral work, the study has limitations which might be addressed during postdoctoral work.

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ANNEXURE A

DECLARATION REGARDING PLAGIARISM

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Declaration regarding plagiarism

Full names of student:	Munyadziwa Dzebu
Student number:	15413277
Title of the study:	**Development of strategies for patients' self-referral in the tertiary hospitals in Gauteng Province**

Declaration

I understand what plagiarism is and am aware of the University's policy in this regard. I declare that this proposal is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements. I have not used work previously produced by another student or any other person to hand in as my own.

I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE: _____

ANNEXURE B1

DATA COLLECTION GUIDE FOR PATIENTS

Munyadziwa Jane Dzebu

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DATA COLLECTION INSTRUMENTS

Interview Guide for Patients

Title**:** DEVELOPMENT OF THE STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

Aim: To develop strategies for managing patients' self-referral in tertiary hospitals

TOPIC GUIDE FOR IN-DEPTH INTERVIEWS PATIENTS

Grand Question: What are the strategies to incorporate patient self-referral in the draft referral policy? What do you understand by patient self –referral in your own words?

How did you find out about the self- referral pattern?

How do you view the self- referral pattern?

Probing Questions might be:

What are the contributing factors to patients' self- referral by patients in tertiary health facilities?

Kindly explain the current patient self-referral patterns from rural to urban public health facilities?

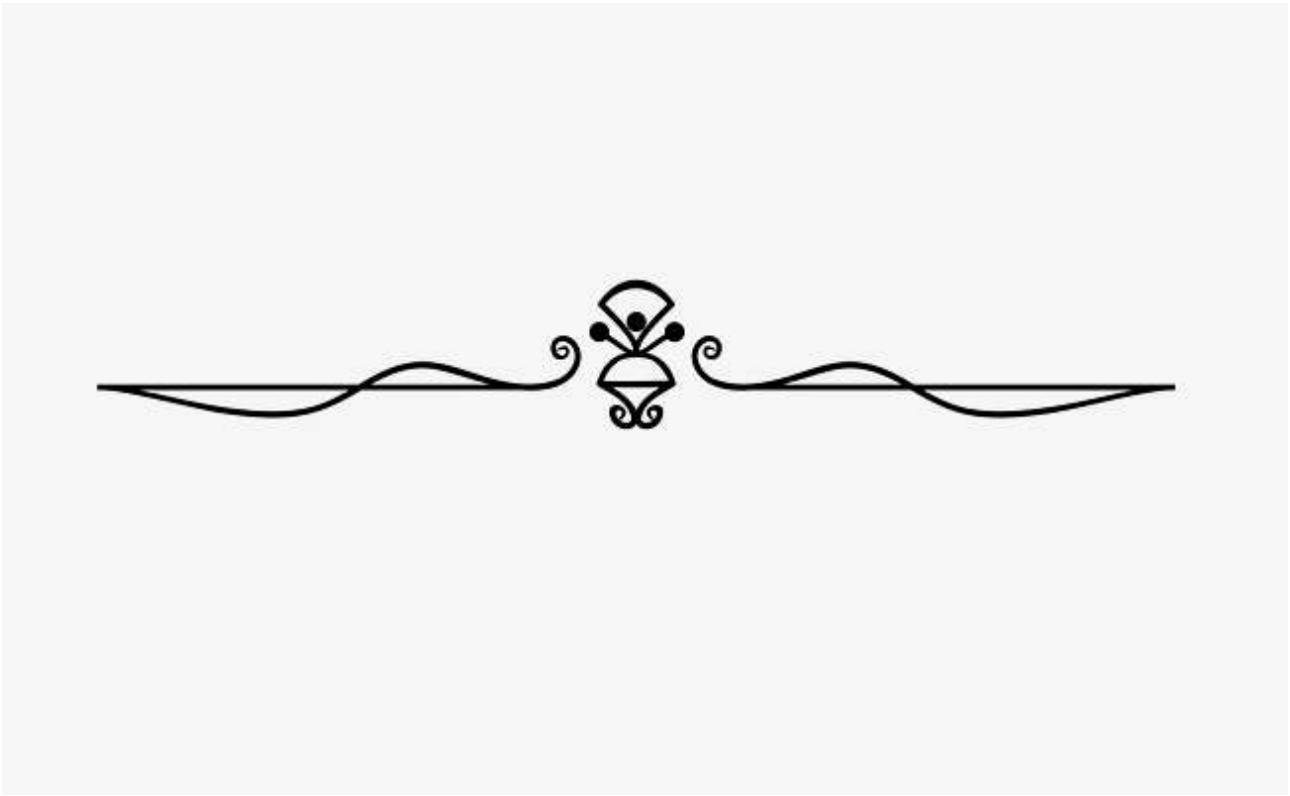
From your own perspective how do you view patient self-referral?

How should it be managed?

What should be included in the draft policy from the patients' self-referral factors and patterns**.**

ANNEXURE B2

DATA COLLECTION GUIDE FOR HEALTHCARE PROFESSIONALS



Munyadziwa Jane Dzebu

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DATA COLLECTION INSTRUMENTS

Interview Guide for HEALTHCARE PROFESSIONALS

Title: DEVELOPMENT OF THE STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

Aim: To develop strategies for managing patients' self-referral in tertiary hospitals

TOPIC GUIDE FOR IN-DEPTH INTERVIEWS HEALTHCARE PROFESSIONALS

Grand Question: What are the strategies to incorporate patient self-referral in the draft referral policy?

Probing Questions might be:

- What are the contributing factors to patients' self- referral by patients in tertiary health facilities?
- Kindly explain the current patient self-referral patterns from rural to urban public health facilities?
- From your own perspective how do you view patient self-referral?
- How should it be managed?
- What should be included in the draft policy from the patients' self-referral factors and patterns?

ANNEXURE C1

PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT FORM

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT FORM

TITLE OF STUDY: DEVELOPMENT OF THE STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

1. INTRODUCTION

The researcher invites you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator / interviewer / name of person / Munyadziwa Dzebu

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to incorporate patients' self-referral in the draft referral policy.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves unstructured interviews. The researcher will ask you some questions about what strategies should be used to incorporate patients' self-referral in the draft referral policy. The interview will be recorded with your permission, notes will be taken also to review the answers and ask more question as the need arises to clarify.

4 RISKS AND DISCOMFORT INVOLVED

There are no risks in participating in the study. The interview will take about 45 minutes of your time.

5. POSSIBLE BENEFITS OF THE STUDY

Although you will not benefit directly from the study, the results of the study will assist in establishing how self-referral of patients can be incorporated in the draft referral policy.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, telephone numbers 012 3541677 / 012 3541330, contact person:

8. INFORMATION AND CONTACT PERSON

The contact person~~s~~ for the study is Munyadziwa Dzebu, e-mail munyadziwa2002@yahoo.co.uk

If you have any questions about the study please contact the researcher on the following telephone numbers. Alternatively you may contact the supervisor at telephone numbers: 012 354 1445 and 0715591327 respectively.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time

to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study.

Participant's name			**(Please print)**
Participant's signature		**Date**	
Investigator's name			**(Please print)**
Investigator's signature		**Date**	
Witness's Name			**(Please print)**
Witness's signature		**Date**	

ANNEXURE C2

PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT FORM FOR THE EXPERTS

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

THE GROUP OF EXPERTS PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT FORM

TITLE OF STUDY: DEVELOPMENT OF THE STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

1. INTRODUCTION

The researcher invites you to participate as a member of a group of experts in this research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator / interviewer / name of person / Munyadziwa Dzebu

2. THE NATURE AND PURPOSE OF THIS STUDY

The main aim of the study is to develop the strategies for patients' self -referral in tertiary hospital in Gauteng Province. The aim of this current step: is the reduction of errors in interpretation of findings and to validate the findings of the study by this group of experts.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

As part of the preparation for the second phase of this study, which is Imbizo, you are requested to go through these 5 transcripts in order to assist in articulating the core message(s) in all of them. I have transcribed and interpreted ALL the transcripts and my own interpretations brought out 5 main Themes which I referred as pathways to self-referral as mentioned in the letter. Your participation in this step is of great value as it will reduce errors in the interpretation for this study and validate the findings. Kindly go through each transcript add, correct, delete and even comment by writing on the document along the margins and send it back through Google + as it was sent to you. You are given 2weeks to send the work back.

4 RISKS AND DISCOMFORT INVOLVED

There are no risks in participating in the study. The interview will take about 45 minutes of your time.

5. POSSIBLE BENEFITS OF THE STUDY

Although you will not benefit directly from the study, the results of the study will assist in establishing how self-referral of patients can be incorporated in the draft referral policy.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, telephone numbers 012 3541677 / 012 3541330, contact person:

8. INFORMATION AND CONTACT PERSON

The contact persons for the study is Munyadziwa Dzebu, e-mail munyadziwa2002@yahoo.co.uk

If you have any questions about the study please contact the researcher on the following telephone numbers. Alternatively you may contact the supervisor at telephone numbers: 012 354 1445 and 0715591327 respectively.

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All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study.

Participant's name			**(Please print)**
Participant's signature		**Date**	
Investigator's name			**(Please print)**
Investigator's signature		**Date**	
Witness's Name			**(Please print)**
Witness's signature		**Date**	

ANNEXURE C3

PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT FORM FOR IMBIZO

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT DOCUMENT
Imbizo

TITLE OF STUDY: DEVELOPMENT OF THE STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

1. INTRODUCTION

The researcher invites you to participate in the consensus workshop.. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator / interviewer / name of person / Munyadziwa Dzebu

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to develop strategies for patients' self-referral in tertiary hospitals in Gauteng Province..

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

This phase of the study involves reaching consensus on the hybrid strategies that might be used for .self –referral of patients to tertiary hospitals in Gauteng. You will be asked to participate in the activities in the workshop that will lead to the development of strategies for patients' self-referral in the tertiary hospitals.. The workshop will be recorded with your permission; notes will be taken as the evidence of this event and also for clarification purposes.

4 RISKS AND DISCOMFORT INVOLVED

There are no risks in participating in the study. The workshop will take about 2 hours of your time.

5. POSSIBLE BENEFITS OF THE STUDY

Although you will not benefit directly from the study, the results of the study will assist in the development of the the self-referral strategies in Gauteng tertiary hospitals.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason. The will be no negative consequences if you do not want to participate e.g.: Refusal of treatment.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, telephone numbers 012 3541677 / 012 3541330, **Ethics Code :503/2016**

8. INFORMATION AND CONTACT PERSON

The contact persons for the study is Munyadziwa Dzebu, e-mail munyadziwa2002@yahoo.co.uk

If you have any questions about the study please contact the researcher on the following telephone numbers. Alternatively you may contact the supervisor at telephone numbers: 012 354 1445 and 0715591327 respectively.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that my participation in this consensus workshop have been explained to me regarding the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study.

Participant's name			**(Please print)**
Participant's signature		**Date**	
Investigator's name			**(Please print)**
Investigator's signature		**Date**	
Witness's Name			**(Please print)**
Witness's signature		**Date**	

ANNEXURE D

REQUEST FOR PERMISSION

No **2**5 Neptune Street,

Atlasville

1459

11th September 2016

The CEO,

Hospitals A, B & C

Dear Sirs /Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDYFOR THE DEGREE OF D.Litt et Phil

I hereby request your permission to conduct a study in the tertiary hospitals in Gauteng Province.

