Business Management Practices Employed by Speech-Language Therapists and Audiologists in Private Clinical Settings

By

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SUMMARY

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This study examined the business management practices employed by speech-language therapists and audiologists in private clinical settings. A sample of 199 speech-language therapists and audiologists in private practice, selected from the SASLHA database, served as respondents. The respondents were requested to complete and return a questionnaire concerning the use of various business management practices in their clinical settings and their attitudes towards the management of their businesses. Results of this study indicate that the majority of the respondents lacked knowledge and expertise in business management. It was evident that the private practitioners were aware of some of the management concepts, principles and practices included in the questionnaire, however, they failed to

use this awareness in the management of their practices. The results consequently indicated a need amongst private practitioners for training and education in business management. The implications of the findings of the study, in terms of training and service delivery in the private sector, were identified along with suggestions for the improvement of private practitioners' business management skills. The data from the study as well as the respondents' opinions regarding future training proved useful in establishing a recommended curriculum for business management training that would be appropriate and relevant to speech-language therapy and audiology private practitioner's specific management needs.

Key Words: speech-language therapy and audiology, business management practices, business management skills, private practitioners, private clinical settings.

OPSOMMING

Die Toepassing van Besigheidsbestuurspraktyke deur Spraak-taalterapeute en Oudioloë in Privaatpraktyk

deur

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Hierdie studie ondersoek die toepassing van besigheidsbestuurspraktyke deur spraak-taalterapeute en oudioloë in privaatpraktyk. 'n Steekproef van 199 spraak-taalterapeute en oudioloë wat privaat praktiseer is uit die SAVSTG-databasis geselekteer om as respondente te dien. Die respondente is versoek om 'n vraelys te voltooi en terug te stuur. Die vraelys was gerig op die respondente se toepassing van verskeie besigheidsbeginsels in hul privaatpraktyke asook op hul houdings betreffende die bestuur van hul besighede. Resultate van die ondersoek toon aan dat die meerderheid van die respondente 'n gebrek ten opsigte van kennis en vaardigheid in besigheidsbestuur het. Dit is uit hierdie ondersoek wel duidelik dat die respondente bewus is van sommige van die bestuurskonsepte, -beginsels en –praktyke waarna in die vraelys verwys is, maar dat die toepassing daarvan in

hul praktyke nie na wense gerealiseer word nie. Die bevindinge dui derhalwe op 'n opleidingsbehoefte in besigheidsbestuur by privaatpraktiserende spraak-taalerapeute en oudioloë. Die implikasies van hierdie bevindinge ten opsigte van opleiding en diensverskaffing in die privaatsektor word geïdentifiseer, terwyl voorstelle gemaak word vir die verbetering van besigheidsbestuurspraktyke vir privaatpraktiserende spraak-taalterapeute en oudioloë. Die data wat in die studie ingesamel is, sowel as die houdings van die respondente rakende opleidingsbehoeftes, word as betekenisvol beskou vir die daarstelling van 'n konsepkurrikulum in besigheidsbestuursopleiding wat spesifiek gerig is op die behoeftes van privaatpraktiserende spraak-taalterapeute en oudioloë.

Sleutelwoorde: spraak-taalerapeute en oudioloë, besigheidsbestuurspraktyke, besigheidsbestuursvaardighede, privaatpraktiserende spraak-taalerapeute en oudioloë, privaatpraktyk.

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CHAPTER ONE

TRANSFORMATION IN HEALTH CARE AND THE IMPACT ON SPEECH-LANGUAGE THERAPY AND AUDIOLOGY PRIVATE PRACTICES

***Aim**: To introduce the problem that this research study addresses, to provide the rationale therefore, to describe the terminology used, and to present an overview of the content and organization of the thesis.*

1.1 INTRODUCTION

"The future of speech-language therapy and audiology as a profession depends on a variety of factors in the private practice arena. The ability to stand alone in the business community as a profitable, valuable private practice is essential" (Metz, 1996:294). The future, success and profit of existing professionals in private practice will thus be in proportion to the practitioner's educational and skill level as well as their willingness and ability to change (Stanbridge, 1999; Tuomi, 1994). Although astute business practices are critical, success will not occur because of these only, but more importantly because the speech-language therapist and audiologist in private practice will offer benefits and a high level of quality and technologically advanced service that is unavailable elsewhere to clients with communication disorders or delays (Masterson, Wynne, Kuster & Stierwalt, 1999; Klop, 1998). The future of the profession therefore depends on how well speech-language therapists and audiologists are able to take their clinical training and business management skills to the marketplace (Metz, 1996). Consequently, training in both clinical and business management skills is essential to ensure the growth and future of the profession of speech-language therapy and audiology in the transforming health care market.

The above predictions are amongst many in the literature regarding the future of health care in general, and more specifically private practice. Green (1998)

and Jamieson (1998) are amongst a group of South African researchers and professionals who believe that the health care industry is changing in many ways including the following:

FROM		TO
Solo practice	→	*Group practice*
Curative public expenditure	→	*Primary healthcare expenditure*
Paper office	→	*Electronic office environment*
Treatment regardless of cost	→	*Cost containment*
Third party financial risk	→	*Practitioner's risk.*
Clinical autonomy	→	*Peer review and treatment protocols*
Limited access	→	*Unlimited access*

Figure 1.1 Changes in the health care industry

The reason for the shift from solo to group practices is that single unaffiliated practices will generally find it harder to survive in a managed care environment (Isenberg, 1998). In addition, the managed care system will demand practitioners to be more accountable for the level of service and treatment they provide in private practice to ensure that they are fairly remunerated by these organisations (Metz, 1996). Furthermore, the need for cost containment will put practitioners under pressure to save time by eliminating repetitive administration tasks (Leven, 1998) and by compromising on quality patient care to save money (Green, 1998).

The above shifts in focus and behaviour are indications that health care in South Africa is in the process of transformation. This transformation or re-engineering of health care is well-documented in literature (Green, 1998; Jamieson, 1998; Brown, 1994) and is also legislated in the White Paper on Health in South Africa (1997). Some of the explanations given for

transformation are that marketplace dynamics have changed or that society's view of health care has changed, yet the biggest factor driving health care transformation appears to be the need to contain costs (Goldberg, 1996; Ashby, 1995). Health care reform therefore aims to eliminate the high cost of health care by forcing uniformity through legislation and a regulatory structure and it is expected that most private practitioners who are out of bounds in this arena will not be able to survive (Jamieson, 1998). Service delivery may thus remain as the only distinguishing competitive factor (Beckwith, 1997; Metz, 1996). However, the dilemma facing the private practitioner is how to create improved service or value in a climate of diminishing resources brought about by the need to cut costs.

The profession of speech-language therapy and audiology has not been unaffected by the health care reform taking place and has undergone its own form of transformation globally (Goldberg, 1996; Goldberg, 1995; Ashby, 1995) as well as locally in South Africa (Hugo, 1998; Uys & Hugo, 1997; Tuomi, 1994). A number of particular challenges faced by the profession include managed care, cost containment, the treatment of conditions relating to HIV/AIDS, the development of new fields such as early intervention, as well as technological advancements such as cochlear implants and oto-acoustic emissions. Despite these challenges being similar to those experienced elsewhere in the world, South African speech-language therapists and audiologists are also confronted with a number of additional challenges. These include political, social and economic change, fewer public sector posts, diminishing resources, a great need for academic development in the field, and a trend towards primary and community health care (Uys & Hugo, 1997; Tuomi, 1994). Perhaps the most significant challenge in the transformation of the South African health care system is the government policy which advocates accessible health care for all and free health care to all pregnant women and children under five years, since this has far-reaching consequences, particularly for early intervention endeavours (White Paper on Health, 1997).

Accompanying each of these challenges are the implications that they have for the speech-language therapist and audiologist in private practice who must continue to do business in the transforming health care environment. Consequently it is essential for private practitioners to stay abreast of the political, social, economic, and professional changes in order to make the appropriate decisions that will strategically manoeuvre their businesses to remain competitive and financially sound (Brown, 1994; Duncan, Ginter & Swayne, 1992). The challenge, however, is for speech-language therapists and audiologists in private practice to remain informed about new developments in the field, to continue providing effective, accountable services to clients, and to equip themselves with the necessary business management skills to ensure the future success of their businesses.

1.2 STATEMENT OF THE PROBLEM AND RATIONALE FOR THE STUDY

In the past, the majority of the population in South Africa has had some access (although limited) to the services of the public health sector. However, due to political, social, and economic transformation, the resources in the public sector have decreased and the negative impact this has had on health care services has encouraged those who can afford it to switch to the private sector (Goudge, 1999). One of the reasons for this shift is purported to be overall economic growth in South Africa. Economic growth has enabled more individuals to pay for private health care which is evident in the growth of African membership of medical schemes from 24% of total membership in 1990 to 36% in 1995 (Goudge, 1999). As a consequence of this increased demand for private services, it is expected that the private sector will expand its activity further in order to meet these demands.

Moreover, private sources of health care have become increasingly important as a consequence of the financial constraints imposed on health care. This has resulted in staff shortages due to the movement of personnel out of the public sector to the private sector. There is also evidence of this trend being followed in the speech-language therapy and audiology profession (Tuomi, 1994). Tuomi (1994:7) believes that the transition to private practice is

occurring because "...the government's neglect of the public sector has resulted in falling standards of care, reduced financial rewards and lack of job security." Faced with these prospects, speech-language therapists and audiologists are encouraged to seek employment by entering the private sector.

Current statistics show that of the professionals registered with the South African Speech-Language and Hearing Association (SASLHA), private practitioners make up approximately 44% (Smith, 1998). A growing proportion of this percentage is presumed to be made up of new graduates and inexperienced clinicians who are entering private practice as the preferred working environment, very often with no more clinical experience than that which they acquired during their university training (Smith, 1998; Tuomi, 1994). The rapid establishment of private practices by practitioners presumed to be inexperienced in clinical and business management skills has significant consequences for the establishment of sound business processes, systems and management practices due to lack of exposure and training in this field (Stanbridge, 1999). The actions of these private practitioners can be detrimental to the profession since they may be perceived as negligence which portrays to the public and other medical professionals the image that speech-language therapists and audiologists in private practice are incapable of successfully managing a business (Cherow, 1994).

Despite the private sector having attracted large numbers of trained personnel and new graduates away from the public sector, the government cannot abolish or ignore the private health sector since it has grown year upon year since 1982 and is expected to continue doing so (van den Heever, 1994). It is recommended that the government should rather use regulations as a means of influencing and controlling private sector behaviour to ensure quality service delivery and enable the construction of public-private partnerships from which the public sector can benefit (van den Heever, 1994).

It is therefore important to acknowledge and recognise the great potential and capacity of South Africa's private health care sector. In return for a relatively

small investment in terms of designing an appropriate policy and regulatory environment, this sector has the potential to provide great benefits in terms of improving access to quality speech-language therapy and audiology services for all South Africans (Wolvardt & Palmer, 1997). The relevant speech-language therapy and audiology training institutions and associations therefore need to equip their practitioners with the necessary skills to build a strong and powerful private speech-language therapy and audiology sector that will act synergistically with the public sector with much sharing of vital resources to ensure that the community benefits.

In addition to the potential and capacity of the private sector, entering private practice may also be a speech-language therapist and audiologist's only opportunity to increase her income (Flower, 1984). Furthermore, private practice is a particularly attractive option to practitioners since the setting provides a unique opportunity for individual therapists to profit from their skills and better control their professional destiny (Shriver, 1985). Private practice also provides practitioners with satisfaction and remuneration for their own personal performance, which can be very rewarding (Flower, 1984).

A further incentive to enter private practice came about in 1990 when a legal decision enabled speech-language therapists and audiologists to start dispensing hearing aids. This decision opened up the retail arena to the profession, with exposure to a more business-like environment, which Metz (1996) believes should be viewed as one of the single largest factors in allowing the audiologist to enter the private arena. Metz (1996) also states that the increase in speech-language therapists and audiologists entering private practice is an indicator of the gradual maturation of the field of speech and hearing evaluation and rehabilitation. Entering the private practice arena, however, has also produced many special issues that require a renewed evaluation of the type of training and skills required by practitioners to enable them to achieve success in the private sector.

The private practitioner's clinical skills have traditionally played a large role in the success of a private practice, however, with the recent increase in

practitioners entering private practice, communication, marketing, administrative and financial skills have become increasingly important to survive (Metz, 1996; Goldberg, 1996; Ashby, 1995; White, 1995). However, these business management skills are areas for which the profession generally is poorly trained (Stanbridge, 1999; Goldberg, 1996). Speech-language therapy and audiology training at universities in South Africa, for example, is not sufficiently geared towards the new evolvement of private practices, consequently business management is only covered superficially in the undergraduate curricula (Smith, 1998). In addition, for many speech-language therapists and audiologists there has traditionally been some conflict between the clinician's and the business person's role (Goldberg, 1996; Metz, 1996). Private practitioners will need to resolve this conflict and become well trained in business skills required of them in order to succeed in private practice (Naudé, 2000; Stanbridge, 1999; Metz, 1996).

Subsequent to the impact of transformation within health care and the profession of speech-language therapy and audiology, there have been various endeavours to adapt the curricula at training institutions to enable future private practitioners to cope with these changes (Smith, 1998; Metz, 1996). The South African literature documents numerous adaptations regarding the africanisation of the profession and the approach to training, as well as the change in the focus of training to community care (Hugo, 1998; Uys & Hugo, 1997).

However, despite the private sector having grown considerably over the last ten years (Goudge, 1999), training institutions appear to be more focused on adapting curricula to accommodate issues impacting on the public sector than in equipping future private practitioners with the skills required to achieve success in private practice. This is obvious since training institutions are expected to train prospective practitioners to provide clinical services to the majority of the population, not only to an elitist group who can afford private services. A further explanation is that many professionals believe that the private sector is driven by profit, is unconcerned with public health issues, and its activities can result in inappropriate services in terms of type of service,

quality of care, and in the distribution of facilities, equipment or human resources (Goudge, 1999). Despite these beliefs there is a growing need for training institutions to supplement their current curricula with a module on business management or private practice management that equips speech-language therapists and audiologists to enter private practice with confidence and good prospects for success (Stanbridge, 1999; Trulove & Fitch, 1998; Metz, 1996).

Further support for private practitioners' need for business management skills is the fact that many health care practitioners are attending popular business management courses designed to help them deal with the increasing debt, high interest rates, and cash flow constraints that threaten the survival of their private practices (Naudé, 2000; du Preez, 1998). The reported popularity of the courses show that an increasing number of private practitioners have realised that such skills, not previously taught in health care curricula at university, have become indispensable if they want to manage private practices efficiently and survive in the marketplace (Naudé, 2000; Stanbridge, 1999).

Despite the preponderance of literature on how speech-language therapy and audiology private practices should be managed and what skills are required to do so, there is little evidence in the literature of how private practices are currently being managed (Trulove & Fitch, 1998). Furthermore there is relatively little known of the South African private practitioner's specific needs in terms of business management skills, training courses and practical business advice. To the researcher's knowledge there has been only one research study, namely that of Klop (1998), which addressed the management aspects of a South African speech-language therapy private practice. The results of this study indicate that a management programme developed for, and implemented in a private practice, enabled the practitioner to enhance problem solving, efficiency, cost-effectiveness, and client satisfaction (Klop, 1998). Moreover, Klop (1998) demonstrated the relevance of and the need for management principles to be implemented and utilised in a South African speech-language therapy and audiology private practice.

Therefore, prior to deciding the extent and type of business management skills private practitioners should acquire, there is a need to determine **how South African speech-language therapists and audiologists currently manage their private practices in the transforming health care environment with the additional disadvantage of a limited availability of business management training.** This research question provides the impetus for the current study. The merit and relevance of conducting a study on speech-language therapists and audiologists in private practice in South Africa lies in the fact that this group has only been studied in a limited capacity. However, numerous studies of this nature have been conducted in the USA and appear to be relevant to and useful for speech-language therapists and audiologists in private practice (Trulove & Fitch, 1998; Metz, 1996).

The aim and purpose of this study is therefore **to determine how speech-language therapists and audiologists in South Africa manage their private practices**. From the information obtained in this study the researcher will postulate the reasons for the findings and recommend a course of action. Implications drawn from the results will indicate whether business management training is necessary and the private practitioner's opinions regarding when training should occur and who should conduct it will also be presented and discussed. Figure 1.2 presents a summary of the fundamental research components upon which this study is based.

Statement of the problem: South African speech-language therapists and audiologists in private practice are faced with numerous changes in the economic, social, political and professional environment that have implications for the management of their businesses. Furthermore, they have restricted opportunities to develop business management skills due to the limited business training received at undergraduate level.

Implications: Speech-language therapists and audiologists entering private practice without essential business management skills will find it increasingly difficult to successfully manage their businesses through and beyond the transformations in the profession as well as the South African health care industry.

Research question: How do South African speech-language therapists and audiologists manage their private practices in the transforming health care environment and with the additional disadvantage of a limited availability of business management training?

Aim of study: To determine the type and prevalence of business management practices that are used by speech-language therapists and audiologists in private clinical settings in South Africa and to ascertain the opinion of private practitioners regarding the need for training and education in business management.

Intentions:
- To highlight the impact and effect that health care transformation will have on private practices in the near future.
- To outline the strategic management process and to indicate how the various management tools, techniques and methodologies are relevant to and appropriate for managing a private practice.
- To determine speech-language therapists' and audiologists' attitudes towards the management of their businesses.
- To determine what knowledge practitioners have of business management concepts and how they use that knowledge in the management of their practices.
- To determine private practitioners' opinions regarding future business management training.

Outcome: To make recommendations, based upon the empirical results, regarding the development of business management training for South African speech-language therapists and audiologists entering private practice.

Figure 1.2 The fundamental research components of the study

(adapted from Moodley, 1999)

1.3 DESCRIPTION OF TERMINOLOGY

Table 1.1 provides the definitions of the terms that are used most frequently in this study. These definitions are based upon the most appropriate interpretation of the terms for the purpose of this research study.

Table 1.1 Definitions of terms used in the research study

Term	Definition
Business management	Business management is the process of organising, regulating and being in charge of a private practice to ensure that the professional administration and public undertakings of clinical services are optimised (Tulloch, 1993). Furthermore, it refers to the process of optimising human, material, and financial resources to achieve organisational goals (Pearce & Robinson, 1989).
Business management practices	These refer to the techniques, systems, approaches and tools that the private practitioner makes use of in optimising resources in the private practice to attain the practice goals (Duncan et al., 1992).
Business management training	Business management training refers to the teaching and tutoring of course content relating to the ability to function in a private practice environment (Metz, 1996). It provides the private practitioner with the basic skills to organise, regulate and control resources within a private practice that will empower her to manage her business successfully (du Preez, 1998).
Private clinical settings or Private practice	A private practice is a business in which a speech-language therapist and / or audiologist, singly or in affiliation with one or more individuals has total ethical, professional, and administrative control of the practice. Furthermore, the practice owner(s) have total financial and legal responsibility and liability for the practice and are reliant upon themselves for referrals from multiple sources through independent contractual arrangements (Cherow, 1994).
Private practitioner	The term "private practitioner" refers to a speech-language therapist and / or audiologist that is self-employed, and that is not an employee of an individual, organisation, or any other entity providing clinical or consultative services unless also owner of that entity. The private practitioner is someone who depends solely on the private practice for income and who "operates with the ultimate and relatively clear objective of maximising profits" (Collins, 1994:20). A speech-language therapist and audiologist is not considered a private practitioner if she augments her basic income in the evenings or on weekends through private practice. The private practitioner bears full responsibility for the "overhead expenses of the business and the overall management" (Flower, 1984:74). Since the large majority of private practitioners are female, the researcher refers to the singular practitioner as "she" and "her" in the text.
Managed care	This term is used to describe organised efforts to manage cost containment and quality of treatment in healthcare delivery (Green, 1998). It refers to specific financial incentives that encourage individuals to use less expensive providers of healthcare (Isenberg, 1998) through the continuous, external monitoring of the practitioner-patient relationship.

1.4 ABBREVIATIONS

The researcher makes use of various abbreviations in the text of this dissertation. Table 1.2 provides a list of these abbreviations and their meanings in full.

Table 1.2 Abbreviations used in the study

Abbreviation	Term
SASLHA	South African Speech-Language and Hearing Association
RCSLT	Royal College of Speech-Language Therapists
ASHA	American Speech-Language-Hearing Association
HPCSA	Health Professions Council of South Africa

1.5 BRIEF DESCRIPTION OF CHAPTERS AND ORGANISATION OF THE THESIS

In order to orientate the reader to the layout of the text, this section provides a brief description of this chapter, the four ensuing chapters comprising the research study, and the appendices.

1.5.1 Chapter One - Transformation in Health Care and the Impact on Speech-Language Therapy and Audiology Private Practices

A theoretical background is presented in the introductory chapter of this thesis to place the research study in perspective and to provide a rationale for the general postulate. The transformation in health care and the growth of the private sector in South Africa are discussed with relevance to the impact that they have on the speech-language therapist and audiologist in private practice. In addition, an explanation and motivation is provided for the reason private practitioners need to start relying more on non-clinical skills to survive in the dynamic health care environment. The literature is drawn upon to substantiate the argument that business management skills in particular are required in private practice. Therefore, the need to determine how private

practitioners manage their businesses in the transforming South African environment, and within a limited availability of business management training, is made apparent. In addition, the terminology and abbreviations used in the discussion of business management is defined and the organisation and content of the thesis is briefly discussed in this chapter.

1.5.2 Chapter Two - The Challenge for Speech-Language Therapists and Audiologists in Private Practice in South Africa

The aim of chapter two is to provide an orientation of the topic and a critical evaluation of the literature relating to business management in speech-language therapy and audiology private practices. Factors impacting on South African speech-language therapists and audiologists in private practice and how the influence of these factors pose great challenges to the private practitioner who must endeavour to manage her private practice in a dynamic and transforming profession, are also discussed. An overview of the need for business management skills in a private practice setting is included, followed by a comparison of the business management training received by undergraduate speech-language therapists and audiologists in South Africa, the UK and the USA. Thereafter, the strategic management process is discussed in detail, indicating the relevance and applicability thereof to a speech-language therapy and audiology private practice in South Africa.

1.5.3 Chapter Three - Research Methodology

Chapter three outlines the methodology that was applied in determining the business management practices of speech-language therapists and audiologists in private practice. In this chapter the main research aim and sub-aims are specified and the choice and rationale for the research design is discussed. Thereafter the selection and description of the respondents and the materials used in the study is presented. An outline is provided of the aim, content and compilation of the questionnaire used in the study, accompanied by the pilot study, reliability and validity measures thereof. Finally, the procedure for executing the study, the methods for data analysis and ethical issues in carrying out the study are discussed.

1.5.4 Chapter Four - Analysis and Interpretation of the Results

This chapter presents a detailed statistical and qualitative analysis of the results of the compiled questionnaire in an organised manner according to the main aim and sub-aims of the study. The results of the practitioners' knowledge and use of business management practices are graphically represented by means of tables and graphs, followed by detailed discussions thereof. Interpretations are made based upon these results and upon what the relevant literature asserts.

1.5.5 Chapter Five - Conclusions and Implications

Chapter five is the final chapter of the research study and therefore provides an organised summary of the main conclusions drawn. This is followed by a discussion of the theoretical, practical and research implications of the study as well as a critical evaluation of the research study. Thereafter a curriculum for a business management training course for speech-language therapists and audiologists in South Africa is recommended. In addition, a number of opportunities for further investigation into specific business management needs and the training of speech-language therapy and audiology private practitioners in South Africa are presented. Finally, recommendations are made for further use of the information gained by the current study.

1.5.6 Appendices

The appendices include four documents that were used in the research process.

1.6 CONCLUSION

According to Jamieson (1998) the old competencies of accuracy, attention to detail, and traditional clinical acumen are not obsolete, they are just no longer considered enough to assure success in private practice. The ability to adapt to continuous change in the transforming healthcare environment requires an increase in the practitioner's capacity to learn new skills and to accept disruption and lack of closure. This transition period is a critical window of opportunity for the private practitioner in the strategic management of her

practice. Given the growth of the private sector and the critical role that it will continue to play in the speech-language therapy and audiology profession, it is essential that the private practitioner emerges as an influential and credible player in the transformed health care environment. To ensure that private practitioners are ready to meet this challenge it is essential to determine their business management needs. In achieving this goal it is necessary to determine how speech-language therapy and audiology private practitioners currently manage their practices within the constraints and limitations of the prevailing environment.

1.7 SUMMARY

The aim of this chapter was to introduce the topic of study, to place the research study into perspective and to provide a rationale for the general postulate. The transformation in health care and the growth of the private sector in South Africa are discussed with relevance to the impact that they have on the speech-language therapist and audiologist in private practice. In addition, an explanation and motivation is provided for the reason private practitioners need to start relying more on non-clinical skills to survive in the dynamic health care environment. The literature is drawn upon to substantiate the argument that business management skills in particular are required in private practice. Therefore, the need to determine how private practitioners manage their businesses in the transforming South African environment, and within a limited availability of business management training, is made apparent. A description is provided of all the relevant terms and abbreviations used in the research study followed by a brief outline of each of the five chapters.

CHAPTER TWO

THE CHALLENGE FOR SPEECH-LANGUAGE THERAPISTS AND AUDIOLOGISTS IN PRIVATE PRACTICE IN SOUTH AFRICA

***Aim**: This chapter serves as a theoretical underpinning for the research and provides a critical evaluation and interpretation of the literature.*

2.1 INTRODUCTION

In the past decade a new focus has emerged in the dynamic international health care industry, namely that of management of health care professions (Moskovitz, 1994). The profession of speech-language therapy and audiology has been no exception with the trend of management issues emerging quite strongly in the literature (Trulove & Fitch, 1998; Metz, 1996; Harrison & Frattali, 1994).

This is also true on a national level in South Africa where progress has come about due to a number of reasons. Firstly, the emergence of managed care in South Africa has driven practitioners to become more cost conscious and accountable to ensure that their services are adequately remunerated (Green, 1998). Secondly, the profession has had to compete for limited financial resources from the government and prove the value of speech-language therapy and audiology services as making a change not only to communication but also to a way of life (Tuomi, 1994). Thirdly, the speech-language therapy and audiology profession is in a period of transformation (Uys & Hugo, 1997; Goldberg, 1995; Ashby, 1995) due to changes in the focus and approach to treatment. Finally, the gradual maturation and growth of the profession has taken it to new levels of competency and autonomy (Metz, 1996; Cherow, 1994). This progress, as well as the transformation efforts within the profession of speech-language therapy and audiology, has consequently posed numerous challenges to the private practitioner.

In order to address these challenges, private practice management has become a subject of particular interest in the speech-language therapy and audiology literature and research since 1990. Numerous publications have stressed the need for speech-language therapists and audiologists to focus on the business management aspects of their private practices. The majority of the literature on private practice management proposes how practitioners can ensure more efficient and effective service delivery through the application of various management principles. Examples of the management principles covered in the literature include marketing (Smith, 1996; Gilligan & Louw, 1996; Ashby, 1995; Clifford, 1993), business plans (Brooks, 1995; Moskovitz, 1994), business strategy (Brown, 1994), personnel management (Brooks, 1994), and re-engineering (Jamieson, 1998; Ashby, 1995; Goldberg, 1995). These are all examples of management principles that are traditionally used by large organisations in all industries including the health care industry. Moreover, the inclusion of management issues in the literature indicates that management and business principles are also applicable to small and medium sized businesses such as private practices, even though this may be on a different scale. Furthermore, the abundance and depth of this current literature serves as an indication that speech-language therapy and audiology private practices should be managed like businesses with the use of widely accepted business management principles.

There has also been an abundance of published material pertaining to the need for speech-language therapists and audiologists in private practice to use more sophisticated accountability measures (Trulove & Fitch, 1998), to use technology in office management (Levin, 1998; Goldberg, 1996), and to improve service delivery (Metz, 1996; Lacap, 1994). In addition, there has been a focus on the importance of outcome data, which is influenced by the above-mentioned factors. Plausible explanations of private practitioners' need for this information are the growth in the autonomy of the profession (Cherow, 1994), and the need for private practices to prove their independence in the business community by being profitable, valuable small businesses (Metz, 1996), thereby upholding the image of the profession.

The recent emergence of managed care in South Africa has also created the need amongst private practitioners for information regarding the impact that managed care will have upon private practices (Jamieson, 1998; Green, 1998; Pappelbaum, 1995; Nazarian, 1995). Managed care is synonymous with cost containment, which has been well documented in the speech-language therapy and audiology literature (Goldberg, 1996; Ashby, 1995; Goldberg, 1995). Although managed care has not yet directly affected the speech-language therapy and audiology private sector in South Africa, it is expected that that the private practitioners will be influenced by its principles in the near future.

Health care periodicals have also recently advertised private practice, financial, and business management courses to subscribers and readers, which indicates that there is a definite demand for private practitioners to develop their business management knowledge and skills (GP Bulletin, 1999). Furthermore, associations such as the South African Speech-Language and Hearing Association (SASLHA) has organised similar courses conducted by financial and business experts who have recognised the market for this form of business training. Whilst there is a great need for this form of business training, Metz (1996) believes that it is essential that an appropriate person conducts the training. According to Metz (1996:294) the trainer should be someone who understands "...the difficult relationship between patient and profit that serves the patient above all else and yet still serves the business from a financial viewpoint." It can therefore be assumed that Metz (1996) is referring to someone not only with business experience, but also with a health care background.

The majority of the current literature in the speech-language therapy and audiology field, which deals with management related issues, focuses on a single skill, system, process, or management concern. However, many of the publications fail to show how these issues relate to the total management of a business. Providing a holistic picture of how the different management practices are related in a business and how they can be used in conjunction

with one another is necessary to provide the speech-language therapy and audiology private practitioner with a business management perspective. This perspective is necessary to enable the private practitioner to establish and maintain an efficient, profitable and customer service oriented private practice that aligns all the aspects of the business with its specified objectives. Furthermore, a business perspective will assist the private practitioner to realise the importance of and ensure that a competitive advantage is maintained in the health care market, thus ensuring the survival of the business.

One of the more successful attempts to link the different aspects of management was achieved by an edition in the Seminars in Hearing Journal (1994). The journal was dedicated to the theme "Total Quality Management" (TQM) and was concerned with 'how you do business' (Harrison, 1994). The authors of the articles discussed the various aspects of TQM and provided examples of how these could be applied to the practice of audiology in any setting or organisation. These articles guaranteed that TQM would help practitioners to become better, more cost-effective, and more competitive in their workplace. The disadvantage of these articles, however, was that they did not provide practical advice on how exactly this could be attained. That is, practitioners were not provided with anything that they could return to their practices with and begin using immediately. Furthermore, the well-publicised TQM strategy is considered difficult to grasp and even more difficult to implement without the assistance of a professional or experienced TQM user (Harrison & Frattali, 1994).

Furthermore, quality management has been a topic of interest in both local and international research studies in the speech-language therapy and audiology field (Klop, 1998; Harrison & Frattali, 1994). Amid the South African literature on the topic of private practice management, one particular research study applied to the speech-language therapy profession warrants attention. Klop (1998) defined, developed and implemented a quality management programme to every aspect of her own speech-language therapy private practice. Klop (1998) claims that the development and implementation of the

quality management programme provided her with a systematic approach to enhance various management issues such as accountability, efficiency, cost-effectiveness and client satisfaction. Whilst the merits of this study was that it was the first of its kind to be applied to private practice in the speech-language therapy and audiology profession locally, its limitations make it impossible to generalise the findings to other private practices. However, Klop's (1998) business plan methodology and process of discovering opportunities to improve quality management in her private practice provide an excellent basis for future research. Furthermore, the value and relevance of drawing up a business plan for a private practice was demonstrated in her study and serves as an example to other private practitioners.

Confronted with the literature which has proved that management-related issues are applicable and necessary to private practices, speech-language therapy and audiology private practitioners have a responsibility to the profession to ensure that they are considering and implementing these ideas in the management of their businesses. One of the most important reasons for applying business management principles in a private practice is to improve the efficacy and quality of services within the private sector, thereby also improving accountability. Furthermore, it is stated in the SASLHA Code of Ethics (1997), under the section regarding responsibility towards the advancement of knowledge, that members must endeavour to constantly update their knowledge of the field with regard to new management procedures. Therefore, not only do private practitioners have an ethical obligation to the community to provide a much-needed service, but also to ensure that their services are effective, accessible, affordable and efficient to the communities they serve. This is an immense responsibility considering that speech-language therapists and audiologists are mainly trained to perform specific forms of clinical assessment and treatment.

The aim of this chapter is to provide an overview of factors impacting on speech-language therapy and audiology private practitioners in South Africa. The existence of these factors emphasises the practitioner's need for business management skills and puts them into perspective in the dynamic

and transforming health care environment and speech-language therapy and audiology profession. To indicate the relevance and value of business management skills in a private practice, the phases of a traditional strategic management process are applied to a speech-language therapy and audiology private practice. This discussion endeavours to reveal how each phase in the strategic management process enhances the effectiveness and management of a speech-language therapy and audiology private practice.

2.2 FACTORS IMPACTING ON THE SPEECH-LANGUAGE THERAPY AND AUDIOLOGY PRIVATE PRACTITIONER IN SOUTH AFRICA

In order to understand the challenge ahead for the speech-language therapist and audiologist in private practice in South Africa, the problems and issues facing the practitioner, the profession, and the country need to be taken into account. For the purpose of this discussion, the relevant factors currently impacting on the private practitioner have been classified into three main areas namely, the South African context, the health care industry, and the speech-language therapy and audiology profession. Figure 2.1 diagrammatically displays all the factors impacting on the private practitioner in the speech-language therapy and audiology profession in South Africa in the year 2001. The ensuing discussion is based upon the diagram in Figure 2.1 and provides a detailed explanation regarding how each of these factors impacts on the private practitioner.

2.2.1 Factors pertaining to South Africa

Owning and operating a business within the South African context poses many challenges to the speech-language therapy and audiology private practitioner. South Africa has many rich and diverse cultures, many official languages, and geographically widespread citizens, amongst other factors, which should be taken into consideration by private practitioners. Five factors were identified that encompass the most significant issues in the South African context that pertain to speech-language therapy and audiology private practitioners. Each of these factors is discussed forthwith.

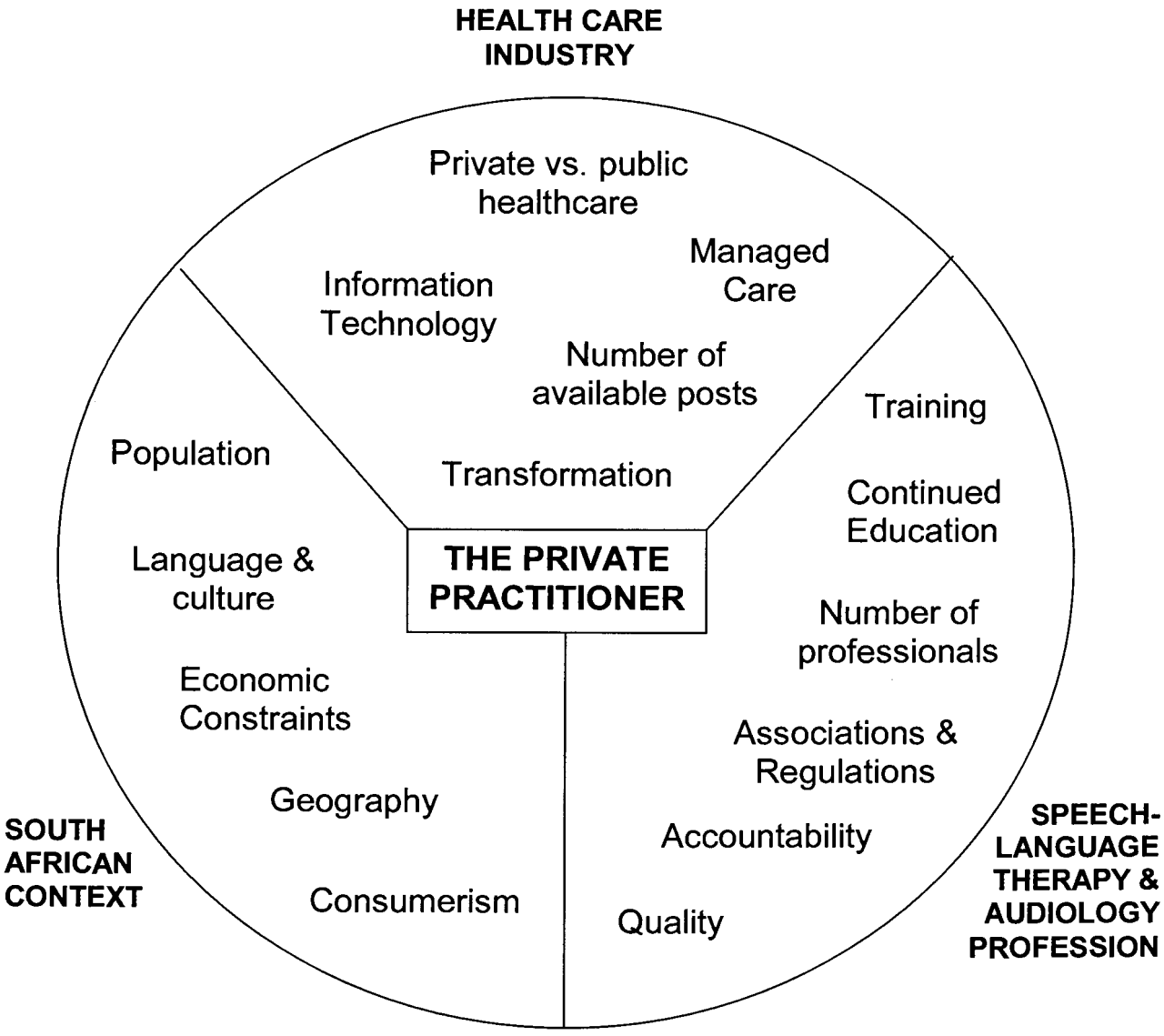

Figure 2.1 Factors impacting on the private practitioner in the speech-language therapy and audiology profession in South Africa in the year 2001

2.2.1.1 Population

South Africa has a population of approximately 39 million people (HSRC, 2000) and has numerous cultures and ethnic groups represented within a wide range of social classes and income. The diverse cultures, political beliefs and religions are a source of pride to its people, which is evident in the name "Rainbow Nation" that is so often linked with discussions on South Africa. The diversity of the population poses a challenge to South African speech-language therapy and audiology private practitioners who must deal sensitively with individuals within the multicultural environment, which necessitates a great deal of understanding of the cultures, languages and norms of the different communities. (Kent, 1994).