I am a nurse in one of the tertiary hospitals and I am currently studying at the University of Pretoria for the degree D.Litt. et Phil and as part of my studies I am to conduct a research. The title of my thesis is "DEVELOPMENT OF STRATEGIES

FOR PATIENTS' SELF –REFERRAL IN TERTIARY HOSPITALS IN GAUTENG PROVINCE".

I have developed an interest in patients doing a self -referral, as this is the worldwide concern for patients today, within the healthcare fraternity as it results in burnout of nurses, unable to plan comprehensive care to and for patients. Their care is interrupted and they undergo unnecessary painful repetition of procedures which were done previously but patients with no referral letters hence no history. I would like to interview the self –referred patients and healthcare professionals caring for these patients, have Imbizo to discuss this issue and finally help with the development of strategies for self-referral patients.

All information collected will be treated with utmost confidence and no names of the participants will be revealed. I trust that the results will be to the ultimate benefit of all concerned and I agree to inform you and the other relevant authorities and individuals of the results of the study in due course.

Please forward your response to my request to the address above or email listed here.

Munyadziwa Jane Dzebu

Munyadziwa Jane Dzebu

Email:munyadziwa.dzebu@gauteng.gov.za; munyadziwa2002@yahoo.co.uk

ANNEXURE D1

LETTERS OF ETHICAL APPROVAL: UNIVERSITY OF PRETORIA

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

24/11/2016

Approval Certificate
New Application

Ethics Reference No.: 503/2016

Title: THE STRATEGIES FOR PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS

Dear Munyadziwa Dzebu

The **New Application** as supported by documents specified in your cover letter dated 17/10/2016 for your research received on the 17/10/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 23/11/2016.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (503/2016) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee

We wish you the best with your research.

Yours sincerely

DFR Somraree, MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

☎ 012 356 3084 ✉ deepika.behari@up.ac.za / fhsethics@up.ac.za 🌐 http://www.up.ac.za/healthethics
✉ Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 69, Gezina, Pretoria

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved on 22 May 2002 and Expires 03/20/2022.
- IRB 0000 3235 IORG0001762 Approved on 22/01/2014 and Expires 00/14/2020

13 June 2019

Approval Certificate
Annual Renewal

Ethics Reference No.: 503/2016
Title: The development of e-strategies for patients 'self-referral in tertiary hospitals in Gauteng Province.

Dear Mrs MJ Dzebu

The **Annual Renewal** as supported by documents received between 2019-06-03 and 2019-06-12 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-06-12.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2020-06-13.
- Please remember to use your protocol number (503/2016) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4.00, Level 4, Tuwkipere Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
Email deepika.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Munyadziwa Jane Dzebu

ANNEXURE D2

LETTERS OF ETHICAL APPROVAL: GAUTENG PROVINCE

Log off My Account Help & Support

Manage Assigned Applications Reports Search Admin

RESEARCH PROPOSAL DETAILS: GP_2017RP7_489

Research Committee

GAUTENG HEALTH RESEARCH COMMITTEE

APPLICATION DETAILS

Title of Research Project

The strategies for patients self-referral in tertiary hospitals

Status of Application

coming (New application)

Status of Project

On-going

Proposal Submission Date

2017/08/05

Comments

You will find a list of all comments made on the current research application. The list below displays comments made by both the Applicant and Research Committee

Comment	Comment Date	Comment By

Research Staff assigned to Project/Proposal

Title	Name	Initials	Role	Institution	E-Mail	Telephone No.	Mobile No.	Fax No.
MRS	Munyadziwa	Jane	Student		[redacted]	011 9033663	[redacted]	None

Postal Address Line 1	Postal Address Line 2	Postal Address Line 3	Postal Address Line 4	Postal Code
[redacted]				2017

Aim and Objectives

The overall aim of this study is to develop strategies for patients' self-referral in tertiary hospitals in Gauteng province. In order to achieve this aim, the specific objectives of the study will be to determine factors that affect self-referral patterns, to explore and describe current patient self-referral patterns, to explore the perceptions of the healthcare professionals on self-referral patterns, and to develop the strategies for self-referral in tertiary hospitals in Gauteng.

Study Area(s)/Field(s)

Description

Public Health

Study Design(s)

Description

Descriptive

Exploratory

Data Collection Method(s)

Method Selection	Method Description
QUALITATIVE	File Review
-	Medical Records Audit

Sample

A qualitative research approach using critical ethnography will be used. Purposive or judgment sampling will be used as the researcher considers the participants to have more knowledge and in-depth information on the phenomenon, however the size of the sample will be determined by data saturation.

Data Analysis Tool(s)

Tool Description

Content Analysis

Information / Data Request ?

Yes

Information / Data request details.

Review of relevant site documents which will be the various documents that are used in tertiary hospitals for managing self-referral patients. It might be consultation, admission which might be public or private documents. Example OPD registers, patient files and referral policies of the tertiary hospitals. The researcher is asking for the permission to access such documents from the Department of Health.

Locations(s) where study will be conducted

Facility

- Charlotte Maxeke Hospital
- Chris Hani Baragwanath Hospital
- Dr George Mukhari Hospital
- Steve Biko Academic Hospital

Anticipated Start Date

2017/02/01

Anticipated Completion Date

2017/12/31

Ethics Institution(s)

[illegible] (Student) - University Of Pretoria Faculty Of Health Sciences Student Research Ethics Committee

Ethics Approval Number

530/2016

Date of Ethical Approval

2016/11/21

Date Ethical Approval Expires

2017/11/21

If Clinical Trial, MCC Approved

No

National Clinical Trials Registry Number

Not applicable

Funding source

no donor, self supporting

Budget (in ZAR)

Mu


NHRD - Details
Back to List

ANNEXURE D3

LETTERS OF ETHICAL APPROVAL: THREE TERTIARY HOSPITALS

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

STEVE BIKO ACADEMIC HOSPITAL
Private Bag x169 Pretoria 0001

Enquiries: Dr AP van der Walt
Tel no: +27 12 354 2336
Fax no: +27 12 3542151
E-mail: andrevdw@gpg.gov.za

For attention:
Munyadziwa Dzebu

GP study ref. number: GP_2017RP7_489

Dear investigator

Re. CONDITIONAL PERMISSION TO CONDUCT RESEARCH AT STEVE BIKO ACADEMIC HOSPITAL

TITLE: THE STRATEGIES FOR PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS

Conditional permission is hereby granted for the above-mentioned research to be conducted at Steve Biko Academic Hospital. Please note that full approval is subject to receipt of a copy of Ethics approval granted by the University of Pretoria Faculty of Health Sciences Research Ethics Committee (irrespective of Ethics approval that may have been granted by another institution).

Yours sincerely

Dr AP van der Walt
DIRECTOR CLINICAL SERVICES

4 May 2017

STEVE BIKO
PRIVATE BAG X169
2017 -05- 04
PRETORIA 0001
ACADEMIC HOSPITAL

-1-

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

CHRIS HANI BARAGWANATH HOSPITAL
Enquiries: Ms. D.F. Ngidi | Telephone: (011) 933 - 8770/8157
Fax number: 086 419 2281 | Email: dimakatsogidi@gauteng.gov.za

Date: 02 June 2017

Ms. M.J. Dzebu
University of Pretoria
Faculty of Health Science
Department Of Nursing Science

Re: Permission to conduct research on "The Strategies for patients' self –referral in Tertiary Hospitals"

With reference to the request to conduct research at Chris Hani Baragwanath Academic Hospital.

Ms. Dzebu has applied for permission to conduct research at Chris Hani Baragwanath Academic Hospital. Prof. Pettifor has agreed in principle and subject to my approval as Nursing Director

I therefore request that you discuss the matter and seek approval from Clinical Heads

Kind Regards

Mrs. D.F. Ngidi DN
Nursing Director

Date: 05/06/2017

Supported/Not Supported

Dr. S. Sathekge
Clinical Director (Mother & Child)

Date: 05/06/2017

Supported/Not Supported

Dr. K. Mustafa
Clinical Director (Surgery & Clinical Support)

Date: 05.06.2017

Chris Hani Baragwanath Hospital
Chris Hani Road
DIEPKLOOF Ext. 5
SOWETO

PO Bertsham
2013

Telephone number (011) 933-8000

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

OBSTETRICS AND GYNAECOLOGY
School of Clinical Medicine

Department of Obstetrics and Gynaecology
Chris Hani Baragwanath Academic Hospital, PO Bertsham 2013, South Africa. Telephone: t 27 11 933 8156 .Fax 2711 938 1534

TO: Matron Ramela

From: Dr J.Jeebodh
Acting Head of Department

Date: 20 June 2017

Re: Developmental strategies for patient self -referral on tertiary hospitals in Gauteng

Chris Hani Baragwanath Academic Hospital strives to offer tertiary care to patients.

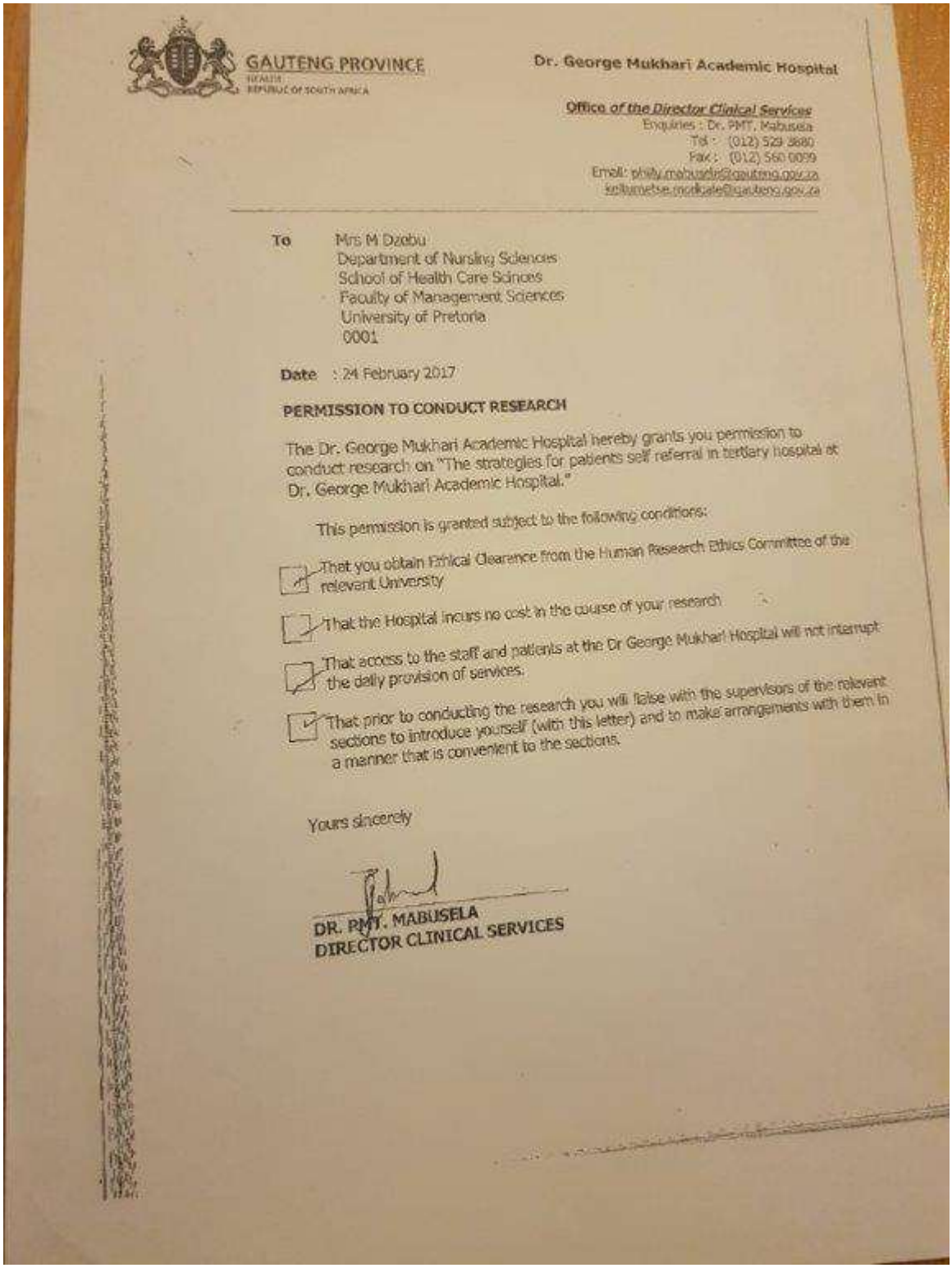
We therefore want to inform the Operational Managers in our department that permission has been granted to Sister Dzebu who will be visiting our department to conduct research on developmental strategies for patient self-referral on tertiary hospitals in Gauteng.

Thank you,

Jeebodh

Dr J.Jeebodh
Acting Head of the Department
Head Clinical Unit Fetal Medicine Unit
Obstetrics & Gynaecology Department
Chris Hani Baragwanath Academic Hospital

Date: 20 June 2017



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Dr. George Mukhari Academic Hospital

Office of the Director Clinical Services
Enquiries : Dr. PMT. Mabusela
Tel : (012) 529 3680
Fax : (012) 560 0099
Email: phaly.mabusela@gauteng.gov.za
kollumetse.morikuale@gauteng.gov.za

To Mrs M Dzebu
Department of Nursing Sciences
School of Health Care Sciences
Faculty of Management Sciences
University of Pretoria
0001

Date : 24 February 2017

PERMISSION TO CONDUCT RESEARCH

The Dr. George Mukhari Academic Hospital hereby grants you permission to conduct research on "The strategies for patients self referral in tertiary hospital at Dr. George Mukhari Academic Hospital."

This permission is granted subject to the following conditions:

- ☑ That you obtain Ethical Clearence from the Human Research Ethics Committee of the relevant University
- ☑ That the Hospital incurs no cost in the course of your research
- ☑ That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.
- ☑ That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

DR. PMT. MABUSELA
DIRECTOR CLINICAL SERVICES

ANNEXURE E

DOCUMENTS REVIEW CHART

DOCUMENT REVIEW WORKSHEET

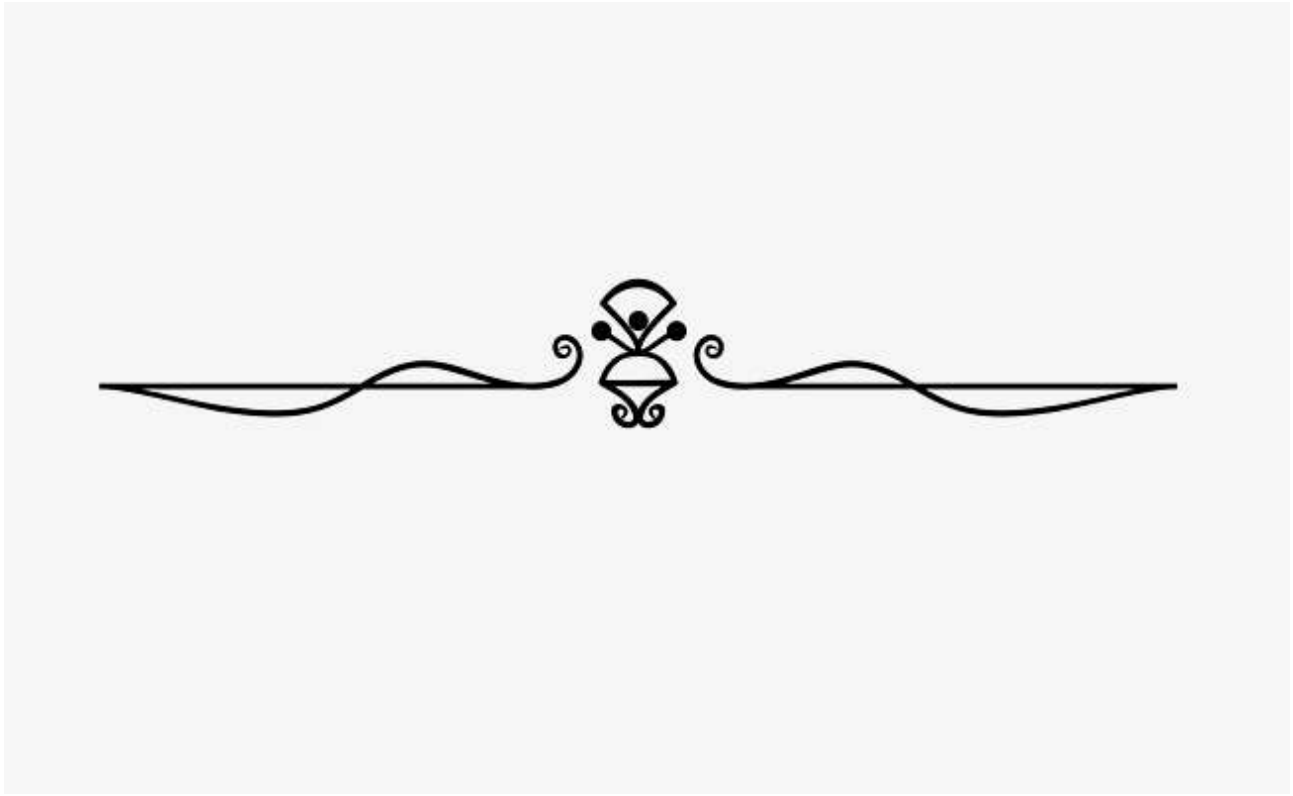
Title: **DEVELOPMENT OF STRATEGIES OF PATIENTS' SELF-REFERRAL IN TERTIARY HOSPITALS**

Document Category ☐ 1= Public related ☐ = 2 Patient Personal ☐= 3 Other

1.	NAME/ TITLE OF THE DOCUMENT :
2.	TYPE OF DOCUMENT(Check one) ☐ Memo ☐ Patient's Result ☐ Patient Record ☐ Provider's Record
3.	UNIQUE PHYSICAL CHARACTERISTICS OF THE DOCUMENT (Check one or more) ☐ LETTERHEADS ☐ SEALS ☐ NOTATIONS ☐ OTHER ☐ " RECEIVED" STAMP
4.	DATE(S) ON THE DOCUMENT IF AVAILABLE :
5.	CREATOR OF THE DOCUMENT: POSITION(TITLE) OF THE CREATOR:
5.	PURPOSE OF THE DOCUMENT :
6.	FOR WHAT AUDIENCE WAS THE DOCUMENT WRITTEN:
7.	CONTENT IN THE DOCUMENT:

ANNEXURE F

DATA SHARING LEAFLET



Faculty of Health Sciences

TITLE: THE DEVELOPMENT OF STRATEGIES FOR PATIENT SELF-REFERRAL IN TERTIARY HOSPITALS OF GAUTENG PROVINCE

AIM OF THIS CURRENT STEP: REDUCTION OF ERRORS IN INTERPRETATION

Dear Participant

You have been purposively selected from the total number of participants whom I have interviewed on my study.

As part of the preparation for the second phase of this study, which is Imbizo, I am humbly requesting you to go through these 5 transcripts in order to assist in articulating the core message(s) in all of them. I have transcribed and interpreted ALL the transcripts and my own interpretations brought out 5 main Themes which I referred as pathways to self-referral:

- EMERGENCY ADMISSION
- DISGUISE ADMISSION
- WORD OF MOUTH ADMISSION
- ABILITY TO PAY ADMISSION
- HUMAN RIGHTS AND SENSE OF BELONGING ADMISSION

Your participation in this step is of great value as it will reduce errors in the interpretation for this study.

Procedure

Kindly go through each transcript add, correct, delete and even comment by writing on the document along the margins.

Kindly contact me for clarification through email and phone.

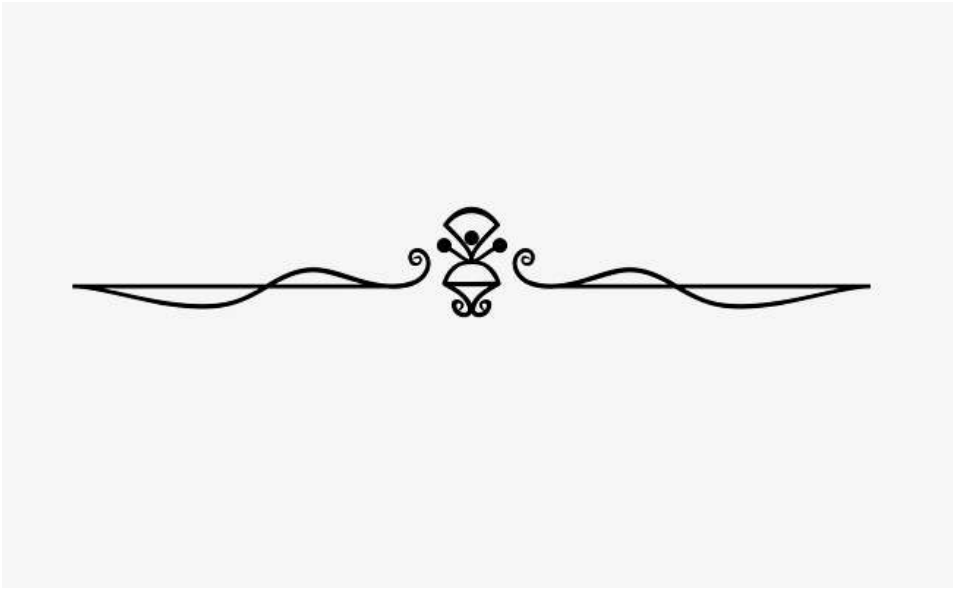
Thank you!

Munyadziwa Dzebu

Munyadziwa Jane Dzebu

ANNEXURE G

TRAILERS EXAMPLE



Munyadziwa Jane Dzebu

TRANSCRIBED BY MD. JUNE 2017

TRANSCRIPTION OF CONVERSATION # 5

DR85 (14 .5 .17)

RESEARCHER: MD

PARTICIPANT: DR # 5.1

PROLOGUE

MD: Good Afternoon my name is Munyadziwa Dzebu. I am doing a research study on the Strategies of patient self–referral in tertiary hospitals in Gauteng Province. (hmm) and the aim is to get this patterns of self-referral and then develop Strategies which will be in cooperated into the referral system which is still in a draft form of Gauteng of Republic of South Africa in future. My first question of the only four questions which you can answer the way you want is can you kindly tell me about self -referral patterns that you know and what self -referral patterns means to you?