Hugo (1998) verifies the importance of multiculturalism in the training of speech-language therapists and audiologists by indicating that this will ensure that future practitioners are able to practice within the multicultural environment in South Africa. There is a possibility that many practitioners currently in private practice were not specifically trained to provide services to a multicultural community since multiculturalism has more recently become a topic of interest in training institutions (Hugo, 1998). There may thus be a need for previously trained practitioners to adapt to changes taking place in South Africa by familiarising themselves with cultural-specific assessment and treatment methods, tools and practices.

2.2.1.2 Geographical factors

South Africa is a large country divided into nine provinces and is characterised by rugged mountain ranges, coastal cities, and arid plains. Approximately half of the population live in rural or remote areas and have limited, if any access to speech-language therapy and audiology services. The remainder of the population live in urban cities where, due to the economic, social and political legislation in the past, the majority of them still have limited access to speech-language therapy and audiology services (Pickering et al., 1998).

The majority of the population relies on the public healthcare delivery system, which services both rural and urban areas. The wide geographical spread of the population within South Africa and the large rural population therefore necessitates widespread access to speech-language therapy and audiology services (Pickering et al., 1998). Unfortunately the number of professional speech-language therapists and audiologists working in public-based rural hospitals, clinics and schools is extremely limited, partially due to economic healthcare constraints and a limited number of available posts. Furthermore, due to the undesirability of living in remote or rural areas, speech-language therapy and audiology private practitioners in these areas are also limited.

Collins (1994) believes that the reason for limited access to healthcare services is that South Africa, like all other third world countries, still bears the imprint of colonial inheritance. The type and organisation of healthcare services in a country is considered to be strongly related to the social, political and historical context in which the country has developed and operated (Collins, 1994). This is consistent with the fact that, in colonial times, private medical practices operated mainly to serve the upper and middle classes in urban areas that could afford the services. In the current South Africa, it appears that little has changed in terms of access to private speech-language therapy and audiology services.

The speech-language therapy and audiology private practitioner in South Africa is thus faced with the challenge of fulfilling her ethical obligation of providing accessible care to the community whilst continuing to serve the business from a financial viewpoint (Metz, 1996). By extending her services to the disadvantaged community, the private practitioner may have to travel to communities further afield thus increasing the cost of her services. Furthermore, she will be required to make her services more affordable and culturally appropriate to her patients. In addition, the risk of non-payment is likely to be much higher. The private practitioner is thus faced with a dilemma - on the one hand she should uphold her ethical obligation of increasing accessibility of speech-language therapy and audiology services to the wider community, however, on the other hand she should strive to develop a viable

private practice. The challenge facing the private practitioner is whether these two notions can be achieved concurrently.

2.2.1.3 Linguistic and cultural factors

Language is inherently linked to the diverse cultures prevailing in South Africa where eleven official languages are used in education. This is of great importance to the speech-language therapist and audiologist as the past language constraints in the education system and poor funding of black education have resulted in a large number of children who require intervention (Pickering et al., 1998). Furthermore, language is of exceptional importance to the speech-language therapist and audiologist as it is not only the medium of rehabilitation but also the eventual goal (Hugo, 1998).

Hugo (1998:7) proposes that "...the communication pathologists of the future must therefore be much better equipped than in the past to participate in programmes to non-first language speakers in the school." Private practitioners are no exception to Hugo's (1998) proposition as the africanisation of the profession is not exclusive to government-based speech-language therapists and audiologists.

Although multilingualism is an asset to a country and promotes cultural awareness, it poses a challenge to speech-language therapists and audiologists in private practice. As a possible solution, Tuomi (1994) suggests that more students who speak African languages need to be recruited. This view is supported by Hugo (1998), yet Hugo (1998) cautions that africanisation of the profession does *not only* entail acquiring black students. Recruiting and training more first-language speakers in all the African languages will provide a meaningful service to the South African population, however, this is a very long-term solution considering that approximately 80 to 100 newly qualified graduates enter the workforce each year (Tuomi, 1994).

Translation is an alternative way in which private practitioners can overcome linguistic diversity (Pickering et al., 1998) however it is presumed that very few private practitioners have the access to or can afford interpreters. The most

appropriate short-term solution comes from a statement made by Makgoba (1996) that the pursuit of knowledge and social responsibility should guide the practitioner in South Africa. Factors that provide the private practitioner with a distinctive competitive advantage and that enable her to fulfil her social and ethical responsibility therefore include learning to speak at least one black language, ensuring services, methods and tools are culturally appropriate, using a translator when necessary, and taking the client's cultural norms and traditions into consideration. This list is by no means complete, yet it provides a few short-term options available to the private practitioner who endeavours to improve the effectiveness and quality of her services to the wider population in South Africa.

2.2.1.4 Economic constraints

South Africa is undergoing intense social and economic transition (Pickering et al., 1998). The budgetary constraints facing the public healthcare sector continue to result in the under-delivery of its responsibilities which is reflected in the continuing decline of quality standards offered by public hospitals (Kadish, 1999). One of the means by which the problem of economic healthcare constraints is being addressed is through managed care, which is being introduced into the medical industry in South Africa. Managed healthcare essentially revolves around the cost-effective provision of quality medical care.

Given the government's policy to accommodate economically active people not covered by medical aid, managed health care companies will have a key role to play as increasing numbers of the population seek some form of cover. Managed care is seen as pivotal in providing quality, private health care to this new emerging market and managed care providers are under pressure to develop managed care systems that are driven around the needs of the patient. The emerging black middle class is seen as the key target for future managed care initiatives. Up to 14 million new patients are expected to demand a system through which they will have access to affordable, quality, private health care (Jackson, 1998).

Unfortunately, managed care is a medium to long-term solution. In the interim and transition period the economic constraints in public healthcare will continue to increase, particularly with the impact of the HIV/AIDS epidemic. It is therefore important that the speech-language therapist and audiologist in private practice takes advantage of this transition period by marketing her services to the emerging middle class. This form of marketing means raising awareness about communication disorders in order to educate people and help those in need of treatment to receive it (Silverman, 1990).

The goal of this form of marketing is to educate a defined sector of the population about the speech-language therapy and audiology profession and the services offered by private practitioners. The rationale for educating the population in this manner is that many people need the services of a speech-language therapist or audiologist but often do not realise it (Smith, 1990; Silverman, 1990). In summary, Larkins (1993:50) aptly states that speech-language therapists and audiologists in private practice "...cannot afford to be silent. In order to secure a future in an environment in which consumers will be seeking the best for less, we must be vocal."

2.2.1.5 Consumerism

An emerging consumerism in health care is encouraging clients to 'shop around' for quality services. For those who can afford to consult a speech-language therapy and audiology private practitioner in South Africa, there are a number of practitioners to choose from, particularly within the capital cities and surrounding suburbs. This culture of consumerism is not surprising since the private sector contributed 60.8% of the total amount of R30 billion spent on healthcare in South Africa in 1992/3. The majority of this money came directly from medical aids and nearly one quarter came directly from patients' pockets (ReHMIS Survey, 1992/3).

It is assumed that higher demands and expectations from consumerist patients is the result of them being better informed of healthcare choices, as well as the substantial fees demanded by private practitioners for private healthcare services. Speech-language therapy and audiology as a profession

is no exception to this consumerist approach. A particularly good example of this is the case of a patient seeking a hearing aid from an audiologist in private practice. As hearing aids are expensive items to purchase, the client is likely to 'shop around' until he or she is satisfied with the quality, affordability, and service of the private practitioner and the hearing aid. In addition, consumerism increases competition in the private sector and thus creates a need for private practitioners to continually evaluate the quality and affordability of their services in order to be competitive in the healthcare market.

2.2.2 Factors pertaining to the health care industry

Managing a small business within the strictly regulated health care industry requires a different emphasis compared with simply managing a general service business. A strict code of ethics and code of practice, from various associations to which practitioners must be affiliated, bind the owner of a health care private practice. Furthermore, speech-language therapy and audiology private practitioners usually rely on medical insurance companies for payment of their services. The private practitioner also has ethical responsibilities towards the profession, the client as well as society. There are several other factors in the health care industry that impact on the speech-language therapy and audiology private practitioner, of which the five most important are discussed forthwith.

2.2.2.1 Private versus public health care

Approximately 5.5 million people, 14% of the South African population, have access to quality private health care (Jackson, 1999). The remainder of the population relies upon the financially limited public health care service that consequently has insufficient resources and long waiting lists. Consistent with this view is Mutloane's (2000) statement that 80% of South Africa's population consumes 40% of the total health care budget. This means that 60% of the total health budget in the country is consumed by 20% of the population through the private health care system (Mutloane, 2000). These statistics are indicative of two issues. Firstly, that private health care is far more expensive than public health care. Secondly, that there is limited access to quality public

health care for the majority of the population. Furthermore, the fact that most of the healthcare budget is spent in the private sector reveals the importance of recognising the great potential and capacity within the private sector. The following statement by Wolvardt & Palmer (1997:44) substantiates this view: "... this sector has the potential to provide great benefits in terms of improving access to quality health services for all South Africans."

One of these benefits is the fact that many speech-language therapy and audiology private practices are located in the community, thus eliminating the need for transport to clinics or hospitals. Furthermore, there may be great benefits regarding accessibility if the speech-language therapists and audiologists in the private and public sectors can work synergistically to share resources and thus reach a far greater number of clients in need of their services (Mutloane, 2000).

Managed care has an important role to play in achieving the goal of improved access to quality healthcare services as it will provide up to 14 million more people with medical aid cover (Jackson, 1998). It is expected that this will enable them to better afford the services of speech-language therapists and audiologists in private practice. Managed care will thus draw patients from the public sector to the private healthcare sector, reduce state spending and free up revenue for health care in disadvantaged communities (Kinghorn, 1994). This will inevitably extend private speech-language therapy and audiology services to significantly more people in South Africa.

The speech-language therapy and audiology private practitioner's role in managed care will be to provide accessible and affordable care to the community. Before this is achieved, however, it is essential to know the distribution and density of speech-language therapy and audiology private practices relative to patients as this will assist with the assessment of service availability in an area. Furthermore, this information will assist new private practitioners to choose the location for their practices wisely (McCusker, 2000).

Mutloane (2000:102) therefore believes that "...we need to build a very strong and powerful private health sector..." in order to achieve the goal of improving access to quality health care services to all South Africans. The speech-language therapist and audiologist in private practice has a responsibility towards the profession as well as to the community to take part in these transformation efforts to improve accessibility of private care to an increased number of people in South Africa.

2.2.2.2 Transformation

The transformation of healthcare in South Africa has received much attention in the literature as well as the media (Jackson, 1999; Jackson, 1998; Jamieson, 1998; Goldberg, 1995). The traditional methods for delivering care are changing and private practitioners of the future will need to be active instruments of these changes if they are to survive (Nazarian, 1995).

Jamieson (1998) believes that healthcare in South Africa is undergoing a transformation process similar to that of re-engineering, which aims to redesign business processes to increase productivity and quality while lowering cost. Goldberg (1995:46) states very simply that re-engineering refers to "doing more with less." Re-engineering therefore involves reorganising the system to allow the speech-language therapist and audiologist to increase productivity and quality while lowering cost. Re-engineering is best achieved through an improvement process that manages quality and efficiency and is better known as managed healthcare (Jamieson, 1998).

It is expected that the transformation of healthcare will help to eliminate the cost-price arena by forcing uniformity amongst competing private practitioners (Jamieson, 1998). It is therefore possible that many speech-language therapy and audiology private practitioners who do not control costs and keep their prices affordable will not survive in the reformed healthcare market. Under these circumstances, service is likely to flourish as the distinguished competitive indicator. The dilemma facing the speech-language therapist and audiologist in private practice, however, is how to create improved service or

value in the arena of diminishing resources brought about by the need to cut cost (Jamieson, 1998).

Careful management of resources, time, productivity and costs will be essential for speech-language therapy and audiology private practices to survive the healthcare transformation process in South Africa. Furthermore, speech-language therapists and audiologists in private practice will need to become increasingly client-centered in their approach to treatment and be proponents of client satisfaction (Klop, 1998; White, 1995) in order to achieve the service levels expected of them.

2.2.2.3 Managed care

There is a great need to provide speech-language therapy and audiology services to the communicatively disordered population who do not have the financial means or access to the services of a speech-language therapist and audiologist (Pickering et al., 1998; Uys & Hugo, 1997). Of particular interest to the private practitioner should be the emerging new middle class of approximately three to four million employed people who are currently amongst the medically uninsured section of the South African population (Kadish, 1999). They will soon be demanding access to quality private speech-language therapy and audiology services and their demands are not unfounded. Providing high quality private care to this emerging new middle class is the single greatest challenge facing the speech-language therapist and audiologist in private practice today (Jackson, 1999).

The demands of this medically uninsured population have led to the formation of a new cost-driven health plan based on managed care principles (Jackson, 1999). Managed care, however, will introduce many changes in the traditional manner in which private practitioners and clients interact. In the past, the private practitioner earned income from the client who required therapy. The payment for the service was made by the medical aid scheme after the necessary formalities had been carried out. The current problem with this system, however, is that employers are putting pressure on the medical schemes to control the cost of medical care because medical aid contributions

are costing employers too much (Jackson, 1999; Green, 1998). This is resulting in employers changing medical schemes to suit their expense management programmes (Magennis, 1999). Therefore, the most appropriate solution to the problem is if the private practitioner providing the service works together with the medical aid organisation to profit both parties. The advent of managed care has therefore brought about a fundamental shift from the fee-for-service approach towards an outcomes-oriented health management process involving the speech-language therapist, the patient, and the medical funder (Jackson, 1999).

The underlying principle of managed care is cost containment, which means that controlling costs is paramount to the speech-language therapist and audiologist private practitioner (Trulove & Fitch, 1998; Goldberg, 1996; Ashby, 1995). Cost containment, however, puts the private practitioner under pressure to cut costs or to improve the efficiency of services (Jamieson, 1998), which means that speech-language therapists and audiologists in private practice will need to manage their time, resources, and expenses far more efficiently in the future (Goldberg, 1996; Ashby, 1995). The competitive structure of the managed care industry also increases pressure on speech-language therapists and audiologists to "...succumb to punitive restrictions on their professional autonomy and their annual income" (Pappelbaum, 1995:822).

Under managed care, a client's privileges have been curtailed substantially. The decisions regarding who a client can see, when, and for what specific treatment will no longer be matters of his or her personal choice but will be regulated by a corporate entity (Jamieson, 1998). The speech-language therapist and audiologist in private practice will also have to relinquish much freedom of choice in order to accommodate the changes related to managed care (Green, 1998). It is expected that private practitioners will derive their authority from and will be responsible and accountable to both clients and the managed care organisation for all assessment and treatment decisions. In addition, speech-language therapists and audiologists will be required to prove, using accurate outcome data, that their services are cost effective and

that they deliver measurable functional improvement (Trulove & Fitch, 1998; Goldberg, 1996).

A further threat facing therapists is the danger of a decrease in the medical aid society's reimbursement of speech-language therapy and audiology services. Therefore as professionals, speech-language therapists and audiologists need to be able to justify the worth of their services in terms of cost and time. Accountability is thus a necessity, as the managed care organisations are increasingly demanding proof of improvement from treatment (Trulove & Fitch, 1998; Ashby, 1995; Boston, 1994). The private practitioner thus derives her authority from and is responsible and accountable to both the patient and the managed care company.

Green (1998) believes that managed care will require adequate data and sound business practices from the private practitioner as well as an informed and receptive consumer culture. This poses a challenge to the private practitioner who will need to focus on providing the best and most appropriate treatment for her clients according to the ethical obligations of the profession, as well as focusing on cost containment and accountability. Jamieson (1998) therefore proposes that speech-language therapy and audiology private practitioners learn to satisfy managed care organisations by devising a marketing plan and implementing it, developing means to monitor service levels and patient satisfaction, and providing a low cost option for those who will not be served by the public sector. Managed care will therefore be a benefit or a burden to the speech-language therapist and audiologist in private practice but will certainly be easier to accept in private practices that are efficiently managed in terms of cost, time and accountability.

2.2.2.4 Number of available posts

The majority of speech-language therapists and audiologists are employed in government hospitals and schools, however, due to demise of the traditional health care system and a limited budget allocated to health care, the number of available posts in the public sector has reduced considerably (Tuomi, 1994). In addition, there is competing pressure for positions from other

essential health care specialisations such as physiotherapy and nursing (Pickering et al., 1998). The consequence of the government's reduction in financial support of healthcare services has resulted in many professionals joining the private health sector. Tuomi (1994:6) believes that the transition to private practice is occurring because of neglect of the public sector on the government's behalf which has caused a decrease in the standard of care, reduced financial rewards for practitioners and lack of job security."

The biggest disadvantage of this transition to private practice is that the private and public health care sectors generally service different populations at present. The private sector almost exclusively services people with private medical insurance, whereas the public sector services the majority of the population that have no private medical insurance. It is therefore the majority of the population that suffers from the lack of speech-language therapy and audiology services in the public sector when practitioners seek the challenge of private practice. However, the introduction of managed care is expected to make medical aid coverage more accessible and affordable to a greater section of the population.

For a speech-language therapist and audiologist the advantages of joining the private sector are the financial and personal rewards, which are usually much greater than in the public sector. Furthermore, private practice offers the practitioner the opportunity to specialise and to work part-time if required. The limited number of posts available in the public healthcare sector may thus provide certain advantages to the private speech-language therapist and audiologist.

2.2.2.5 Information technology

Technology is one of the forces revolutionising the health care and education arenas (Goldberg, 1996). In the field of speech-language therapy and audiology technological trends are likely to reshape educational, clinical, and research programs over the next three decades (Kent, 1994). However, new procedures and techniques, which often make a substantial improvement in the quality of care, involve complex and costly equipment and facilities. Due to

the nature and size of the average private practice there is usually a limited budget for new technology.

Nevertheless, information technology can be used in ways to achieve essential clinical and administrative benefits for a speech-language therapy and audiology private practice (Stanbridge, 1999; Wood, 1986). On the administrative side, the use of computers can decrease the burden of paperwork and simplify or automate clinical reports (Ashby, 1995). In addition, there is the option of a cost-effective, single-entry integrated computer system with software packages that direct relevant data to all the various files that need to be updated such as billing, accounting, productivity, patient demographics and client base. Stanbridge (1999) also mentions that medical insurance companies are highly computerised and increasingly expect the suppliers of services to their members to be compliant with the computerised payment procedures they use. Computers can also be utilised to aid the assessment of clients by analysing data required to be able to make a specific diagnosis. Computers are also useful as treatment or therapy aids, such as computer games to aid language stimulation or computers which automatically analyse the acoustic characteristics of voice which provides useful feedback for cochlear implant recipients. In addition, there are numerous therapy programmes available for sale on the market to assist clients, parents and speech-language therapists and audiologists with speech and language development. Audiologists also have various practical uses for computer that include, amongst others, the selection and testing of the most appropriate hearing aids for clients.

Furthermore, the Internet is a useful resource that provides the practitioner with opportunities to join discussion groups on various issues relating to communication disorders, to consult with colleagues internationally, and to remain updated with the latest literature in the field. Despite all these information technology resources being available, the onus rests upon the speech-language therapist and audiologist in private practice to utilise them to improve her position, her education and her private practice.

In order to succeed, Goldberg (1995) recommends that the speech-language therapists and audiologists in private practice know how to use technology aids and to position their practices for the future by staying abreast of technological advances to remain competitive in the workforce. Kent (1994:46), however, recommends that "...the speech-language clinician should not be solely a consumer of technologies, but also an advocate for their use, and a consultant in their design and refinement." Technology is therefore a force that is revolutionising the health care arena and the challenge to the private practitioner is to harness the technology to deliver the most advanced professional service to clients (Leven, 1998; Goldberg, 1996; Wynn et al., 1993). Herein lie great opportunities for the private practitioner as well as the client.

2.2.3 Factors pertaining to the speech-language therapy and audiology profession

It is appropriate and apparent that the profession of speech-language therapy and audiology will influence the private practitioner. Most professions have varying degrees of control over their members through ethical standards, guidelines, and best operating practices. The profession of speech-language therapy and audiology is no exception. In addition to the control that the profession has over its members, there are also uncontrollable factors within the profession that influence private practitioners. The ensuing discussion consists of six factors that were identified as the most significant issues in the speech-language therapy and audiology profession that impact on private practitioners.

2.2.3.1 Number of professionals

At present there are 1220 speech-language therapists and or audiologists registered with the Health Professions Council of South Africa, the legislating body of medical professions in this country (HPCSA, 2000). The number of practicing professionals is small relative to the population size and demographics of the country (Tuomi, 1994). Consistent with this view is the statement from Pickering et al. (1998) that there is only one speech-language therapist per 8000 people with communication impairments. In addition to this

plight is the fact that there are less than 100 professionals qualifying each year (Uys, 1996) which is insufficient according to the estimations of the projected population growth (Uys & Hugo, 1997).

Nevertheless, this shortage of speech-language therapists and audiologists is in the process of being addressed through the restructuring of the training courses, the adaptation of the current institution-based training approach, and the addition of a community-based focus (Pickering et al., 1998; Hugo, 1998; Uys & Hugo, 1997). It is predicted that this restructuring and adaptation of training will result in students with differing levels of training and qualification that will focus on primary health care and empowerment of the public.

The community-based training is likely to have a positive impact on the private practitioner of the future as a result of exposure to a multicultural environment, which will increase her understanding and insight of people of different cultures. Furthermore, it is hoped that the practitioner's experience within the community will encourage her to acknowledge the great need for an increase in speech-language therapy and audiology services in the community and to find ways in which her private practice can interact with and assist community projects that are in need of human resources.

2.2.3.2 Associations and regulations

The Health Professions Council of South Africa (HPCSA) is the new legislating medical board, which has precise rules on the behaviour of its professional members as well as strict ethical standards for the provision of their services. There are also particular regulations and standards stipulated by the HPCSA pertaining to private practitioners. Amongst these standards are limitations to advertising and marketing of professional services, giving information about products, and reporting research results.

The regulating body in the profession is the South African Speech-Language and Hearing Association (SASLHA) which also provides a strict code of ethics for its members to uphold. Since it is not compulsory to join SASLHA, approximately half of the 1220 HPCSA-registered speech-language therapists

and audiologists are affiliated to SASLHA (Pickering et al., 1998). This serves as evidence of much complacency amongst the members of the profession with regards to uniting to form a strong presence for the bargaining chambers within the medical industry (Smith, 1998).

Amongst the principles that SASLHA promotes amongst its members is the ethical obligation to make every effort to ensure that their services are available and accessible to society (SASLHA, 1997). This is a particular challenge to private practitioners who are usually based in a specific location and who deliver a service to a particular community. Due to the fact that private practitioners are responsible for generating their own income, they are more likely to set up private practices in areas where clients are more likely to afford assessment and treatment. This poses an ethical dilemma for the practitioner, particularly since she is aware that there are many disadvantaged people in greater need of her services but who are unable to afford them.

The SASLHA Code of Ethics (1997) also stipulates a further ethical responsibility, which pertains particularly to private practitioners, namely to ensure that the physical environment in which they work and the equipment used are professional and optimal for the purpose of assessment and treatment. As private practitioners are responsible to find and establish their own professional environment, it is essential that they heed this responsibility and uphold the professional standards of practice expected from the speech-language therapy and audiology profession in order to gain respect from clients and medical colleagues.

2.2.3.3 Quality

Quality has been a driving force in health care in the last decade. In addition, health care services have experienced political and social pressure to improve the quality of care (Klop, 1999). Under these circumstances it is essential for the speech-language therapist and audiologist in private practice to be responsible and accountable for applying quality assurance procedures to ensure that the optimal standards of client care are achieved (Flower, 1984).

Assuring quality is also part of the practitioner's social and ethical responsibility to the community (SASLHA, 1997).

There has been an abundance of literature on the topic of quality within the speech-language therapy and audiology profession (Crosby, 1994; Harrison & Frattali, 1994; Rassi & Fino-Szumski, 1994; Ellis, 1988). Within the South African literature on the topic of quality in speech-language therapy and audiology, one research study is particularly worth mentioning. Klop (1998) demonstrated the relevance and value of a quality management programme in private practice. The research study was based upon an investigation of the principles of quality management and their application to every aspect of a private speech-language therapy practice. Klop (1998) firmly believes that the survival of the profession depends on the ability of speech-language therapists and audiologists to demonstrate the efficacy and cost-effectiveness of their services, both of which can be provided through a quality management programme. The research study serves as a good example for other private practitioners to follow by analysing every clinical and non-clinical aspect of their practices in order to base their service delivery upon the principles of quality management.

Ellis (1988) believes that quality guidelines in health care are necessary to enhance the *autonomy, independence, professional identity and clarity* regarding professional responsibilities. Cherow (1994) substantiates this belief by stating that abridgements of the profession's autonomy can seriously impair the quality of services to the client. In addition, Cherow (1994) asserts that the growth of autonomy in the profession of speech-language therapy and audiology is inextricably related to the growth of services provided through private practice. This can be ascribed to the basis on which the private practitioner earns her income and the source and manner of payment for services which increases the sense of responsibility assumed by private practitioners for economical service delivery. This responsibility also conveys a sense of increased independence within the profession and provides the opportunity for private practitioners to improve their professional identity. The identity of the profession in South Africa needs to be scrutinised since speech-

language therapy and audiology are far from becoming household names (Smith, 1990).

Preferred therapy practices, guidelines and specific minimum performance standards are required to ensure quality within a private practice (Klop, 1998). However, a regulating body is needed to police these standards. Consequently, financing is required to set up an accreditation board and system for policing the quality of service delivery from private practitioners. According to Flower (1984) the assurance of quality within a clinical private practice is based upon supervision, accreditation, peer review, auditing of records, and self-assessment techniques. Peer review as a means for quality assurance is well established in North America and the United Kingdom (Clausen, 1998; van der Gaag, 1996). In South Africa, however, the speech-language therapy and audiology profession lacks peer review in private practice. Possible explanations for this lack of peer review may be financing, lack of resources, or the fact that private practice has only recently become a preferred method of employment due to the limited number of posts available in the public health care sector.

In order to improve the standards of quality service delivery by speech-language therapists and audioloists in private practice in South Africa, it is necessary for the assertions of Ellis (1988), Klop (1998) and Flower (1984) to be taken into consideration, planned and implemented. Furthermore, with peer review being utilised successfully on other continents, there is a good probability of it improving quality standards within the private sector in South Africa. Currently, it remains the responsibility of the private practitioners to ensure that the critical goal of providing optimal quality care dominates every system and technique within her private practice. Nevertheless, it appears that great challenges lie ahead for the private practitioner in terms of quality enhancement.

2.2.3.4 Training

Speech-language therapists and audiologists in South Africa have traditionally been trained in a four-year, honours-equivalent programme at university level.

This training equips students with the relevant clinical knowledge and skills to practice as speech-language therapists or audiologists. In recent years, however, transformation in the health care industry in South Africa as well as within the profession of speech-language therapy and audiology has had far reaching implications for the training of students (Uys & Hugo, 1997).

This transformation has led to an adaptation of the teaching methodology, content, and focus of speech-language therapy and audiology in South Africa to ensure that practitioners are able to deliver effective, relevant and professional service to clients (Uys & Hugo, 1997). In accordance with the transformation process, the curricula taught at the universities have taken on a new focus and intent. Pickering et al. (1998:9) aptly describe the changes in the following statement: "...curricula have been adapted toward a primary health care focus with emphasis on community work, prevention, training of caregivers, and interaction with community-based rehabilitation facilitators." Furthermore, the assimilation of a multi-cultural perspective is required in the training of speech-language therapists and audiologists in order to Africanise students who will operate within the South African environment (Hugo, 1998).

The methods for delivering care within South Africa are changing and private practitioners must be active instruments of these changes (Goldberg, 1995). The above adaptations and intentions for transforming the training within the speech-language therapy and audiology profession will develop and advance over the next decade. Africanisation, however, is likely to be a slow process that will evolve with time. Nevertheless, there is no doubt that the students who have entered training programmes in the past two to three years will certainly reap the benefits of the changes and be able to deliver more relevant and appropriate services to the majority of the population within South Africa.

With much emphasis of current teaching methods on community-based rehabilitation and prevention, equipping students with specific training for private practice is inevitably less important. However, this poses a paradox since there are fewer public sector posts available and consequently more work to be found in the private sector. Nevertheless, until recently practice

management skills have not been covered at all in undergraduate curricula and more recently only covered superficially. The students are therefore seldom sufficiently well equipped to set up their own private practices without additional training and advice (Smith, 1998). In comparison, many universities in North America include a full module of business management in their curricula for speech-language therapy and audiology students (Clausen, 1998). Furthermore, in the United Kingdom practitioners are required to attend a private practice management course prior to entering private practice (Van der Gaag, 1996). It appears that the current programmes in South African universities therefore provide little training specific to management and general business skills, which are required to successfully run a private practice.

2.2.3.5 Continued education

It is essential for qualified professionals to remain current in the fields in which they provide services (Cherow, 1994). To substantiate this view, the Code of Ethics (SASLHA, 1997) includes a section on members' responsibility towards the advancement of knowledge. It states that members should endeavour constantly to update their "...knowledge of the profession with regard to research and theoretical advances, new assessment and management procedures, facilities and resources" (SASLHA, 1997:7). It is therefore essential that practitioners remain abreast of significant developments in the field of speech-language therapy and audiology (Cherow, 1994). This pertains specifically to private practitioners who generally do not work in an education-based environment and who are seldom exposed to new developments in the profession during their daily contact with clients. Klop (1998:100) states that one of the disadvantages of being a solo-practitioner is that working alone often "deprives clinicians of opportunities for sharing information, informal benchmarking and emotional and professional support." Furthermore, Klop (1998) believes that these factors impede the professional development of the practitioner and can therefore have a detrimental effect on the quality of service delivery. This may have serious implications for the private speech-language therapy and audiology sector and thus requires some form of action.

In South Africa the advancement of knowledge, in the past, has been left to the discretion of the SASLHA member. However, without any formal system of measuring the advancement of knowledge, it was inevitable that many speech-language therapists and audiologists did not take heed of this ethical obligation. Therefore, in order to encourage continued professional development amongst speech-language therapists and audiologists, an accreditation system is being developed and implemented by the HPCSA whereby practitioners earn points for attending organisational or small group activities such as seminars, workshops or case conferences, and through individual activities such as self-study and research. A specified number of points (150) are to be earned within a five year period by all speech-language therapists and audiologists in order to remain registered with the HPCSA (Communiphon, 2000).

The continuing professional development system, which will become compulsory from April 2002, will be of great benefit to speech-language therapists and audiologists in private practice as well as to the profession as it will assist practitioners to achieve improved patient care and stay abreast with advances and research in the field. Furthermore, conferences, seminars and workshops will provide the opportunity for private practitioners, who are isolated in remote areas or not closely linked to a training institution, to confer, discuss various issues, and support colleagues in the same profession.

2.2.3.6 Accountability

With the onset of managed care in our country, it is incumbent on the speech-language therapist and audiologist to prove, with data, that they are the best possible health care providers in the assessment and treatment of speech, language and hearing disorders (Green, 1998; Goldberg, 1996). Furthermore, private practitioners will be required to motivate their choice of treatment methods and justify the improvements made by their clients (or lack thereof) to managed care organisations to prove that their services are effective (Smith, 1998). If they are unable to do so their future in the new health care market could be compromised.

Pappelbaum (1995:824) suggests that speech-language therapists and audiologists in private practice should "...accept the fact that they will have to be more efficient, effective and that they will have to enhance their productivity under the new system." The managed care system responds particularly to cost data and outcome data (Green, 1998; Trulove & Fitch, 1996; Goldberg, 1996). Private practitioners will be required to have this data readily available as part of their practice management systems to justify their services and to gain the recognition, support and customer base from the managed care organisations (Smith, 1998). The question remains whether South African speech-language therapists and audiologists in private practice have these practice management systems in place to serve as measures of accountability and proof of effectiveness of their services.

One particular research study on accountability conducted on private practices in the USA by Trulove and Fitch (1998) found that the majority of speech-language pathologists in private practice did not use cost analysis, time management analysis, performance contracting or measurement of client satisfaction. These factors are considered paramount in successfully managing any form of small business as they constitute some of the basic principles of accountability in business management as well as providing managed care companies with the information they require (Stanbridge, 1999). Proving effectiveness through accountability therefore permits the therapist to justify the worth of her services in terms of cost and time (Frattali, 1998; Trulove & Fitch, 1998; Boston, 1994; Lacap, 1994; Maslin, 1991).

Many factors that have intrinsic implications for the private practitioner and how she conducts her business influence the profession of speech-language therapy and audiology. Furthermore, many of these factors interact with elements within South Africa and the Health Care industry and consequently impose restrictions on the private practitioner's delivery of services. However, this is similar to professionals in other fields of business who must also carefully position themselves in the marketplace and provide services required of them. The challenge remains for the speech-language therapist and

audiologist in private practice to embrace all of these factors and seek new ways of delivering effective and quality care and rehabilitation to her clients.

In conclusion, the private practitioner is influenced to a greater or lesser extent by all the factors mentioned within the profession of speech-language therapy, the health care Industry, and South Africa. It is important to take cognisance of their implications for the success of a private practice particularly when considering that the private practitioner should take advantage of the changes, opportunities and developments in the internal and external environment. Furthermore, the private practitioner is required to adapt her private practice to meet the various needs of the community and cope with the changes within South Africa, the health care industry and the profession of speech-language therapy and audiology. In order to do so, the speech-language therapist and audiologist needs specific business management skills to succeed in the dynamic environment of a private practice.

2.3 THE NEED FOR BUSINESS MANAGEMENT SKILLS IN PRIVATE PRACTICE

Persons entering into any business of their own require business management skills in order to survive and to succeed (Stanbridge, 1999). Private practice in the field of speech-language therapy and audiology is no exception. The following section therefore provides the reasoning and justification for private practitioners' need for acquiring business management skills. In addition, examples are drawn upon to make comparisons between the business management training available in South Africa and internationally.

2.3.1 A private practice is a business

A speech-language therapy and audiology private practice is similar to a small business in many ways. Firstly, resources and skills are usually limited as there is often only one person who must perform all the functions of the business, amongst others, answering telephones, typing reports, invoicing, and completing financial records in addition to providing clinical assessment

and treatment. This means that time management is very important to the private practitioner, as she is usually involved in the daily operations of the business. Secondly, the private practitioner is usually trained on the job and relies on learning from her own experiences (Stanbridge, 1999). Thirdly, there is usually no formal procedure for setting up the practice, monitoring the environment, making forecasts, evaluating and controlling a strategy for existence (Plunkett & Attner, 1989). Lastly, a private practice is similar to a small business as it usually has limited start up capital or financial resources and the practitioner will seldom be able to draw a salary within the first six months of setting up the business (Wood, 1986).