DR # 5: There are referral protocols in the National Health for level 1 – 4 hospitals which patients do not follow. This patients coming to the Tertiary hospitals are supposed to be from Secondary hospitals and also from clinics. Lot of patients are emergencies in Obstetrics and Gynaecology, and they are staying near the hospital vicinity and according to the primary health care notation they are allowed to bring themselves or seek healthcare services at this hospital as the distance covers them when it comes to accessibility and availability of care and their rights of healthcare and also the Bathopele principles. They are ideally breaking the law depending on the conditions example ICA's, ectopic and gynea cancer. The issue is the component of the authorities whom when you have reported the self –referral issue the directive from there does not protect the bigger challenge of risk on patients and endangering the lives of the patients .At the ANC patients are booking selves and some are booked already, there are also and some are walk-ins emergencies and are being seen. There is a lot of patients which results in less time of consultation and the standard of care goes down with decrease in resources and budget depleted very quickly, for example speculars shortage in a National Tertiary hospital for the people regarded as Nationals due to this self –referral issue.

Commented [U1]: Emergency

Commented [U2]: Human Rights and Sense of belonging

Commented [lm3]: Emergencies indeed. However, it is wrongly used.
However, patients who are low risk should consult at level 1 and level 2 hospitals including clinics and health care centres.
Most emergencies in our centre are deliveries/labour.

Commented [U4]: emergency

Commented [lm5]: Emergencies at quaternary hospitals are supposed to be referred and not self referrals.

MD: Jaa it's really tough. Hmm tell me about the contributing factors of this pattern as question two.

DR # 5: Patients know their rights and unfortunately they forget to look at the

Commented [U6]: Human Rights

responsibilities. The clinics are under staffed and under resourced. Patients are given only Panado or asked to come back the following days as they are asked to be seen.

MD: Okaay, can you explain to me the patterns off self –referral that you have observed or seen colleagues doing.

DR # 5: Self –referral is increasing day in and day *out. There are some patients who come to the Tertiary set-up because of colloquial arrangements where a doctor arranges with another in that facility to let the patient jump que and come and be treated there or patient adviced by the doctor who ones worked there or who I working in the teriary to go to that tertiary hospital.*

MD: Why?

DR#5: Favours or money exhausted in private sectors or patient very sick

I have seen younger people coming a lot nowadays and a lot of foreigner patients too with no papers and their state of disease being very advanced and with poor hygiene self -care and in need of emergency care and operation.

A lot of gynaecological patients with ICA and with previously done illegal TOP's coming for relook laparotomies. Cancer patients are from other provinces (Limpopo, Kwazulu Natal and Mpumalanga- due to collapsed health system), outside RSA countries people are many too Congo, Zambia, Uganda, DRC, Zimbabwe to mention the few as they hear from other patients who came and got help. These result in collapse of proper consultations where the patients will be seen in a hurry method of saying next next, to finish the long ques. This is because of funds that are being exhausted including the medical aids especially between September and December.

MD: Why?

DR # 5: Because they misuse the funds during the year seeking help in private doctors' rooms, both RSA residents and non-residents of RSA. People from here at home come as emergency because now they are critically sick and now regarded as emergencies then they come as self –referral(MD: yo this is very bad and I think it really needs intervention through our health department). That is where you can see that some has really emergency to be

Commented [U7]: Word of mouth

Commented [U8]: Emergency

Commented [U9]: Emergency

Commented [U10R9]: Correct on first sentence. This is an emergency.

Commented [U11]: Word of mouth

Commented [lm12]: Immigration policy, Cross border relations.

Political relations and National Foreign policy challenges.

Commented [U13]: Emergency

attended to. The other thing with people from outside South Africa some do have a lot of money as they are desperate for

Commented [U14]: Emergency

quality care and when told to go and get money as they are supposed to pay I have seen them coming back with a lot of money in cash to pay though others' operations are cancelled as they are not having money and does not even want to go to local clinics for help and health education on their co morbidities

Commented [U15]: Able to pay

Commented [lm16]: Foreign patients policy within the hospital not strictly followed.

MD: The last question is from your own perspective, how do you view patient self –referral good or bad, substantiate your answers please.

DR # 5: Justifiable because of patient's frustrations and patients seeking better quality care for themselves or for relatives.

MD: Mhhh anything else and what do you think about my suggestion for government health ministry intervention?

DR # 5: Not justifiable as the self –referral is causing a lot of staff absentees, burnout of staff and the moratorium of the government which prevents authorities from recruiting. It is true the government must intervene but with the aid of Gurus in health care professionals and the public representatives I think.

Commented [lm17]: No distributive justice of resources and workload.

MD: What do you think can sort out this issue?

DR # 5: If healthcare worker can tighten, smooth flow of patients from clinics and also improvement of communication between the clinics and tertiary hospitals and the government's revisit of the draft referral policy might maybe help. Thanks.

MD: Thank you.

Munyadziwa Jane Dzebu

ANNEXURE H

APPENDIX OF HOSPITAL PAYMENTS

Munyadziwa Jane Dzebu

ANNEXURE H

(NDOH-June Gilbert 14.6.2002)

Explanation of the Current Policy Regarding the Classification of Patients for the Determination of Fees

1. Introduction

Patients are classified into two main groups for the purposes of service fee determination:

a. Full paying patients

b. Subsidised patients

c. Free services.

This document explains the different categories of patients that have been identified and the associated fees for each category.

This classification of patient categories was accepted by the PHRC in April 2002.

2. Full Paying Patients

This category of patients includes but is not limited to externally funded patients, patients being treated by their private practitioner and certain categories of non-South African citizens. They are liable for the full UPFS fee as listed in Annexure A of this document. Table 1below gives full details of this category of patient.

Table 1: Full Paying Patients

Group	Description
Externally funded patients	1. Patients whose health services are funded or partly funded in terms of: (a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993), (b) the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act No 56 of 1996), (c) a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998). 2. Patients treated on the account of: (a) another state department, (b) local authority, (c) foreign government, (d) any other employer.
Patients treated by a private practitioner	Any patient treated by his or her own private practitioner in a public health care facility will be liable to pay the full facility fee component for services rendered by the private practitioner at the facility and the full UPFS fee for any other service received by the patient.
Non South African citizens	Non South African citizens excluding the following: (a) immigrants permanently resident in the RSA but who have not attained citizenship (b) non South African citizens with temporary residence or work permits (c) persons from SADEC states who enter the RSA illegally.

3. Subsidised Patients

These are patients who do not fall in the category of full paying patients. Subsidised patients are categorised further based on their ability to pay for health services into four categories: H0, H1, H2 and H3. The fees payable by subsidised patients are expressed as a percentage of the fees payable by full paying patients as determined by the latest edition of the Uniform Patient Fee Schedule (UPFS).

The classification of dependants is determined by the classification of their guardians.

Subsidised patients are divided into two main groups:

a. Patients qualifying for full subsidisation: H0

Patients in this group receive all services free of charge. Patients must provide proof in terms of the conditions set out in Table 2 below in order to be classified into this group. Patients can only qualify for full subsidisation if they are referred to hospital from primary health care services.

This is not the default classification for a patient attending a public hospital. Unless proof of status is produced a patient is classified as H1 to 3 depending on income. The default classification for a person without income is therefore H1.

Table 2: Patients qualifying for full subsidisation

Group	Description
Social pensioners	Recipients of the following types of pension/grants are classified as social pensioners: Old age pension Child support grant Veteran's pension Care dependency grant Pension for the blind Family allowance Maintenance grant Disability grant Single-care grant - Persons with mental disorders in need of care discharged from hospitals for the mentally ill but have not been decertified. Should the social pensioners also belong to a medical scheme, they will be regarded as full paying patients.
Formally unemployed	Persons supported by the Unemployment Insurance Fund (UIF). Proof of unemployment must be produced. (Contributors Record Card (UF74)).
Persons re-classified as H0	If a patient cannot afford the fees due on the basis of his or her original classification then the patient may be re-classified as H0 by the person in charge of the health care facility.

b. Patients qualifying for partial subsidisation (H1, H2 &H3)

This is the default group for subsidised patients and the level of subsidisation depends on the assessment of income (frequently called the means test). The income cut-off point between H1 and H2 patients is set at the 80th income percentile as determined by Statistics South Africa. This means that 80% of employed individuals earn less than the cut-off amount per annum. Currently this amount is a yearly income of R36 000 for a single person. The cut-off between H2 and H3 is set at the 90th percentile, namely R72 000 per annum. Patient earning above this amount will pay full UPFS fees. This is to encourage those individuals to take out medical aid. Table 4 below lists the subsidisation percentages for H1 and H2 for the services covered by the UPFS. Illustrative amounts for some common services are listed in Table 5.

Table 3: Categories for Partial Subsidisation

Category	Means Test	Subsidisation (% of UPFS)
H1	Individual : Income less than R36 000 per annum Household : Income less than R50 000 per annum	Consultations : 20% with no differentiation for emergency consultations Inpatient : 1% of the UPFS general ward day tariff summed for 7 days for each 30 days or part thereof (Note 1). No differentiation on the basis of bed type. Patient and Emergency Transport: 5% Assistive devices : 25% All other services : Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H2	Individual : Income less than R72 000 per annum Household : Income less than R100 000 per annum	Consultations: 70% with differentiation for emergency consultations Inpatient days: 7% per day with differentiation on the basis of bed type Procedures, imaging and oral health: 50% Patient and Emergency Transport: 15% Assistive devices : 75% All other services : Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H3	Individual : Income greater or equal to R72 000 per annum Household : Income greater or equal to R100 000 per annum	All services listed in the UPFS at full price

Notes:

1. The H1 inpatient fee is expressed as a percentage of 7 days of the UPFS General Ward Inpatient fee to approximate the average length of stay of inpatients in this category. Although the fee calculation is based on 7 days, for H1 patients this fee will be applicable for each 30 days of inpatient stay or part thereof. No differentiation is made on the basis of bed type.

Table 4: Illustrative Fees **(based on 2002 UPFS fees)**

Service	H1		H2	
Hospital	Level 1 & 2	Level 3	Level 1 & 2	Level 3
Consultations				
Routine, General Practitioner	R20	R20	R70	R85
Emergency, General Practitioner	R20	R20	R145	R155
Inpatient day				
General ward, GP	R50 per 30d	R60 per 30d	R50 per day	R60 per day
ICU, GP (per 12hours)	R50 per 30d	R60 per 30d	R 110 per 12h	R135 per 12h
Procedure, Imaging & Oral Health				
Ambulatory procedure Cat A (GP)	Free	Free	R155	R170
Theatre procedure Cat C (GP)	Free	Free	R1 420	R1 643
Category A X-ray (Radiographer)	Free	Free	R30	R35
Category B Oral Health (Non specialist)	Free	Free	R40	R45
Patient & Emergency Transport				
Patient Transport (per 100km)	R10	R10	R25	R25
Basic Life Support (per 50km)	R25	R25	R70	R70
Intermediate Life Support (per 50km)	R30	R30	R95	R95
Advanced Life Support (per 50km)	R50	R50	R155	R155

4. Free Services.

There exist certain circumstances under which patients will receive services free of charge independently of their classification as full paying or subsidised patients. These circumstances have a statutory basis and apply only to the episode of care directly related to the circumstances under which the patient has qualified for free services. Table 5 below summarises the circumstances under which patients will qualify for free services.

Table 5: Free Services

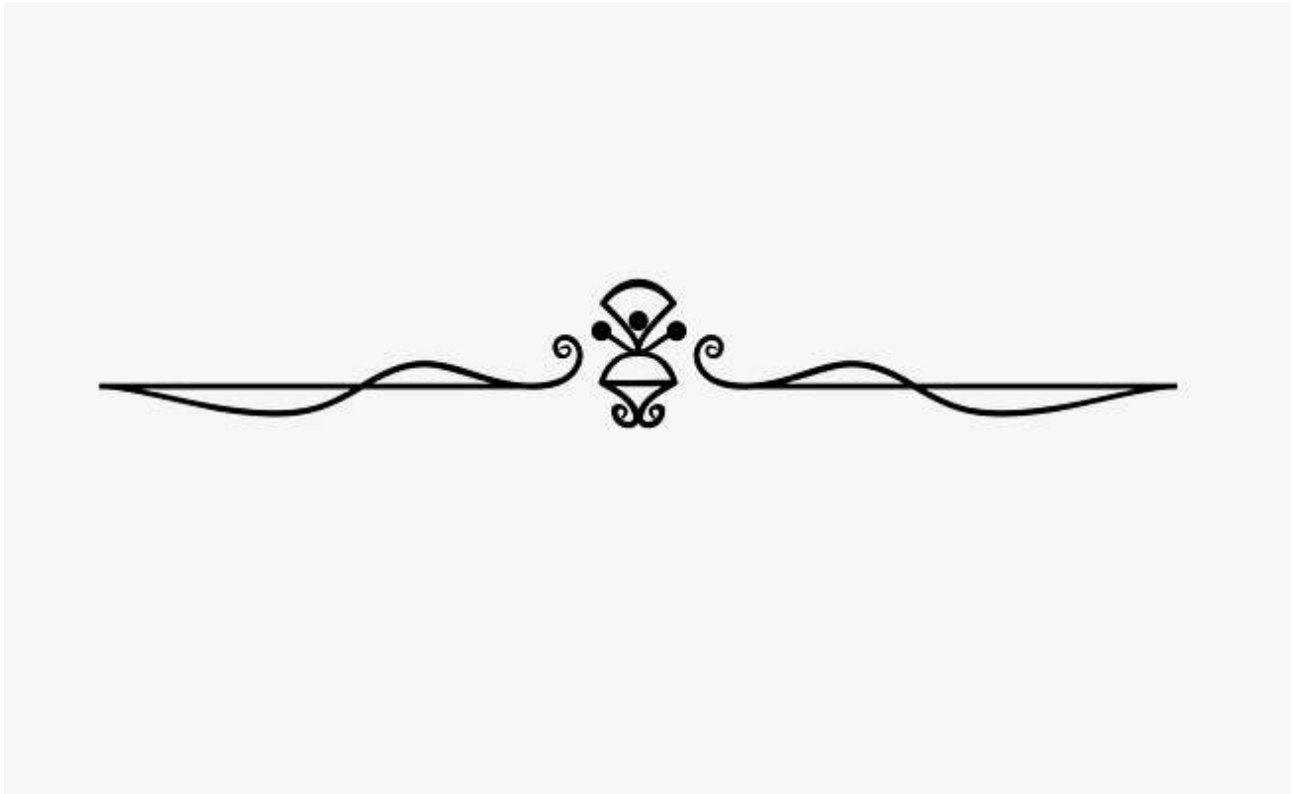
Service	Basis
Free health services for pregnant Women and children under the age of 6 years	NOTICE 657 OF 1994, 1 July 1994 As from 1 June 1994, free health services must be provided to : a. pregnant women for the period commencing from the time the pregnancy is diagnosed to forty-two days after the pregnancy has terminated, or if a complication has developed as result of the pregnancy, until the patient has been cured or the conditions as result of the complication has stabilised; b. children under the age of six years; c. non-citizens of South Africa who are in the groups mentioned in par (a) and (b), and who incidentally develop a health problem whilst in South Africa. Free health services included the rendering of all available health services to the persons mentioned in above, including the rendering of free health services to pregnant women for conditions that are not related to the pregnancy. The following persons are excluded from the free health services: a. Persons and their dependents who are members of a medical scheme. b. Non-citizens of South Africa who visit South Africa specifically for the purpose of obtaining health care.
Free primary health care services	Notice 1514 of 1996, dated 17 October 1996 1. Primary health care services are available free of charge at

	State health care facilities. 2. Services referred to in paragraph 1 are available at- (a) State health care facilities, namely- (i) clinics; (ii) community health centres; (iii) mobile clinics; (iv) satellite clinics; (b) health care facilities that are funded or subsidised fully or partly by the State; (c) hospitals in geographical areas where facilities referred to in subparagraphs (a) and (b) are not available and which are designated by a province for that purpose. 3. Persons receiving primary health care services at facilities other than those referred to in paragraph 2 shall be liable to pay existing rates and an additional fee as determined by the province. 4. An additional fee referred to in paragraph 3 shall not be payable in the case of emergency care. 5. Only South African citizens shall be entitled to free primary health care services. 6. The following persons shall not be entitled to free primary health care services: (a) Persons and their dependents who are members of a medical aid scheme; (b) Persons who make use of the services of medical practitioners of their choice instead of those made available by the health care facility.
Termination of Pregnancy	Act 92 of 1996. Services in respect of the termination of pregnancy to be rendered free of charge and, if complications have developed as a result of the termination, until the patient has been cured or the conditions as a result of the complication have stabilised, under the following conditions:- 1. Upon request of a women during the first 12 weeks of pregnancy; 2. From the 13th to the 20th week of pregnancy if a medical practitioner, after consultation with the woman, is of the opinion that a. continued pregnancy poses a risk to the woman's physical or mental health b. a substantial risk exists that the foetus would suffer from a severe physical or mental abnormality c. the pregnancy resulted from rape or incest d. the continued pregnancy would significantly affect the social or economic circumstances of the woman 3. after the 20th week of pregnancy if a medical practitioner, after consultation with another medical practitioner or midwife, is of the opinion that continued pregnancy would a. endanger the woman's life b. result in severe malformation of the foetus c. would pose risk of injury to the foetus

Criminal Procedure Act	Act 51 of 1977 Services rendered in terms of the above act, as well as the following, when requested by the responsible authorising body. Assault: The examination of the alleged victim and taking of samples and completion of the necessary documentation Rape: The examination of the alleged victim and taking of samples and completion of the necessary documentation Post mortem: The performance of autopsies and attendance at exhumations Corporal Punishment: Preliminary examination for the administration of corporal punishment by the Police Service and attendance at the administration at corporal punishment in prisons.
Child Care Act	Act No 74 of 1983, Section 15. Children who in terms of the above Act are committed to the care of a children's home, industrial school or foster parents.
Persons with mental disorders	Mental Health Act (Act 18 of 1973) The examination of prisoners and detainees for medico-legal purposes with a view to their referral for observation in terms of the Act. Mentally disturbed patients admitted to psychiatric hospitals in terms of section 9 of the Act.
Infectious, formidable and/or notifiable Diseases	1. Venereal diseases (excluding complications) - only on an outpatient basis and including the following: Syphilis, gonorrhoea, chancroid, LGV (lymphogranuloma venereum), non-specific urethritis, venereal warts, granuloma inguinale, ulcus molle, herpes genitalis. 2. Pulmonary tuberculoses. 3. Leprosy. 4. Cholera. 5. Diphtheria. 6. Plague. 7. Typhoid and paratyphoid. 8. Haemorrhagic fevers. 9. Meningococcal meningitis. 10. Aids - only the initial diagnostic procedures and attendant laboratory services are free if patients specifically ask for the HIV test to be done. Patients requiring treatment are assessed at the prescribed tariffs for any hospitalisation and accompanying services.
Other exempt conditions	Persons suffering from the following diseases for treatment only relating to such diseases: 1. Malnutrition 2. Pellagra 3. Any other condition or service as determined by a province
Donors	A donor is a person who, of their own free will, presents themselves specifically for the donation of an organ, blood, milk or human tissue. The exemption refers to services rendered in respect of the donation.