In view of these similarities, Shriver (1985:35) states that a private practice requires "...not only a solid product but also efficient and effective business structures from which to operate." Speech-language therapists and audiologists are considered highly skilled in the provision of clinical services unique to the profession but are seldom prepared for the complexity of establishing and managing a business (Stanbridge, 1999; Metz, 1996; Ashby, 1995). A private practice is thus considered a small business and serves as the foundation from which the therapist provides services and earns an income and must therefore be managed and operated with expertise.

The expertise required to manage a private practice entails the acquisition of clinical skills as well as business management skills (Goldberg, 1996; Metz, 1996; Flower, 1984). A further proponent of this opinion is Kautzmann (in Cromwell, 1985:91) who declares that "...to successfully compete in the arena of private practice, therapists will need to integrate knowledge of sound business practices and clinical expertise." Clinical expertise is what speech-language therapists and audiologists are well trained in during their studies at university and is a skill that they gain with experience in the workplace. Non-clinical expertise, however, consists of management skills, customer service skills, communication, networking, marketing, financial skills, and administration skills which are not usually taught at university but are usually learnt through experience in private practice (Stanbridge, 1999).

The speech-language therapy and audiology literature makes numerous references to the need for business management skills in private practice. Goldberg (1996:28) firmly believes that audiologists and speech-language pathologists' "...livelihood depends on their expertise in marketing, negotiating, contract securing, personnel management and finance." Ashby (1995:35) points out that "some business savvy" is required if a practice is going to survive in the competitive health care marketplace and Flower (1984) recommends that a practitioner needs to be a master of business acumen to ensure that the business runs efficiently and economically. The most pressing point is made by Harrison and Frattali (1994:259), who state that "...speech-language therapists and audiologists are exhibiting a form of denial as they continue to do business as usual in an environment that will probably not continue to tolerate it." There is therefore little doubt that private practitioners need to learn some form of business management skills prior to entering private practice.

A further reason why private practitioners need business management skills is because a client's expectations of a private practitioner are very similar to those expected from most other business service providers, namely affordability, efficiency, effectiveness, customer service and a professional attitude. Traditionally clients in the health care industry were treated as patients, however, in the last two decades the health care industry has learnt from its colleagues in the business industry and started focusing on the needs of the client (Duncan et al., 1992). This trend has introduced speech-language therapists and audiologists to customer service, which is a particularly relevant requirement in any service business (Beckwith, 1997). White (1995) and Klop (1998) refer to customer service in private practice as having a *client-centered practice* or conducting *client-centered therapy*, whereas the business management literature refers to it as *customer relationship management* (CRM) (Bidoli, 2000). Being client-centered or using CRM means ensuring that the private practice and personnel are focused on the needs and requirements of the client in every aspect of service delivery and that every client receives the same high quality of care (Klop, 1998). The speech-language therapist and audiologist in private practice would therefore

benefit from being informed about topics within business management literature such as customer relationship management and the importance thereof to a small service business.

For the reasons stated above a private practice can thus be considered a small business and it can be assumed that the business skills expected of a small business owner or entrepreneur would be the same as that expected of a private practitioner. However, it is granted that a speech-language therapy and audiology private practitioner requires business management skills in addition to excellent clinical skills, which form the basis of the private practice.

2.3.2 Training in business management skills

Despite business management skills being regarded as essential to private practitioners, two questions remain namely: "Why is there a general lack of adequate business training?" and "Why is business management only covered superficially in South African speech-language therapy and audiology undergraduate programmes?" It is possible that these skills are not considered a priority in comparison with essential clinical skills. Furthermore, entering private practice may be regarded as a deflection from the public health service, and private practitioners may be regarded as "on their own" in terms of learning the necessary skills in order to succeed. In addition, private practice may not be considered a suitable employment option for inexperienced speech-language therapists and audiologists but should rather be learned as part of continuing professional development. Nevertheless, the above explanations are merely circumstantial and there is thus a need to empirically determine the current private practitioners' opinions regarding the most applicable time to learn business management skills.

Internationally, the need for educating speech-language therapists and audiologists regarding business management in private practice has been recognised and taken up as a challenge by various professional institutions and associations. In the USA, speech-language therapy and audiology students are required to attend a full module of lectures on private practice and the management thereof (Clausen, 1998). Subsequent to this initial

training whilst they are at university, ASHA also provides assistance to its private practitioners through presentations at national conventions, continued education programmes, as well as individual consultations with private practitioners. Furthermore, the private practitioners network through their state associations and hold regular private practitioner meetings to discuss and review various issues of concern. Similarly in the United Kingdom (UK) the Royal College of Speech and Language Therapists (RCSLT) has an affiliated group named the Association of Therapists in Independent Practice, which serves as a network for private practitioners.

Each state in the USA has its own board of licensure which issues licenses to speech-language therapists or audiologists to practice in a private capacity (Clausen, 1998). In addition to this, ASHA require practitioners to hold a Doctor of Audiology degree before they are allowed to practice audiology in a private capacity (Metz, 1996) and a Masters of Science in Speech-language therapy in order to practice speech-language therapy in a private capacity. One of the factors in the argument regarding the necessity for private practitioners to acquire these degrees is the need for private clinicians to be "...well versed...in small business affairs" (Metz, 1996:283). In comparison the RCSLT in the UK advise that private practitioners have at least two years post-qualification clinical experience before practising independently (Van der Gaag, 1996). Furthermore, graduate clinicians that have been practising for some time in the profession are required to attend a private practice management course and undergo a competency exam prior to entering private practice.

Metz (1996) firmly believes that, due to the growth of the field into the arena of private practice, there is a strong need for training relating to the ability to function in a private business environment. In South Africa the profession of speech-language therapy and audiology is also experiencing a growth in the private practice industry as a result of a decrease in the number of public sector posts. It could therefore be argued that there is also a strong need for private practice management training amongst South African speech-language therapists and audiologists. Compared with the examples cited

above, of the availability of business management training in the USA and the UK, it appears that South Africa is lacking a strategy for adequately training and equipping speech-language therapists and audiologists of various experience levels in business and private practice management.

With regard to the training of business management skills, Metz (1996) believes that it may not be the responsibility of the traditional educational programs to devise and teach courses involving business practices. However, supplemental courses that are taught out of the university departments are also hard to justify due to the busy clinical training schedule of undergraduates. Trulove & Fitch (1998) conducted research on private practitioners and results indicated that the respondents felt that business management training at university level and beyond should be mandatory to acquire the necessary skills to run a private practice. Metz (1996) therefore recommends that the best alternative in the USA would be for business management training to occur after the general clinical certification process is complete. This recommendation appears to be the most suitable as the students' clinical training schedule will not be interrupted for the acquisition of business management skills. By extrapolating this recommendation to the South African context, the most suitable time for speech-language therapy and audiology undergraduates to learn private practice management skills would be if it were incorporated into the students final year of training. It is thus assumed that undergraduate or graduate training in business management methods and practices will lead to more successful speech-language therapy and audiology private practices being established and maintained. This training in turn may lead to private practice being encouraged amongst students and result in further growth of the private health care sector in South Africa, which may improve the autonomy and independence of the profession in the long term.

A further indication that private practitioners in the health care industry require business management skills is the abundance of business management seminars and practice management courses being advertised in medical journals (du Preez, 1998; Sunter, 1998). Many of these courses take the

format of a workshop where private practitioners are provided with practical management advice, training specific to their needs, and opportunities to apply the skills that they have learnt in a meaningful way. The availability of courses in business management is therefore not the hindering factor in educating private speech-language therapists and audiologists to successfully manage their practices.

Business management skills are therefore a necessity for all speech-language therapists and audiologists entering private practice. Managing a private practice in a dynamic and transforming profession will require much focus beyond the clinical responsibilities expected from a private speech-language therapist and audiologist. In conclusion, Nazarian (1995:815) makes the following appropriate comment: "Management based on scientifically grounded guidelines will be in the interest of all." To ensure that this is in the best interests of all, speech-language therapists and audiologists in private practice will need to acquire business management skills. Furthermore, it is essential that these skills and their application are based upon a sound knowledge and understanding of strategic business management. A detailed discussion of strategic management is included here, as it essentially forms the foundation of all subsequent operational management initiatives and decisions in a business. Furthermore, strategic management is a process that is used at all stages of a business' lifespan. It is thus important to recognise the significance of strategic management in the overall planning and operational management of a private practice.

2.4 STRATEGIC MANAGEMENT

The importance of strategic management is highlighted in the words of Duncan et al. (1992:vi) who state that "...health care organisations that do not have a clear strategy are doomed to mediocrity at best - and failure at worst - resulting in poor quality of life for the community." A further substantiation of this view is the aptly stated business maxim: "that organisations do not plan to fail - they fail to plan" (Stanbridge, 1999:123). In describing the strategic management process and its relevance to a private speech-language therapy

and audiology practice, it is essential to note that the term 'strategic management' is not synonymous with the term 'business plan'.

A business plan traditionally refers to a document that is produced prior to setting up a business in order to determine the feasibility of a business venture (Brooks, 1995; Moskovitz, 1994). In comparison, strategic management refers to the "...philosophy of managing an organisation and links strategic planning to operational decision making" (Duncan et al., 1992:15). Strategic management attempts to achieve a productive and creative fit between an organisation's external environment (political, regulatory, economic, technological, and social forces) and its internal situation (vision, values, culture, finance, human resources, and marketing).

Simply prescribing strategic management principles, as described in the literature for the manufacturing industry and the non-medical service industry, to speech-language therapy and audiology private practices is not recommended without making them more applicable to the unique requirements of the profession. Health care management has certainly succeeded in transferring traditional strategic management methods to the administrative and business aspects of health care organisations in general (Smyth, 1996; Hardy, Turrel & Wistow, 1992; Stevens, 1991). Furthermore, there are numerous publications available on private practice management specific to the speech-language therapy and audiology profession (Wood, 1986; Flower, 1984). In addition to these publications the literature is abundant with journal articles on specific aspects of private practice management for speech-language therapists and audiologists (Metz, 1996; Rassi & Fino-Szumski, 1994; Larkins, 1993). However, few of these publications express the synergy that exists between all the aspects of private practice management and how these aspects interact to form the global picture and intent of the private practice. Strategic management provides the basis upon which this synergy can operate and appropriately demonstrates how various factors within a private practice interact.

In the following section the need for strategic management in private speech-language therapy and audiology practices is discussed and the requirements of the private practitioner in the process are presented. Thereafter, the appropriateness of the strategic management process to speech-language therapy and audiology private practices will be presented.

2.4.1 The need for strategic management in speech-language therapy and audiology private practices

The speech-language therapist and audiologist in private practice may perceive the formation of a management strategy to be a corporate activity that does not apply to her business and does not warrant the time and effort due to the small size of her business. However, a management strategy is a necessary component of a private practice as it assists the private practitioner to create a successful practice that offers relevant and quality services to the community and enables the practice to maintain a competitive edge (Plunkett & Attner, 1989).

Strategic management should therefore be perceived by private speech-language therapists and audiologists as a method, a process, or a decision making activity that, if applied and implemented successfully, could enable them to become more business focused, more cost-effective and more competitive (Brown, 1994). This success can be achieved through the strategic management process whereby practitioners are exposed to aspects of their businesses, which they previously had not considered, but which make an impact on their effectiveness and their overall financial health.

The need for strategic management in the context of a private practice is therefore based on the belief that speech-language therapists and audiologists in private practice should continually monitor internal and external events and trends so that timely changes can be made within the business (Brown, 1994). This will help to ensure the compatibility and survival of a private practice and assist the practitioner in understanding environmental trends sufficiently well that she can be future oriented in her plans and decision making. According to Klop (1998:7) "organisation policies must

originate in the deliberate planning of processes that stipulate objectives and strategies to achieve them (because the) planning of all processes and systems is necessary to prevent problems before they happen." Klop (1998) has proved the efficacy and value of a management strategy in a speech-language therapy private practice through generating a quality management programme for her private practice. Despite this being only one example of a management strategy applied to a speech-language therapy private practice in South Africa, the outcomes and benefit to Klop's (1998) practice nevertheless serve as good examples of the need for strategic management.

2.4.2 Requirements of the private practitioner in the strategic management process

In the process of developing and implementing a quality management programme in her speech-language therapy private practice, Klop (1998) also referred to the need for private practitioners to make specific commitments and form the required culture in a private practice. Since strategic management is a philosophy of managing an organisation, it should be embedded in the culture of the private practice and the mindset of the speech-language therapist and audiologist. The process of strategic management as a way of managing a private practice can therefore also be summarised as a series of abilities that the private practitioner requires and commitments that she is required to make. These elements are summarised in Table 2.1.

Table 2.1 Basic elements of strategic management as expressed in a series of abilities and commitments

	Strategic Management Abilities and Commitments
1	The ability to understand competitive behaviour as a system in which competitors, customers, money, and resources interact in a dynamic way.
2	The ability to use this understanding to predict how a strategic move will restore competitive equilibrium.
3	The commitment of resources that can be permanently dedicated to new uses for the prosperity of the business.
4	The ability to predict risk and return with enough accuracy and confidence to justify that commitment.
5	The ability and commitment to make decisions and act upon them.

(adapted from Duncan et al., 1992)

The success of the strategic management process relies upon the private practitioner's knowledge, skill and ability to be able to make the commitments listed in Table 2.1. In order to acquire these abilities the speech-language therapist and audiologist in private practice requires business management training that introduces her to concepts such competitive equilibrium and demonstrates how to restore it. Furthermore, the practitioner will need to learn how to apply her knowledge, skills, and abilities appropriately in the context of her private practice to take advantage of external factors impacting on her business.

2.4.3 The application of the strategic management process to speech-language therapy and audiology private practices

Developing a management strategy can be done in one of three different modes, namely the entrepreneurial mode, the planning mode, and the adaptive mode (Mintzberg cited in Duncan et al., 1992). The entrepreneurial mode is common in the founding and early development of a private practice and consists of an implicit strategy that is worked out by the private practitioner who has extensive knowledge of the market and the competition. The planning mode is described as the organised and logical process that results in decisions being made and strategies developed for the positioning and survival of the practice. In the opportunistic adaptive mode the private practitioner reacts to changes in the environment rather than anticipating and planning for change.

Due to the size and nature of a private practice, as well as the nature of the market and environment, the most appropriate mode for strategic management of a speech-language therapy and audiology private practice is an eclectic approach that combines all three modes. The planning mode, however, will require the most time and focus as the results and decisions from the planning process form the largest component of the strategy. Figure 2.2 illustrates the development of a strategy using all three strategy-making modes.

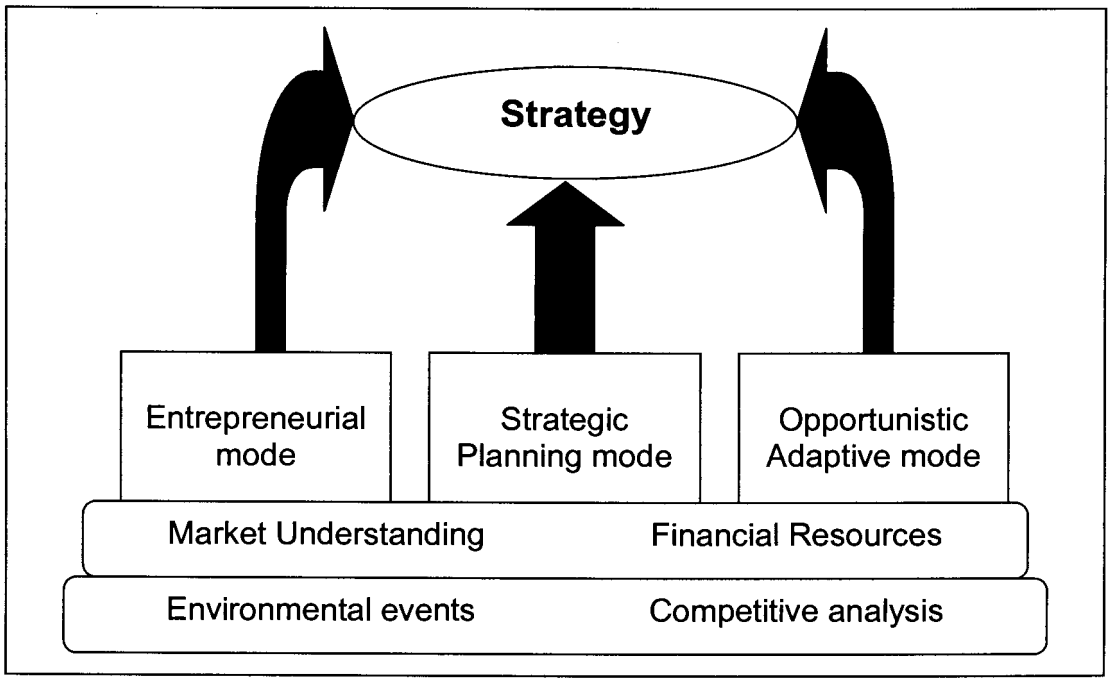

Figure 2.2 Modes of strategy development (adapted from Duncan et al., 1992)

In the initial process of setting up a private practice the practitioner is required to think in the entrepreneurial mode to assess the market, judge the competition, and establish an appropriate vision, mission and purpose for the practice. Thereafter, in the planning mode the practitioner is required to approach the business systematically and comprehensively to establish short and long term development strategies for the private practice. This requires actual understanding and informed judgement of the market, the environment, the competition, and the resources available to the practitioner (White, 1995; Brown, 1994). The strategic planning process is discussed in detail later. Finally, the practitioner will be required to shift into the adaptive mode if events within the practice or forces in the external environment demand immediate decision making and action from the private practitioner in order to survive. This last mode should not be relied upon exclusively because the danger exists that the strategy for the practice will become vague and lost over time.

It must be mentioned that a private practice may have a management strategy even though it lacks a formal planning system. The strategy represents a set of consistent decisions that position the private practice in the market.

Therefore, as long as the practitioner's decisions are consistent over time the strategy can range from a formal process to an intuitive one. However, most strategic management professionals advise speech-language therapists and audiologists in private practice to go through the formal process of strategic management planning particularly in those practices that exist in a climate where there is a high rate of economic, social, demographic and regulatory change. In the South African climate of political and social change, the emergence of managed care, the disintegration of the public health service, and the transformation of the profession of speech-language therapy and audiology, private practitioners' use of a formal strategic management process appears to be relevant and appropriate. This process is expected to assist private speech-language therapists and audiologists to deal with the variables involved in managing a South African private practice (Brown, 1994).

To further describe the strategic management process, the activities within the formal planning process will be discussed. One way in which to understand and apply strategic management to a private practice is through the use of a conceptual model of the process based on systems theory (Shuda, 1994). Systems thinking provides a useful basis for organising, understanding and integrating the variables of concepts such as strategic management (Meyer, 1994). A conceptual model based on systems thinking therefore enables private practitioners to see the "global picture" in proper perspective. The conceptual model of the strategic management process, as illustrated in Figure 2.3, provides a clear and practical overview of the required inputs to strategic management, the processes involved and the outputs of the process. In addition, a better understanding of the interrelationships inherent in the process can be gained from this model. Figure 2.3 serves as the foundation for the remainder of the discussion in this chapter.

The strategic management process consists of four stages or processes: situational analysis, strategic formulation, strategic implementation, and strategic control (Duncan et al., 1992). Each stage is discussed separately to present a broad outline of the relevance and necessity thereof to a speech-language therapy and audiology private practice.

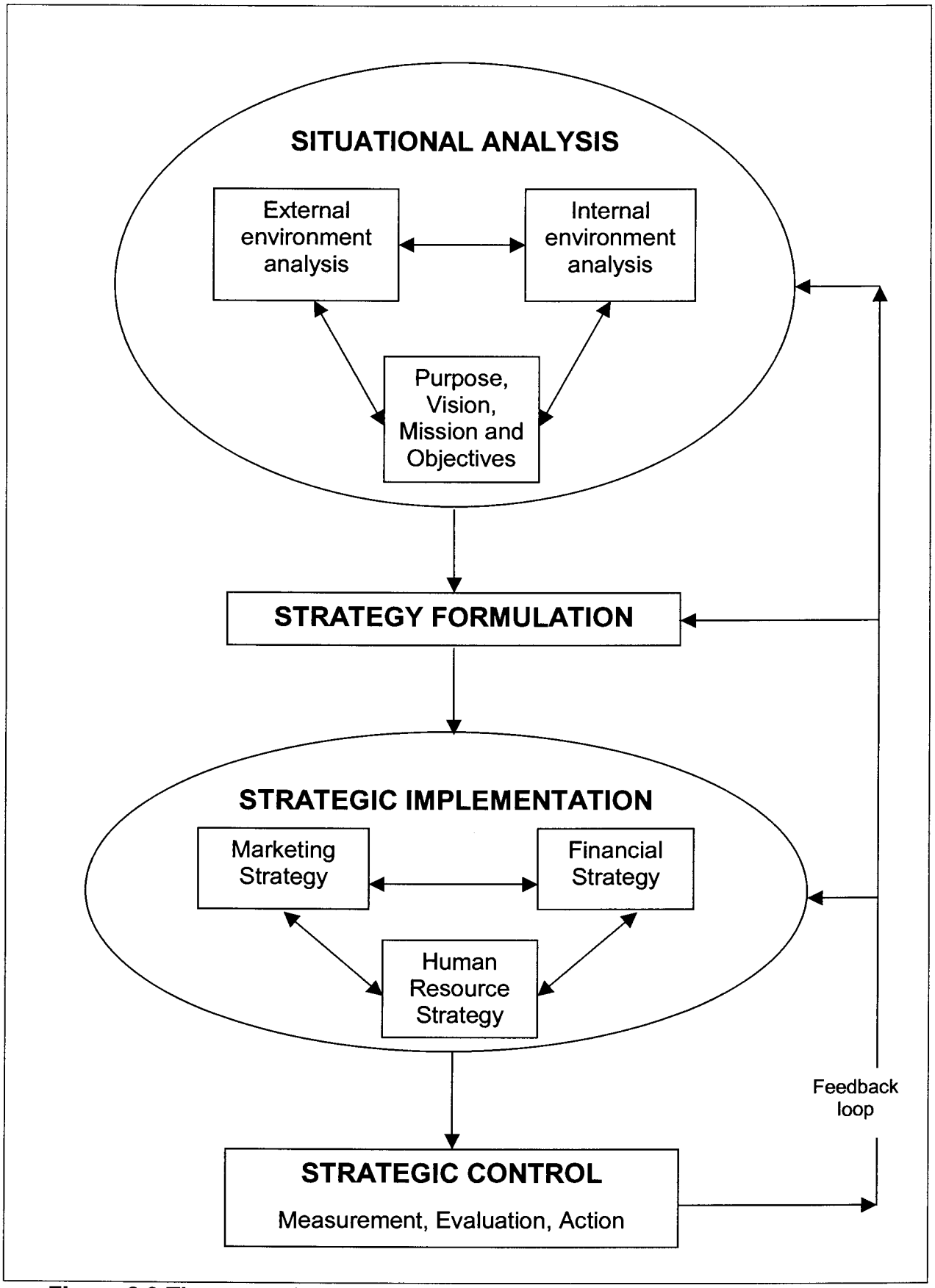

Figure 2.3 The strategic management process (adapted from Duncan et al., 1992)

2.4.3.1 Situational analysis

Analysing and understanding the situation or environment in which the private practice operates is the initial step in the strategic management process. The accumulation and evaluation of information about the environment is obtained through a process called situational analysis (Stanbridge, 1999; Brooks, 1995). This process enables a practitioner to focus on her unique circumstances within the environment (White, 1995). A further benefit of a situational analysis is that it draws attention to the threats and opportunities in the external environment and identifies the internal strengths and weaknesses of the speech-language therapy and audiology private practice. This is known as a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis.

Klop (1998) conducted a situational analysis on her private speech-language therapy practice and found that it provided her with valuable information such as the fact that she held perceptions of her business that were unfounded once she analysed actual data. For example, Klop (1998) took for granted that most of her clients were referred by former clients, yet this could not be substantiated by practice data. Therefore, an additional advantage of a situational analysis is that it encourages the speech-language therapist and audiologist to assess factual data in order to make appropriate decisions for the practice and take action upon them.

A situational analysis is a particularly necessary process for the South African speech-language therapy and audiology private practitioner to undergo because the social, economic, health care, and practice environment is changing rapidly. In addition, there is a possible increase in the amount of competition from other professionals entering private practice due to the shortage of public sector positions. The consequence thereof is that the practitioner constantly needs to review and interpret the changes and make strategic decisions that will enable her private practice to survive in this dynamic environment.

Analysing and understanding the environment is accomplished through three separate processes: external environment analysis, internal environment

analysis, and the development of the practice's purpose, vision, mission, and objectives. As indicated in Figure 2.3, it is the interaction of these three processes that form the basis for the development of a management strategy (Brown, 1994). Furthermore, issues in any of these processes directly and simultaneously affect the other situational analysis processes. They are not completely distinct and therefore overlap, interact with, and influence one another.

To substantiate the need for environmental analysis in a speech-language therapy and audiology private practice, a list of questions was developed that determine whether a private practitioner needs to conduct a situational analysis (see Table 2.2). In South Africa's dynamic health care environment, private practitioners should consider some form of regular environmental analysis to ensure that their practices adapt their plans to better suit the needs of the external environment in order to provide the most appropriate services to clients (White, 1995; Brown, 1994).

Table 2.2 List of questions to determine the need for environment analysis

No.	*QUESTION*	*Yes ✓*
1	Does the external environment influence how capital is allocated in your private practice?	
2	Have previous plans for the practice been scrapped because of changes in the environment?	
3	Has there been an unexpected surprise in the external environment?	
4	Is competition growing in the speech-language therapy and audiology private sector?	
5	Are the other private speech-language therapists and audiologists becoming more marketing orientated?	
6	Do external forces seem to be influencing decisions within your private practice?	
7	Is your current practice situation very different from what you had planned and forecasted?	

(Compiled from: Brooks, 1995; White, 1995; Brown, 1994)

Whilst the overall intent of an environment analysis is to position the private practice within its environment, more specific goals include the following:

- To identify and analyse *current important issues* that will affect the private practice.
- To detect and analyse *emerging issues* that will affect the private practice.
- To speculate on *future issues* that will have a significant impact on the private practice.
- To provide *organised information* for the development of the private practice's purpose, vision, mission, objectives, and internal strategy.
- To *foster strategic and creative thinking* in the private speech-language therapist and audiologist.

(Brooks, 1995; Armstrong, 1994)

When the private practitioner considers the relationship of her practice to the environment, the above goals can be achieved. If appropriate action is taken on this information, it is likely that the private practice will provide a high quality, relevant and innovative service to the community. A more detailed explanation of the external and internal environment analyses is provided below followed by a discussion of the purpose, vision, mission and objectives.

- **External environment analysis**

To effectively manage a private practice, speech-language therapists and audiologists must understand the external environment in which they operate. This can be accomplished by monitoring environmental issues that are significant to private practice, collecting additional information, evaluating their impact, and incorporating them into the practice strategy. It is the practitioner's response to these issues, whether threats or opportunities within the external environment, that may influence the success or failure of the private practice (Armstrong, 1994). To meet these demands, it is necessary to investigate and understand both the broad, general environment as well as the health care environment because their influences are largely beyond the control of the private practitioner.

The **general external environment** contains relevant information about the political, economic, social, demographic and cultural aspects of South Africa, which may directly or indirectly influence a speech-language therapy and audiology private practice (White, 1995; Brown, 1994). This information assists the practitioner in compiling a profile of the market from which she draws clients. In so doing, she familiarises herself with the community served by her private practice. The most salient factors within the general South African external environment were discussed in section 2.2.1 of this chapter. In addition to the factors listed above, population, language, culture, and consumerism are also considered relevant issues in the general external environment.

Information contained in the **health care environment** that is of relevance to the private practitioner broadly refers to clients, suppliers, competitors, referral agents, regulatory bodies, and health care authorities (Brooks, 1995; Brown, 1994). Many of these issues were covered earlier in this chapter in sections 2.2.2 and 2.2.3. The particularly relevant aspect of competition within the speech-language therapy and audiology private sector was covered in the discussion on the number of posts available in the public sector.

The external environment thus provides a rich source of information regarding the development and employment of new technologies, addressing social and political change, adapting and complying with regulatory changes, competing with other health care organisations and participating in the health care and general economies. Being aware of these areas of change will enable practitioners to make appropriate decisions for the future of the private practice.

- **Internal environment analysis**

The internal environment consists of all the aspects of the private practice that the speech-language therapist and audiologist has direct control over. According to Moskovitz (1994) it is important for private practitioners to analyse and understand the practice environment that they have created and the impact it has on the delivery of services to clients. Furthermore,

practitioners need to consider the impact of the external environmental factors on the internal functioning of the private practice. By relating the external threats and opportunities to the internal strengths and weaknesses, practitioners are able to determine the distinctive competencies of their private practices (Duncan et al., 1994).

Distinctive competence consists of the unique attributes that the private practice has that enables it to be better than any other practice. These competencies may or may not result in a competitive advantage because other organisations may offer similar benefits, however they represent ways of establishing competitive advantage.

Internal strengths and weaknesses within a private practice are usually identified through a subjective assessment of its various resources, namely clinical staff, administration, finance, marketing, equipment, facilities, and leadership (Maas, 1991). An example of a list of possible questions that the practitioner might ask herself is provided in Table 2.3.

Klop (1998) stated in her research project that the environment analysis provided her with relevant information about all the aspects of her private practice. Klop (1998) interpreted, analysed and evaluated this information which provided her with valuable insights into her private practice and enabled her to develop more meaningful strategies and practice policies.

The information gathered in the external and internal environment analysis is used to compile the SWOT analysis to identify strengths, weaknesses, opportunities and threats (Brooks, 1995; Maas, 1991). This enables the practice to improve existing, develop new, modify original or eliminate negative aspects of the practice that do not comply with the demands of the environment. In addition, the SWOT analysis aids the practice in being proactive with regard to change. Once the environmental analysis has been completed, the speech-language therapist and audiologist in private practice is equipped with the relevant information to set practice goals and desired end results.

Table 2.3 List of questions for the assessment of resources

RESOURCE	*QUESTIONS*
Clinical Staff	- Do you have sufficient clinicians for your caseload? - Are provisions made to assure staff are current with the latest clinical trends? - Is the morale & performance of the staff up to expected standards? - Do you provide incentives for staff? - Does your staff hold relevant qualifications and are they competent to perform the functions expected of them?
Administration	- Do you have a reliable record-keeping system? - Is the administration system properly designed and maintained to facilitate data capture? - Are communications properly documented to satisfy audit and quality control requirements? - Do you have an effective inventory control system? - Do you have an efficient and reliable invoicing system?
Finance	- Do you generate appropriate financial information? - Do you have the appropriate degree of financial liquidity to ensure cash flow problems do not develop? - Is your operating margin (income less expense) increasing or decreasing? - Are you achieving a satisfactory rate of financial growth? - Can you obtain the necessary financing to achieve growth and development goals?
Marketing	- Do you know where to source client base information? - Do you know the relative market share of your practice? - Have you established attainable market share goals? - Do you have an effective marketing strategy? - Is the current marketing strategy yielding increased business? - Are you promoting your services, staff and location to clients and to referral sources? - Do you have an adequate budget for marketing efforts? - Are there promotional media that you have not used that may be effective in yielding business?
Equipment	- Are practice technologies current to ensure high quality treatment of clients? - Do you anticipate new clinical technologies being introduced in the near future? - Do you have appropriate assessment & treatment material? - Is the equipment suited to the needs of the clients? - Does any of the equipment need replacement?
Facilities	- Do you have proper facilities designed for your purposes? - Is there sufficient and safe parking for your clients? - Is there an adequate and comfortable waiting area? - Is there a clean toilet facility for client use? - Is there comfortable seating for both children and adults?
Leadership	- Are regular meetings held with staff to assure practice communication occurs? - Do you as leader have sufficient experience & confidence to make business decisions?

(Compiled from: Brown, 1994; Duncan et al, 1992; Maas, 1991; Flower, 1984)

- **Purpose, vision, mission and objectives**

The purpose, vision, mission and objectives are types of practice goals or desired end results for a private practice (Brooks, 1995; Maas, 1991). These statements and goals provide a firm foundation from which all management decisions and actions are made (Rassi & Fino-Szumski, 1994). Many private practitioners are probably intuitively aware of having some vision or purpose for their practice, however, Rassi & Fino-Szumski (1994) believe that these need to be translated into written form for reference, planning, and decision-making if they are to contribute to the success of the private practice. Brooks (1995) agrees with this and adds further that management of the private practice becomes easier because all the decisions and actions should be in keeping with the vision and mission of the practice. Klop (1998:126) went through the formal process of expressing the goals for her practice in writing and confirmed that it helped her "...to focus on the fundamental purpose of the practice." In addition, Klop (1998) found that practice management problems requiring her judgement became easier to solve as they were considered against the basis of the written goals.

The *purpose* is the private practice's reason for existing. It is important that the speech-language therapist and audiologist in private practice has a clear idea of why she has entered private practice and what she wants to achieve by delivering services to the community. The *vision* steers a private practice in the direction consistent with its purpose by providing a common objective to everyone in the private practice (Klop, 1998; Duncan et al., 1992). The vision statement refers to how the private practitioner wants the practice to be when it is accomplishing its purpose. Visions are therefore aspirations and should be inspiring, challenging, and flexible to enable the practice to experiment with new ideas in the future (Rassi & Fino-Szumski, 1994). Furthermore, visions should be relevant to the community in which the practice is situated and should motivate the employees of the practice to provide better services to clients (Brooks, 1995; Armstrong, 1994).

The *mission* statement, a formal expression of the purpose of a private practice, is constructed to provide focus for the practice (Rassi & Fino-

Szumski, 1994). It explicitly states who the practice is, what the practice does, whom the practice serves, and what the practice strives to achieve (Brooks, 1995).

In Klop's (1998) application of the above principles to her speech-language therapy private practice, she found that reflecting on the vision and mission of the practice provided her with a much greater sense of responsibility and direction. Furthermore, Klop (1998) states that it enhanced her awareness of the need for these statements to form the foundation upon which she delivered services to clients and made decisions about her business. The outcome of Klop's (1998) application of purpose, vision, and mission to her practice indicates that it is a worthwhile and relevant activity for speech-language therapists and audiologists in private practice to perform.

Once the purpose, vision and mission statements are conceived, it is necessary to translate these goal statements into action and motivate behaviour toward the accomplishment thereof. This process involves defining the organisation's purpose, vision, and mission into more quantifiable and specific short-term objectives that describe what needs to be done to achieve the stated goals in the light of current environmental factors. (Armstrong, 1994; Rassi & Fino-Szumski, 1994).

To enable the organisation to realise its goals, it is necessary to identify specific key strategic areas that are not consistent with the goals of the practice and need to be improved or changed. Klop (1998) identified client service and financial management as two key strategic areas in her private practice that warranted change in order for her practice to achieve its goals of quality improvement. Klop (1998) used the Pareto principle to identify strategic issues causing dissatisfaction in her private practice, however, using the results of the SWOT analysis is an alternative way of selecting issues requiring improvement (Brown, 1994).

Once the strategic areas or issues are identified, short-term objectives need to be set to provide tangible performance targets for each strategic area.

Objectives are statements that represent outcomes of the accomplishment of performance targets in key strategic areas. The objectives in a private practice must be consistent with the mission of the practice, well-defined, challenging, measurable in quantitative terms, and attainable within the specified time (Rassi & Fino-Szumski, 1994; Blanchard, Zigarmi & Zigarmi, 1985).

The setting of objectives for the practice brings the initial process of situational analysis to a close. This process assists the speech-language therapist and audiologist in private practice to describe the current state of the private practice and codify its basic beliefs and philosophy (Duncan et al., 1992). It also provides the private practitioner with a starting point for strategy formulation and the development and implementation of new or revised strategies, which is the focus of the next section.

2.4.3.2 Strategy formulation

Once the private practitioner has formed her overall goals and set objectives for the business, she is required to select a feasible strategy that is consistent with these goals and to write a strategic plan in order to achieve them. A strategy represents the major direction of action for a private practice and is more specific than purpose, vision or mission. Strategy formulation is generally a decision making process with the strategic decision establishing a clear avenue to pursue practice objectives and subsequently initiate and sustain action or momentum for the private practice (Maas, 1991; Plunkett & Attner, 1989).

The private practitioner has two main strategic choices regarding the future of her practice, namely growth and degeneration. Degeneration strategies include retrenchments, liquidation and divestiture and are generally chosen when the practice is bankrupt, can no longer operate, or requires an investment in new technology that is out of the financial reach of the practice (Duncan et al, 1992). The growth strategies available to the speech-language therapist and audiologist in private practice and the rationales for their selection are listed in Table 2.4.