ANNEXURE I

INFOGRAPHIC IMBIZO PRESENTATION



Munyadziwa Jane Dzebu

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e-Strategies Imbizo

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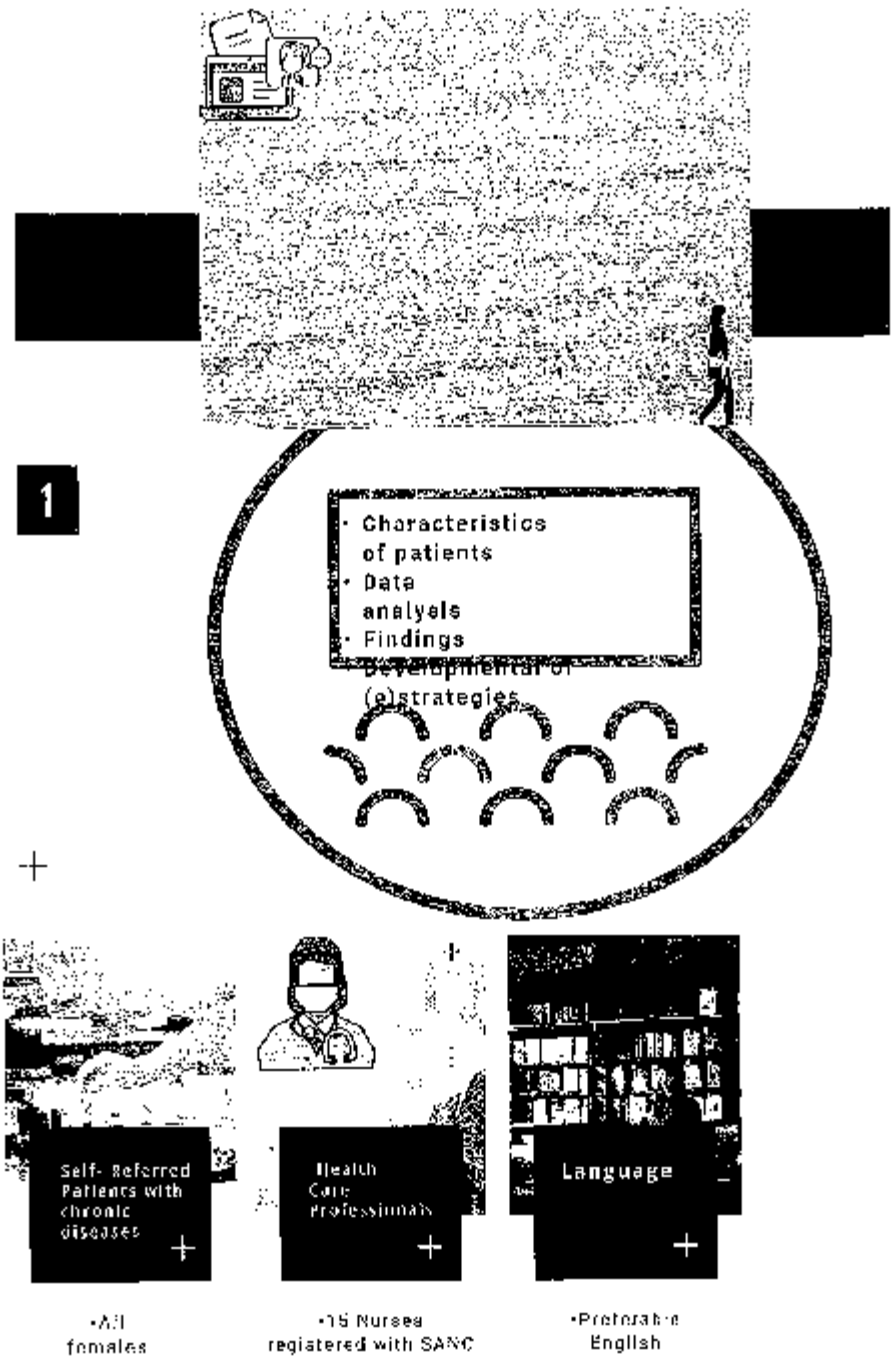
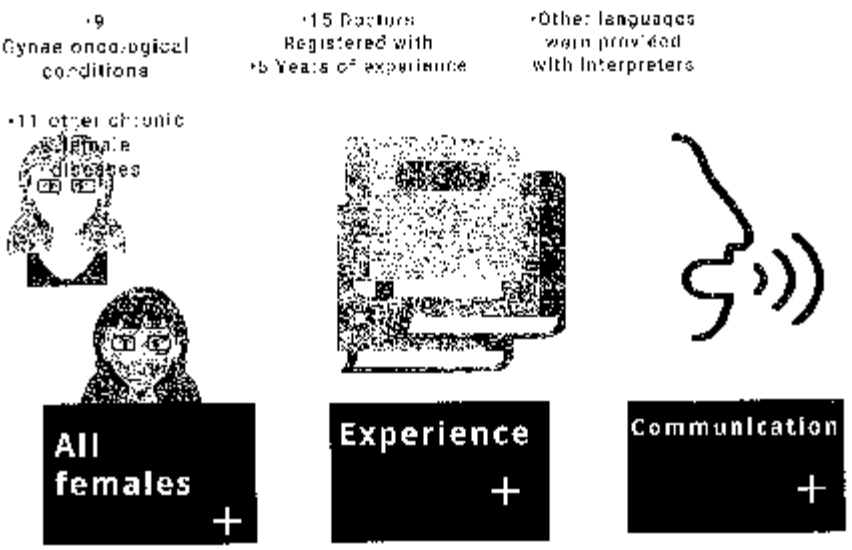
[E]-strategies for the management of self-referral in chronic patients


1
• Characteristics of patients
• Data analysis
• Findings
(e)strategies
Self- Referred Patients with chronic diseases
Health Care Professionals
Language
•All females
•15 Nurses registered with SANC
•Preferable English



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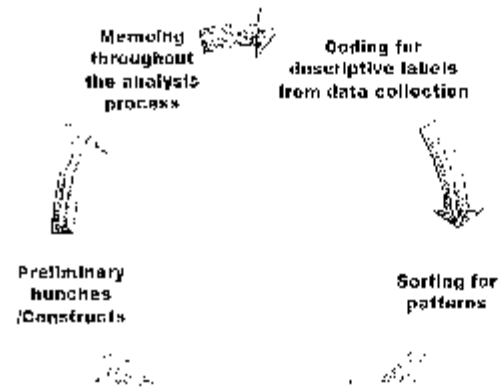


Data analysis

5 Steps by Roper and Shapiro [2000]

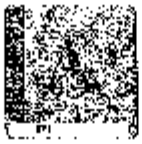
Findings

Pathways to self-Referral

+

Participants:

an eight member advisory group



Inclusion Criteria: participants who elaborated on strategies for self-referral and use of technology

Process: Shared all the trailers of the pathways

1st Stage:
- Brainstorming of trailers of pathways

2nd Stage:
- Compare and prioritize

Development of the (e) strategies... Process:

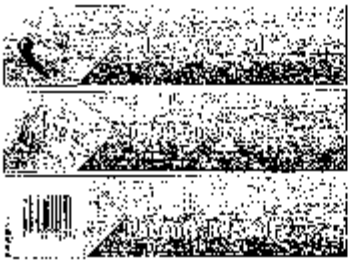
Two Stages:

-

Collated

-

Literature Support -
Different disciplines and
countries



5

Preliminary
(e)
strategies

ANNEXURE J

IMBIZO BROCHURE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Agenda
Faculty of Health Sciences

Imbizo for the Development of the (e) Strategies for Patient Self-referral to the Tertiary Hospitals in Gauteng Province

Aim: To adopt the preliminary (e) strategies for the patient self-referral in tertiary hospitals in Gauteng Province

Venue: Tshwane Learning Centre

Date

1. Tea and Registration
2. Welcome
3. Power Point Presentation to familiarization
4. Questions and Clarifications
5. Additions or Deletions
6. Individual Ranking of the Strategies: Moderator
7. Consolidation:

Acknowledgement and Closure

Folders

Pencils

Stickers (Different Types and shapes)

Print: Emancipatory Model

Moderator: Letter to ask for the Moderator

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

INVITATION TO ATTEND IMBIZO FOR CRITIQUE AND ADOPTION OF strategies for patient self-referral to tertiary hospitals in Gauteng Province

I am Munyadziwa Dzebu a doctoral candidate in the Department of Nursing Science. For my PhD I am developing strategies for patients' self-referral in tertiary hospitals in Gauteng Province.

As an expert in healthcare you are cordially invited to attend an Imbizo scheduled as follows:

Aim: To critique and adopt the preliminary strategies for patient self-referral to tertiary hospitals in Gauteng Province.
Date: 31st August 2018
Venue: University of Pretoria Tshwane Learning Centre
Time: 10h00-12h00

Your presence will be highly be appreciated

Sincerely

Muyadziwa Dzebu

Please RSVP to:
Munyadziwa -0790609228 (Evening) / 011 395 3653 (Evening) or
Email: muyadziwa2002@yahoo.co.uk

ANNEXURE K

NATIONAL DEPARTMENT OF HEALTH DRAFT PATIENT REFERRAL POLICY 2008

Munyadziwa Jane Dzebu

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL DEPARTMENT OF HEALTH

DRAFT PATIENT REFERRAL POLICY 2008

TABLE OF CONTENTS

FOREWORD

South Africa is a democratic country in which the Constitution and the Patients' Rights Charter make provision for rights of citizens which must not be violated, among others, the right to health care. The National Department of Health has seen it fit to draft patient referral policy and put in place, in order that patients are afforded an opportunity to access health services within a multi-disciplinary team. Failure to have a referral policy results in patients being lost in the system as well as interruption of intended interventions.

Patient referrals must be documented, monitored and feedback is provided to health establishments that have initiated the referral, and that issues as well as challenges regarding patient referrals are identified and communicated accordingly to management. Over and above, it is essential that patient referrals must be co-ordinated to ensure continuity of care.

The policy is based on the principle that patients need to experience a seamless health service, whereby Primary Health Care (PHC) facilities refer to District hospitals and District hospitals higher up, as well as down referrals from higher to lower health care levels, based on the capacity and package of services of these facilities.

The policy also addresses the issue of down and back-referrals including Home Based Care.

Each province has a referral policy based on particular circumstances to give effect to best patient care. This policy seeks to harmonise all that is available in the provinces to ensure that all care is taken to ensure that respective circumstances in the provinces are considered, and that provinces do not encounter problems, among others, referrals next to the boundaries and to other countries.

.....
DR AARON MOTSOALEDI
MINISTER OF HEALTH
DATE:

ACKNOWLEDGEMENTS

The contribution and pivotal role of all colleagues at all levels of health care in providing input into the initial draft of this document is gratefully acknowledged.

The commitment of all people to seeing that a policy of such a nature should exist by making constructive recommendations towards its development is highly appreciated.

ACRONYMS

APP	- Annual Performance Plan
AIDS	- Acquired Immune Deficiency Syndrome
ANC	- Ante -Natal Care
ART	- Anti-Retroviral Therapy
CCG	- Community Care Giver
CHC	- Community Health Centre
CHW	- Community Health Worker
DOH	- Department of Health
DOTS	- Directly Observed Treatments
CSM	- Clinic Supervision Manual
DHER	- District Health Expenditure Reviews
DHP	- District Health Plan
DHS	- District Health System
DMT	- District Management Team
EC	- European Commission
EDL	- Essential Drug List
EMS	- Emergency Medical Services
GP	- General Practitioner
HIV	- Human Immune-deficiency Virus
HPCSA	-Health Professions Council of South Africa
IPC	- Infection Prevention and Control
MOU	- Midwife Obstetric Unit
MOU	- Memorandum of Understanding
NDOH	- National Department of Health
OPD	- Outpatient Department
STP	- Service Transformation Plan
PLWHA	- People living with HIV and AIDS
PHC	- Primary Health Care
PMTCT	Prevention of mother-to-child transmission
PNC	- Post Natal Care
QA	- Quality Assurance
SANC	- South African Nursing Council
STIs	- Sexually transmitted infections

TB	- Tuberculosis
TBA	- Traditional Birth Attendant
THP	- Traditional Health Practitioner
UNAIDS	- United Nations on AIDS
UOFS	- University of Free State
VCT	- Voluntary Counseling and Testing
WHO	- World Health Organization

GLOSSARY

Ease with which health services may be obtained and utilised, encompassing geographic, financial and social aspects.

Admission
An act of taking in a patient within a health establishment for observatory, curative or rehabilitative purposes.

Appropriate referral
Referral for care to an appropriate level in line with the package of services.

Clinic
A fixed structure in which basic health services are provided by nurses, and is linked to a Community Health Centre

Community-based care
Care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people and encouraged traditional community life and creates responsibilities.

Community Health Centre
A 24-hour health facility that provides a variety of services than a clinic

Discharge
Release of a patient from care or interventions of a health establishment for observatory, curative or rehabilitative purposes.

District Hospital
First level non-specialist hospital to which patients from lower levels (clinics, CHCs) may be referred.

Down referral
Referral from upper to lower level of care.

Home care

Provision of health services by formal and informal community based workers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health, including care towards a dignified death.

Hospital Complex

A group of provincial hospitals rendering level 2 and 3 care which have been rationalized to a single entity for purposes of management and service provision.

Internal Referral

Referral of patients that takes place within a health establishment for a more specific intervention.

Lateral referral

Referral of patients between same levels of care.

Primary Health Care Approach

Provision of comprehensive health care services that includes preventative, promotive, curative and rehabilitative care, within the context of community participation and inter-sectoral collaboration.

Provincial hospital

A hospital providing specialist and super-specialist care, managed by the provincial department of health.