Table 2.4 Rationales of growth strategies

GROWTH STRATEGY	*RATIONALE*
Market Share Building (Penetration)	- Present market is growing - Service/product innovation will extend market or product lifecycle - Expected revenues are high - Practice has competitive advantage
Market Share Building (Development or Diversification)	- Current markets are saturated - New markets are available - New markets may be served more efficiently - Expected revenues are high - Practice has competitive advantage
Market Share Holding	- Practitioner does not want to expand practice - Market has little potential for future growth - Maturity stage of product lifecycle or service excellence - Practice has no real competitive advantage
Turnaround	- Competitive position is weak - Market is still strong - Practice has operational inefficiencies - Practice is positioned poorly in the environment

(Adapted from Duncan et al., 1992)

From the rationales given in Table 2.4 it is evident that the practitioner's choice of strategy is dependent upon internal and external environmental factors. Considering the external environmental factors that are faced by South African speech-language therapists and audiologists in private practice (see sections 2.2.1 and 2.2.2), it is assumed that they will require a combination of the above growth strategies. Market penetration as well as market development appears to be the most suitable strategies for South African speech-language therapy and audiology private practices. The market for speech-language therapy and audiology services in South Africa has yet to reach its full potential as the majority of the population has had limited knowledge of the profession and limited access to services due to resource limitations. As a result of this situation, much of the market for speech-language therapy and audiology services lies dormant, and therefore warrants strategic growth in the profession. This much-needed growth is not only the

responsibility of the public sector but also the private sector and represents a particular challenge for the private practitioner.

In addition, the turnaround strategy may also be relevant to many speech-language therapy and audiology private practitioners as their practices may have operational inefficiencies. Klop (1998) discovered that her private practice had inefficiencies in its financial management system, which were contributing to quality problems, client dissatisfaction, and financial loss. Klop (1998) therefore advocated the use of a turnaround strategy, which was aimed at eliminating the inefficiencies by devising a new financial strategy for the private practice.

Furthermore, the inference can be made from the results of research on accountability, conducted by Trulove & Fitch (1998), that most of the private practices investigated warranted turnaround strategies. This inference is based upon the inefficient use of accountability practices such as cost effectiveness, time management, and productivity, by the private practitioners who participated in the study (Trulove & Fitch, 1998). Growth strategies and turnaround strategies therefore currently appear to be the most appropriate and relevant for the speech-language therapy and audiology profession, particularly for private practices.

Once the practitioner has selected a strategy, it needs to be written into a strategic management plan that stipulates how the strategy will be accomplished (Duncan et al., 1992). The strategic plan is developed through a series of decisions that define the entry into the market, the scope of operations, and the map of the future direction of the organisation. Furthermore the plan must state the relationship of the private practice to the environment in terms of service scope, geographical boundaries, competition, goals and objectives, and payment procedures (Duncan et al., 1992). These decisions collectively represent the explicit or intended strategy of a private practice.

When the strategy for the organisation has been formulated and the strategic plan documented, functional strategies that support the practice strategy are defined, developed and integrated to provide specific policies and procedures for the most important areas of the practice. These activities constitute the strategic implementation phase of the strategic management process.

2.4.3.3 Strategic implementation

This phase focuses on the development of functional strategies, which serve as the means for implementing the strategy selected in the previous process - strategy formulation. There are three major areas for which functional strategies must be developed, namely marketing, finance, and human resources (Stanbridge, 1999; Wood, 1986). These will be discussed in detail to indicate the relevance and necessity thereof to a speech-language therapy and audiology private practice.

- **Marketing strategy**

Limited communication to clients, referral sources, and payers regarding the outcomes of speech-language therapy and audiology services has resulted in failure to use these services, along with inadequate compensation and reimbursement for them (Larkins, 1990). These past practices indicate that speech-language therapists and audiologists cannot afford to be silent any longer. The literature advocates the use of effective marketing as a means to overcome the above mentioned problems in the speech-language therapy and audiology profession (Stanbridge, 1999; Smith, 1996; Ashby, 1995). It is postulated that marketing can influence the growth of the profession, communicate the importance of speech-language therapy and audiology to targeted publics, and expand service delivery (Smith, 1996; Larkins, 1993; Smith, 1990).

Private practices are particularly affected by the need for marketing speech-language therapy and audiology services as private practitioners need to market themselves in order to survive in the competitive marketplace (Smith, 1996). In addition, the rationale for marketing endeavours in South African private practices is that there are many practitioners entering the private

sector as the preferred working environment (Tuomi, 1994). Furthermore, marketing is necessary because consumerism is on the increase due to the emergence of managed care initiatives in South Africa and the need for cost containment (Smith, 1996; Ashby, 1995).

Marketing refers to the "...intentional process of creating and maintaining the customer relationship" (Galligher, cited in Smith, 1996:35). Therefore, any endeavour to satisfy a current or potential client relationship in a private practice can be considered a form of marketing. Killingsworth (1993:39) states that marketing also includes "...everything you do directly or indirectly to bring revenue into your practice." Furthermore, educating the public about the profession of speech-language therapy and audiology and the services provided by private practitioners is considered a form of marketing because the more informed the public are, the higher the demand for services (Smith, 1996).

Educating and informing the public about communication disorders and their prevention and treatment are also ethical obligations stipulated in the SASLHA Code of Ethics (1997). In addition to this there are also certain restrictions and ethical boundaries on marketing and advertising speech-language therapy and audiology services (HPCSA, 2000; SASLHA, 1997). The SASLHA Code of Ethics (1997) stipulate that private practitioners have a responsibility towards society to provide correct information about services and products which does not misrepresent or mislead the public or contradict the marketing standards stipulated by statutory bodies such as the HPCSA.

Despite these regulations and responsibilities, speech-language therapists and audiologists in private practice have a great deal of freedom in the choice of marketing strategies and tools. The process of developing a marketing strategy for a private practice includes a number of steps, which are outlined in Figure 2.4.

Figure 2.4 Steps in formulating a marketing strategy

(Adapted from Larkins, 1990)

Stanbridge (1999) states that most private practitioners do not devote the time, energy and persistence that are necessary for successful marketing. Furthermore, some practitioners underestimate their worth and ability as marketers, whilst others find the process "demeaning and unprofessional." Following the steps outlined in Figure 2.4, however, will ensure that marketing efforts are focused and yield the required results. The reality is that those practices that are marketed well are generally the most successful financially (Stanbridge, 1999:57).

One of the difficulties experienced in marketing the speech-language therapy and audiology profession is the diversity of the group of clients that need to be targeted, namely consumers, referral sources, medical aid companies, educators, parents and other health care professionals (Clifford, 1993; Smith, 1993). It is therefore an important consideration for private practitioners to regularly monitor the efficiency and appropriateness of the marketing tools

that they use as well as the success of their marketing efforts (Stanbridge, 1999; Clifford, 1993).

Marketing presents a challenge for the speech-language therapist and audiologist in private practice, particularly if she has received no training in marketing (Ashby, 1995). However, by placing the marketing strategy within the context of the strategic management process she will gain insight into the need for an organised and planned marketing initiative. Once the marketing strategy is complete, the private practitioner should proceed to the development of the financial strategy.

- **Financial strategy**

Developing a financial strategy for a speech-language therapy and audiology private practice is the 'reality check' in the strategic management process. It serves as a mechanism to check if the practice goals that have been set are feasible within the financial resources available to the private practitioner (Duncan et al., 1992). Private practitioners are in business to pursue economic proficiency and professional autonomy (Dunlop & Martins, 1995), therefore, they need to think of the financial implications of their decisions. A well-developed financial strategy provides speech-language therapy and audiology private practitioners with a set of standards and targets from which to make appropriate decisions for their practice. Furthermore, a sound financial strategy increases the likelihood of the proper control of finances that will in turn assist the private practitioner in obtaining the necessary financing to fund projects (Moskovitz, 1994).

There are several important steps in developing a successful financial strategy for a private practice (see Figure 2.5). Adhering to these steps will assist the private practitioner with the accurate analysis and evaluation of the financial implications of the strategic plans for her private practice (Duncan et al., 1992).

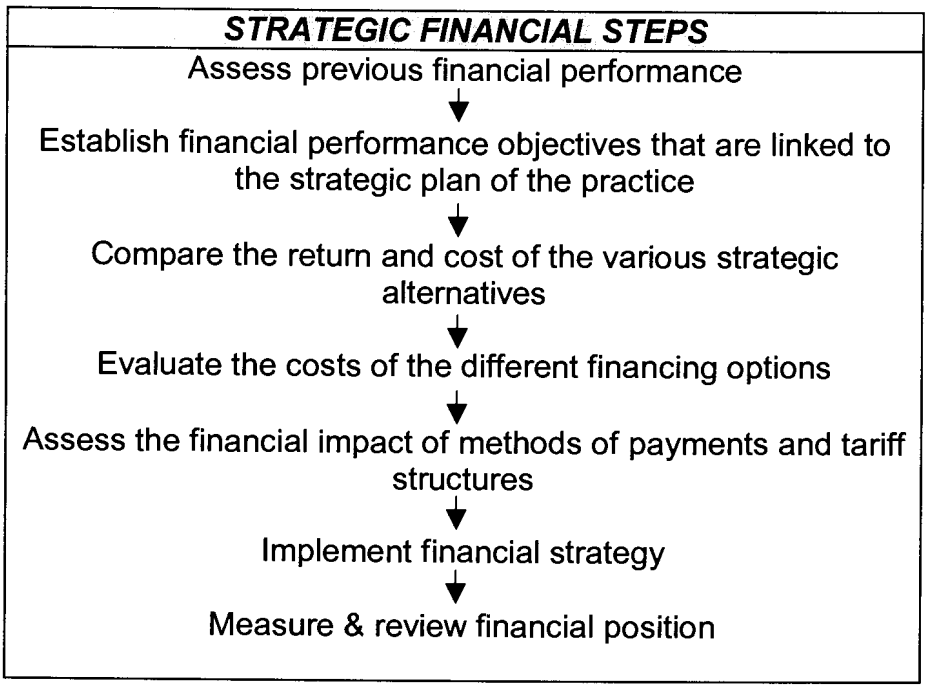

Figure 2.5 Steps in formulating a financial strategy

(Adapted from Duncan et al., 1992)

Klop's (1998) research study provides evidence that factors within a financial strategy can be the cause of quality problems within a private practice. In Klop's (1998) study the financial management system was ineffective, inefficient and cost-ineffective which resulted in financial loss, complaints, rework and frustration. It is thus imperative that speech-language therapy and audiology private practitioners consider the impact of a number of financial factors when developing a financial strategy. These factors are detailed in Table 2.5, which also provides a rationale for the impact these factors have on the financial health of the private practice.

Table 2.5 Factors to consider when developing a Financial Strategy

FACTORS	*RATIONALE*
Sources of finance	Private practices usually have limited start up capital so the practitioner needs to plan carefully how the money is spent to ensure that the funds available will be sufficient for the strategic plans to be realised (Wood, 1986). The practitioner must assess the different sources of finance available and the risks involved of each in order to make an appropriate decision i.e. whether to raise capital, take out a loan or use readily available funds to finance development or growth plans (Moskovitz, 1994; Dunlop & Martins, 1995).
Budget	Planning is essential to effective financial management and a budget is a crucial factor in annually estimating the ability of a private practice to relate expenditure to income. An effective budget identifies the most effective way to use financial resources to reach strategic goals and objectives and to ensure that financial resources are allocated appropriately and used effectively. (Tulloch, 1993).
Cash Flow	Cash flow is an important measure of the financial capability of a private practice. Private practitioners often experience problems with cash flow due to improper management thereof (Stanbridge, 1999). Good cash flow management demands that cash inflow be related to cash outflow. To achieve this, accounts receivable must be converted to cash as soon as possible and cash outflows must be delayed for as long as possible. One method of ensuring adequate cash flow is to provide incentives for cash payment or delay paying bills until the last due date (Wood, 1986).
Cost Containment	In the managed health care environment cost containment is essential as it enables private practices to be competitive (Metz, 1996; Ashby, 1995; Pappelbaum, 1995). In private practice cost containment can be achieved by: improving productivity and time management, increasing client contact time, and stipulating the minimum number of client contact hours per week, outsourcing administrative duties, decreasing the number of cancellations of sessions, decreasing bad debts, and by holding clients financially liable for sessions not attended.
Cost-Benefit Ratio	The practitioner must calculate whether the cost of the service is offset by the income generated from it and by what margin (Flower, 1984) because in no other environment is profit and loss more crucial than in a private practice (Metz, 1996).
Tariff structures	Private practitioners must decide whether they will be charging medical aid rates or RAMS rates and justify their decision, and audiologists dispensing hearing aids must decide on the profit margin for the sale of hearing aids (Moskovitz, 1994) as this will have an impact on profit, patient flow, & competitiveness.
Method of Payment	Private practitioners must define the methods of payment they are willing to accept as this has a large impact on the cash flow of the business (Flower, 1984). The practitioner should take into account that the waiting period for payment from medical aids or third parties can take up to six months.

It is essential that the financial strategy be integrated into the total strategic management process. Financial strategies should therefore always be consistent with the mission and objectives of the speech-language therapy and audiology private practice (Rassi & Fino-Szumski, 1994). In South Africa, where environmental factors inspire private practitioners to develop growth strategies, it is expected that the financing of these growth strategies will become a focus of attention. This may provide a good opportunity for the private and public sectors of the speech-language therapy and audiology profession to work conjointly in an effort to improve accessibility to services.

Once a financial strategy has been established the private practitioner should focus her attention on the human resource strategy, which forms the last of the three functional strategies and thus completes the strategic implementation process.

- **Human resource management (HR)**

A human resource strategy generally consists of a plan for the management of personnel (Duncan et al., 1992). Health care organisations usually present a number of unique human resource challenges, some of which include competence, skill shortages, and the questionable ethics of imposing cost containment rules upon personnel. Health care organisations need to develop human resource strategies that cope with these challenges. A typical human resource strategy would include decisions regarding the following aspects: management of professionals, ensuring an adequate supply of professionals, coping with personnel shortages, reimbursement of personnel, alternative methods of compensation, and management of diversification in the industry (Duncan et al., 1992).

In small businesses, and similarly in speech-language therapy and audiology private practices, there is usually less focus on human resource management as there are few employees (if any) and communication is likely to be direct and immediate (Wood, 1986; Flower, 1984). Consequently, the organisational structure is simple, flat and the private practitioner or entrepreneur is involved

in the daily activities and management of the organisation. There is usually also less specialisation of skills and division of duties in small businesses like private practices, i.e. all employees are generalists, performing both the clinical and administrative duties (Flower, 1984). Furthermore, dedicated staff for administrative purposes are generally absent in private practices due to costs involved (Wood, 1986). For the above-mentioned reasons, human resource strategies are not always totally relevant to speech-language therapy and audiology private practices, as they are more applicable to organisations with complex organisational structures.

Despite the small size of the private practice, however, the speech-language therapist and audiologist with any number of employees should develop some form of a human resource policy to provide the basis from which a number of activities are performed. These activities, which are outlined in Figure 2.6, are based upon the opinions and recommendations of Brooks (1994), Wood (1986), Blanchard, Zigarmi & Zigarmi (1985), and Flower (1984).

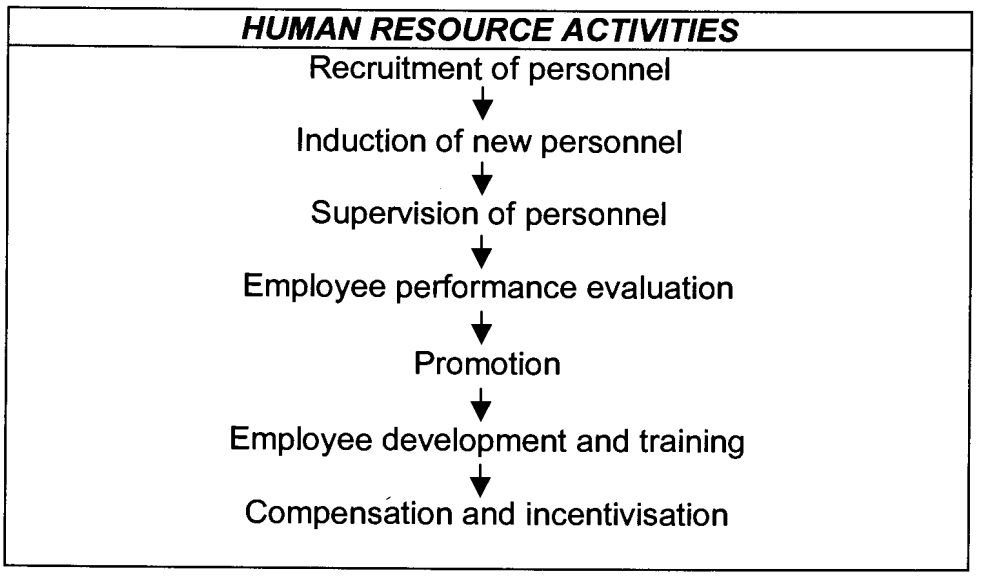

Figure 2.6 Activities forming the basis of a human resource strategy

(Compiled from: Brooks, 1994; Wood, 1986; Flower, 1984)

The human resource strategy is also closely linked to the culture and values that are expressed in the vision and mission statements of a private practice (Brooks, 1995; Rassi & Fino-Szumski, 1994). Therefore the outcome of an

effective human resource strategy should be consistent with the vision and mission of the private practice. Outcomes cited in the literature include positive team spirits and good morale amongst personnel (Brooks, 1995). These outcomes encourage quality service provision and the fostering of good relationships with clients, which is likely to increase client satisfaction. Client satisfaction was one of the areas that Klop (1998) selected for quality improvement in her private speech-language therapy practice as it was presumed that incorporating client satisfaction into every process of service delivery would result in the greatest quality improvement. If Klop (1998) had employed other speech-language therapists in her private practice, it would have been necessary to ensure that client satisfaction measures were included in her human resource strategy.

Once the speech-language therapist and audiologist has developed appropriate marketing, finance, and human resource strategies for her private practice, it is necessary to determine how the practice's strategy compares to its progress in the accomplishment of its goals.

2.4.3.4 Strategic control

Roush & Ball (cited in Duncan et al, 1992:368) state that "a strategy that cannot be evaluated in terms of whether or not it is being achieved is simply not a viable or even useful strategy." These words emphasise the importance of strategic control in the strategic management process. Control is defined as a combination of components that act together to ensure that the level of actual performance comes as close as possible to the set of desired performance specifications as written in the practice strategy (Duncan et al., 1992). A strategic control system provides the speech-language therapy and audiology private practitioner with an early detection system that indicates when conditions or progress is not satisfactory, and provides a method for correcting these conditions.

Strategic control is essentially directed towards controlling the purpose, vision, mission and objectives of the private practice by monitoring, evaluating and adjusting the functional strategies (marketing, finance and human resources),

the management strategy itself, and the situational analysis process (Duncan et al., 1992). The cycle of strategic control is illustrated in Figure 2.7. The first two steps in the cycle are the measurement of current private practice performance and the comparison thereof against planned performance standards. Performance factors are the clearest indicators that the strategy is performing well or poorly (Duncan et al., 1992). Quantitative and qualitative measures of performance that the practitioner integrates into the procedures and practices of the private practice during the strategic planning process are used as measurements to indicate progress and performance. Examples of quantitative measures of performance are financial ratios (profit margin, return on investment) or measures of market standing, and examples of qualitative measures are consumer outcome or client satisfaction. Drucker (1991) firmly believes that the result of a good business is a satisfied customer. In few other service-oriented businesses is this fact more applicable than in a speech-language therapy and audiology private practice. The measurement of client satisfaction as an indicator of quality in the research study conducted by Klop (1998) further substantiates Drucker's (1991) opinion.

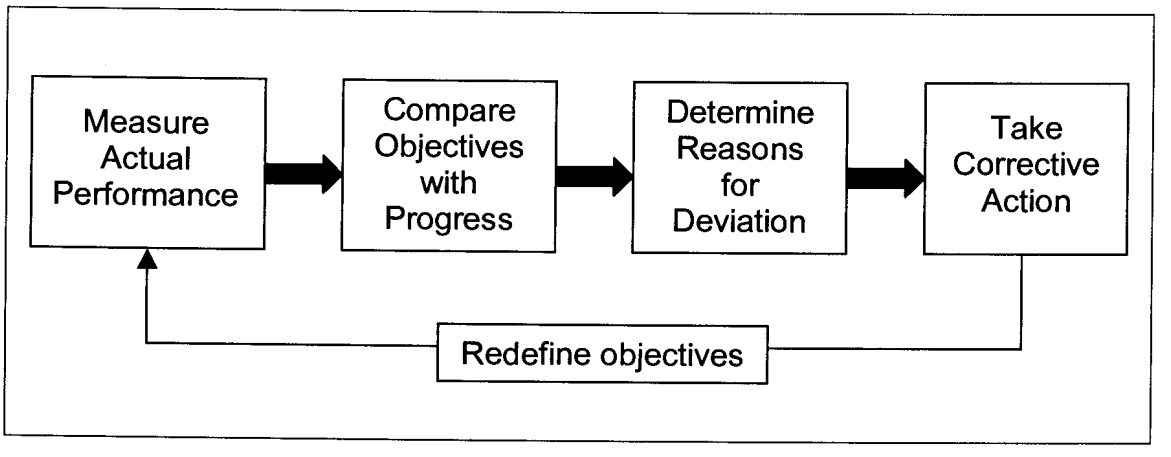

Figure 2.7 Strategic control cycle (adapted from Duncan et al., 1992)

Once the private practice's performance and progress has been measured, the next step in the control cycle is to determine the reasons for deviations against planned performance. The speech-language therapy and audiology private practitioner needs to ask herself which aspect of the management strategy is no longer applicable or appropriate. It may be that the assumptions underlying the management strategy of the private practice are no longer valid

because factors in the external or internal environment have changed. Alternatively, the current practice strategy or functional strategies may no longer be correct and may not be moving the private practice towards its objectives and mission or making the appropriate contributions towards them. Examples of typical questions that the private practitioner can ask herself to determine the source of deviation are included in Table 2.6. Once the possible reasons for deviation have been determined, the speech-language therapy and audiology private practitioner must take corrective action.

Table 2.6 Examples of questions for self-evaluation of a management strategy

PROCESS	*QUESTIONS*	*Yes/ No*
External environment	- Are the forecasts on which the strategy is based really credible? - Do we have an honest and accurate appraisal of the competition? - Is our market share sufficient to be competitive & generate an acceptable profit?	
Internal environment	- Is the strategy consistent with internal strengths? - Is there sufficient capital to support the strategy? - Do we have the necessary skills to successfully carry out the strategy?	
Purpose, vision, mission	- Are we doing things now that we should not be doing? - Are we doing some things now that we should continue to do but in a different way? - Do our purpose, mission & vision fit the needs of our clients?	
Strategy	- Are all the important assumptions on which the strategy is based realistic? - Is the strategy appropriate for the practice's present and future position in the market? - Have we determined the potential impact of risk?	
Functional strategies	- Can the strategy be implemented in an efficient and effective manner? - Do we have the resources required to successfully implement the functional strategies? - Is the timing of implementation appropriate in the light of market conditions?	

(Adapted from Duncan et al., 1992)

The following step in the control cycle is therefore to take corrective action to ensure that the private practice continues to strive towards its goals. Revision of any of the following processes described in the strategic management process may be required: purpose, vision, mission, and objectives (performance standards), strategy, and functional (implementation) strategies. These elements form a hierarchy, with relatively little change at the top and more frequent change further down the hierarchy. In addition, a change in one element will likely call for change in every element below it (Duncan et al., 1992). For example, if the mission is appropriate but the strategy must be changed, then the functional strategies will also require modification. Once a careful assessment of each element has determined the need for change, the private practitioner must take appropriate action and revise previous assumptions, objectives and strategies to ensure that the management strategy is more appropriate and leads to the achievement of the desired goals.

Klop (1998) stated that an analysis of the existing policies in her speech-language therapy private practice enabled her to determine the relevance of those policies and services in the light of the situational analysis and against the mission and goals of her practice. Klop (1998) found two of her policies to be inconsistent with the overall quality focus of her private practice and thus formulated revised practice policies. Some success was achieved with these revised policies, which indicates that the changes impacted positively on the overall functioning of the practice.

It could be argued that strategic control is the first stage of strategic management and not the last because new or revised strategies and plans are borne out of old ones. Perhaps the best explanation is that strategic management is a circular process and all of its processes are continuous. Strategic control, however, provides the impetus for change and change is a fundamental part of survival (Metz, 1996). By creating change, the speech-language therapy and audiology private practitioner creates new beginnings, new chances for success, new challenges for employees, and new hopes for clients.

The need for strategic management in speech-language therapy and audiology private practices has been highlighted and the requirements of the private practitioner in the entire process made apparent. From these discussions it is evident that the strategic management process is applicable to speech-language therapy and audiology private practices and is relevant to the needs of the profession in South Africa. The results of Klop's (1998) research study serve as further evidence that a management strategy can be successfully applied to a speech-language therapy private practice.

2.5 CONCLUSION

The factors influencing South African speech-language therapists and audiologists in private practice have a great impact on their ability to survive in the private sector of the dynamic health care environment. Furthermore, these private practitioners are placed at a disadvantage due to the limited training they receive at university level with regards to business management. To address this problem, speech-language therapists and audiologists in private practice need to receive more comprehensive business management training and apply it to the management of their private practices. The strategic management process, as presented in this chapter, indicates that it is appropriate and relevant to apply business management strategies to speech-language therapy and audiology private practices in South Africa. In addition, the research study recently carried out by Klop (1998) has proved that the implementation of a management strategy in a private practice is a meaningful and essential process for speech-language therapists to undergo.

2.6 SUMMARY

The aim of this chapter was to orientate the reader on the topic and to provide a critical evaluation and interpretation of the literature. In order to achieve this aim the reader was initially familiarised with the most pertinent factors impacting on the South African speech-language therapist and audiologist in private practice. In addition, since there are many factors to consider in the dynamic environment of a private practice, the need for practitioners to

acquire business management skills was discussed. Finally, a thorough review of the strategic management process was presented to indicate the relevance thereof to the management of a speech-language therapy and audiology private practice.

CHAPTER THREE

RESEARCH METHODOLOGY

***Aim**: To present the plan and implementation of the research study.*

3.1 INTRODUCTION

Researchers have the specific ethical responsibility to execute relevant and effective research (Whiston, 1995). According to Hugo (1998) this means that research must be socially justifiable as well as relevant to the context. The Commission on Health Research for Development in South Africa (as cited in Hugo, 1998), which identifies research as the process whereby equality of development can be achieved, believes that research in the field of essential health should be given preference.

Extensive research in business management in the health industry has contributed to a theoretical orientation of management of a private practice (Trulove & Fitch, 1998; Metz, 1996; Brown, 1994; Rassi & Fino-Szumski, 1994). However, the application of the theoretical concepts in different social, cultural, economic and physical service delivery contexts necessitates observation and study that is best achieved through the research process (Pickering et al., 1998). In addition, the literature states that the future of existing professionals might, to a large extent, depend on private practitioners in the field (Tuomi, 1994). Consequently, it is necessary to evaluate the needs and abilities of private practitioners, the stakeholders, particularly in South Africa where professionals in the workplace are trying to overcome past political influences.

Research is inherently linked with teaching and service delivery. Research should thus be relevant and lead to the implementation of a participative action methodology in order to take into account the needs of the country and particularly the relevant stakeholders such as the clients and practitioners

(Uys & Hugo, 1997). Consequently, the needs of the stakeholders should form the basis upon which research, training and service is built. One method of evaluation of the needs, abilities and attitudes of private practitioners is through qualitative, descriptive research studies. *Such research endeavours will demonstrate how the needs of the private practitioner can be satisfied through training in order to deliver a more effective service to the community.*

In addition, the information derived from the research process will contribute to the discipline of private practice management in three ways. Firstly, by increasing the body of knowledge on the management of private practices in South Africa; secondly, by utilising the information on the need for business management training, to develop various training courses; and thirdly, by enhancing the image of the profession and the service delivery to the community through these training efforts. Furthermore, it is hoped that this information will equip the training institutions with the relevant information to adapt their curricula to suit the dynamic and increasing demands of speech-language therapists and audiologists in private practice.

Due to financial constraints and rapid political and social change over the past nine years, South Africa has faced numerous reductions in the number of government-based speech-language therapy and audiology posts (Tuomi, 1994). This has caused a lack of job security, job opportunity and poor remuneration for professionals in the field. As a result of these factors many speech-language therapists and audiologists in South Africa have entered private practice with little more experience than that which they gained at university (Tuomi, 1994). In addition, there is a very limited focus on private practice and business management training in the curricula of the speech-language therapy and audiology degrees in South Africa (Smith, 1998). The current situation faced by private practitioners in the field of speech therapy and audiology in South Africa thus emphasizes the need for further research relating to the management of private practices and the training required by practitioners to set up a business of their own. In conjunction with the demands for justifiable and relevant research in the field of health by Whiston (1995), Hugo (1998), and the Commission on Health Research for

Development in South Africa (Hugo, 1998), the present study was undertaken to determine the business management practices and needs of private practitioners in order for recommendations to be made regarding business management training for these professionals.

If the propositions of Whiston (1995), Hugo (1998) and the Commission on Health Research for Development in South Africa (Hugo, 1998) are to be accepted as a challenge to researchers then this research study will be of particular interest and use in the field of speech-language therapy and audiology in South Africa. The focus of this chapter is to discuss and describe the research methodology that was used in this study in order to determine how speech-language therapists and audiologists manage their private practices.

3.2 AIM AND OBJECTIVES

One principal aim and five objectives were formulated for the purpose of this study, each of which is described in detail.

3.2.1 AIM

The aim of this study is to determine the type and prevalence of business management practices that are currently used by speech-language therapists and audiologists in private clinical settings in South Africa. Furthermore, the study aims to ascertain the opinion of private practitioners regarding the need for training and education in business management.

3.2.2 OBJECTIVES

The following five objectives outline the means by which the principal aim of the study was accomplished:

3.2.2.1 To determine what the private practitioners' opinions are towards the management of their businesses.

3.2.2.2 To determine what knowledge the private practitioners have of business management concepts.

3.2.2.3 To determine how the private practitioners manage their private practices.

3.2.2.4 To determine what the private practitioners' opinions are regarding the need for training and education in the principles of private practice management.

3.2.2.5 Based on the empirical results, to make recommendations regarding the development of business management training for private practitioners in the field of speech-language therapy and audiology.

3.3 RESEARCH DESIGN

The choice of a research design should be consistent with, and appropriate to, the purpose of the study (Leedy, 1997). A research design should thus be selected after an evaluation of all the available methods of design as well as careful consideration of what the study would like to achieve. On the one hand, descriptive research is a particular type of research employed to examine group differences, trends, or relationships among variables. The observations from descriptive research provide an empirical picture of a group at one particular time without manipulation of independent variables by the researcher (Ventry & Schiavetti, 1986). Researchers in descriptive studies are thus passive observers studying a particular phenomenon under investigation. On the other hand, survey research is designed to provide a detailed inspection of the prevalence of conditions, practices, or opinion in a given environment by asking people about them rather than observing them directly (Ventry & Schiavetti, 1986).

A ***descriptive survey research design*** was therefore chosen for this study as it was considered to be the most appropriate to achieve the research aims formulated. This design suited the type of data to be obtained namely, the type and prevalence of business management practices (management behaviour), the knowledge of management issues, and the opinion of private practitioners towards the need for business management training. According to Ventry & Schiavetti (1986), descriptive research is an important endeavour in the behavioural sciences and constitutes a large portion of the research

found in speech pathology and audiology literature. Furthermore, the literature revealed the use of the survey design in investigating the prevalence of business methods and practitioners' attitudes (Trulove & Fitch, 1998).

The data collection methods and instruments available to the researcher in a survey design include questionnaires, interviews, or a combination of the two. A ***structured data collection method***, in the format of a postal survey, was selected as the most appropriate method to achieve the aims of this study with the available resources (Schnetler, 1989). From a practical point of view, the data for the study would be derived from observations in the form of a questionnaire because questionnaires are generally more appropriate for collecting relatively restricted information from a wide range of respondents (Fink, 1995). Furthermore, one of the most useful aspects of a postal survey is that the respondent himself or herself completes the questionnaire and that the questionnaire is the only means of communication between the respondent and the researcher (Schnetler, 1989). This increases the confidentiality of the data and decreases the effect of researcher bias in the study.

Despite the suitability of the descriptive survey method selected for the purpose of the present study, the drawbacks thereof should be acknowledged as the data is especially susceptible to distortion as a result of bias (Moodley, 1999; Leedy, 1997). Due to the fact that questionnaires were used as the method of data collection in this study, the likelihood of the questionnaires being a potential source of bias and threat to the internal and external validity of the study was carefully considered.

The mortality threat to internal validity is reported to be a common problem in survey research (Ventry & Schiavetti, 1986). In this context, the number of people in the survey who fail to respond to the survey instrument represents mortality. If the non-response rate is high, the sample may be biased. Welman & Kruger (1999) report average response rates of lower than 50% in South African postal surveys. However, considerable time and effort can be spent on implementing control measures that will prevent a biased and

unrepresentative sample brought about by a low response rate. Furthermore, all the factors and controls influencing the response rate (or mortality) are considered during the analysis and interpretation of the results of the study to ensure that the results are valid.

A further weakness in descriptive survey studies is the instrumentation threat to internal validity (Ventry & Schiavetti, 1986). This is directly related to the adequacy and suitability of the survey instrument, in this study, a self-compiled questionnaire. The compilation of a questionnaire is a complex undertaking for a novice researcher. However, the literature provides clear guidelines on the development of question type, response format and content (Leedy, 1997; Fink, 1995; Tesner, 1995; Schnetler, 1989). In addition, it is suggested that the questionnaire be pre-tested on a small sample of representative individuals to obtain their reactions, suggestions and comments (Schnetler, 1989). Consideration was given to all the above factors during the compilation of the questionnaire as well as in the analysis and interpretation of the results.

A further consideration in descriptive design methods is the threat to external validity, which limits the degree to which internally valid results drawn from the sample of respondents can be generalised to other subjects, settings and measurements (Alant, 1998). No single research study, however, is expected to have wide-ranging generalisibility to many different cases, as this is rather a result of cumulative research on a given topic (Ventry & Schiavetti, 1986). Researchers build a case for generalisation from the comparison of the results of many studies. As this study is one of the first studies determining the business management practices in the field of speech-language therapy and audiology in South Africa, there is unfortunately very little local research to draw upon to validate the results (Klop, 1998). However, international research studies have been a source of reference and served as a guideline to validate this study (Trulove & Fitch, 1998; Rassi & Fino-Szumski, 1994).

A critical aspect of both the internal and external validity of a descriptive survey is subject selection (Ventry & Schiavetti, 1986). This threat concerns

the degree to which the subjects selected for the study are representative of the population to which the researcher wants to generalise the results of the study. It is thus recommended that when selecting the method of sampling, the researcher considers all factors such as maturation, history, size of population, as well as subject selection bias, in order for the research sample to resemble the population (Bourque & Fielder, 1995). The above factors were taken into consideration when selecting the sampling method and the criteria for the subjects in the research design. Furthermore, the impact of the subject selection was acknowledged in the interpretation of the results.

In conclusion, the literature states that the researcher should choose the research design that best suits the purpose of the study, and that is compatible with the available resources (Leedy, 1997). A descriptive survey research design was therefore selected for this study as the most practical and appropriate method for achieving the prescribed aims within the constraints that face behavioural science research.

3.4 RESPONDENTS

The aim of a survey is to reach conclusions concerning a population as a whole (Stoker, 1989). Furthermore, to maximise the internal and external validity of the study, it is essential that the sample should in all relevant respects be representative of the population (Leedy, 1997). The target population for this study is all the speech-language therapy and audiology private practitioners that practice within the boundaries of South Africa.

3.4.1 Criteria for the selection of respondents

The criteria for the selection of private practitioners to take part in the study was as follows:

- **Academic qualifications**: The speech-language therapists and audiologists needed to be registered with the Health Professions Council of South Africa and had to hold a valid qualification in either speech-language therapy, audiology, or both fields of study. Respondents who

have a Master's degree or a Doctorate in speech-language therapy and audiology were also included. This was deemed necessary because this study is investigating business management practices of private practitioners within the field of speech-language therapy and audiology

- **Affiliations**: Due to the lack of complete and current information available on all private practitioners in South Africa, the speech-language therapists and audiologists needed to be registered as private practitioners with the South African Speech-Language and Hearing Association (SASLHA) in order to be included in the study. This database excluded all private practitioners who were not SASLHA members. This criterion was considered to be important, as the study required an informed and interactive group of respondents to participate in the study.

- **Practice context**: Strict criteria for differentiating private practitioners from other part time speech-language therapists and audiologists were used. The speech-language therapist and audiologist needed to own the practice and work independently or employ one or more speech-language therapist and or audiologist in the business. Whether or not the owner was employed full time in the practice was not essential. The number of employees was also not restricted. A person was not considered a private practitioner if she augmented her basic income in the evenings or on weekends through private practice. A clear distinction was also made between being engaged in private practice and being employed in private practice. The former is a person who owns his/her own business and the latter is someone who works for a private practitioner but bears no responsibility for the overhead expenses of the business, nor the overall management (Flower, 1984). This criterion was considered important as the questionnaire asked specific questions pertaining to the management of the business that, it was presumed the owner of the business would have exclusive access to.