Referral

Movement of a patient to another level of care, either upward or downward for continuity of care. It is a process in which the treating health practitioner at a lower or higher level of health service, has inadequate skills by virtue of his or her qualification or scope of practice, or lower facilities to manage a clinical condition, seeks the assistance of a better equipped or specially trained person, with better resources at a higher level to guide him/her in managing or taking over the management of a particular episode of a clinical condition in a beneficiary.

Referral pathway/chain

The route provided for referred patients to take until the desired/intended destination.

Regional hospital

A secondary hospital to which patients are referred from the District Hospital. It serves many districts and has more specialised services available.

Routine referral

Referral of a patient for continuity of care as part of the treatment package or protocol.

Self referral

Any person who presents at the hospital/ higher level of care for examination, medication or treatment without being referred.

Step-down facility

A health facility/ establishment that admits patients beyond the acute stage but not yet ready to be discharged.

Specialist

A person who is registered with a statutory health professional body in terms of the domestic law in force in the countries and who has significant skill, experience or knowledge in a particular filed or activity related to human health.

Tertiary hospital

A hospital with more specialised services to which referrals from the district and regional levels of care are received.

1. INTRODUCTION

It is recognized that health care services in South Africa are rendered at different levels of care with specific care packages. Situations arise when a patient needs to be referred to another level of care for further management or continuity of care. This usually happens where the level at which he/she presented cannot be responsive in terms of intended interventions. Referral pathways and support responsibilities of the various levels of the health system must be clearly delineated and communicated to consumers of health services.

One of the pillars of the health sector is the concept of cost-effective and quality essential health care packages. An essential health package comprises health interventions (promotive, preventive, curative and rehabilitative), including inputs. Those are selected on the basis of their ability to have the greatest impact on disease burden reduction at that specific level. This is to ensure that under no circumstances are the users health care needs compromised or there be treatment interruptions due to administrative factors like transport, inadequate communication, etc.

2. LEGISLATIVE FRAMEWORK

2.1 ACTS

Health care in South Africa is provided according to set Acts and policies to ensure that the rights of users to health care are respected. The following legislative mandates stipulate conditions on how this could be achieved.

2.2.1 The South African Constitution, Act 108 of 1996

The Constitution provides every citizen with the right to health care services. The state is required to take legislative and other measures within its available resources, to achieve the progressive realisation of these rights.

2.2.2 National Health Act No. 61 of 2003

The Act provides for the establishment of a National Health System (NHS), which encompasses public, private and non-governmental organisations in terms of health service delivery and which provide the population and citizens of South Africa with the best possible health services that available resources can afford. Rights and duties of users and providers are also stipulated.

A user may attend any public health establishment for the purposes of receiving health services and if a health establishment is not capable of providing the necessary treatment or care, the public health

establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment or care.

A health care provider must provide a user with a discharge report at the time of discharge from a health establishment containing such information as the nature of the health service rendered prognosis, and the need for follow-up treatment.

2.2 POLICIES

2.2.1 The ANC National Health Plan

One of the functions of the Provincial Health Authority is to plan and control the functioning of the referral system.

2.2.2 White Paper on transformation of Health Services

Key policy principles are included in support of the provision of equitable health care to communities. The White Paper spells out under the functions of the health district that with implementation of the DHS, the responsibility for establishing functioning and regulated access referral systems at primary secondary and tertiary levels was devolved to health districts.

2.2.3 Policy for Development of the District Health System in South Africa

This policy provides for basic principles of the establishment of the District Health System (DHS). The DHS serves as the vehicle for the delivery of primary health care services in a decentralised manner. Both provinces and the national health department agreed unanimously that there were twelve principles with which planners must comply with in the development of the DHS, among others, access to health services. These principles imply that the referral system should ensure that consumers are treated at the lowest appropriate level of care, and where an appropriate level of care is not available within the DHS, should enable the referral of the consumer to an institution outside a given health district where appropriate level of care can be obtained.

2.2.4 A Policy on Quality in Health Care for South Africa

Delivering quality care in the District Health System includes that the District Management Team ensures that proper processes are in place for assuring and improving the quality of clinical services they provide within communities, clinics, CHCs, District Hospitals and other district-based health facilities. This will include, among other measures, processes to ensure an effective referral system.

2.2.5 Batho Pele Principles

Batho Pele principles outline how public servants should serve the public by putting people first and

ensuring that health workers provide the best health care respect and listen to patients and clients and work in partnership with communities.

2.2.6 Patients' Rights Charter

The Patients' Rights Charter, which also includes users' responsibilities, forms part of the national strategy to improve the quality of health services at all levels of care. This ensures effective access to all patients to health care as provided for in the Constitution of the Republic of South Africa.

3. PURPOSE OF THE POLICY

The purpose of this policy is to provide a framework within which patient referrals can be coordinated in South Africa. To this end the importance of co-ordination of patient referrals is recognised in order to promote and guide strategic decisions to achieve optimal health for all. An integrated approach to care is recommended to ensure continuity of care within the context of the District Health System (DHS) across the country.

4. GOAL

The policy is geared towards ensuring that patients experience a seamless health care service and strengthening the patient referral system.

5. OBJECTIVES

The objectives of this policy are to:

- Provide an enabling framework for patient referrals that will improve management of the referral system;
- Define and determine the context within which patient referrals need to occur
- Set out responsibilities of different levels of care;
- Communicate with stakeholders within the referral chain; and
- Encourage use of appropriate level of care.

6. SCOPE OF THE POLICY

The policy shall be applicable to all public and private health establishments in both the public and private sectors in the patient referral chain in South Africa. Inter-sectoral collaboration is essential in order to promote co-ordination of various stakeholders in the referral system. Implementers of this policy shall be but not limited to:

•National, Provincial and Local Government;
•Professionals (nurses, medical practitioners, allied health workers); and
•Community Care Givers, NGOs, CBOs, FBOs and Traditional Health practitioners.

7. GUIDING PRINCIPLES OF THE REFERRAL SYSTEM

The following principles will guide the system and these include:

- Accessibility: Health services should be accessible to patients at all times;
- Competency levels: Patients should be treated at an appropriate level of care
- Continuity of care: Patients should be managed until they recover or are able to live within the limitations caused by their illness.

8. POLICY DEVELOPMENT PROCESS

The policy resulted following consultation with provinces on patient referrals. This was followed by a pilot project. It was discovered during the workshops that not all provinces have patient referral policies. Instead there are referral pathways that have been established. It thus became clear that there was a need for a National Patient Referral Policy.

Several observations were made:

- One, some patients bypass Primary Health Care (PHC) facilities and present themselves at the hospitals with ailments that could have been managed at the PHC level. Reasons mentioned included among others, lack of medicines at the clinics. Patients also preferred to go to the hospitals as some equate PHC to sub-standard care, a mindset that needs to be altered.

- Two, referring facilities do not receive feedback regarding the outcome of the referrals they have initiated. This impacted on the continuity of care of patients.

This draft policy seeks to address these issues and will be implemented and monitored by patient referral co-ordinators that have been appointed within the districts, in liaison with management structures in the district and province.

9. MODEL OF THE REFERRAL SYSTEM

Health care service delivery takes place in health establishments at primary, secondary and tertiary levels. This also happens at ancillary level, i.e. outside health facilities at community level by

appropriately trained community health workers, care givers, including but not limited to DOT supporters, home-based carers and / or traditional health practitioners. This is based on WHO's recommendation that considers health care systems as shifting from acute, hospital-based care to community-based, patient-centred chronic care.

When interventions at any given level of care are in anyway unable to manage a particular condition, the user must be referred to an appropriate level of care. This next level must be capable of giving optimal health care and to ensure continuity of care. All users must be provided with a referral letter in addition to any direct telephonic arrangements that could have been made.

10. LEVELS OF REFERRALS IN THE REFERRAL SYSTEM

A) EXTERNAL

CLINICS AND COMMUNITY BASED CARE

All users (including non-emergency) should access health services at this level as the first contact.

COMMUNITY HEALTH CENTRE (CHC)

The CHC must have a doctor on site who will treat and where necessary refer users to level 1, that is District hospital. A referral letter stating the reason(s) for referral, must be provided and any relevant documents to be attached.

DISTRICT HOSPITAL

The District hospital refers to level 2 or 3 hospital, depending on the setup in the province. Similarly, always with a referral letter, stating the reason(s) for referral and relevant documents to be attached. Referrals to these levels of care must be preceded by a telephonic discussion with the receiving doctor. Once stabilised the users should be discharged or down-referred to lower levels of care for continuity of care, and where necessary be booked for a return date.

LEVEL 2 HOSPITALS

Referrals at this level are from doctors in the CHCs, GPs, surrounding District Hospitals and Family medicine level 1. If the referral letter does not clearly indicate the section to which the patient needs to be referred to, or there was no prior telephonic arrangement with the head clinician, the user will be seen by the Family Medicine Doctors.

LEVEL 3 HOSPITALS

Similarly, a referral letter should always be provided, stating the reason(s) for referral and relevant

documents should be attached. Referrals to these levels of care must be preceded by a telephonic discussion with the receiving doctor. If the referral letter does not clearly indicate the section to which the patient needs to be referred to, or there was no prior telephonic arrangement with the head clinician, then the user will be seen by the Family Medicine Doctors.

INTER-PROVINCIAL REFERRALS

The referral of a user that needs tertiary health 2, 3 and quaternary services will be referred only on communication between the specialists.

Each tertiary or secondary hospital has an obligation to support the referring institutions, providing services and developing skills of the personnel. In turn, each primary and secondary care facility has an obligation to ensure that only appropriate cases are referred to the next level of care.

B) INTERNAL REFERRALS

Within the same institution, a senior clinician or consultant will make a final decision to refer the patient after consultation, preferably telephonically with his/ her colleague in another section, with a summary of user's notes, where the consultant will then advise on further management of the user.

SHOULD A REFERRED USER BE DISCHARGED HOME, THE REFERRING FACILITY MUST BE NOTIFIED AS TO THE OUTCOME OF THAT REFERRAL. ALL DOWN REFERRING HEALTH FACILITIES MUST PROVIDE MEDICATION TO THE PATIENT IF NOT WITHIN THE EDL, WITH PRIOR ARRANGEMENTS WITH THE PHARMACIST.

11. REFERRAL STANDARDS

The following standards need to be in place and complied with:

- Each province, district and health establishment should have a user referral policy for all levels of care, with a monitoring and evaluation mechanism in place;
- A profile of users to be referred must be made available to all stakeholders
- All users classified as outgoing (transfers and discharged) and incoming (admissions) must have a referral letter where indicated for continuity of care and be given first preference;
- All emergency users requiring referral must first be stabilized before being referred;
- Under no circumstances should a user be turned away without being examined;
- Users, their families as well as service providers must be provided with the outcome (feedback)

regarding the referral;

- Users must be provided with an opportunity to be involved in their own care;
- Each facility should have a map of the catchment population and all service providers in the referral chain, according to the referral pathway (including private and local government health facilities);
- Each district should have a Disaster Management or Coordinating Committee as well as Referral Policy Committee; and an Ethics Committee
- All health facilities must have functional systems, i.e. communication, transport etc.;
- Data on referrals to and out of the facility must be kept and monitored;
- Senior clinicians should provide ongoing support and outreach services;
- Resources such as the EDL must be available and utilized in all health establishments;
- All clinical records must contain adequate information, e.g. to support diagnosis and justify care and treatment
- Communication with the Governance Structures (Hospital Boards and Clinic Committees) of health establishments, as well as the District Management Team (DMT) regarding patient referrals and their implications/ impacts must be done;
- An orientation programme of each health establishment must include the referral system; and
- It is the responsibility of the referring facility to ensure that there is a bed available for a referred patient.