- **Geographical area**: All the private practices of the speech-language therapists and audiologists needed to be situated within one of the nine provinces of South Africa. This criterion was required as the study aims to make recommendations that will be applicable within the specific political, social and economic climate of South Africa.

No further criteria were imposed, as the population of speech-language therapists and audiologists constituted a heterogeneous population - differing in age, experience, and qualifications. Any impact that these variables may have had on the private practitioners responses were taken into consideration in the analysis of the data and used to account for differences amongst more homogeneous groups. In addition, the size of the population group would have been substantially limited had further criteria been imposed. This would have made the study less representative of the population group as a whole and thus hindered the reliability of the results.

3.4.2 Selection of respondents

There are 259 private speech-language therapy and audiology practices registered with SASLHA for the year 2000 (SASHLA, 2000). Of this original number, 47 practices are registered under speech-language therapy as well as under audiology. The remaining 212 practices were selected for inclusion in the study and deemed the *actual* number of SASLHA registered private practitioners in South Africa. This number automatically excludes all private practitioners not registered with SASLHA as stated in the selection criteria. It is uncertain what percentage the registered private practitioners represent of the total number of registered and unregistered private practitioners in South Africa, as there is currently no accurate data available that states the exact size of this dynamic population.

The disadvantage of the exclusive use of SASLHA registered private practitioners was that they may differ from non-registered private practitioners. This may have an impact on the generalisation of the results on the wider population of private practitioners in South Africa. Nevertheless, this external validity factor was considered in the interpretation of the results.

A ***probability systematic sampling procedure*** was used in the study as every practitioner in the population had a known positive probability of being included in the sample and was chosen from a complete list of practitioners (Stoker, 1989; SASLHA, 2000). All of the 212 private practitioners registered with SASLHA were thus included in the study. This represents 100% of the total population that fitted the selection criteria for the respondents. According to Fink (1995), the more heterogeneous a population is, the larger the sample should be to represent all the characteristics of the population. It was thus considered appropriate to use the entire population since it would be more representative of the population whilst remaining compatible with the resources available. A representative sample of the population group is desired in order for valid conclusions to be made from the assimilated data. Furthermore, with the sample containing the whole population, the study is better protected against the adverse effects of a low response rate, which is notorious in postal surveys (Wellman & Kruger, 1999).

3.4.3 Selection procedure

The process of selecting respondents was as follows:

- The 212 private practitioners in the sample group were telephoned over a period of 5 days from the 20th to 24th June 2000 to request their participation in the study and to increase the likelihood of a high response rate.
- During the telephone call a standard message was read to the private practitioner, a transcription of which can be found in Appendix A. This message introduced the researcher, stated the purpose of the telephone call, explained the aim of the study and requested their participation.
- Of the 212 private practitioners telephoned, 199 gave their permission to be part of the study. The remaining 13 practitioners were not included in the study as they could not be contacted, they were no longer practicing, or they refused their participation.

It is important to note that there was a distinct possibility that certain SASLHA private practitioners did not fit the selection criteria of a private practitioner or

of a respondent as stipulated in the criteria for inclusion in the study. However, this bias was overcome by stipulating explicitly in the covering letter that the respondent of the questionnaire had to be the owner of the private practice. Furthermore, when the completed questionnaires were received it was evident from the respondent's responses in Section A of the questionnaire whether or not they matched the criteria.

In addition, the Hawthorne effect may have an impact on the respondents. In other words, the respondents may give responses that are a function of their knowledge of participation in a study rather than their actual knowledge, opinion or behaviour (Ventry & Schiavetti, 1986). There may also have been a tendency for the private practitioners that are more successful in their businesses to respond to the questionnaire. Likewise, there may have been respondents who were motivated by a special interest in business management, which could influence their knowledge, opinion and behaviour. The likelihood of these biases were acknowledged by the researcher and prevented as far as possible. The impact of these factors on the results of the study will be considered during the interpretation of the results.

A further uncontrollable variable is that the private practitioners may receive help in completing the questionnaire. This would have an impact on the results of the study, however, it is stipulated clearly in the covering letter and instructions that the private practitioner is to complete the questionnaire. To counteract the impact of this bias the language in the questionnaire was kept simple and easy to understand. In addition, the terms used in the questionnaire were familiar business terms, which should have been understood by all of the private practitioners. To prevent the terms from being misunderstood, section B of the questionnaire contained descriptions of the business terms used. Furthermore, each section of the questionnaire was introduced by an explanation of the topic being questioned.

Finally, due to the demographics of South Africa it is expected that the respondents may not be completely representative of all nine provinces in South Africa. According to Pickering et al. (1998), professionals tend to cluster

in urban areas, thus resulting in a high incidence of private practices in the cities and surrounding suburbs. The possibility therefore exists that there may have been a bias towards the views of private practitioners from urban areas. The views and behaviour of practitioners from the rural or less densely populated areas are thus likely to be overshadowed. An attempt to prevent this bias is to group the respondents into the nine provinces and to make comparisons of their opinions, where necessary, to determine whether there is any significant difference amongst them.

In conclusion, the procedure for the selection of respondents was deemed appropriate for the aims of the study. Furthermore, all of the possible uncontrollable variables were taken into account in the selection of the respondents and steps taken to decrease or nullify the effects of the biases that may have invalidated the results of the study.

3.4.4 Description of the respondents in the study

Of the initial 199 private practitioners, 137 responded by returning the questionnaires in the self-addressed envelopes. The *response rate* was therefore 69%, however, a total of eight questionnaires were eliminated from the sample due to various problems. One respondent was no longer practicing, two were retired, one respondent was an employee of an Ear, Nose and Throat specialist and thus did not fit the criteria for inclusion, two questionnaires were sent back partially answered or unanswered, and the remaining two questionnaires were received past the cut off date. Therefore, of the 137 questionnaires returned, only 129 were valid for inclusion in the study decreasing the response rate to 65%. According to Fink (1995), no single response rate is considered the standard. A 20% response rate is not uncommon for a first mailing attempt, nevertheless, with effort response rates can be elevated to 70% (Fink, 1995). Wellman & Kruger (1999) report an average response rate of 50% for South African postal surveys. The response rate of 65% attained in this study is therefore considered "good to very good" (Ventry & Schiavetti, 1986). The good response rate for such a large and heterogeneous sample of practitioners means that the data is more than adequate for the purposes of analysis and interpretation.

Unfortunately, not all of the questions in this study were completed by all of the respondents. This *item non-response* can also introduce bias (Fink, 1995). Possible reasons for this occurrence are the following:

- The respondent did not understand the question or terms used in the question.
- The respondent was unsure or did not have an answer for the question.
- The respondent accidentally missed the question or wanted to return to it later.
- The respondent did not respond because the question was not applicable to her practice.
- The respondent believed the question was sensitive, embarrassing, or irrelevant.

(Fink, 1995)

Nevertheless, guidelines from the literature for promoting responses, minimising bias and reducing survey error were used to overcome the effect of non-response (Fink, 1995; Schnetler, 1989).

The 129 respondents who returned their questionnaires are described forthwith. The data for this section is derived from the biographical data section at the beginning of the questionnaire that was designed for the purpose of describing the respondents. The data revealed the following about the respondents:

- **Geographical area**

  The respondents came from all of the nine provinces in South Africa, but as expected, the provinces were not equally represented as is evident in Figure 3.1. The majority of the respondent's private practices were situated in the Gauteng province (66%) followed by the Western Cape with 10.7%. The Northern Province (0.7%) and the Free State (0.8%) each had the least number of private practices. These statistics are generally consistent

with the population statistics and demographics of South Africa (HSRC, 2000) as well as the presumption that private practices tend to cluster around urban areas and capital cities within most countries (Pickering et al., 1998). Furthermore, Uys & Hugo (1997) state that the existing services in South Africa are distributed unevenly in the country and that services are mainly limited to metropolitan areas. However, it does appear that private practitioners tend to dominate the Gauteng area more so than the other provinces. This phenomenon cannot be explained from this data alone.

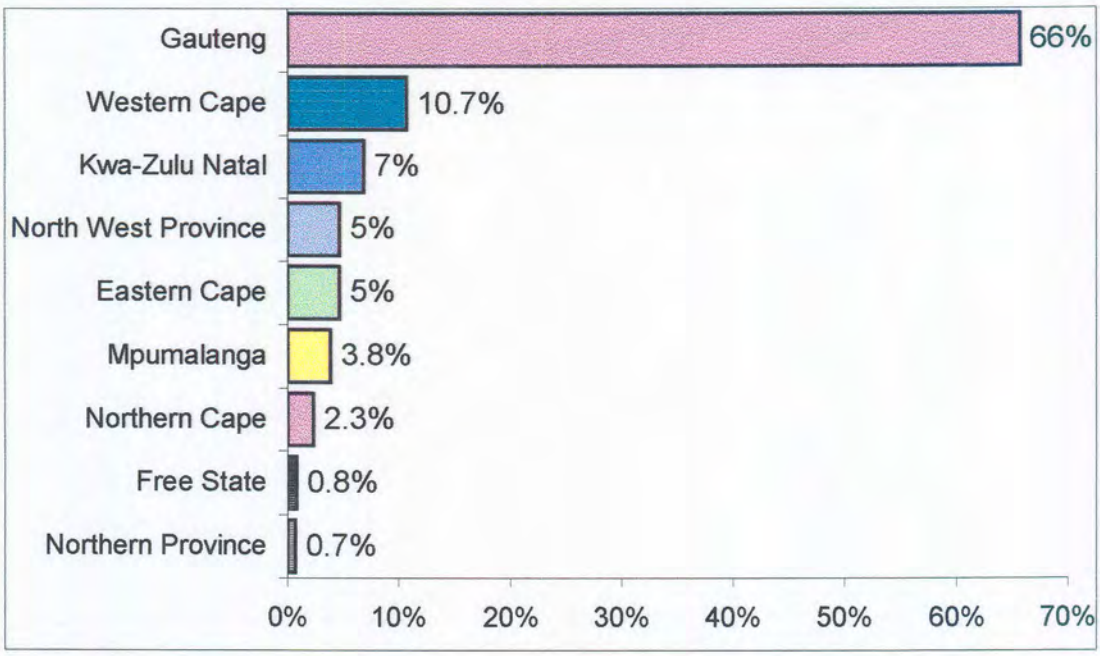

Figure 3.1 Geographical distribution of private practices in South Africa

- **University attended by respondents**

  Of the five training institutions that offer speech-language therapy and audiology degrees, the university attended by the majority of the respondents (54%, *n* = 70) was the University of Pretoria (see Figure 3.2). The University of the Witswatersrand was the second most frequently attended university (35%, *n* = 45). These results were expected since the University of the Witwatersrand and University of Pretoria have two of the oldest and the largest speech-language therapy and audiology training

institutions of all the universities. Furthermore, it appears that the respondents who attended the University of Pretoria are also more inclined than students from all the other universities to take part in research efforts.

The fact that 89% of all the respondents (n = 115) trained in the Gauteng province is one explanation for the large number of private practices situated within this province as indicated in Figure 3.1. There was one respondent amongst the sample group who indicated that she had obtained her qualification in the United Kingdom (1%).

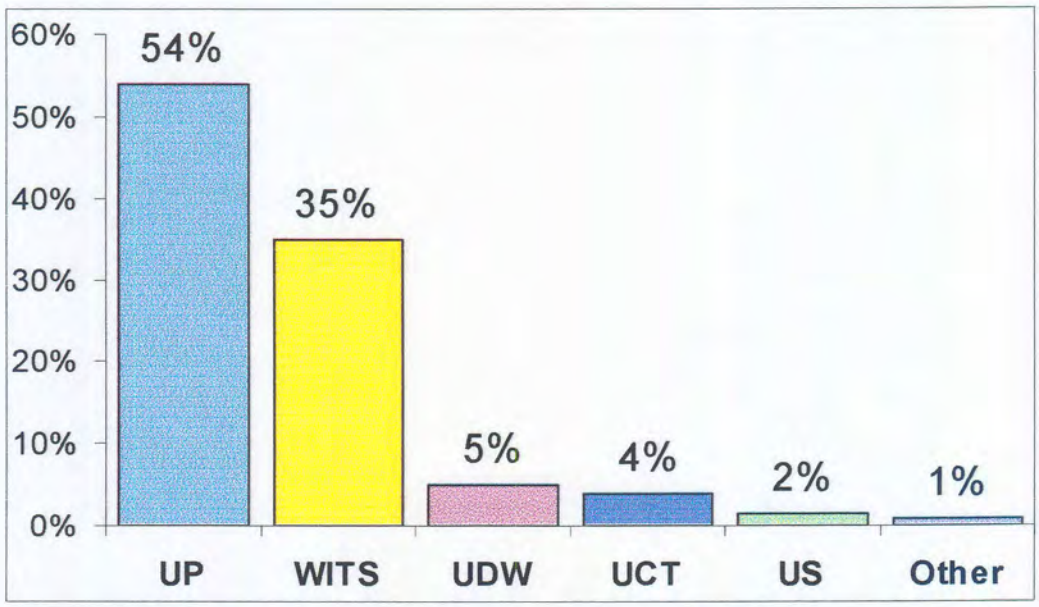

Figure 3.2 Percentage of respondents' attendance at Universities

- **Year in which degree was obtained**

The respondents obtained their degrees between 1956 and 1999, eighty-nine of which were obtained within the last twenty years (see Figure 3.3). It can thus be assumed that there are a number of very experienced speech-language therapists and audiologists in private practice. However, it appears that private practice is more popular amongst newly qualified speech-language therapists and audiologists. An alternative explanation for this is that there are currently more universities offering speech-language therapy and audiology degrees and there are more students

being accommodated within each of the universities than in previous years.

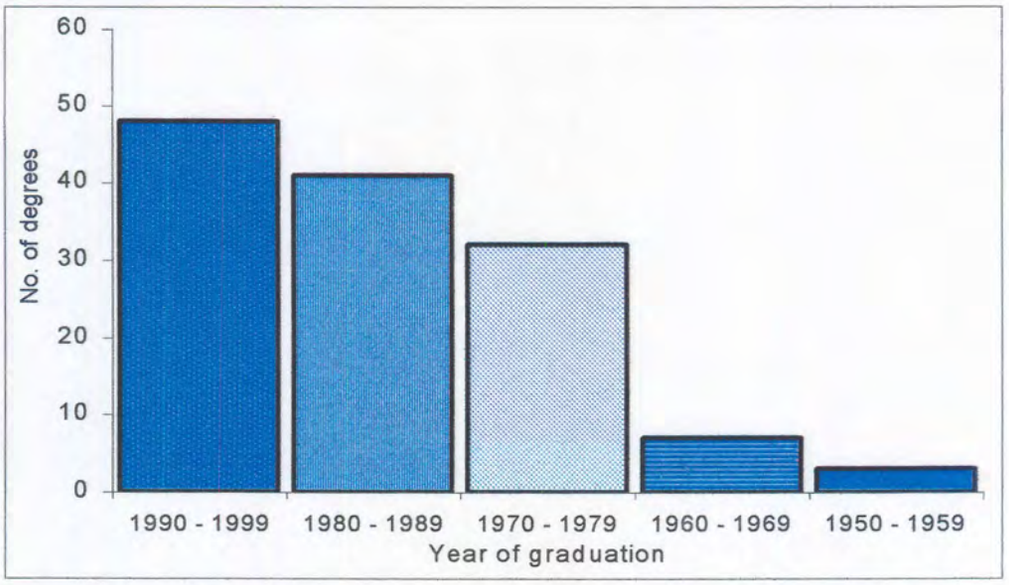

Figure 3.3 Number of degrees obtained from 1950 to 1999

- **Qualification**

  The majority of the respondents (87%, *n* = 115) reported that their highest degree was a Baccalaureate in speech-language therapy and audiology. In comparison, only 10% (*n* = 14) held master's degrees and 1.5% (*n* = 2) earned doctorate degrees. A further 1.5% (*n* = 2) held diploma qualifications in other countries, which they obtained in 1973 and 1975 respectively. These results indicate that whilst the respondents were well qualified in comparison with the rest of the population, within the profession only a small number of private practitioners have benefited from post-graduate study. In addition, if one compares this position with that of North America and the United Kingdom, it is evident that South Africa is the only country that does not specify a post-graduate qualification prior to allowing a practitioner to enter into private practice (Clausen, 1998; Van der Gaag, 1996).

- **Experience**

  The respondents reported a mean of 15 years' experience in the field and a mean of 10 years' private practice experience, which indicates that the

majority of private practitioners were very experienced. However, 70% (*n* = 89) of the respondents reported entering private practice within the first 5 years of gaining experience (see Figure 3.4). This figure verifies the difference between the mean years of total experience and the mean years of private practice experience. On closer analysis of Figure 3.4, however, it is evident that a high number of respondents entered private practice within the first and second year of experience. This trend is consistent with Tuomi's (1994) belief that more newly qualified professionals have entered private practice due to lack of job opportunity in the public health care sector.

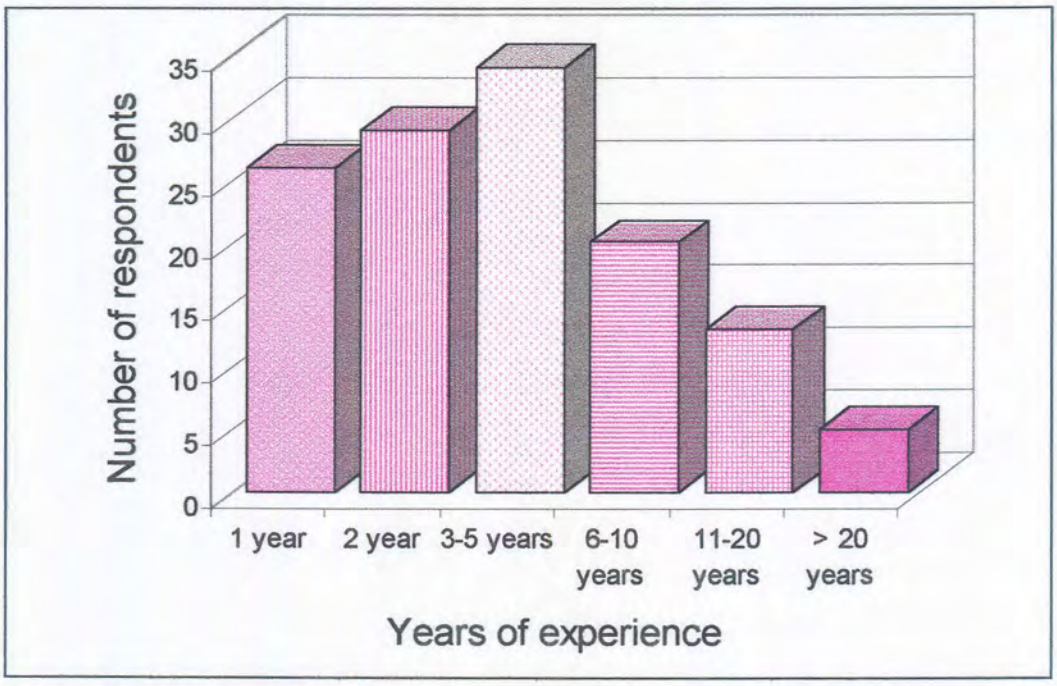

Figure 3.4 Respondents' years of experience prior to entering private practice

- **Scope of practice**

The majority of respondents (53%, n = 70) reported that they only offered speech-language therapy services compared with 8% (n = 11) who only offered audiology services (see Figure 3.5). A further 18% of the respondents (n = 23) indicated that at least half of their caseload included speech-language therapy. The average split between the two services was 72% speech-language therapy and 28% audiology. These findings are

consistent with those of Tuomi (1994:5) who states that "despite the graduates' dual qualifications, most practice only as speech-language pathologists." A feasible explanation for this is that well-equipped audiology private practices require more financing and capital than speech-language therapy practices (Wood, 1986).

However, the demand for speech-language therapy or audiology services as well as the prevalence of speech-language and hearing disorders in the community should also be considered when making decisions regarding the scope of a private practice. Uys and Hugo (1997) believe that the need for speech-language therapy and audiology services in South Africa is underestimated and that there is also much ignorance about the prevalence of communication disorders. Based on this assumption, the scope of the respondents' private practices as presented in Figure 3.5 may well be insufficient, particularly with regard to audiology.

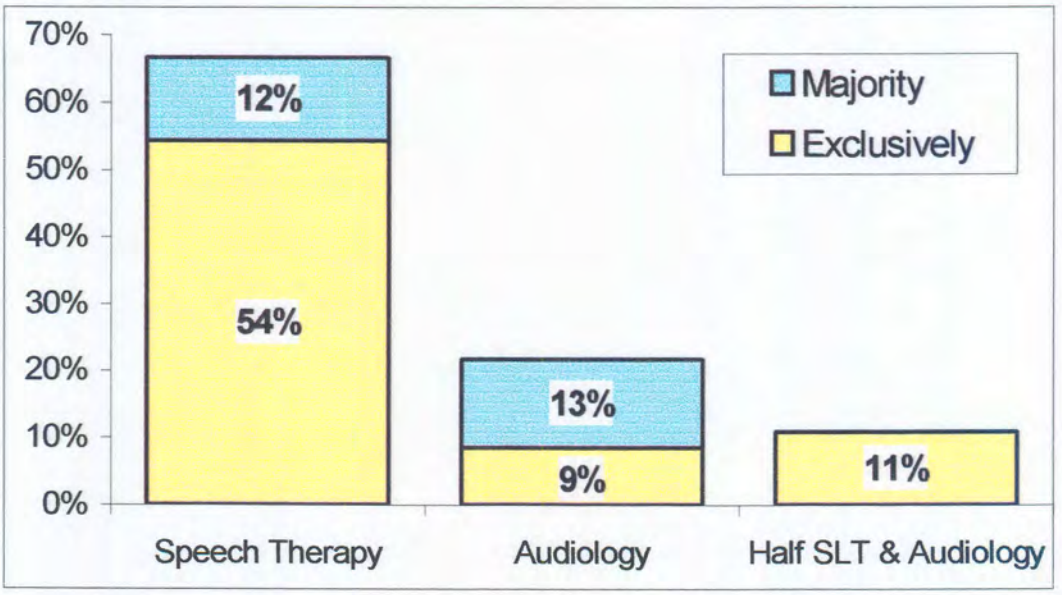

Figure 3.5 Scope of services provided by respondents

- **Employees**

  The majority of the respondents are sole practitioners (65%, *n* = 82), however, 46 respondents (35%) indicated that they employed at least one therapist in their private practices (see Table 3.1). Of the 46 respondents

who employed staff, most only employed one therapist (17%, *n* = 23), however there was one respondent who reported employing six speech-language therapists and audiologists. In total 93 professionals were employed by the private practitioners in the study. These results are consistent with most of the literature on private practice that states the reason for entering private practice is to gain satisfaction and remuneration for ones own personal performance (PSPA, 1990; Wood, 1986; Flower, 1984). Furthermore, it may be an indication that most private practitioners do not wish to take on the additional responsibility of employing staff and run the risk of having less control over the quality of service delivery (Wood, 1986).

Table 3.1 Number of practices that employ staff

No. of employees	No. of practices	Total employees
No employees	**82**	**0**
1 employee	**23**	**23**
2 employees	**11**	**22**
3 employees	**4**	**12**
4 employees	**5**	**20**
5 employees	**2**	**10**
6 employees	**1**	**6**
Total	**128**	**93**

- **Working hours**

  The responses to the questionnaire revealed that 32% (*n* = 42) of the practitioners practiced part time compared with 68% (*n* = 89) who practiced full-time. The working hours reported by the respondents ranged from 2 to 12 hours per day, with a mean of 6.8 hours for the group as a whole. The high number of practitioners who practice part-time is an indication that private practice lends itself to flexible working hours. Furthermore, according to the Private Speech Pathology Association in Australia (1990), private practice is one of the few areas of part-time work available in speech pathology and in a female dominated profession this is a very appealing reason to enter private practice.

In addition, 12% (n = 15) of the respondents indicated that they worked 6 days a week in their practices. This indicates that there is a demand for private practitioners' services outside of normal working hours and that they are willing to accommodate these clients. It is also a competitive advantage that the private speech-language therapists and audiologists have over their colleagues who are employed in the public health care sector.

- **Client base**

  The client base of the individual respondents was varied, consequently the means per group were calculated and can be found in Figure 3.6. The client groups most frequently treated by the respondents were pre-school and school-aged children which equalled 62% of their total client base. This figure is consistent with a similar survey conducted by the PSPA (1990) in Australia, which indicated that 75% of clients seeking a private speech pathology consultation are less than eight years old. However, with the reported increase in number of individuals over the age of 65 in the last two decades (Pickering et al., 1998), it is assumed that the private practitioner's client base may shift towards the geriatric population. The only hindrance factor may be that this group may not be able to afford the services of private practitioners.

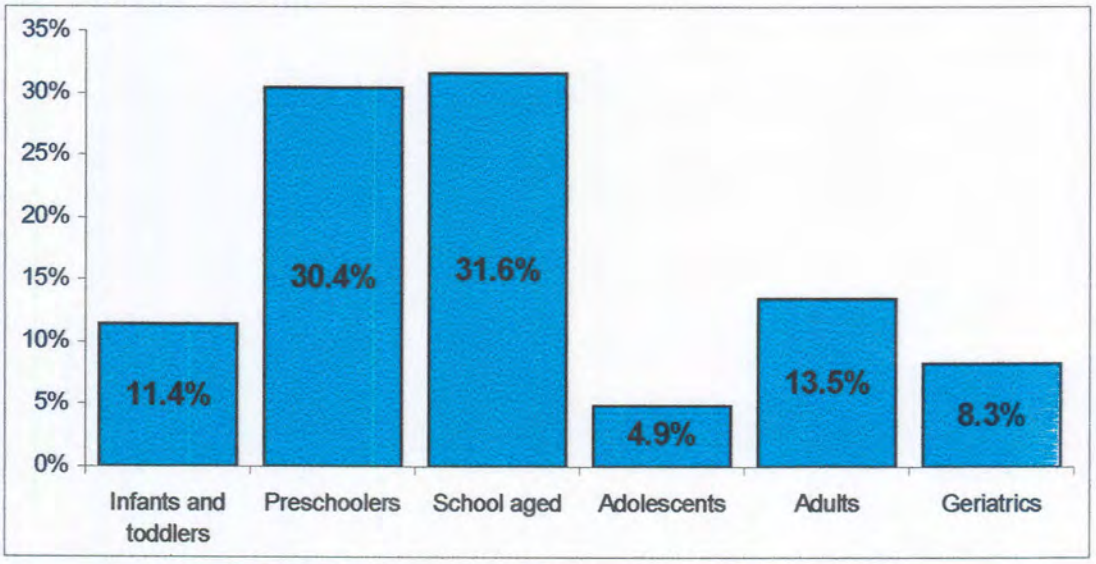

Figure 3.6 Average client base of respondents

- **Services provided**

  The majority of respondents reported that they rendered assessment, individual therapy and screening services to their clients (see Figure 3.7). These results indicate that the majority of private practitioners offer their clients the traditional clinical services expected from the profession. The literature, however, suggests that the scope of services offered by speech-language therapists and audiologists in South Africa should become "Africanised" to better serve the community through preventative programmes, community-based education, group therapy, and transdisciplinary rehabilitation with other health care professionals (Hugo, 1998; Uys & Hugo, 1997). There is evidence of these services being offered by only the minority of the respondents.

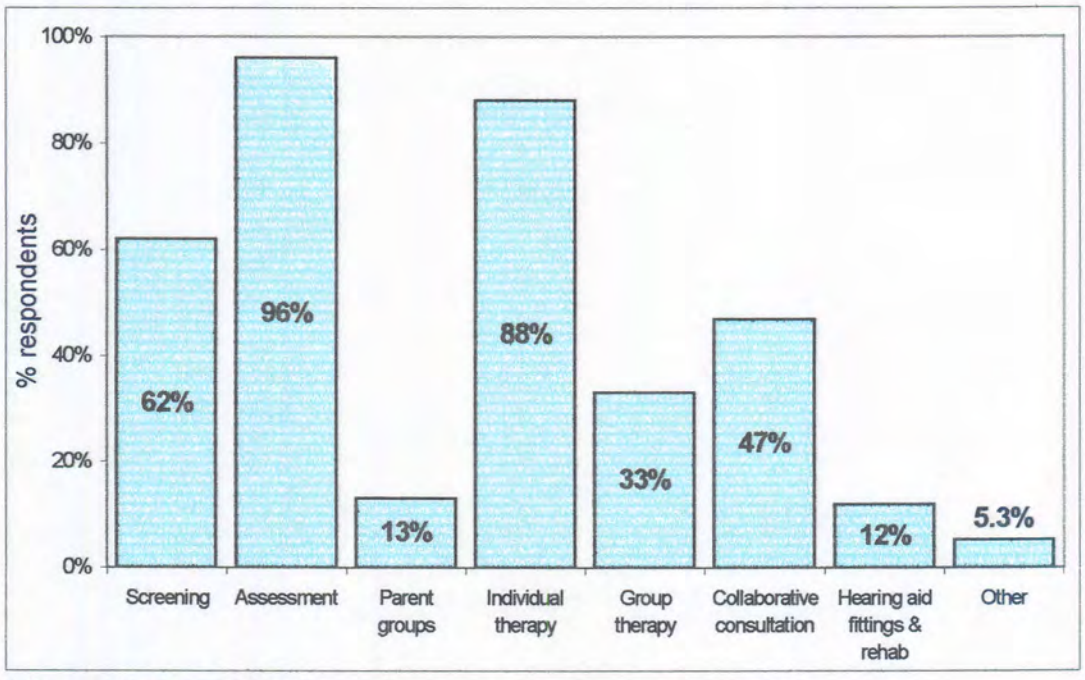

Figure 3.7 Range of services provided by the respondents

The high percentage of practitioners who screen and assess clients appears to be out of proportion when compared with the percentage of practitioners who treat clients. A possible explanation for this trend is that many parents who bring their children for assessment or screening have unfounded fears regarding their children's communication development.

An alternative explanation is that clients often prefer a diagnosis or prognosis from a private speech-language therapist or audiologist who has a much shorter waiting list than in a hospital or clinic. Furthermore, many clients may be unaware of the extent and length of treatment required after diagnosis of a communication disorder and are often unable to afford treatment from a private practitioner.

In conclusion, the respondents comprise a heterogeneous sample of private practitioners who differ in geographical location, experience, service delivery, type and size of private practice amongst other factors. These differences are taken into account and are used to compare data in the analysis of the results.

3.5 MATERIALS AND APPARATUS

The instrumentation threat to internal validity is directly related to the adequacy of the survey instrument (Ventry & Schiavetti, 1986). The survey instrument, in this study a self-compiled questionnaire, is thus a critical component of the research study. Careful consideration is therefore required concerning the decision of the most applicable type of instrument for the purpose of the study as well as the development thereof. The following sections contain a detailed discussion of the rationale for the choice of a questionnaire, the aim thereof, and content of the questionnaire.

3.5.1 Rationale for the use of a questionnaire

A questionnaire was selected as the means for obtaining the data for this study based on the nature of the population and the nature of the data under investigation, as suggested by Alant (1998). Firstly, with reference to the nature of the population, a questionnaire was deemed appropriate as the population of private practitioners in South Africa is widely spread geographically. Moreover, the minimum level of education of the respondents was guaranteed, and nature of their business (private practice in speech-language therapy and or audiology) was similar. Secondly, the nature of the data was the knowledge, opinion and behaviour of the respondent, which lent it to being measured in the format of a questionnaire (Fink, 1995).

According to Schnetler (1989), postal surveys are one of the least expensive of all survey methods. Postal surveys are also popular for their speed and ease of processing and all respondents can be reached with relative ease (Tesner, 1995). Telephonic interviews were disregarded due to the high costs and time involved. Of all survey methods postal surveys provide the greatest possibility of anonymity (Welman & Kruger, 1999). This is of particular importance if the questionnaire is of a personal nature, as respondents perceive anonymity to be a high priority in these circumstances (Tesner, 1995).

On account of the researcher being unable to supervise the completion of the questionnaire in postal surveys, the chances are great that some questions may be omitted or not responded to in the order presented (Schnetler, 1989) which has implications for data analysis. The lack of researcher presence also means that the non-verbal behaviour and spontaneity of the respondent's completion of the questionnaire cannot be judged. The observation of spontaneity is useful in that it allows the researcher to detect hesitation on some questions or issues, which may influence the responses.

An advantage of the lack of researcher presence, however, is that it prevents researcher bias that is often present in personal and telephonic interviews. Biases that affect the reliability of the data, such as poor tester reliability and inconsistency in interpretation of responses is also eliminated by the use of a questionnaire (Fink, 1995). Although it is impossible for researchers to give explanations in postal surveys if respondents do not understand the question, this lack of supervision can elicit more detailed information (Tesner, 1995).

According to Tesner (1995) the respondents of a postal survey are usually uncertain of the cut-off date for the return of the questionnaires. One way in which the researcher can influence this is by requesting that the questionnaires be completed within a certain time limit of, for instance, two weeks. A further drawback of postal surveys is that the researcher has no control over the conditions under which the respondent completes the

questionnaire (Schnetler, 1989). However, postal surveys do allow the respondents to complete the questionnaires in their own surroundings and at their own speed. This freedom allows the respondent to take more time to contemplate answers if required. This lack of control thus holds a potential advantage in the sense that respondents are allowed to complete the questionnaire at their own convenience.

A further disadvantage of postal surveys is that they are perceived to be inflexible because they are standardised documents, yet this can be seen as an advantage because every respondent receives exactly the same stimulus (Tesner, 1995). In addition, all the respondents receive their questionnaires at approximately the same time, which is useful when time is of the essence.

By far the biggest disadvantage of postal surveys is the notoriously low response rate, which may give a biased representation of the population (Tesner, 1995; Schnetler, 1989; Ventry & Schiavetti, 1986). According to Trulove and Fitch (1998), who conducted a postal survey on private practitioners and achieved a 28% response rate, a low response rate may indicate that the persons in private practice lack interest in the topic under evaluation. However, the literature suggests many ways of increasing the response rate of a questionnaire (Leedy, 1997; Fink, 1995; Schnetler, 1989). These include telephoning respondents prior to posting the questionnaire, personalising the documents, following-up by letter or telephone call, and incentivising the return of questionnaires. Personalising the documents is defined as any indication that the researcher has been involved personally in the questionnaire and its dispatch. One study found that questionnaires dispatched in envelopes with stamps yielded a higher return rate than those that were franked (Henley, 1976).

The drawbacks to postal surveys as discussed above, however, can be overcome to a large extent because they have been identified. Therefore, in spite of these apparent drawbacks, a questionnaire was used for the inherent purpose of obtaining the data required of the respondents. It was deemed the most cost and time effective method in comparison with alternative survey

methods as well as the most suited to the nature of the data to be collected and the nature of the population under investigation. Furthermore, the researcher ensured that the necessary controls were implemented to maximize the response rate and prevent biases linked to postal surveys as discussed in the above paragraphs.

3.5.2 Aim of the questionnaire

The questionnaire aims to determine how speech-language therapy and audiology private practitioners in South Africa manage their private practices. The private practitioners' knowledge, opinion and behaviour are questioned to determine the prevalence of various management practices, the frequency with which these practices are used, the reasons for their use, and the importance thereof to the business. A concomitant sub-aim of the questionnaire is to determine the private practitioners' need for training and education in business and management related issues that have reference to private practice in the health care field of speech-language therapy and audiology.

3.5.3 Content of the questionnaire

The content of the questionnaire was developed after a thorough review of the literature on business management to ensure that the questions included were appropriate and relevant to the aims and context of the study (Leedy, 1997). To validate the questionnaire, it is essential that the contents thereof thoroughly and appropriately assess the knowledge, opinion and behaviour intended for measurement (Fink, 1995). Consequently, to accentuate the relevancy of the content of the questionnaire, the researcher adhered to the following guidelines as suggested by Bailey (1982):

1. The aim of the study must be *clear* and *communicated* to the respondent.
2. All the questions must be *relevant to the aim* and thus *transparent* to the respondent.
3. The questions must be *relevant to every respondent* in order to elicit interest and participation in the study.

With regard to content, the type of questions used in the questionnaire should vary according to the information required (Schnetler, 1989). The study aims were therefore kept in mind when selecting the following types of content questions for inclusion into the questionnaire:

- factual questions are included to obtain demographic and personal information;
- behaviour questions are included to analyse the presence or absence of behaviour, the nature, frequency, and degree of importance of the behaviour;
- knowledge questions are included to identify gaps in knowledge that warrant education, and that help explain attitudes and behaviour; and
- questions on opinions and attitudes are also included to probe feelings, ideas, priorities, presuppositions and convictions (Fink, 1995).