12. ROLES AND RESPONSIBILITIES

Management of the referral system is critical and must be prioritised at all levels of care, to ensure that patients and clients experience a seamless health care service. This includes national, provincial district, sub-district, facility and community level. Noteworthy is the fact that good management practices will be required to be put in place, as well as leadership and ownership of the system by all stakeholders (including the private sector), ensuring that there is an understanding of the referral system as well as responsibilities of respective levels.

A referral must be communicated and explained with the patient and/ family/ relatives as part of the treatment plan. At all levels of care, a standardised referral letter that would serve to channel clinical information both upward and downward in the referral chain is obligatory.

12.1 THE NATIONAL DEPARTMENT OF HEALTH

Political support cannot be over emphasised. This is extended at the provincial and local levels. Leadership is essential to ensure that the referral system is functional and managers at provincial, district,

sub-district and facility levels undertake regular monitoring of the referral system.

MOUs (contracting arrangements) as well as clearly defined **PROTOCOLS** signed with respective countries for patients entering South Africa must be monitored. Strengthening the surveillance system will benefit the whole country for diseases not normally within the borders of the country and there must be an implementation strategy in line with notification and management of such diseases, with clear early warning systems in place both in the public and private health sectors.

Areas and forms of co-operation must be clearly outlined where there are twinning agreements. The policy provides that the agreements shall enter into force on the date of signature and shall be renewable every (5) years. Each party may terminate the agreement giving a written prior notice six (6) months before its expiry.

It is also the responsibility of the National Department of Health to have data on referred patients within the SADC Region/ Member States, profile those patients in line with package of services, pre-admission arrangements and authorisations, ensure that there is a follow-up mechanism in place and establish a Treatment Abroad Advisory Committee (TAAC), with clear terms of reference and the final decision will lie with both the sending and host country Ministries of Health.
Further communication must be done through the Embassy, and this includes but not limited to accommodation of patients and accompanying relatives, travelling, psychological and financial support as well as interpretation services.

Prescription of medicines not available from the referring country must also be considered to ensure continuity of care.

Coordination of referrals

This policy provides for establishment of a coordinating committee for patient referrals to and in South Africa, as well as a fund **that would manage patient referrals.**

12.2 THE PROVINCIAL DEPARTMENT OF HEALTH

1. Ensure appropriate governance of the referral system;
2. Ensure and support implementation of the referral policy, with equitable resource allocation and clear communication strategies. These must be in line with the IHPP, District Health Plan, APP, STPs and package of services according to the level of care. This means that resources should be dedicated to promote sustainability of the referral system. Cross-border co-operation and contracting must be looked at, as these also impact to patient mobility; and

- Distance and transportation needs to be taken into consideration, with regards to patients benefit. Provinces can be flexible and have an arrangement of a billing system (UIF) where patients need to be referred outside the referral pathway established.

12.3 DISTRICT/ LOCAL LEVEL

- Support establishment of referral pathways;
- Ensure that there are referral committees / fora to discuss patient referral matters;
- Supportive Supervision of health establishments must also be worked on in order to make the referral system functional; and
- The DMT needs to ensure that there is availability of resources such as finance, facilities, equipment, transport, skilled personnel to ensure a functional referral system.

All health facilities should participate in the development of District Health Plans (DHPs), Annual Performance Plans (APPs) and Service Transformation Plans (STPs), in order to address needs and issues pertaining to the current state of infrastructure, human resource capacity and budget allocations, as failure to do so may create problems within the referral system.

12.4 THE HEALTH ESTABLISHMENT/ FACILITY

Effective management of the referral system is essential. One of the roles of the DMTs is to ensure that the District Health System is functional. One such measure is on the effective referral system. This also includes effective monitoring and evaluation. Accommodating or finding accommodation for referred patients must be done at this level. Where the bed or service capacity is unable to support any further referrals at the designated referral institution, the responsibility lies with the referral institution to make appropriate and timeous arrangements to re-direct these patients to other institutions.

Noteworthy is the fact that the institutional management team is responsible to ensure bed availability and other managerial issues related to patient care whilst the clinical personnel (nurses and doctors) must primarily be responsible for the clinical care of patients.

12.5 NGOs, CBOs etc

These are organs of civil society and have a role to play in the referral system. They provide services to the community and have staff compliment(s), either specialising or as part of PHC services, including preventative programmes that promote the total well-being of communities.

12.0 EMERGENCY MEDICAL SERVICES (EMS)

12.6.1 It is the duty of the EMS Operation Centre to inform the health facility of the estimated time of arrival to enable preparation time and the nature of the emergency. No facility may delay the ambulance's return for any reason. The receiving doctor and patient must be identified by name and by referral hospital/ health facility.

12.6.2 Planned Patient Transport (PPT)

All elective patients and those for repatriation must be pre-booked with Planned Patient Services through an institutional referral coordinator.

13. MONITORING AND EVALUATION OF THE REFERRAL SYSTEM

Monitoring and evaluation are essential aspects at all levels of care. They are key to maintaining satisfactory quality levels of health services. This ensures that gaps and challenges are identified in time and appropriate interventions executed, so that patients experience a seamless health service, and that the referral system is acceptable, efficient and efficient in meeting the goal.

A patient referral module, monitoring and evaluation tools will be developed within the context of the District Health Information System (DHIS), with clearly defined indicators. Monthly and quarterly reports must be generated to indicate progress, trends and gaps in the referral system at all levels of care in the referral chain and must be communicated to management accordingly. Of critical importance is a follow-up and feedback mechanism on referrals.

Draft Indicators (Annexure A) have been developed as they serve as a benchmark and provide evidence as to the achievement or lack of results and activities. These will comprehensively determine:

- the number of patients referred;
- feedback given and received by referring facilities; and
- users reaching the referral destination and ensuring continuity of care.

Continuous support of health facilities will assist to identify gaps and address issues around health facility bypass by patients. Effectiveness and efficiency of the referral system will be determined and whether it benefits patients

All levels of care need to ensure that the policy is implemented and monitored. Communication to and compliance by all stakeholders cannot be over-emphasised.

14. POLICY REVIEW

This policy is seen as a framework which will assist provinces to develop their own referral policies and will be reviewed every three years based on the circumstances or needs, with all stakeholders.

15. CONCLUSION

This policy encompasses all health establishments in accordance with their level of care and service packages both in the public and private sectors, to enhance access of health services by communities.

16. REFERENCES

1. A Policy for the Development of a District Health System for South Africa. 1995. National Department of Health.

2. A Policy on Quality in Health Care for South Africa. 2007. National Department of Health.

3. Appraisal of Home/Community -Based Care projects in South Africa. 2002-2003. Department of Health.

4. Eastern Cape Province Draft Referral Policy

5. National Health Act 61 of 2003.

6. The Constitution of the Republic of South Africa, Act 108 of 1996.

7. North West Province Draft Referral Policy 2004.

8. WHO. District Health Management Team Training Modules.

ANNEXURE A:

PROPOSED DRAFT: REFFERAL INDICATORS

INDICATOR	DESCRIPTION	JUSTIFICATION	METHOD OF CALCULATION	SOURCE OF DATA	FREQUENCY OF REPORTING
1. % Referral to PHC from NGO's, CBO's	Patients that were referred from a community health structure to a PHC facility	Show the level of community participation in the health system (The participation mean is that the CBO's and NGOs can refer patients to health facilities and health facilities can refer patients back to CBO's and NGO's)	Numerator: Number of patients referred to a PHC Denominator: Total Number of patients seen in the PHC	Referral module/DHIS Interface	-Quarterly
2.% of Referrals from District hospitals to tertiary (provincial) hospitals	Patients that were referred by district hospitals to a higher level of care	This is for patients needing final clinical diagnosis/further management and those needing access to specialist care	Numerator: Number of patients referred from district hospital Dehominator: Total number of patients admitted and seen in OPD of the tertiary/provincial hospita	Referral module/DHIS Interface	-Quarterly
3.% of referrals in which feedback was received by a referring institution	Feedback/report on patients that were referred & sent to a referring institution. (Institutions that receive patients from institutions needs to provide feedback reports to indicate how the patient has been treated and what the referring institution still needs to do for the patient).	To strengthen feedback and interdepartmental collaboration, improvement of knowledge management for referring facilities	Numerator: Number of referrals feedback received in a month Denominator: Total number of referrals in a month	Referral module/DHIS Interface	-Quarterly
4. % of patient referrals from foreign countries requiring specialised health care	Total number of foreign patients receiving specialised health care treatment in South African health facilities	Measurement of the level in which South Africa specialised health facilities are utilised by foreign countries.	Numerator: Number of patients referred from foreign countries for specialised care in SA health facilities Denominator: Total number of patients that received special ized health care in	Referral module/DHIS Interface	-Yearly

7.1% of self-referral patients in a district hospital from one province to another	Total number of patients who move from one province to another with a proper referral system	Measures the level to which patients seek medical care outside their provincial boundaries	Statistics in South Africa Numerator: Number of patients that self-refer to district hospital from other neighboring province Denominator: Total number of patients seen in district hospital	Referral modules/EHR interfaces	-Quarterly
8.5% of patients with inappropriate referrals	Patients whose referral was not essential and could have been managed with the level of care provided by their referring institution (criteria that were developed without using national protocols/guidelines)	Measure the quality of care and improve service delivery	Numerator: Number of referrals that were deemed non-essential by the receiving institution Denominator: Total number of referred patients	Referral modules/EHR interfaces	-Quarterly
7% of down referrals from District hospitals to PHC facility for continuum of care	Total number of patients that was referred to PHC facility	Shows the level of community participation and the surveillance of downward system	Numerator: Number of patients referred to PHC facility from a District hospital Denominator: Total Number of patients seen	Referral modules/EHR interfaces	-Monthly -Quarterly -Half yearly -Yearly
8.5% of self-referrals in District Hospitals	Patients who bypass the PHC facility to District hospitals	Informs us if the patients' needs are satisfied. Informs the areas requiring improvement in service delivery	Numerator: Number of self referrals in a District hospital Denominator: Total number of patients seen in OPD	Referral modules/EHR interfaces	-Monthly -Quarterly -Half yearly -Yearly

3.5% of clients within the 1st week of referral from district to tertiary hospital	Patients who are in transfer during the first week of being referred	Appropriateness and timeliness of the referral by the referring institution	Numerator: Number of referrals received during the 1st week of referral Denominator: Total no of referrals referred	Referral module in DHIS Interface	Monthly
11.1% of hospitals with a coordinated referral structure	Hospitals that have posts for referral coordinators filled	Measure the level of commitment of health facilities by ensuring staff to be responsible for referral coordination	Numerator: Number of health facilities with a post designated for referral officer/clerk Denominator: Total number of facilities	Referral module in DHIS Interface	-Monthly -Quarterly -1st yearly -Yearly