Following the initial biographical section in the questionnaire, there was thus an emphasis on behaviour questions throughout sections C, D and E of the questionnaire. The remaining two sections in the questionnaire, sections B and F, placed greater emphasis on the practitioners' opinion of management priorities and training needs. Table 3.2 provides the breakdown of the specific type of content questions that were included in the questionnaire.

Table 3.2 Types of Content Questions Included in the Questionnaire

SECTION	FACTUAL	BEHAVIOUR	KNOWLEDGE	OPINION
A	1, 2, 3, 4, 5, 6, 7, 8			
B				9
C		11, 12, 13, 14, 15, 16	10	
D		19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29	17	18
E		20, 31, 33, 34, 36, 37, 38, 39, 40	32, 35	41
F		42, 44		43, 45, 46, 47

3.5.3.1 Content of the six sections in the questionnaire

Each of the six sections in the questionnaire is discussed in detail below to verify its relevance to the overall aims of the study and to motivate its inclusion into the questionnaire. This is accomplished to ensure that the content is relevant to speech-language therapists and audiologists in private practice, including information required to successfully own and manage a small business in the health care industry. The discussion of the questionnaire commences with the section on biographical information.

- **Section A: Biographical Information**

The speech-language therapy and audiology private practitioners in South Africa form a heterogeneous group that differs in age, experience, geographical situation and working conditions. Little factual information, however, is obtainable about this group in South Africa. The biographical information section was included in the questionnaire to assist in building a profile of the private practitioner in South Africa and to account for the differences in the opinion and management behaviour of the respondents. The information was also used to identify trends in the responses and make comparisons between the different groups of practitioners. The information was not used to identify individual respondents in any way.

- **Section B: Priorities**

According to Metz (1996), good clinical practices must serve the needs of the patient and profit should be the result. However, when business practices and clinical practices collide, the ethics of a clinical practice require that the patient's interests be served first and foremost. The field of speech-language therapy and audiology must therefore strive to maintain the correct balance between business and clinical practice (Metz, 1996). In other words, clinical practice and good business practice are not mutually exclusive in a private practice. The second section of the questionnaire therefore probes the opinion of the private practitioners regarding the prioritization of clinical and non-clinical activities in the private practice. This information could also be used to account for the responses given later in the questionnaire, for example: if cost

analysis was considered a low priority in section B, it may account for the practitioner not using tools to analyze costs which is questioned in Section E.

- **Section C: Strategic planning**

The third section of the questionnaire explored vision statements, goal setting, and environmental analyses which all form the initial stages of a business plan, namely strategic planning (Duncan et al., 1992). This section attempted to identify if the practitioner used information about the internal and external environment to guide the strategic planning procedure for the practice and to determine whether or not goals were set for the practice to grow or develop. Moskovitz (1994) believes that planning enables the practitioner to clarify and identify the practice goals, to strategically position the practice, its services, and its resources in such a way that the practice can continue to be a profitable and successful business. According to White (1995), a further purpose of scanning the environment is to help the practitioner focus on her unique circumstances. It is also part of the process of taking ownership and helps the practitioner translate information into meaningful action within the practice. In addition, staying ahead with new developments in the profession as well as new developments and changes in the environment assists the practice in maintaining the competitive edge over fellow practitioners (Larkins, 1993). This section therefore probes to what extent private practitioners analyze circumstances and set goals to achieve their plans.

- **Section D: Strategic implementation**

The next major section consists of 4 sub-sections, marketing, finance, information technology and personnel management. The first rationale for including this section is to determine if marketing, financial management, information technology and personnel management are used in the private practice. The second rationale is to determine which specific management tools are used, the frequency of their use, and the reasons for their use in the practice. The third and final rationale is to detect the simplicity or complexity of the tools used by the practice to determine whether there is a need for

training in the use of these tools. The motivation for the inclusion of each of the sub-sections is discussed forthwith.

Sub-section D1: Marketing

In order to ensure that clients have access to quality speech-language therapy and audiology services, they must be educated (Larkins, 1993). In other words, practitioners have to market their services and qualifications to the community to make them more aware of the services available. This is especially applicable to the private practitioner whose success depends on how effectively she markets herself and her profession (Smith, 1990). In addition, a marketing message is an indicator of business acumen, clinical skill and quality of service (Smith, 1990). This sub-section therefore determines the private practitioners' knowledge of the concept of market share, competitive advantage, as well as the use and success of different marketing tools within a private practice.

Sub-section D2: Finance

According to Moskovitz (1994), financial records are deemed necessary by law (the Receiver of Revenue), necessary to obtain financing, and to maintain financial control over a business. In a typical private practice where there is usually limited start-up funds available, specific financial practices and controls are essential to ensure that the business remains financially stable and provides an adequate return on investment for the owner or shareholders (Duncan et al., 1992). In addition, careful cash-flow management is required due to the delayed payment of accounts by medical aid organisations. Furthermore, bad debts are a high risk to small businesses and can financially cripple a private practice if control measures such as a debtor's analysis are not used (Wood, 1986). This sub-section therefore determines the financial tools used by private practitioner and probes into the allocation of monies required for essential components of the practice.

Sub-section D3: Information Technology

"Computers result in your practice being more efficient and you being better organised, better informed and thereby better able to do your job" (Leven,

1998). Wynn, Seaton & Allen (1993) believe that computers have become an integral part of any modern business practice and can yield great profits when management is restructured to take advantage of this technology. Furthermore, computerising office management can help practitioners automate repetitive business routines and allow practitioners to track trends in performance, respond promptly to changes in the system, and produce a more attractive output that can lead to a better professional image. In addition, Kent (1994) states that specialists in the field of speech-language therapy and audiology must be deliberately trained to become competent users of emerging technologies. This sub-section therefore explores the use of computers in the practice setting in order to make recommendations regarding information technology training.

Sub-section D4: Personnel management

The quality of speech-language therapy and audiolgy services delivered to the community relies on the clinical skills of those performing the assessment or treatment of the clients. In other words, the people involved in carrying out the services in the business are of utmost importance (Wood, 1986). By the very nature of a private practice there is usually less focus on personnel related issues, as there are fewer staff and little specialisation or division of duties (Flower, 1984). However, it remains the duty of the private practitioner to ensure that the correct persons are recruited and that their roles, responsibilities and duties are outlined in a job description. Providing induction, training, promotion, and effective performance feedback are also essential components of personnel management (Duncan et al, 1992). It is therefore important to determine what personnel management tools, if any, are used by practitioners who employ fellow speech-language therapists and audiolgists.

- **Section E: Accountability and Control Measures**

Accountability and control measures can be defined as the means by which a practice maintains its' business ethic and remains in control of the activities undertaken in serving the public (Trulove & Fitch, 1998). Accountability is especially important considering the responsibility a practice has to the public

as well as to the medical schemes or managed care organisations. Furthermore, a practice exists for its service to clients (Flower, 1984). This means that a high level of client service is required to ensure that the clients' needs are met by the practice. This section, consisting of five sub-sections, was included in the questionnaire to determine the level of accountability maintained in private practices within South Africa. Each sub-section determines whether an accountability tool is used, the regularity of its use and the reason for its use. This information will be used to comment on accountability measures currently used in private practices and whether these suffice for reporting to managed care organizations in the future as well as for the overall advancement of the profession. The inclusion of each sub-section will be motivated separately in the paragraphs below.

Sub-section E1: Cost analysis

"Cost containment means no more business as usual. Controlling costs is paramount" (Goldberg, 1996). According to Goldberg (1996), cost containment is revolutionizing health care, particularly due to the emergence of managed care, which means that the profession of speech-language therapy and audiology is under pressure to deliver more, better, quicker, cheaper. With the development of managed health care in South Africa, it is important for private practitioners in the field of speech-language therapy and audiology to analyse costs and to develop ways in which costs can be contained.

Sub-section E2: Time management

Time management is one of the many forms of accountability measurement (Trulove & Fitch, 1998). Simple and complex systems of analysing management of time and tracking of activities through client scheduling, caseloads and productivity analysis are reported in the literature as key components in the overall organisation and functioning of a private practice (Wood, 1986). Moreover, the practitioner should ensure that sufficient time is spent on billable professional activities, and non-billable clerical or administrative duties (Trulove & Fitch, 1998). This section thus explores the

type of time management system used by the respondent and the problems encountered with time management in the private practice.

Sub-section E3: Record keeping

The care with which documents are kept will reflect the quality of care clients receive (ASHA Technical Report, 1994). ASHA (1994) also stresses the importance of private practitioners guarding against risk associated with documentation by holding detailed records of all communication, correspondence, contact, recommendations, consent and reports. Clinical reports are inherent to all professional practices, however, in a private practice it is the prerogative of the practitioner to decide upon the record keeping system and the type of clinical reporting adopted (Wood, 1986). Furthermore, with the emergence of managed care in South Africa, practitioners may be required to make records available to health care insurance companies during audits (Green, 1998). Therefore the quality, accessibility, usability and accuracy of the recorded clinical, financial and administrative data must be guaranteed (Wood, 1986). This sub-section explores the record keeping habits of private practitioners to determine whether or not they need to become more sophisticated in these administrative tasks.

Sub-section E4: Client satisfaction

Crosby (1994) states that a satisfied client is a successful client. In a similar vein, Lacap (1994) describes a satisfied client as the most valuable marketing tool available. The measurement of client satisfaction is an essential component of determining clients' needs in order to respond to the way quality service is delivered to the client (Klop, 1998). A client satisfaction survey in itself will not necessarily enhance the quality of the services; therefore, the practitioner must be committed to act upon the findings of surveys. It would otherwise compromise the practitioner's credibility. In this sub-section, the respondents are asked to indicate whether or not they have measured client satisfaction, how they measured it, and what adaptations were made in accordance with the clients' suggestions.

Sub-section E5: Accountability practices.

The pervasive thread connecting most of the current literature is the urgent call for greater accountability in the profession of speech-language therapy and audiology (Trulove & Fitch, 1998; Boston, 1994; Paul-Brown, 1994; Wynn et al., 1993). Trulove and Fitch (1998) report that their study indicated that speech-language pathologists in private practice are concerned about accountability. Furthermore, it is believed that accountability measures can prove the worth of speech-language therapy and audiology services to health care reformers and can guarantee that the profession is included in the services insured (Boston, 1994). In addition, third-party payers are increasingly demanding proof of improvement from treatment (Magennis, 2000). It is thus important for speech-language therapy and audiology private practitioners to be aware of the need for accountability in all the aspects of their assessment and treatment of clients. The section on accountability in the questionnaire requested respondents to give their opinion of the recent demand for more accountability in the field of speech-language therapy and audiology.

- **Section F: Training and Education in Business Management**

Metz (1996) states that the curriculum currently being taught by most training institutions in North America serves, to a large degree, the needs of a clinical education. Yet, university training systems are being criticised for not responding quickly enough to the needs of the private practitioner. According to Uys & Hugo (1997) transformation in teaching the communication pathology curriculum is required to prepare the professional of the future to meet the needs of South Africa. However, the argument remains whether it is the responsibility of the university training programmes or that of continued education, which should teach courses that involve business practices. In order to make recommendations on future training programmes for private practitioners it is thus important to determine their needs and opinions regarding training.

The final section of the questionnaire includes an investigation of the respondents' previous training details and explores their future interest in

practice management training. In addition, their attitude towards receiving assistance from people outside the profession, in particular business professionals, was established. The final two questions requested the respondents' opinion on the level of experience at which training in business management should be aimed and whose responsibility it is to provide training. These questions were deemed important as, based on the outcome of the analysis, recommendations could be made to certain institutions regarding the targeting of specific groups to which training in private practice management would be most beneficial.

In conclusion, the detailed motivations outlining the relevance and rationale of the inclusion of the six sections in the questionnaire have been discussed in the above passages. The content appears to be relevant to the topic and justifiable for research on subjective analysis of the researcher.

3.5.3.2 Descriptions of and justification for questions included in the questionnaire

To supplement the above discussion, each question in the questionnaire is described briefly in Table 3.3 and a short justification is provided for its inclusion in the questionnaire. This table is based on a similar example by Moodley (1999).

Table 3.3: Descriptions of and justification for questions included in the questionnaire

Section	Area & Questions	Motivations for questions
A	**Biographical Information:**	
	1. Location of practice in South Africa.	To determine the geographical spread of PP's to account for differences in behaviour and training needs.
	2. University attended and year of graduation.	The training institution may influence the practitioner's knowledge and management behaviour.
	3. Highest professional qualification in speech-language therapy and audiology.	This factor may influence the practitioner's knowledge and opinion regarding business management.
	4. Years of speech-language therapy / audiology experience.	Experience may influence the knowledge, management practices & needs of the PP.
	5. Percentage split between speech-language therapy and audiology.	This factor may influence the use of certain management practices in the different private clinical settings.
	6. Number of speech-language therapists / audiologists employed.	This factor may influence the management behaviour of a practitioner.
	7. Average hours per day and days per week worked.	The employment status may impact on the need for certain business management practices and training required.
	8. Client base of the private practice and services provided to the community.	These two factors were included to identify the most common services provided amongst PP's and to determine who is their client base in order to comment on the needs of the private practitioner within these settings.
B	**Priorities**	
	9. Respondent's opinions were requested on the prioritisation of clinical and non-clinical functions in their businesses. This question listed 10 functions, which were to be rated 1-4 in order of importance to the respondent. A description of each of the functions was provided to ensure understanding.	Excellent business practices and quality clinical practices are required to successfully manage a PP (Flower, 1984). All private practitioners should be knowledgeable about the importance of these 10 areas of the PP. The prioritisation of these 10 items also helps to account for responses given later in the questionnaire.

Table 3.3 continued

C	Strategic Planning	
	10. Respondents were requested to indicate whether or not they had a vision for their practice and to state it if they had one.	A vision statement is the first element of a business plan for a PP as it articulates the aspirations of an organisation (Rassi & Fino-Szumski, 1994). This question determines whether the practitioners have the knowledge of what a vision is and whether they have formulated one for their own PP.
	11. This simple yes/no question requests the practitioner to indicate if an annual business plan is drawn up for the practice.	A business plan enables the practitioner to objectively look at her practice so that she can manage it better and work towards its success (Moskovitz, 1994). This factor may thus influence the type of management behaviour in a PP.
	The following 3 questions list various issues that should be reviewed during strategic planning of the practice. They cover the internal and external environment of the practice as well as the health care industry.	Strategic planning is a process which a practice follows to plan for the future, to set goals and to develop an action plan to achieve goals (Brown, 1994). In order to carry out this process, the practice has to consider its practice environment and the external and internal influences on the practice. The requirements for a SWOT analysis are included in the following 3 questions.
	12. Respondents were requested to indicate the information about the environment that they review when planning. A list of 11 issues was posed for selection.	The issues questioned in no. 12 pertain to the internal environment of the practice.
	13. This question assessed which issues in the community are reviewed by PP's when they plan. 5 issues were listed for selection.	These issues pertain to the external environment or community and how these may influence the PP and the goals set for the PP.
	14. Five issues in the health care industry were listed from which the PP selected those that she reflects upon and aligns her practice with.	These 5 issues pertain to industry specific information required by the PP for inclusion into the business plan.
	15. This question comprised five aspects of business (financial, marketing, customer service, education and quality) for which goals are usually set. Respondents were requested to indicate the type of goals set and the time period for which they are set.	Goals identify where a PP wants to be with regard to specific elements of the business, e.g. financial, marketing etc. (Moskovitz, 1994). This will influence the practitioner's management practices and the need for change in the PP. The time period for which goals are set may indicate the strictness of controls (especially financial controls).

Table 3.3 continued

	16. Private practitioners' long term plans for their businesses were probed in this yes/no question. A statement of these plans was requested if the answer was yes.	This factor may influence the need for training in business management issues and may have an impact on the management practices used in the PP.
D	**Strategic Implementation**	
	Marketing: 17. Respondents were asked to indicate the proportion of market share that they have in their area. Five possible answers were provided in intervals of 20% & the sixth answer was "Unsure". 18. In a simple yes/no question format, respondents were requested to indicate whether or not they had a competitive advantage over other private practices. If the response was yes, they were asked to state the advantage. 19. This question was composed of 7 marketing tools which the respondents were requested to rank according to the frequency of use (never, once/twice, 2-4 times, >5 times). In addition, they were asked to indicate if the tool was successful in yielding business opportunities.	It is important for private practitioners to know what their market share is as this will enable them to realise whether or not there is further potential for increasing speech therapy and audiology services in the community. This factor will influence practice goals, long term development plans and marketing initiatives. Knowing what the PP's competitive advantage is over other practices gives the practitioner an opportunity to market herself and the PP's services more effectively and may influence the type of marketing effort used (Smith, 1990). The type of marketing effort varies according to the practice setting. Marketing plans are also flexible and responsive to changing situations. The amount of money that is committed to marketing also determines the strategy used. Since all these factors influence the type of marketing tools used, the practitioners' use of these tools was determined.
	Finance: 20. The means by which private practitioners receive payment for their services was probed in this question. Responses were elicited in the form of approximate percentages of total payment for all services. 21. The respondents were asked to indicate in a yes/no format whether or not they had experienced cash flow problems.	Tariff structures and means of payment for services have a huge impact on the business and the clientele it serves (Moskovitz, 1994). This factor may have implications for the client base, competitiveness of the PP, financial health of the business, amongst other related aspects affecting financial controls. This factor may be related to poor initial financial planning of the business, means of payment for services rendered and financial control over the PP.

Table 3.3 continued

	22. This question requested respondents to indicate their practice's bad debts as an approximate percentage of annual income. 23. Respondents were requested to name the person who completes the annual tax returns for the practice. 24. A list of 7 financial records was drawn up from which respondents were requested to mark those used in their practice. 25. This question assessed the allocation of monies to marketing, equipment, stationery, & continuing education as a percentage of annual gross income.	Bad debt is an indication of financial control over a PP (Duncan et al., 1992) and may also be related to socio-economic factors in a community. This factor is likely to have implications for the financial health of a PP. Responses to this question may indicate the need for training with regard to tax matters. Financial records are crucial for outlining current and future financial requirements for the PP (Moskovitz, 1994). The degree to which a PP has control over the financial aspects of the business is directly related to the financial success of the PP. These factors constitute the major expenses for most PP's (Flower, 1984), therefore, the allocation of money for these purposes may be an indication of PP growth, need for training, and priority for the practitioner.
	Information Technology: 26. Practitioners were asked to indicate whether or not a computer was used in the practice. 27. This question assessed the different functions for which the computer was used in the practice. Five possible responses were suggested and space was provided for the respondent to fill in any other function for which the computer was used. 28. This yes/no question assessed whether or not practitioners had access to the Internet. If the answer was no, they could indicate that they would like to have access. 29. Practitioners were required to indicate if they had searched the Internet for speech-language therapy and audiology related topics.	The following 2 questions relate to the use of computers in the PP. Successful practitioners need to employ every available resource to optimise office management (Wynn et al., 1993). Furthermore, computerising office management can yield great profits and will help prepare private practitioners to respond to the dynamic demands of the community and the profession (Goldberg, 1995). It is therefore important to know whether or not computers are used in the PP's in South Africa and to determine the function of the computers in the PP. These 2 questions refer to the level of information technology used in PP's. The Internet helps to keep practitioners up to date with the changes in the field and to explore the potential of the profession. Research, online conferencing and discussion formats are some of the uses of the Internet (Masterson et al., 1999). Technology also allows practitioners ready access to each other and to many clients. Responses to these questions may also be an indication of the need for further training or information.

Table 3.3 continued

	Personnel Management: 30. The private practitioners who employed other speech-language therapists and audiologists were requested to select, from a list of 6, all the forms of personnel management they used in their practice.	Sound personnel management practices are a critical element of maintaining a good professional image in a PP (Flower, 1984). The 6 items listed in the question form the basic components of personnel management and are required in all successful PP's with any number of employees (Duncan et al., 1992).
E	**Accountability and Control measures**	
	Cost Analysis: 31. In this question, respondents were requested to indicate whether or not they had determined the cost of their services in terms of money or time spent. 32. Respondents were asked to indicate whether or not the services they provided were indeed cost effective. A "don't know" response was provided to cater for respondents who were unsure. 33. Respondents were requested to explain, in words, how their practice contains costs.	Businesses usually act with the sole purpose of making a profit (Flower, 1984). For this reason the cost of the services need to be determined in order to be able to calculate the economic value of various services such as assessment, group therapy or a hearing aid evaluation. Cost analysis is a measure of accountability and is necessary to assess the cost of services for billing purposes and tariff structures (Trulove & Fitch, 1998). This in turn will have implications for the financial success of a PP. The need for containing costs and the manner in which this is achieved will highlight the commonality of problems with costs containment amongst PP's.
	Time Management: 34. The type of time management used in the practice was assessed in this question. Respondents had a choice of daily, weekly, monthly, quarterly and annually to choose from. 35. With reference to the above question, respondents were requested to list the problems they encountered with time management.	Time management is a form of accountability within a PP (Trulove & Fitch, 1998). The use of time management controls is essential to the organisation of the practice and to determine the productivity of employees. This may also have an effect on the cost of services rendered to the community. A list of common problems with time management may stress the need for training in this regard.

Table 3.3 continued

	Record keeping: 36. Six types of record keeping systems were listed in this question and respondents were requested to indicate which ones they used in their practices. The final option was "other" to cater for those responses that did not fit into the 5 named options. 37. The type & frequency of recording information used to monitor client progress was assessed in this question. Five types of information were listed and respondents were requested to indicate how frequently, if ever, they used this information to record client progress.	The type of record keeping system employed by practitioners may indicate the need for training in alternative systems. The requirements of medical aid and managed care organisations can also be satisfied through accurate and sufficient record keeping methods (Boston, 1994). Private practitioners have much freedom in the way records are kept and the type of information to include (Wood, 1986). However, records are becoming increasingly important as managed care organisations are requiring access to records to determine the outcome of treatment (Jamieson, 1998). For the profession of speech therapy and audiology to remain accountable and professional within the managed health care industry, record keeping habits may need to become more standardised.
	Client Satisfaction: 38. Private practitioners were asked whether or not they have measured client satisfaction. A simple yes/no format was provided for their response. 39. In this question, information regarding the type and frequency of client satisfaction tools used in the practice was evaluated. Four tools were listed and respondents had a choice of quarterly, bi-annually, annually and never to choose from. 40. This question explored the actions of the practitioner after measuring client satisfaction. Respondents were asked if they had acted upon suggestions made by clients and adapted their practices.	The 3 questions regarding client satisfaction emanate from TQM requirements, managed care standards and the ethical responsibility to provide outcome based, quality focused services (Green, 1998; Cherow, 1994; Fratali, 1994). Furthermore, client satisfaction cannot be assumed, it has to be measured to be improved (Klop, 1998). The responses to the questions on client satisfaction will thus indicate whether there is a need for training in determining client satisfaction, what clients main concerns are about therapy, and whether private practitioners practice the client-centered approach to therapy.

Table 3.3 continued

	Accountability Practices: 41. The extent to which private practitioners should be accountable for their choice of assessment and treatment methods was under investigation in this question. Private practitioners were required to give their opinion in a yes/no format and to motivate their choice.	The opinion of the private practitioners in respect of the need for more accountability is in accordance with the current literature on accountability measures, managed care initiatives and outcomes-based data (Frattali, 1998; Trulove & Fitch, 1998; Boston, 1994). Improvements in accountability within the profession are directly related to the practitioners' perception of the need for accountability in assessment and treatment, and the manner in which they fulfil that need.
F	**Training and Education in Business Management**	
	42. Private practitioner's training in business & private practice management was assessed in this question. Respondents were requested to indicate whether or not they have attended courses or lectures in this field and to provide details of the training attended. 43. This question ascertained whether the respondents would be interested in attending a course on private practice management. Practitioners needed to respond by stating yes or no. 44. This question explored respondents' attitude towards receiving business advice & assistance from family, friends, business and financial professionals. Respondents were required to indicate whom they have approached and whom they would consider approaching for advice.	Previous experience, informal training or formal education in business management principles or private practice management may have an influence on the current needs or interest of the practitioner to attend business-training courses in the future. Previous training will also have an effect on the practitioners' responses to sections C, D, and E of this questionnaire. The type and number of courses attended may also give an indication of what training is currently available and popular amongst private practitioners. Furthermore, the number of years of private practice experience may affect respondents' desire and interest in learning about business management. This factor may indicate the practitioners' accessibility to resources of business management knowledge, and the degree to which they believe they need advice and assistance in managing their PP. This may also have an effect on whether or not they feel they need training in business management principles.

Table 3.3 continued

	45. The opinion of the respondents, with regard to when it is necessary for therapists to learn about practice management, was requested in this question. Respondents were offered 5 choices including "Never" which catered for the differences in opinion. 46. Respondents were asked for their opinion as to who they thought should run business management courses for therapists. 47. This was an open-ended question that requested private practitioners to write, in words, what they would like to see covered in a course for private practitioners.	These 2 questions were included in order to make recommendations to training institutions about the training needs of private practitioners in South Africa. In order for business management training to be successful and applicable to private practitioners, it needs to be focussed at the required level of experience in the profession. Furthermore, an appropriate group or organisation that will be able to understand and cater for the specific needs of the private practitioner should conduct the training. Ideas and recommendations for the content of a course compiled specifically for private practitioners would indicate the most prominent training needs amongst respondents. These needs can therefore be communicated to training institutions to ensure that training is appropriate.

3.5.4 Compilation of the questionnaire

3.5.4.1 Design

A well-constructed questionnaire can boost the reliability and validity of data, whereas a poorly constructed questionnaire can invalidate any research results (Fink, 1995). Furthermore, according to Leedy (1997), poorly constructed questionnaires result in poor quality data. It is therefore of the utmost importance that the questionnaire design and format immediately appeals to the respondent and is considered "user-friendly" in order to elicit the required responses (Bourque & Fielder, 1995). Due to the length of the questionnaire (six pages) and two additional pages for the inclusion of a covering letter and instructions, the questionnaire was printed in an A5-sized booklet format that would appeal to the respondents more than eight loose pages.

The front page of the booklet contained the covering letter, the second page the instructions for completion of the questionnaire, and the remaining pages consisted of six sections containing 47 content questions. The questionnaire was constructed in such a way as to ensure that the majority of the respondents could complete it within 20 to 30 minutes to prevent the respondents from becoming fatigued. It was neatly typed, had adequate margin space and care was taken to ensure that the initial and overall impression was uncluttered. Furthermore, a clear and simple method for marking off responses was used, sufficient spaces were left between questions, and predominantly short closed-ended questions were used to ensure the user-friendliness of the questionnaire (see Appendices B, C, and D).

3.5.4.2 Covering letter

According to Leedy (1997) the covering letter accompanying the questionnaire is very important and should be carefully and thoughtfully constructed in order to address the respondents' concerns. Tesner (1995) recommends that a covering letter should identify the researcher, explain the purpose of the study, explain why the respondents participation is important, to reassure the respondent that there are no correct or incorrect answers, and that anonymity

and confidentiality is assured. In addition, the letter should be positive, courteous and demonstrate the researcher's appreciation to all the respondents (Leedy, 1997). The above recommendations were heeded when compiling the covering letter for this study. Furthermore, in the closing of the letter, an opportunity was extended to all the respondents to indicate whether they would like to know the outcome of the research project. It was hoped that this would increase the likelihood of commitment to responding to the questionnaire (see Appendix B).

3.5.4.3 Instructions

Instructions are the tools by which the researcher attempts to elicit the desired response and to maintain a consistent response set across subjects (Ventry & Schiavetti, 1986). Inappropriate, inadequate or poorly worded instructions thus pose an instrumentation threat to internal validity (Bourque & Fielder, 1995). The instructions to the questionnaire used in this study were self-compiled by the researcher to ensure that they were appropriate to the task of completing the particular questionnaire used in this study. The instructions were brief, clear and sufficient in detail (see Appendix C).

3.5.4.4 Language, wording and phrasing of questions

The language proficiency of the respondents needed to be taken into account with the formulation and wording of the questionnaire since the questionnaire is only printed in English (Schnetler, 1989). It is thus presumed that there is a bias towards English speaking respondents, as they will have better control over and use of the language. It is, therefore, important that the questionnaire contains familiar business terms that are relevant and understood by the all private practitioners in order for them to make informed responses to the questions. Consequently, the wording of the questions is kept simple and concise throughout the questionnaire and technical terms are avoided (Bourque & Fielder, 1995).

Certain business management terms are described in Section B of the questionnaire to assist the respondent in understanding the meaning of the terms and to ensure uniformity of understanding of the terms among all the

respondents. Furthermore, each section is introduced by an explanation of the topic under question.

In addition, the tone of the questionnaire is courteous to encourage cooperation and enhance the chances of having the questionnaire elicit the attention required (Fink, 1995). The clarity and simplicity of the language and terms used in the questionnaire was monitored during the pilot study and adapted where necessary to improve the understanding of the questions by all the respondents.

3.5.4.5 Question format included in the questionnaire

There are two basic questions formats that can be used in a questionnaire, namely, closed and open questions, with various combinations of these formats (Tesner, 1995). A closed question can be described as one where the response categories are clearly specified and mutually exclusive, from which the respondent selects the one category that best suits her response. Alternatively, an open question does not specify any particular response category but encourages the respondent to express her response freely (Schnetler, 1989). The advantages and disadvantages of both types of questions will be discussed below.

According to Leedy (1997), one of the advantages of using closed questions in a survey is that the answers are standard and can thus be compared with ease and without any ambiguity. Furthermore, the responses to closed questions are easier to encode and facilitate data processing and analysis. Moreover, the respondents have clarity regarding the meaning of the question because they can deduce information from the answer choices available to them. There are also fewer irrelevant responses elicited with this type of questioning. One reason why respondents prefer closed questions is because they are easier to answer, as the respondents have only to choose from the given answers (Fink, 1995).

There are, however, also a number of disadvantages of closed questions. The main disadvantage is that the respondent's preferred response is not available

in the answer choices given on the questionnaire (Schnetler, 1989). There may also be too little detail entailed in the response category, which could lead to frustration on the respondent's behalf, as he or she is not granted the opportunity to explain his or her actual point of view. Furthermore, respondents may differ in the interpretation of the items or question, make clerical errors, simply guess or choose the simplest answer of "Unsure" if this is available (Fink, 1995).

According to Tesner (1995), every questionnaire should consist of at least one open-ended question, as this type of question has the advantage of offering the respondent an opportunity to make a suggestion and give an opinion without any influence from the researcher. Most of the advantages and disadvantages of open questions are the opposite of those of closed questions and will therefore not be repeated. However, it should be mentioned that one of the biggest disadvantages of open questions is the fact that they are notoriously difficult to encode into meaningful data for analysis. This may be overcome though, by reporting on similarities in the responses or by quoting the most prominent responses. This disadvantage is offset by the advantages open questions have in being more appropriate for measuring a wide range of opinions, motives and sensitive behaviour (Schnetler, 1989).

For the purpose of this study, a selection of closed and open question formats were included to ensure that the subject matter was adequately covered and the respondents' true opinions elicited. As suggested by Tesner (1995), the majority of questions included were in closed questions so that the responses could be encoded quickly and compared easily. Furthermore, there was a great deal of subject matter to cover and the researcher did not want the respondents to become fatigued from responding to many open questions. The open-ended questions were distributed throughout the questionnaire and were used for the following reasons:

- to elicit suggestions from the respondents
- to allow the respondents to motivate their opinion or behaviour in their own words
- to request the respondents to state their vision, long term development plans, and competitive edge
- where it was unsure how many or what answer choices to include so as not to limit the respondent to the given answer choices

In conclusion, the questionnaire consists of 11 open questions and 42 closed questions, which is detailed in Table 3.4. This number does not add up to 47 (the number of questions making up the questionnaire) because 6 questions are a combination of closed and open question formats, that is, the question begins with an answer choice and then later asks for a motivation or statement. The combination of open and closed format questions is deemed appropriate for the study in order to gain as much insight into the respondents' behaviour as possible.

3.5.4.6 Response format

In addition to the open and closed type of questions, the literature describes three response formats for closed questions, namely nominal, ordinal, and numerical (Tesner, 1995). A brief description of each type of response format will be given with an example of how each is used in the questionnaire.

- **Nominal:** This refers to response choices without numerical or preferential values. The most popular nominal response format is Yes / No. An example of a nominal response format in the questionnaire would be as follows:

  Question 29: Have you searched the Internet for speech-language therapy and audiology related topics?

YES	NO

- **Ordinal:** The second type of response format is called ordinal. In this type of format respondents are asked to rate or order choices, for example:

  Question 9: A scale from 4 = "EXTREMELY IMPORTANT!" to 1 = "NOT AT ALL IMPORTANT!" IS SHOWN BELOW. Choose a number that best describes how important you feel the activity is.

4	3	2	1
EXTREMELY IMPORTANT	QUITE IMPORTANT	NOT REALLY IMPORTANT	NOT AT ALL IMPORTANT

	Rating
Planning and setting goals	
Marketing	
Financial management	

(An abbreviated version of the response format is given)

- **Numerical:** This response format calls for numbers. An example of this response format in the questionnaire is the following:

  Question 22: Please indicate bad debts as a percentage of your annual income.

  _____% Bad Debts (approximately)

(Fink, 1995)

Table 3.4 lists the type of question and response format used for each of the questions in the questionnaire. Following the table, a motivation is given for the use of each type of response format in the questionnaire.

Table 3.4 Type of questions included in the questionnaire

Type of response format	No. of questions with this response format	List of question numbers
Open	11	1, 2, **10**, **16**, **18**, 23, 33, 35, **40**, **41**, 47
Closed:	42	
- **Nominal**	30	3, **8**, **10**, 11, 12, 13, 14, 15, **16**, 17, **18**, 21, 24, 26, 27, 28, 29, 30, 31, 32, 34, 36, 38, **40**, **41**, 42, 43, 44, 45, 46
- **Ordinal**	4	9, 19, 37, 39
- **Numerical**	8	4, 5, 6, 7, **8**, 20, 22, 25

It is evident from Table 3.4 that the majority of the response formats are nominal. The reason for this being that the nominal format is the quickest and simplest for the respondent to understand and for the researcher to encode (Schnetler, 1989). The nominal response formats in this study offered the respondents between 2 and 11 categories to choose from. Furthermore, 13 of the nominal format questions allowed the respondent to mark more than one category.

The remaining questions are comprised of four ordinal and eight numerical response formats. These formats are less prevalent in the questionnaire as they require more thinking and understanding on the respondent's behalf (Fink, 1995). Furthermore, the researcher did not want the respondents becoming fatigued from responding to too many complicated question formats.

Overall, the type and variety of response formats chosen for the questionnaire suited the goals, subject content and the desired responses from the respondents. Furthermore, the results of the pilot study (Section 3.6.5) complimented this view. After the compilation of the questionnaire and covering letter, it was essential to evaluate the reliability and validity of the instrument used for data collection (Ventry & Schiavetti, 1986), in order to draw accurate conclusions from the amassed data. In the following two sections, the procedures undertaken to ensure the questionnaire's reliability and validity are discussed.

3.5.4 Reliability

"A reliable survey instrument is an accurate one. It is reliable if each time you use it, you get the same information" (Fink, 1995). The reliability or consistency of information can be jeopardised by poorly worded and imprecise questions and instructions (Ventry & Schiavetti, 1986). Furthermore, if a questionnaire is unreliable, it is also invalid because one cannot have accurate findings with inconsistent data. Moreover, valid survey instruments are always reliable (Fink, 1995).

A reliable survey instrument is one that is relatively free from "measurement error" that may be caused by a number of factors. In some instances the measure itself (the questionnaire) is the source, in other instances the researcher or the respondent may be the source of measurement error. Since the researcher has little influence over the respondents, measures to improve reliability are focused on the reliability of the questionnaire and the researcher's involvement in the construction of the questionnaire. The following measures were used to improve the reliability of the questionnaire:

- A pilot study was undertaken to increase the reliability of the questionnaire items, as discussed in detail under section 3.6.
- Careful attention was paid to the formulation and content of questions, since this could affect the homogeneity of the items.
- Separate motivations for each question are given to justify the relevance of it being included in the questionnaire.
- The pilot study respondents considered all the questions to be directly related to the aims of the study and the topic under investigation, thereby increasing the likelihood that the items are homogeneous.
- Due to the high number of possible questions to include in the questionnaire, the researcher edited the initial number of questions through a process of elimination to check the relevance and homogeneity of the individual questions and to ensure that they elicited the required information from the respondents.
- The researcher was elected the sole recorder of data from the questionnaires, which rules out inter-rater reliability errors.
- An assistant checked the recorded data to ensure that it was encoded consistently, thereby increasing the intra-rater reliability.
- A computer spreadsheet, used for the recording of data, detected errors that occurred in the initial recording process.

With regard to test-retest reliability, the present study only undertook one testing procedure of the questionnaire. However, to increase the reliability of the questionnaire, recommendations will be made in the final chapter of this

study regarding further opportunities to make use of the questionnaire in similar forthcoming studies.

In conclusion, reliability is not an all-or-nothing phenomenon: different measurement instruments have different degrees of reliability (Ventry & Schiavetti, 1986). The factors affecting reliability in the questionnaire used in this study have been acknowledged and controlled as far as possible to ensure the reliability of the study. Reliability does not ensure validity; however, it is a necessary prerequisite for validity.

3.5.5 Validity

"Whereas reliability means consistency or precision of measurement, validity means truth, correctness or reality of measurement" (Ventry & Schiavetti, 1986). Validity is therefore the attempt to determine whether a type of measurement actually measures what it is presumed to measure. In the context of this study, the validity of the questionnaire is analysed according to the four types of validity reported in the literature, namely: content, face, criterion, and construct validity (Alant, 1998; Fink, 1995; Schnetler, 1989). Each of these is discussed below, with reference to the questionnaire used in this study.

- Face validity refers to how a measure appears on the surface, whether or not it answers all the research questions and whether or not it uses the appropriate language and language level to do so. The face validity of the present questionnaire was based on the researcher's subjective judgement.
- Criterion validity compares responses to future performance or to those obtained from other, more well-established surveys. This research study consisted of an initial testing of private practitioners' management practices in South Africa and thus does not have a previous criterion to be measured against. However, the literature cites examples of questionnaires used in studies with a similar purpose (Trulove & Fitch, 1998).

- Content validity refers to the extent to which a questionnaire thoroughly and appropriately assesses the behaviour and knowledge it is intended to measure (Fink, 1995). The questionnaire in this study was compiled after an extensive review of the literature to ensure that it included all the items relevant to the topic of research. Furthermore, the self-compiled questionnaire in this study was pilot tested to verify the content of the questions to ensure that they were applicable and relevant to the purpose of achieving the aims of the study. The results of the pilot test are discussed in section 3.6.5. In addition, an expert in private practice management approved the questionnaire, thus contributing to the measure's content validity.
- Construct validity refers to the degree to which a construct or concept is actually measured. Examples of constructs in the present questionnaire are the following: the *opinion* of the private practitioner, their management *behaviour* in their practices, and their *knowledge* of business management principles. During the construction of the questions, the researcher carefully considered the guidelines in the literature with regards to question type, response format, and construction. This attention to detail improved the construct validity of the questionnaire, which was verified by the respondents of the pilot study.

In conclusion, the study appears to have taken into consideration all the precautions and control measures to ensure the reliability and validity of the questionnaire, which allows for meaningful conclusions to be drawn from the data assimilated from the returned questionnaires.

3.6 PILOT STUDY

The first draft of a questionnaire is never perfect and ready to administer (Bourque & Fielder, 1995). It is therefore suggested that the questionnaire and all related administrative procedures that will be used in the study be pilot tested prior to the actual data collection (Leedy, 1997). The pilot study is a tool for providing the researcher with valuable information for changing aspects of the questionnaire and the administrative procedure. It also makes the

researcher aware of biases contained in the questionnaire (Bourque & Fielder, 1995). The aim of the pilot study for this research project, the respondents and procedure used, and the results of the pilot study are discussed in detail in the paragraphs below.

3.6.1 Aim of the pilot study

The aim of this pilot study is to determine the validity and reliability of the self-compiled questionnaire as well as its suitability to private practitioners and to improve on these aspects by adapting the questionnaire where applicable (Schnetler, 1989). A number of sub-aims were set for this purpose, namely:

- To evaluate the aptness of the covering letter
- To evaluate the clarity of the instructions
- To identify and eliminate the presence of ambiguous and misleading questions
- To determine the understanding of the terms used
- To determine the time taken to complete the questionnaire
- To determine the ease of completion of the questionnaire
- To determine the ease of scoring the questionnaire on a self-compiled spreadsheet

The above aims were listed in a check sheet that was completed by the researcher after the respondents of the pilot study had completed their respective questionnaires.

3.6.2 Respondents of the pilot questionnaire

The questionnaire was pre-tested on a small population of three speech-language therapists and audiologists in private practice. The respondents were carefully selected to ensure that each respondent fitted the criteria of being a private practitioner as discussed in Chapter 3 (section 3.4.1 - Criteria for selection of respondents). Two of the pilot study respondents were English speaking and one was Afrikaans speaking. Each of them owned their own private practice and each had been practicing in a private clinical setting for at least two years. The respondents selected were all resident in Cape Town

which made it convenient for the researcher to be present during the completion of the questionnaire, to monitor all non-verbal behaviour, and to obtain direct feedback immediately after the questionnaire had been completed.

3.6.3 Materials and apparatus used in the pilot study

The questionnaire used in the pilot study was an exact replica of the self-compiled questionnaire with the same format and content as described previously in Chapter 3 (section 3.5.3). The only differences were those made after the analysis of pilot study respondents' feedback.

3.6.4 Pilot study procedure

All the aspects of the research procedure were tested during the pilot study except the initial telephone call and the posting and collecting of the questionnaires as this was deemed unnecessary to be pre-tested and time consuming.

The procedure for the execution of the pilot study was as follows:

- Once the pilot study respondent had been selected, she was asked if she would take part in the study. All three respondents agreed.
- The researcher and the respondent met at a mutually convenient time in a quiet area and set aside 60 minutes to complete the questionnaire and give feedback.
- The questionnaire was then personally handed to the respondent with the following verbal instructions from the researcher:

> *"Please read all the text and follow the instructions in the questionnaire booklet. Please also indicate with a star on the questionnaire, all the problems, ambiguities, and uncertainties you encounter. We will discuss these in detail at the completion of the questionnaire."*

- Whilst the respondent read and completed the questionnaire, the researcher timed the respondent and made notes of all hesitations as well as questions which took longer than expected to answer.
- A period of individual feedback was held at the completion of the questionnaire during which time the researcher completed the following worksheet:
- At the end of the session, once all the questions had been answered, the respondents were thanked for their participation.
- The researcher then analysed the feedback and scored the data collected from the three pilot study respondents on the spreadsheet designed for this purpose.

Table 3.5 Pilot study worksheet

No.	QUESTION AND RESPONSE
1.	In your opinion, was the covering letter appropriate to the aim of the study, as you understood it? **Response:**
2.	Were the instructions clear and did you understand them? **Response:**
3.	Did you encounter any ambiguous or misleading questions in the questionnaire? If so which questions in particular? **Response:**
4.	Did you understand all the terminology and the descriptions given for each term? If not, which terms in particular did you not understand? **Response:**
5.	Did you find the questionnaire easy to complete? If not, why? **Response:**
6.	I noticed that you hesitated on question ___. Do you remember why? **Response**:
7.	Do you feel that any items or issues have been omitted or need to be pursued further with additional questions or answer options? **Response:**
	Time taken to complete questionnaire:___minutes

3.6.5 Results of the pilot study

The pilot study resulted in a small number of changes to the questionnaire. A short description will be given of the results.

With regard to the aptn etter and the clarity of the instructions, respondents reported that both were clear and simple to understand. In addition, the covering letter was reported to be courteous and appropriate to the study. On the issue of misleading or ambiguous questions, all three respondents indicated that questions 8, 17, and 19 required more clarity in terms of wording and instructions. One respondent also reported that question 39 had insufficient answer choices. These questions were re-written with the respondents giving input as to the way in which the old question was misunderstood.

The respondents all agreed that the terminology used in the questionnaire was appropriate for the level of education of the practitioners and the type of business they were involved in.

With regard to the ease of completion of the questionnaire, the respondents mentioned that the questionnaire was not difficult to complete but had made them think about their respective businesses from a new perspective. Furthermore, when they had reached the last section of the questionnaire, they realised that they were in need of training in business management and indicated this on the questionnaire.

The time taken to complete the questionnaire ranged from 15 to 30 minutes, with an average of 20 minutes. This was within the time limits originally planned for the completion of the questionnaire. It was expected, however, that some respondents would take longer than the prescribed 20 minutes due to, amongst others, translation of words and environmental disruptions.

The scoring of the questionnaire on the self-compiled spreadsheet took longer than expected due to initial difficulties with the manner in which responses were coded on the answer sheet and to accommodate and score the open ended responses. It was likely that the scoring would become more rapid with practice.

In as far as improving the validity and reliability of the self-compiled questionnaire are concerned, the above adaptations to the questionnaire were considered appropriate and sufficient for the purpose of the pilot study. Furthermore, the respondents gave positive feedback on how comprehensive the questionnaire was and how it probed real issues relating to private practitioners. The questionnaire was thus deemed suitable for private practitioners in the field of speech-language therapy and audiology.

The pilot study therefore achieved its purpose of improving the reliability, validity and suitability of the questionnaire in as far as the sub-aims were realised.

3.7 PROCEDURE

The procedure for the implementation of self-administered questionnaires requires considerable coordination and attention to detail (Bourque & Fielder, 1995). This multi-stage process comprises of the dissemination of the questionnaires, the collection of data, and the recording of data. The detailed procedure within each of these components will be discussed in bullet form below.

3.7.1 Dissemination of the questionnaires

The procedure for the dissemination of the questionnaires was as follows:

- Once the practitioner had indicated over the telephone that she would like to take part in the study, the researcher prepared the questionnaire booklet and hand-wrote the address on the envelope for posting.
- A faxed or posted copy of the questionnaire was sent to the respondents, whichever method was more convenient for the respondent.
- The postal questionnaires were sent by conventional postal service on the day that the respondent had been telephoned. Posted questionnaires included self-addressed, stamped return envelopes to minimize the cost, time and effort of the participants to return the completed questionnaire.
- For those respondents who indicated that they would prefer a faxed transmission, a short cover page was typed with the relevant names and

return fax numbers. The questionnaires were faxed immediately after the initial telephone call and delivery slips were printed and filed for future reference.

- Respondents were requested to complete the questionnaires within two weeks and return them to the address stated on the envelope.
- Although the covering letter requested the respondents to return the questionnaire within two weeks, a period of six weeks was allowed for the return of the completed questionnaires. This was considered sufficiently long enough to accommodate respondents who were on leave from work during the school holidays which fell within the designated return period. Furthermore, this period accommodated potential postal delays as well as respondents who experienced excessive administrative workloads towards the end of the school term.

Once the questionnaires had been distributed to all the respondents, a process that lasted from 20th to 24th June 2000, the process of collecting the data commenced.

3.7.2 Data collection

The data in the form of the completed questionnaires was collected as follows:

- The completed questionnaires were accepted in two forms, namely by post and via fax.
- Late questionnaires were not accepted after the allotted six weeks had passed. One questionnaire was received late and was therefore not included in the study.
- The completed questionnaires were collected from the relevant post box on a regular basis from the 24th of June to the 5th of August.
- The faxed questionnaires were collected immediately after transmission from the respondent and kept in a confidential file for recording at a later stage. This was done to ensure the confidentiality of the responses.

Shortly after the commencement of the data collection process, the detailed process of data recording began.

3.7.3 Data recording

The data contained within the questionnaires was recorded in the following manner:

- The receipt of the completed questionnaires, returned by both post and via fax, was recorded by assigning a number (from 1 to 137) to the top left hand corner of the envelope in the order in which the questionnaires were returned.
- A self-compiled excel spreadsheet was designed specifically for the purpose of recording the responses from the questionnaires. The left-hand column listed the number of returned questionnaires (from 1 to 137) and all the answer options of all the questions were listed in the top row.
- Once a minimum of 10 questionnaires had been collected, each envelope was opened separately and the responses were recorded on the self-compiled spreadsheet in the following manner:
  - The questionnaires were initially scanned for additional notes from the respondents, completion of the questionnaire, skipped questions or any other anomalies. These were handled at the discretion of the researcher.
  - The responses were then recorded in the row number that corresponded with the number assigned to the returned questionnaire.
  - Responses were recorded horizontally across the row until responses to all 47 questions were recorded.
  - Written responses to the open questions were carefully typed and listed on separate worksheets. Each worksheet consisted of the responses of all the respondents to a particular question.
  - Responses that were not among the available answer choices in the questionnaire were ignored.
- To counter the impact of illegible handwriting and markings that were not made clearly over one response choice, the researcher enlisted the opinion of two colleagues. If neither the researcher nor the colleagues were able to decipher the response, it was left unrecorded on the data-

recording sheet. In all other instances a consensus was reached amongst the three people.

- To counter the impact of incomplete questionnaires, only the questions that were completed in full were included in the study. Blank responses on the questionnaire were left blank on the data-recording sheet.
- Once the data from a questionnaire was recorded it was checked by a second independent person to ensure that the data recording was accurate. Minor errors were detected using this method of checking.

Once all the data from the 137 respondents had been recorded on the self-compiled spreadsheet and worksheets, it was sent for in-depth analysis.

3.8 DATA ANALYSIS

The analysis of data in the research process is characterised by organising and summarising data, and by using statistics, to draw conclusions and make inferences from data (Stoker, 1989). There are many techniques available for analysing data yet the statistical methods and techniques selected should be appropriate and sufficient for the purpose of the study, and justifiable and parsimonious for the data (Ventry & Schiavetti, 1986). In other words, the data must be statistically analysed and presented in a manner that contributes to the research aims.

Therefore, for the purpose of this study descriptive statistical techniques are selected as the method for analysing the data collected from the questionnaires. Descriptive measures are applied to the data to highlight the main features and facilitate the interpretation of the assimilated data. This technique is deemed appropriate and sufficient to the aims of the study, namely to determine how speech-language therapists and audiologists manage their the private practices and what their specific needs are in respect of business management skills.

Firstly, the numerical data are described by means of summary statistics using measures of central tendency and variability. These measures were used to check if the distribution of data were skewed which would impact on the applicability of the data analysis. The central tendency measures used most frequently in the analysis of the data in this study were the mode, median, and mean values of sets of data. Variability measures, used to indicate the amount of dispersion in the sets of data, consisted of range, variance, and standard deviation measurements. In addition, the data was represented in a meaningful way using graphic and tabular formats.

The data analytical measures for particular sets of data were selected according to the type of question and response format and how the question satisfied the overall goal of the study. Furthermore, the analytical and statistical measurements were determined with the aid of a computer.

Secondly, in the case of written responses to open questions, the most pertinent issues raised in the responses were listed in columns and tallied up to determine the prevalence of a particular opinion or issue amongst the respondents. Nine of the open questions were analysed in this manner. Furthermore, the written responses were analysed qualitatively to detect unusual or pertinent individual responses. These were discussed and quoted where it was deemed appropriate for the purpose of the study.

The descriptive data analysis techniques and measures used in this study were simple but considered effective enough to achieve the aims of the study. Furthermore, the analysis techniques used were based on those used in a similar questionnaire research study conducted by Trulove and Fitch (1998) which verifies the aptness of using this form of data analysis for the purpose of this study.

3.9 ETHICAL ISSUES

Ethical considerations are an essential component of every research attempt particularly where humans are involved (Ventry & Schiavetti, 1986). The

ethical considerations that impact on descriptive research, as proposed in the literature, are discussed below and then applied to the present study.

One of the first ethical considerations when selecting a research topic is whether there is a justification to experiment. According to Whiston (1995), researchers are ethically bound to execute relevant and effective research. In other words, the research attempt must yield results that will benefit society. This study aims to evaluate the business management needs and abilities of speech-language therapy and audiology private practitioners in South Africa in order to improve knowledge, adapt training and enhance the service delivery by private practitioners to the community. These predetermined aims were considered appropriate after a thorough review of the literature. In addition, to the researcher's knowledge, there has been only one similar research study on private practitioners in this field in South Africa (Klop, 1998), yet there is evidence in the literature of many similar studies being carried out in America (Trulove & Fitch, 1998; Metz, 1996; Rassi & Fino-Szumski, 1994). The above facts are considered by the researcher to assume the research aims of the present study to be justifiable and relevant to its purpose.

Secondly, justification to conduct research relies further upon the voluntary and informed consent of the respondents. This necessitates a fair explanation of the aim of the research, the duration of participation required from the respondent and an explanation of risk involved. In addition, the respondents should be granted the opportunity to withdraw from the research if they wish to do so. This study ensured that all respondents were given an opportunity to consent to participation in the study by indicating this during the initial telephone call. If the respondent felt obliged to take part in the study and did not want to indicate this over the telephone, a further opportunity was created to refuse participation by simply not returning the questionnaire. Therefore, by completing the questionnaire and posting it the respondents once again gave their consent for the use of their responses in the study.

Thirdly, the researcher is ethically bound to discuss with the respondents how confidentiality will be maintained (Alant, 1998). All respondents have a right to

privacy, confidentiality and anonymity. The method used to accumulate raw data should be selected after careful consideration of the impact it has on the confidentiality of the respondents (Alant, 1998). For the purpose of this study, a postal survey was selected as the most appropriate method for collecting the required data and ensuring the confidentiality of the respondents. The initial telephone call, covering letter and instructions to the questionnaire gave a written or verbal guarantee that all the data would be held confidential and the origin of the data would remain anonymous to protect the privacy of the individual respondents. However, respondents were requested to voluntarily provide their addresses if they desired a summary of the results of the study. Respondents were under no obligation to identify themselves on the questionnaire.

Although the questionnaire could be returned via fax, which is not as confidential as a sealed and posted envelope, respondents remained unidentified unless they had indicated that they wanted a copy of the results of the study. Office personnel were briefed to ensure the confidentiality of questionnaires returned via fax.

In addition, the data was not used for any other purpose besides that of the current study. The raw data collected during the study was not revealed to any person other than the researcher and, in the case of illegible handwriting, two fellow colleagues. The statistician was allowed access to the recorded data only (not the raw data) to further guarantee the anonymity of the respondents.

Finally, the researcher has an ethical duty to continue with the research effort if is considered to be successful. The researcher of this study is prepared to continue with research of this nature if this is considered necessary and purposeful to the profession and the community.

3.10 CONCLUSION

The literature is abundant with information concerning the importance of ethical, relevant and justifiable research in the health sciences (Uys & Hugo,

1997; Ventry & Schiavetti, 1986). It is possible to achieve this through the careful planning and execution of research principles as well as the selection of an appropriate research design and method. The selection of a descriptive survey design for the purpose of this study was taken after careful consideration of all possible research designs. Furthermore, a questionnaire as the choice of survey method was perceived to be the most useful and appropriate method for collecting data of the nature required in the study.

In conclusion, relevant and justifiable research is necessary in order to link research with teaching and service delivery (Hugo, 1998; Uys & Hugo, 1997). It is therefore intended that the information derived from this research endeavour will contribute to the discipline of private practice management by demonstrating how the needs of the private practitioner can be satisfied through training in order to deliver a more effective service to the community.

3.11 SUMMARY

Chapter three provided a detailed outline of the complete methodology of the study including the aims, design, respondents, materials, procedure, and analysis. It is hoped that this provides future researchers with guidelines for replicating the study in similar circumstances. Furthermore, the pilot study and ethical issues to consider in this study were discussed. In the ensuing chapter the results of the analysis of the data are presented and discussed in detail.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF THE RESULTS

***Aim**: To present the results of the research study and elucidate the meaning and significance thereof.*

4.1 INTRODUCTION

In South Africa speech-language therapists and audiologists in private practice are faced with numerous changes in the economic, social, political and professional environment that have implications for the management of their businesses (Jamieson, 1998). Furthermore, they have restricted opportunities to develop business management skills due to the limited business training received at undergraduate level. Since business management skills are relevant to and appropriate for speech-language therapists and audiologists in private practice, it is therefore expected that practitioners entering private practice without these skills will find it increasingly difficult to successfully manage their businesses through the transformation period in health care. It was therefore the purpose of this research study to determine how private practitioners currently manage their businesses and to ascertain what their business management training needs were in order to make recommendations regarding future training.

Since there is an inherent link between research, teaching and service delivery, it is expected that research should form the foundation upon which training and service is established (Uys & Hugo, 1997). The anticipated outcome of this research study was thus to provide guidelines for business management training courses and to facilitate improvement in service delivery in the private sector. It is therefore vital that the planning and implementation of future business management training for speech-language therapists and audiologists be based upon meaningful results of research studies such as those to be discussed in this chapter. Moreover, it is anticipated that the once private practitioners realise the importance of and need for acquiring business management skills that they will act upon this need. The acquisition of business management knowledge and skills should have a positive effect on

service delivery by enabling private practitioners to improve the efficiency and quality of their speech-language therapy and audiology services to the private sector.

The results and conclusions drawn from this research study are based upon the analysis of raw data obtained from questionnaires utilised in a descriptive survey research design (Leedy, 1997). The high response rate of 65% (n = 129) that was achieved in this questionnaire is indicative that the data provides a reliable picture of the population and its characteristics. Furthermore, it is evident of private practitioners' interest in the topic of business management. The data is therefore representative of the population and the results are more than adequate for the purposes of analysis and interpretation (Stoker, 1989). Unfortunately not all the respondents (n = 129) answered all of the questions included in the questionnaire. Consequently, the number of respondents (n) differs for each question. Therefore, the effects of unit and item non-response that were present in the study are acknowledged and taken into account during the presentation and interpretation of the results by stipulating the specific number of respondents who completed each question in full. No attempts were made to compensate for non-response. Bias, which is omnipresent in all forms of research analysis, was kept to a minimum by focusing on the actual data and making limited interpretations of the results (Ventry & Schiavetti, 1986).

The aims of this chapter are threefold; firstly, to present the results for each of the research objectives in a meaningful way using statistical analysis and data organisation techniques. Secondly, to interpret the results against the current literature, and thirdly, to draw meaningful conclusions and extrapolate the findings so that recommendations can be made for the future business management training of South African speech-language therapists and audiologists in private practice. To facilitate the process of enlightenment, the data from the questionnaire are analysed and interpreted in a manner corresponding to the main research question and objectives of the study. The framework for the organisation of the results in this chapter is presented in Figure 4.1.

Main Research Question:
How do South African speech-language therapists and audiologists manage their private practices in the transforming health care environment with the additional disadvantage of a limited availability of business management training?

Preliminary steps taken to answer the research question:

- Step 1: Private practitioners' **opinions** regarding the management of their businesses (research objective 1)
  - Opinions regarding business management activities
  - Opinions regarding the need for more accountability
- Step 2: Private practitioners' **knowledge** of business management concepts and **how** they **manage** their businesses (research objectives 2 and 3)
  - Strategic planning knowledge and practices (internal, external, and health care environment)
  - Strategic implementation knowledge and practices (marketing, finance, IT, and personnel)
  - Strategic control knowledge and practices (cost analysis, time management, record keeping, and client satisfaction)
- Step 3: Private practitioners' **opinions** regarding the **need** for business management training (research objective 4)
- Step 4: Recommendations for **future training** based on the results of the research (research objective 5)

Conclusion:
The manner in which speech-language therapists and audiologists, with limited business management knowledge and skills, currently manage their private practices in the transforming health care industry in South Africa, and their need for business management training in order to improve the quality and delivery of their services to the community.

Figure 4.1 Framework for the organisation of the results
(Adapted from Moodley, 1999)

To answer the main aim of the study, it is necessary to follow steps one to four in Figure 4.1, which involve presenting and interpreting the results of the five objectives that precede the final conclusion and provide evidence to support it. The first step required the determination of respondents' opinions towards the management of their businesses. The second step was to determine private practitioners' knowledge of business management

principles and to determine the type and prevalence of business management practices used by the respondents in private clinical settings in South Africa. The results of the second and third objectives were combined and reported on concurrently to prevent repetition of the results that pertained to both research objectives. In addition, the respondents' knowledge and skills were presented separately for the various business management activities that were included in the questionnaire. Figure 4.1 indicates how these activities were grouped under three main areas of business management namely, strategic planning, strategic implementation and strategic control.

The third step was the determination of private practitioners' opinions regarding the need for training and education in business management. These results pertained to the fourth research objective and also provided the information from which the fifth objective was realised, namely to make recommendations for future business management training, which formed part of the fourth step. In the final section of this chapter, general conclusions from the study are drawn and the main research question is answered.

4.2 SPEECH-LANGUAGE THERAPISTS' AND AUDIOLOGISTS' MANAGEMENT OF THEIR PRIVATE PRACTICES AND THEIR NEED FOR BUSINESS MANAGEMENT TRAINING

The overall aim of this research study is to determine how South African speech-language therapists and audiologists in private clinical settings manage their businesses and to determine their particular needs for business management training. To achieve this aim, a research sample of the entire population of 199 SASLHA-affiliated practitioners who owned their own private practices was selected to complete a questionnaire. The first section in the questionnaire, biographical data of the respondents, was discussed in detail in chapter three under the description of respondents in the study, Section 3.4.3. This section was therefore not reanalysed, however the data was used to draw comparisons between the data presented in the remaining sections of the questionnaire and in the interpretation thereof. The presentation of the

results of the remainder of the questionnaire thus commences with the first of the five objectives established for this research study.

4.2.1 PRIVATE PRACTITIONERS' OPINIONS REGARDING THE MANAGEMENT OF THEIR BUSINESSES

The first objective was to investigate respondents' **opinions towards the management of their private practices**. Two of the questions in the self-compiled questionnaire explored these opinions namely, Q9 and Q41. The results of the data analysed for these questions provide the basis for the ensuing discussion. In question nine, respondents were requested to rate the importance of ten activities within a private practice on a scale of one to four, with one representing 'Not at all important' and four representing 'Extremely important'. The mean values of the respondents' importance ratings, as assigned to each business management activity, are sorted from most important to least important in Figure 4.2. These importance ratings are discussed under this objective as well as in the context of the results of the respondents' business management knowledge and practices, which are reported under the second and third objectives.

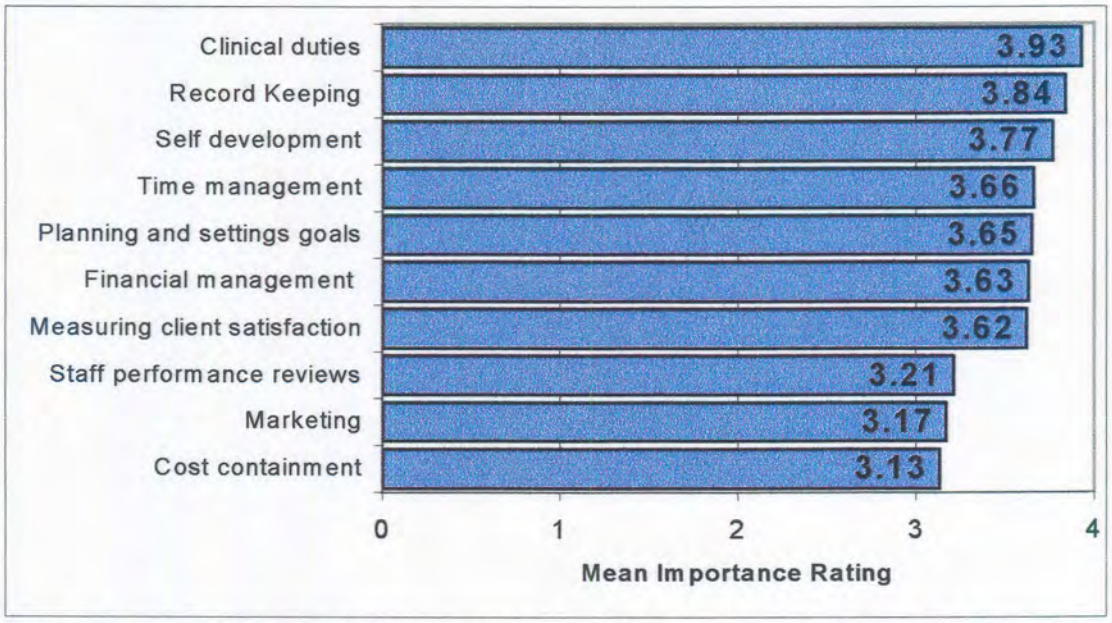

Figure 4.2 Respondents' mean importance ratings of business management activities

It is interesting to note that the mean rating for all of the management activities was between the values of "Quite important" and "Extremely important," which indicates that the respondents generally rate all of the activities as relatively important. It is evident from Figure 4.2 that respondents indisputably rated clinical duties (M = 3.93) as the most important of the ten activities included in the questionnaire. This result is predictable since speech-language therapists and audiologists rely heavily upon their clinical skills as a source of income. The high rating of clinical duties by the respondents also confirms Metz's (1996) belief that when business practices and clinical practices collide, private practitioners ensure that the patient's interests are served first and foremost. In addition, the results may attest to the fact that the respondents are striving to maintain the correct balance between business and clinical practice as none of their mean ratings of the business activities were below the category of "Quite important." However, the respondents' specific management behaviour, which is explored and reported on in subsequent questions, will substantiate or counteract the respondents' importance ratings.

It could be argued however that the activity with the lowest rating, namely cost containment (M = 3.13) as indicated in Figure 4.2, was unpredictable since the health care industry is currently being compelled to contain costs due to the establishment of a managed care system. Cost containment refers to passing on cost efficiency to clients through quality services at the lowest reasonable cost (Wood, 1986). Many factors affecting cost efficiency of a service affect cost containment, which in turn affects charges to the client and margin of profit for the private practitioner (Flower, 1984). It is thus presumed that the emergence of managed care in the speech-language therapy and audiology profession, the current economic factors in South Africa, and the desire to be financially sound, would increase the need for the respondents in this study to contain costs in their private practices.

Furthermore, cost efficiency is greatly affected by time management since increased contact time reduces client costs (Wood, 1986). The logical assumption is therefore that the importance ratings of these two activities

should be similar. Cost containment can also be closely linked with another activity, namely financial management, which includes budgets that stipulate how costs are to be controlled. However, the results in Figure 4.2 indicate that time management is rated as the fourth most important activity, financial management the sixth, and cost containment the tenth. It thus appears that the majority of the respondents may not be aware of the link between these three activities. A possible explanation for the respondents' low rating of cost containment is that the other business management and clinical activities or issues in private practice take preference over containing costs. Furthermore, it is assumed that the effects of managed care and related health care transformation have until recently not had any impact on speech-language therapy and audiology private practices. An alternative explanation for the low rating may be that the respondents did not understand the concept of 'cost containment' due to a lack of training in financial management issues. A more in-depth analysis of respondents' management of costs and time management is provided in section 4.2.2.2.

Table 4.1 presents the number of responses and standard deviations for the importance ratings of each of the ten activities. Of the activities included in question nine, all were rated by more than 98% of the respondents. This is consistent with the fact that the respondents assigned relatively high importance ratings to all the activities. However, the exception is 'Staff performance reviews' which was only rated by 87 of the 129 (67%) respondents. The rationale for this is the fact that the majority of the respondents indicated that they did not employ any staff (see Table 3.1) and therefore did not need to conduct performance reviews.

Standard deviations were calculated to indicate the homogeneity of the respondents' importance ratings (see Table 4.1). The analysis revealed that the smallest standard deviations were recorded for the activities with the three highest mean importance ratings namely, clinical duties (SD = 0.26), record keeping (SD = 0.41) and self-development (SD = 0.44). This was also true in reverse, that is, the largest standard deviation was reported for the activity with the lowest importance rating, namely cost containment (SD = 0.83). The

standard deviation for cost containment indicates that the respondents' opinions are the most heterogeneous regarding this activity. A more detailed analysis of the results in Table 4.1 indicates that the largest number of low ratings (1 = Not at all important, 2 = Not very important) were assigned to cost containment by the respondents. However, there were also a number of practitioners who rated it as extremely important. It therefore appears that practitioners are divided as to the importance of cost containment in a private practice.

Table 4.1 Standard deviations of mean importance ratings of business management activities

Rank	*Business Management Activity*	*No. of responses (n = 129)*	*Standard Deviation*
1	Clinical duties	128	0.26
2	Record Keeping	127	0.41
3	Self development	128	0.44
4	Time management	128	0.54
5	Planning and settings goals	127	0.54
6	Financial management	128	0.58
7	Measuring client satisfaction	128	0.61
8	Staff performance reviews	87	0.79
9	Marketing	127	0.81
10	Cost containment	128	0.83

Nevertheless, since the standard deviations for all of the activities were small relative to the rating scale, it can be concluded that the respondents constitute a relatively homogenous group (Ventry & Schiavetti, 1986). One explanation for this homogeneity amongst the group of respondents is that they have all received similar training and operate in relatively similar work environments. However, since the respondents differ greatly in terms of age, year of graduation and experience, it is surprising that they form such a homogenous group. An advantage of the homogeneity of the sample is that generalisations made from the results are more likely to be applicable to speech-language therapists and audiologists in private practice who were not respondents in this research study (Welman & Kruger, 1999).

It can therefore be concluded from the results of question nine that the respondents consider *clinical duties* as more important than any of the

business management activities listed in the question. This leads to the assumption that the respondents consider business management activities to be not as important as clinical duties. As mentioned previously, this result was predictable since speech-language therapists and audiologists rely upon their clinical skills and knowledge to deliver a service to clients. Furthermore, the emphasis of undergraduate training is upon acquiring clinical skills, whereas business management skills receive far less emphasis in comparison. Since the goal of the provision of speech-language therapy and audiology services is to benefit clients with communication disorders or delays, the high importance rating assigned to clinical duties is appropriate. However, it is important to consider the effect of business management practices that have a great impact on client satisfaction. From the respondents' opinions regarding activities within the practice environment, it therefore appears that the respondents' appropriately prioritise their duties according to what they have learnt. It is postulated that with more emphasis upon the acquisition of business management skills and knowledge in training programmes, that more of these respondents will appreciate the value and importance of business management activities in a private practice.

The second question concerning respondents' opinion towards business management activities pertained to accountability within a private practice. Accountability can be considered a type of business management since it involves management activities such as cost-effectiveness, time management, record keeping, outcome data, and productivity, which are all essential to ensure that the operational aspects of a business are well managed (Frattali, 1998; Trulove & Fitch, 1998, Paul-Brown, 1994). In question 41 of the questionnaire respondents were asked for their opinions on whether or nor private practitioners should be more accountable for their choice of assessment and treatment methods and the outcome thereof. Ninety percent of the 129 respondents answered this question, which confirms that accountability, which is a current and notable topic of discussion in the literature, is considered by the respondents to be an essential component of service provision in a private practice setting (Trulove & Fitch, 1998).

Seventy-nine percent of the respondents (n = 92) agreed with the opinion that private practitioners should be more accountable than they are currently. This indicates that there is not total unanimity amongst respondents regarding the need for increased accountability. Nevertheless, the majority of the respondents were in agreement with the need for private practitioners to be more accountable. This is a positive indication that the focus on accountability in the literature in the past decade has made an impact on the respondents by making them more aware of the need for increased accountability practices and should encourage respondents to implement improved accountability practices in their businesses (Frattali, 1998; Boston, 1994). However, the negative implication of the result is that the respondents may not yet have heeded the advice in the literature by implementing sufficient accountability improvements, which is evident in some of their written responses to be discussed shortly and which is discussed further in section 4.2.2.3. Furthermore, this provides evidence towards the fact that the respondents view the profession of speech-language therapy and audiology in South Africa to currently not be as accountable as it should be. Moreover, there is also evidence of this trend in other countries such as the USA where research findings by Trulove and Fitch (1998) are consistent with those of the present study. The investigation by Trulove & Fitch (1998), into the accountability practices of private practitioners in the USA, indicated that their respondents also lacked adequate accountability measures. The lack of accountability may therefore not be limited to the South African private practitioners who took part in this study but may be a more widespread phenomenon. This has far reaching implications for the autonomy and the reputation of the profession (Cherow, 1994), particularly since the managed care system is based upon comprehensive outcome data and accurate record keeping (Isenberg, 1998).

It is interesting to note that respondents who disagreed with the opinion that private practitioners should be more accountable (21%) graduated on average in 1980. In comparison, the average year of graduation for those who agreed with the opinion was 1985. This may be an indication that there is an association between the year of graduation of respondents and their opinion regarding accountability. This association can be attributed to the

preponderance of published literature on the topic of accountability in the last decade, which has induced a change in attitude and personal awareness amongst respondents and a focus on accountability in teaching practices, (Frattali, 1998; Trulove & Fitch, 1998; Boston, 1994; Zampella & Blake, 1992). An analysis of the respondents' 92 written motivations was conducted to determine the most prominent reasons for their opinions regarding accountability. The written statements were categorised into the six most common motivations for the need to be more accountable in private practice. The six categories and their related results are graphically represented in Figure 4.3, which is followed by a discussed thereof and a list of examples of respondents' motivations.

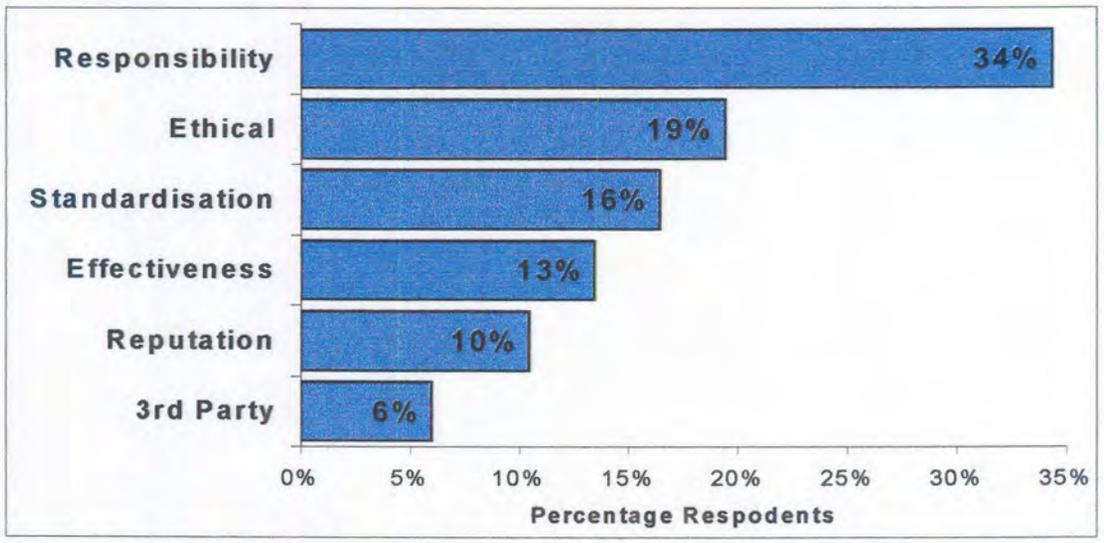

Figure 4.3 Analysis of respondents' motivations for being more accountable (n = 92)

The results in Figure 4.3 reveal that there was limited consensus amongst respondents regarding their motivations for the reason private practitioners need to be more accountable. The most popular opinion amongst respondents was that they believed that accountability meant that private practitioners should be more *responsible* for their choice of assessment and treatment methods (34%, n = 23). The second most popular opinion (19%, n = 13) was that private practitioners should consider accountability as an *ethical* obligation towards the profession and the clients that are the recipients of their services. The lack of appropriate standardised assessment and treatment

material in South Africa was considered a hindrance to respondents' accountability (16%, n = 11) as the available tools prevented them from appropriately assessing and treating clients. Additional motivations that were less supported by the respondents included the following: the need to prove the *effectiveness* of speech-language therapy and audiology services to the medical community and to clients; to uphold the *reputation* of the practitioner and the profession; and to be more accountable to *third parties* by providing them with relevant and appropriate information.

Since question 41 limited its definition of accountability to clinical aspects of private practice, namely assessment and treatment methods, the general motivations given for accountability did not make any reference to the types of accountability used in traditional business settings, such as cost-effectiveness, productivity, and time management (Trulove & Fitch, 1998). Nevertheless, the results in Figure 4.3 indicate that the respondents' opinions are generally consistent with the literature, which states that accountability is a private practitioners' professional *responsibility* and *ethical* obligation (Frattali, 1998; SASLHA Code of Ethics, 1997). Furthermore, the literature states that accountability implies being liable for providing information that proves the *effectiveness* of services to clients, the medical community and other *third parties* (Boston, 1994; Zampella & Blake, 1992). It could also be argued that the respondents' reference to *reputation* is also relevant, particularly in private practice, since the consequence of not being accountable can negatively affect the client's and the referral agents' estimation of the practitioner. To further analyse the respondents' written motivations, examples of the comments from the respondents' questionnaires are provided below.

- *"The profession stands under a great deal of criticism because therapists are not inclined to see accountability as the main issue when treating a client. It's difficult to motivate the usefulness (of speech-language therapy and audiology), more posts, better money, etc. if you can't prove your work."*

- *"Greater emphasis on outcomes based assessment and treatment would facilitate an enhanced image of the profession from the perspective of the healthcare funders, and is an ethical obligation."*
- *"As long as clients are rehabilitated, accountability for methods used is of lesser importance."*
- *"Accountable to whom?"*

Although the motivations were categorised into six different categories, there were nevertheless some varied responses, particularly from those respondents who did not agree with the statement that private practitioners need to be more accountable. Thirteen percent of the respondents (n = 12) stated that private practitioners were already accountable enough and there was no need to be more accountable. Furthermore, the third and fourth examples cited above indicate that there were also a few variations from the more widely accepted views on accountability. Statements such as these indicate that there is still some way to go before the concept of accountability is fully understood by all the respondents, the importance thereof acknowledged, and the appropriate accountability methods implemented in private practice.

It can therefore be concluded that the majority of the respondents are aware of the need for *greater accountability*. However, the fact that they agree with the statement that private practitioners should be more accountable may be considered an admission that they are currently not as accountable as they ought to be (which is determined in greater detail in 4.2.2.3). This creates an opportunity for improvement in the respondents' accountability in their respective private practices. As mentioned previously this result is consistent with Trulove & Fitch's (1998) findings of private practitioners in the USA. Moreover, the results of the present study further substantiate the urgent call for greater accountability in the profession which forms the pervasive thread connecting most of the literature on accountability (Boston, 1994; Paul-Brown, 1994; Wynn et al., 1993; Zampella & Blake, 1992).

The respondents' varied justifications of their opinions is concerning since there is no general consensus regarding the need for greater accountability amongst respondents. A possible explanation for this variation in opinion is the heterogeneity within the group of respondents in terms of year of graduation, age, and experience. Furthermore, many of the respondents that disagreed with the statement, as included in the questionnaire, did so because they believed they were already accountable enough. Private practitioners should, however, consider accountability as a continual process of improvement instead of a goal that can be attained (Trulove & Fitch, 1998). It therefore appears that the respondents could benefit from training that focuses on the concept of accountability and demonstrates how a number of operational and business management practices impact on accountability in private practice.

According to Metz (1996) private practitioners should not allow business issues or financial gain to diminish their focus on the clients clinical requirements. In addition, Stanbridge (1999) believes that it is essential for private practitioners to acknowledge the importance of business management as a way to improve efficiency in a private practice. Despite the above results indicating that respondents regard business management activities to be less important than clinical duties, it is also evident that they rate business management activities as relatively important. Furthermore, the respondents generally consider that private practitioners need to be more accountable in their clinical duties of assessment and treatment of clients. This leads to the conclusion that despite respondents considering their clients to be the foremost concern in private practice, that they still require training in concepts of business management such as cost containment and accountability in order to gain a wider perspective of their impact upon a private practice.

4.2.2 PRIVATE PRACTITIONERS' KNOWLEDGE OF BUSINESS MANAGEMENT CONCEPTS AND THE PREVALENCE OF THEIR MANAGEMENT BEHAVIOUR

The results of the second and third objectives are presented and discussed conjointly as the respondents' knowledge and understanding of business

management concepts is closely linked to their use of specific management practices and tools (Metz, 1996). Furthermore, a negative or non-response to any of the behavioural questions in the questionnaire may serve as an indication of respondents' lack of knowledge of business management rather than an indication of poor management skill. The questions pertaining to these two objectives are thus discussed and interpreted together and reference is made to the respondents' business management knowledge were applicable.

The second objective was to determine the respondents' knowledge of business management concepts by using business management terminology in the questionnaire and relating questions specifically to the knowledge thereof. Four questions in particular were included in the questionnaire to determine specific knowledge of business management concepts, namely questions 10, 17, 32 and 35 (see Appendix A). The third objective encompassed the following goals: firstly, to determine the specific practices and tools used by the respondents to manage their private practices; secondly, to determine the reason for their use; and thirdly, to determine the regularity of their use. Sixty percent of the questions in the questionnaire (28 out of 47) pertained to the respondents' management behaviour within their private practices.

In the questionnaire the respondents' knowledge and behaviour in three main areas of business management was determined namely, **strategic planning**, **strategic implementation**, and **strategic control**. The results of each of these areas are presented and discussed separately.

4.2.2.1 Strategic Planning

The first area of business management, strategic planning, explored the direction and purpose which the respondents intended their private practices to follow. In addition, this section probed the extent to which the respondents analysed circumstances in their environments and used this information to align their goals for the future to continue achieving their planned purpose in the community. In terms of the strategic management process as discussed in

chapter two, this section pertains to situational analysis (see Section 2.4.3.1) and strategic formulation (see Section 2.4.3.2).

The first two questions in this section explored respondents' *vision* and *long-term development plans* for their respective private practices (Q.10 and Q.16). The results from these two questions, which determined whether or not the respondents had visions or long term development plans for their private practices, are graphically represented in Figures 4.4 and 4.5. The pie chart in Figure 4.4 indicates that 71 respondents (56%) had formal or defined visions for their practices. In comparison, Figure 4.5 indicates that only 48 respondents (39%) had formulated long-term development plans for their practices. According to Rassi & Fino-Szumski (1994), vision statements describe the aspirations of an organisation and represent what that organisation desires to become in the future. Therefore, vision statements and long term development plans are closely connected. In addition, visions form the framework for an organisation's goals and unites strategy to achieve these goals (Klop, 1998).

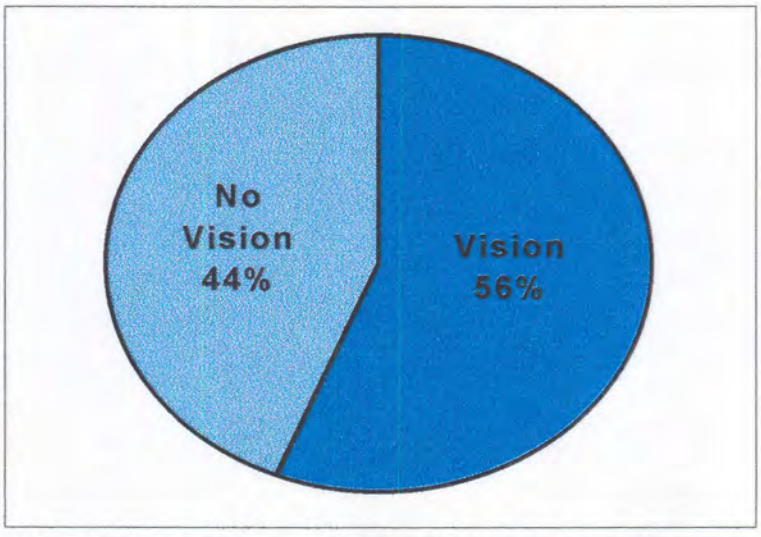

Figure 4.4 Percentage of respondents with vision statements (n = 129)

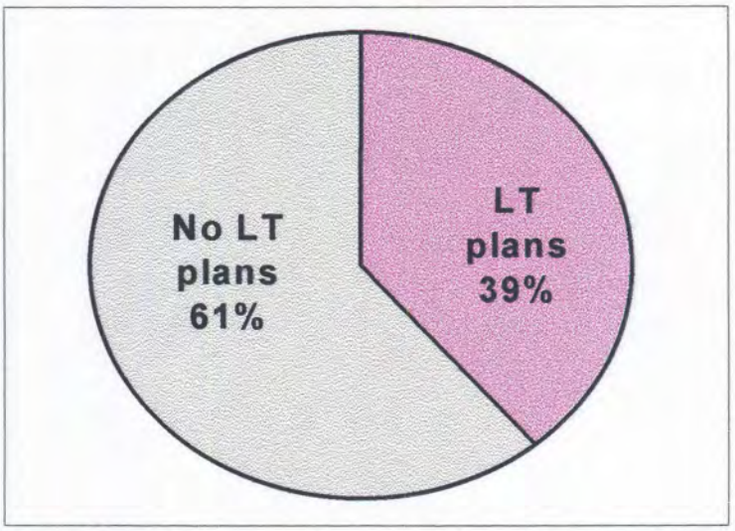

Figure 4.5 Percentage of respondents with long-term plans (n=129)

The fact that only 39% of the respondents had long term development plans but just over half the respondents (56%) had visions for their practices, may therefore be an indication that the respondents do not understand the concept of a vision. This subjective perception is further substantiated by the fact that the majority of the respondents' written vision statements were informal or unofficial vision statements and unlike those described in the literature (Brooks, 1995; Rassi & Fino-Szumski, 1994; Armstrong, 1994). In response to the request in the questionnaire for the detail of the respondents' vision statements, a total of 71 respondents provided their written visions, which were subsequently analysed to reveal the following similar characteristics:

- *To provide valuable, reliable and efficient services to the community.*
- *To maintain excellent quality standards.*
- *To uphold a good reputation.*
- *To prosper and grow in the long term.*
- *To achieve financial success.*
- *To remain focused on client needs and priorities.*

In addition, the respondents (39%) who indicated that they had long-term development plans for their practices provided a written statement of these plans. A few common ideals among the respondents' development plans were evident on a closer analysis and are listed as follows:

- *To expand the business physically and financially by increasing the number of sessions, the number of employees, and the type and number of services offered to clients.*
- *To specialise in a particular aspect of the profession and to provide specialist services to the community.*
- *To make services more accessible to persons of different age groups as well as the wider community, in particular, groups that have had limited access to speech-language therapy and audiology services thus far.*
- *To provide employment and train new therapists*

These visions and long-term development plans are vague but nevertheless in accordance with Frattali's (1991) belief that visions and long-term development plans should represent what the organisation desires to become in the future. However, visions and development plans should be challenging, realistic, measurable, and achievable within a specified time scale (Rassi & Fino-Szumski, 1994). The visions and long term development plans stated by the respondents do not reflect the properties of formal vision statements and thus indicate that, despite a number of the respondents vaguely understanding the meaning of a vision statement, the concept and its importance to the business is not understood. The respondents' lack of comprehension of a vision is a possible repercussion of their lack of business management training since this concept would form part of any small business or private practice management training course (Du Preez, 1998). According to Rassi & Fino-Szumski (1994) one of the advantages of translating ideas about visions into a written form is that it forms a useful reference to ensure that planning and decision-making contributes to success of a private practice. Klop (1998) discovered that developing a vision for her private practice provided her with a much greater sense of responsibility and it enhanced her awareness of the need for a vision to form the foundation upon which she delivered services to clients and made decisions about her business. It can therefore be concluded that the respondents require training that will enable them to comprehend the concept of and need for a vision, acknowledge its effect and purpose in the management of a private practice, and equip them to form their own vision statements.

The literature states that the initial step in the process of strategic planning is to draw up an annual business plan which is a tool that helps the user to evaluate her practice in its entirety so that she can proceed with its implementation (Moskovitz, 1994; Duncan et al., 1992). The next question pertaining to respondents' planning and goal setting practices within their respective clinical settings therefore began with an investigation of whether or not respondents' went through the process of completing an annual business plan for their private practices (Q. 11). Of the 127 responses to this question, the results indicated that 72% (n = 91) of the respondents did not draw up annual business plans. The logical deduction is that this result is an indication that the respondents are unaware of what a business plan is and what its importance is to a business. Their knowledge rather than their management behaviour (or lack thereof) may thus be the reason for their responses. This perception is strengthened by the fact that, on closer analysis of the responses to the following five questions, it was evident that some of the respondents at least gave some thought to the key elements of a business plan (Brooks, 1995; Moskovitz, 1994; Duncan et al., 1992).

During a private practitioner's strategic planning process it is essential for her to analyse the current, emerging and future issues within the environment that will affect her business (White, 1995). This should assist her in the assessment of the inherent *strengths, weaknesses, opportunities and threats* within her business and enable her to make more appropriate plans for the future. Consequently, the respondents' in the present study were requested to indicate, from a list of choices, the information that they regularly reviewed about their *internal, external* and *health care environments* when planning for the future. Each of the areas that probed this information is presented separately in a table and discussed individually. It was difficult to determine whether or not some of the respondents purposefully avoided answering the three questions pertaining to the environment or if they did not review the relevant information. Therefore, the total number of respondents in the study (n = 129) is used to calculate the percentages in the three ensuing tables. These lists are also ranked from the highest percentage to the lowest

percentage of positive responses. It is appropriate to note here that the planning and setting of goals in a private clinical setting was assigned a mean importance rating of 3.65 by the respondents which placed it as the 5th most important activity (*SD* = 0.54) (Figure 4.2).

- **Internal environment**

The internal environment consists of all the aspects of private practice that the practitioners have direct control over. According to Moskovitz (1994) it is important for private practitioners to analyse and understand the internal environment that they have created and the impact that it has on the delivery of services to clients. Table 4.2 provides a detailed analysis of the percentage of respondents that review various aspects of information about the internal environment. The results from Table 4.2 indicate that the two forms of information most commonly reviewed by the respondents are equipment and facility needs (61%) and referral sources (60%). The remaining internal environmental issues were generally reviewed by less than half of the respondents.

Table 4.2 Percentage of respondents that reviewed aspects of the internal environment

Internal Environment Information	*Percent positive responses*
Equipment & facility needs	61%
Referral sources	60%
Type of services offered	59%
Client base	51%
Strengths & Weaknesses	47%
Opportunities and Threats	47%
Financial position	45%
Geographical area serviced	42%
Marketing strategy	36%
Staff & admin needs	28%
Dominant payers of accounts	26%

- **External environment**

The external environment contains relevant information about the economic, social, demographic and cultural aspects of South Africa, which may directly or indirectly influence a private practice (Brown, 1994). Furthermore,

reviewing information from the external environment assists the practitioner with compiling a profile and competitive structure of the market from which she draws clients. Table 4.3 provides the breakdown of the results, which indicates the percentage of respondents that review various factors within the external environment. The two factors most commonly reviewed by the respondents were the type of services offered by other private practitioners (53%) and the number of private practices in the area (45%). Both these factors pertain to competition between professionals within the marketplace. None of the remaining results in Table 4.3 appear to be significant or warrant discussion thereof.

Table 4.3 Percentage of respondents that reviewed aspects of the external environment

External Environment Information	***Percent positive responses***
Services offered by other PP's	53%
No. of PP's in the area	45%
Purchasing power of clients	37%
New practices opening	24%
Major housing developments	9%

- **Health Care Environment**

Information contained in the health care environment that is of relevance to the private practitioner broadly refer to suppliers, competitors, referral agents, regulatory bodies and third party health funders. Reviewing information in the health care environment is necessary to ensure that practitioners remain informed regarding various changes in policies, rules and technology. Table 4.4 provides the breakdown of the percentage of respondents that indicated which factors they reviewed within the health care environment. The majority of the respondents considered two main issues worth consideration, namely the changes in medical aid tariffs (71%) and advances in technology (60%). Less than half of the respondents reviewed the remaining factors within the health care environment.

Table 4.4 Percentage of respondents that reviewed aspects of the health care environment

Health Care Environment Information	*Percent positive responses*
Medical aid tariff changes	71%
Advances in technology	60%
Changes in MA membership	45%
Changes in administration of MA	39%
New medical centres / hospitals	36%

The above results indicate that there are respondents that review some of the essential factors within the internal, external and health care environments, however they are in the minority. Many important factors concerning and influencing a private practice are not taken into consideration or reviewed by the majority of the respondents. The literature recommends that all of the factors listed in Tables 4.2 to 4.4 should be taken into account when drawing up a business plan (Brooks, 1995; Brown, 1994; Moskovitz, 1994). Consequently these results provide evidence in support of previous findings, namely that the majority of respondents reported not drawing up annual business plans.

The purpose of reviewing the internal, external and health care environment is to assist practitioners to focus on their unique circumstances and forms the initial part of the process of translating information into meaningful action (White, 1995; Armstrong, 1994). Furthermore, in order to be successful in a rapidly changing environment, Brooks (1995) recommends that it is necessary to analyse and interpret the practice environment continuously. Klop (1998) verified the importance of reviewing environmental information in a private practice by reporting the various benefits thereof, namely that it provided valuable information that led to the development of appropriate strategies and policies for her private practice. The respondents' lack of consideration and review of environmental factors as an essential part of strategic planning may be attributed to a lack of knowledge of the importance of reviewing environmental factors in a private practice. It is once again assumed that the respondents' limited knowledge arises from a lack of training in the effects of the environment on a private practice. Relevant training pertaining to the

effects of the environment should include the importance and benefits thereof, how to conduct an environmental analysis, and how to use of the information collected in the process.

The respondents' *goal setting* habits were examined in question 15 by determining the frequency with which financial, marketing, customer service, training and quality goals are set within a private practice. The results, which are calculated from the total number of respondents (n = 129), are presented in Figure 4.6 and Table 4.5. Figure 4.6 indicates that more than 72% of the respondents set goals for all five aspects of business. The highest number of positive responses were recorded for goal setting in respect of education and training (90%, n = 116) and quality issues (84%, *n* = 108). The result for education and training confirms earlier findings that the respondents rated continuing professional development as the third most important of all business and clinical activities (*M* = 3.77, *SD* = 0.44) (see Figure 4.2).

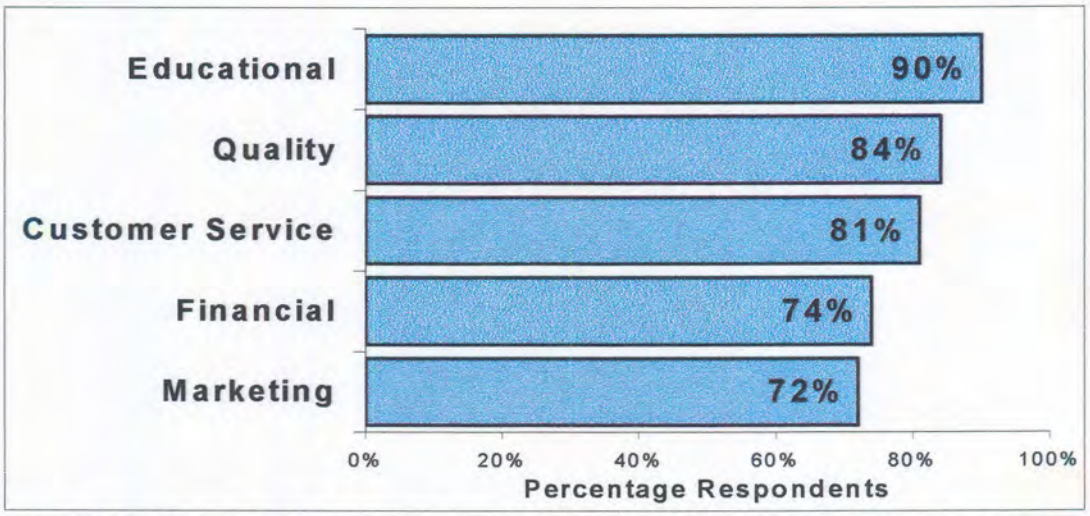

Figure 4.6 Percentage of respondents that set goals for five aspects of business (n=129)

In addition, the fact that 84% of the respondents set quality goals confirms the opinion that quality commitments should be a priority in a private practice (Klop, 1998). Quality is also closely associated with accountability since private practitioners must be held accountable for applying quality assurance procedures to ensure that the optimal standards of client care are achieved (Flower, 1984). Therefore, the large percentage of respondents who set

quality goals (84%) may be an indication that the respondents are striving to be accountable in their service delivery.

A surprisingly high percentage of respondents reported never having set marketing (17%) or financial goals (19%) for their private practices. These two results are of particular importance if one considers that Wood (1986) cites the Small Business Administration as declaring that two of the primary reasons for failure of small businesses is poor financial planning and poor market analysis. The practitioner's primary focus when setting goals for a private practice should thus be on sound financial planning and innovative marketing techniques (Silverman, 1990; Smith, 1990; Wood, 1986).

Table 4.5 Homogeneity of the frequency with which respondents set goals

Goal	*Frequency of goal setting*	*Standard Deviation*
Financial	Monthly / Annually	1.17
Marketing	Annually	0.97
Customer service	Monthly	1.07
Education & training	Monthly / Quarterly	0.96
Quality	Monthly	1.02

The standard deviations in Table 4.5 indicate that there was little homogeneity in the frequency with which the respondents set goals. It appeared that marketing goals were generally set annually by the respondents (*SD* = 0.97), whereas customer service (*SD* = 1.07) and quality goals (*SD* = 1.02) were more likely to be set monthly. The respondents, however, were divided as to how often they set financial (*SD* = 1.17) and education goals (SD = 0.96) for the business. Table 4.5 indicates that there was a more even spread across the choice of monthly and quarterly goal setting for education and an even spread across annual and monthly goal setting for financial matters.

The above results confirm that the majority of the respondents set goals for their private practices. It can therefore be presumed that they are aware of the need for setting goals and commitments for their businesses in order to achieve what is defined in the vision of the practice (Rassi & Fino-Szumski,

1994). However, the two most important aspects of business planning, namely marketing and financial planning, received the least number of responses. This is concerning since financial and marketing achievements set the limits and the boundaries of what can be accomplished in a private practice because these goals serve as guidelines for action and provide a basis for most management activity and behaviour within an organisation (Armstrong, 1994).

In conclusion, the results of strategic planning indicate that there is definitely a lack of knowledge amongst respondents regarding the need for a *formal vision statement*, the need for a *business plan*, the importance of *reviewing environmental information*, and the prioritisation of *setting goals* for a private practice. This lack of knowledge manifested itself in the respondents' strategic planning behaviour, which may impact on the overall management and efficiency of their respective private practices.

4.2.2.2 Strategic Implementation

Strategic implementation refers to the process of developing functional strategies for various operational aspects of a business, which serve to manage and control operations in an efficient and effective manner (Duncan et al., 1992). Strategic implementation therefore examined *which* of the *management practices* and *tools* described in the literature were in actual use by private practitioners in South Africa and *how frequently* these tools were used. The management practices examined were *marketing, finance, information technology,* and *personnel management*. The results from each of these areas are presented and discussed separately.

- **Marketing**

Marketing knowledge and marketing tools used by the respondents were the first areas of strategic implementation focus. Specific knowledge pertaining to marketing of a private practice was determined by testing the respondents' knowledge of the concept of market share (Q.17). A total of 123 responses were analysed which revealed that 55% of the respondents were unsure of their market share (n = 68) (see Figure 4.7). The standard deviation of the remaining responses was high (SD = 1.22) indicating heterogeneity amongst

the respondents, which provides evidence of the fact that some respondents report having a very high market share whereas others do not.

Figure 4.7 Ranges of market share held by respondents (n = 123)

The high proportion of uncertainty regarding market share (55%), as evident in Figure 4.7, may be an indication that the respondents either do not fully understand the concept of market share or that they have not taken the trouble to determine the size of the market for their speech-language therapy and audiology services. According to Moskovitz (1994), knowledge of the entire market for speech-language therapy and audiology services as well as the market share of a private practice is essential before a practitioner opens a practice, pursues additional marketing efforts, plans growth for the practice, or invests financially in a business. Private practitioners should therefore be aware of their market share and use this information to improve their marketing efforts and development plans for the future (Smith, 1993; Larkins, 1993; Clifford, 1993).

Delving deeper into the actual reasons for the percentage market share enjoyed by private practitioners, the respondents were asked whether or not they had a competitive advantage over other private practices and to state it if they had. This question received great interest from the respondents as 126 responses were elicited and 85 written reasons for competitive advantage were recorded. The results indicated that 68% (n = 85) of the respondents

who answered this question believed that they had a competitive advantage over other private practices. Wood (1986:106) states: "...if you don't have anything to market, stay out of the marketplace." In other words, expertise and specialisation in clinical skills are absolutely necessary to stay in the marketplace as a competitive player. It is thus surprising that 32% of the respondents do not believe that they have a competitive advantage. Furthermore, not having or not knowing what a private practice's competitive advantage is may also have implications for marketing efforts, especially if marketing is considered the second lowest priority in private practice (see Figure 4.2).

An analysis of the most common characteristics of the 85 respondents' written competitive advantages revealed an interesting variety of reasons for competitive advantage. The most frequently reported advantage was the type and range of services provided, followed by geographical or physical location, experience and training, and private practice or practitioner reputation. Affordable tariffs, a guaranteed referral base and efficient, well-trained staff were less popular choices yet were also among the reasons stated for competitive advantage over other private practices. It was interesting to note that, among the respondents who rated experience as their competitive advantage, half of them had less than 10 years of experience.

When most of the reasons stated above are considered in view of the literature on competitive advantage they appear to be temporary and transient (Beckwith, 1997). The reason for this is that there is always a possibility that a practitioner with more experience, better technology, or specialised services sets up a practice in a more accessible location, with affordable services and a professional client-centred approach. Under these circumstances even reputation may no longer be a competitive advantage. Beckwith (1997) therefore recommends that business owners stay abreast of changes in their internal and external environments and regularly review their marketing strategies to enable them to maintain a competitive advantage. The fact that there is evidence, in Tables 4.2 to 4.4, that the respondents take very few important factors within the environment into consideration indicates that they

are unaware of the close association between the environment and market share and thus further substantiates Beckwith's (1997) recommendation.

The type of marketing tools used by private practitioners was explored in the final marketing question, which was completed by all 129 respondents. Respondents were requested to rate the regularity with which they used seven marketing tools and to indicate whether or not they considered those marketing tools to be successful in yielding increased business opportunities. Figure 4.8 provides a detailed description of the results of this question. It is important to note that the respondents rated marketing as one of the least important activities in their practices (M = 3.17, SD = 0.81) on a scale of 1 to 4 (see Figure 4.2).

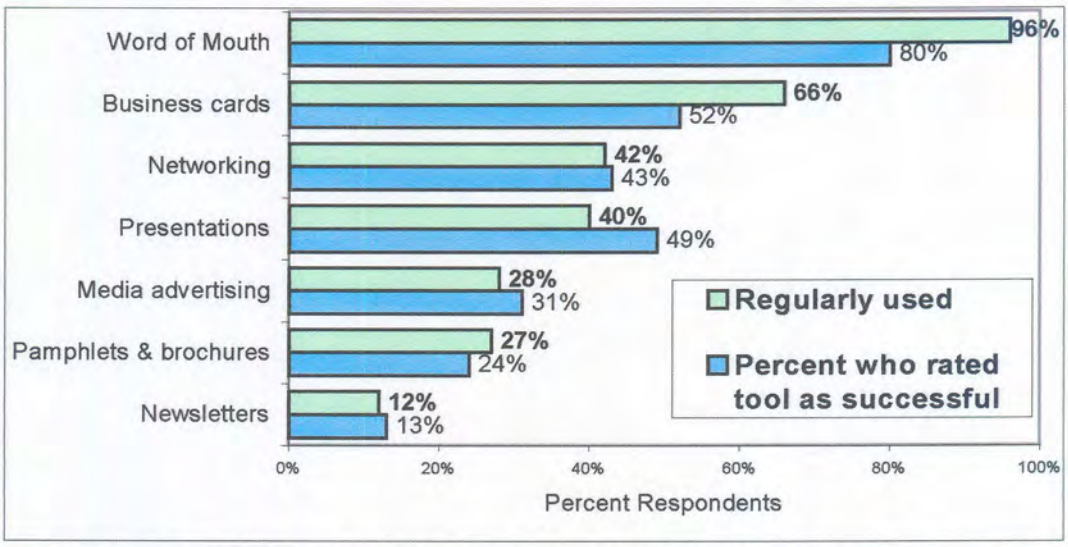

Figure 4.8 Regular use and success of marketing tools as rated by respondents

The results presented in Figure 4.8 indicate that word of mouth is the most regularly used (97%) and successful (80%) of all the marketing tools listed. In addition, all of the 129 respondents had used word of mouth as a means of marketing at some time. This result was predictable since word of mouth is a form of marketing that requires the least amount of effort on the practitioner's behalf as it usually happens naturally, and is a marketing tool over which private practitioners have limited control. Business cards were also favoured as a regular form of marketing (69%) and was consequently also rated by the

respondents as the second most successful in yielding increased business opportunities (52%). Newsletters, pamphlets and brochures were rated as the least successful marketing tools and were consequently not used very regularly by any of the respondents. According to Smith (1993), marketing efforts should respond to the consumers' information needs. The type of marketing tools used should therefore differ depending on who the recipient of that information is. Referral sources such as physicians for instance are reported to prefer more personal sources of information such as brochures or newsletters, whereas clients are more inclined to be referred by word of mouth (Smith, 1993).

The goal of marketing is to educate a defined sector of the population about the profession and the services that are offered and to promote the services that will help people improve the quality of their lives. With the exception of word of mouth, 47 respondents on average reported never having used the six remaining marketing tools. This is surprisingly high considering that many potential clients in South Africa are not familiar with the profession and that there is a long way to go before speech-language therapy and audiology become household names (Smith, 1990). It is therefore important for private practitioners to market their services and in so doing market the profession because marketing can influence the growth of the profession, communicate the importance of speech-language therapy and audiology to the targeted public, and expand service delivery (Smith, 1996, Ashby, 1995). In order to reach the entire communicatively disordered and delayed population in South Africa it is therefore essential for private practitioners to market themselves and the profession through education and awareness to the general public (Larkins, 1993).

In conclusion to the strategic implementation of marketing practices, the respondents are uncertain about their proportion of market share, they rely on temporary reasons for their competitive advantage, they make little use of the variety of marketing tools available to them and they don't rate the importance of marketing very highly. These are all factors that indicate that the current marketing knowledge and behaviour of the respondents is insufficient. The

consequences of poor marketing of a private practice are that potential clients and referral sources may be unaware and uneducated about the possible benefits of services and that the client base of the practice may remain limited (Larkins, 1993). In addition, new technologies, techniques and facilities may go unused and unnoticed by current clients and referral sources if they are not marketed appropriately to the relevant populations (Ashby, 1995).

- **Finance**

The second area of focus in the strategic implementation of business management practices pertains to *financial management practices* and *financial knowledge*. It is important to note here that respondents gave financial management an overall mean importance rating of 3.63 (*SD* = 0.58) (see Figure 4.2) which indicates that the respondents rated financial management relatively high and that the group was relatively homogenous concerning the importance of financial management. To further explore the financial management practices being used in private clinical settings, six financially related questions were posed to the respondents.

The first question (Q.20) requested respondents to report on the percentage of the various *methods of payment* that they accept for services rendered. The statistical results of the 128 responses to this question are provided in Figure 4.9 and Table 4.6. The results in Figure 4.9 reveal that medical aid payment (*M* = 42%, *SD* = 0.34) and monthly payment made by clients (*M* = 37%, *SD* = 0.36) were the two most popular methods of payment accepted by the respondents as they represented the largest share of payments made for services rendered. Payments classified by respondents as "Other" usually referred to credit card payment and represented the smallest share of payment accepted (*M* = 2%, *SD* = 0.10).

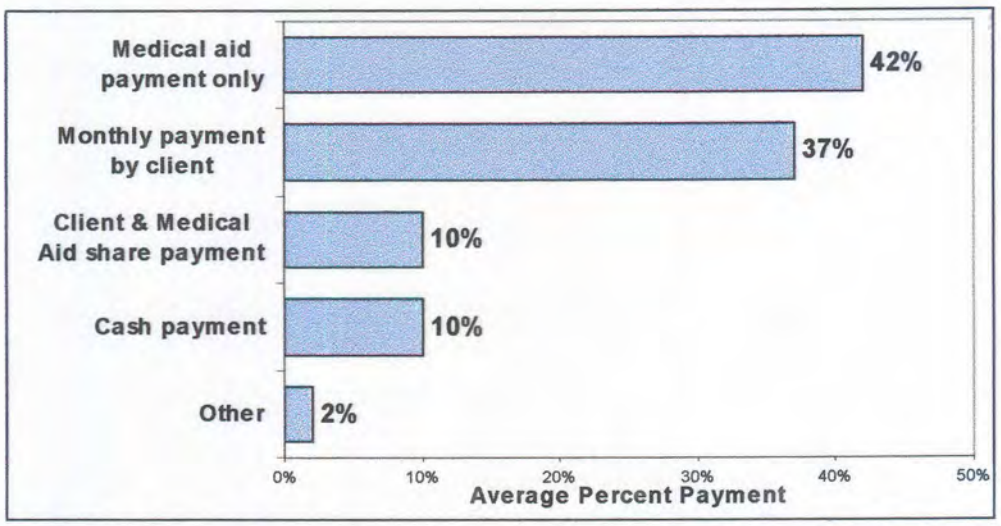

Figure 4.9 Average percentage of methods of payment accepted by respondents (n = 128)

Table 4.6 indicates that there was a large degree of homogeneity amongst the respondents with regard to their reported percentages of payment received by cash, credit card and shared payment. However, the most heterogeneity amongst respondents existed in the acceptance of monthly payments from clients and payments from medical aid societies. This may be linked to the fact that 9% of the respondents accepted only one form of payment, namely monthly payment. Furthermore, this may be an indication that the respondents accepted one of either a large percentage of monthly payments or a large percentage of medical aid payments.

Table 4.6 Standard deviation of average percentage of methods of payment

Payment method	*Standard Deviation*
Cash payment	0.19
Monthly payment by client	0.36
Client & Medical Aid share payment	0.17
Medical aid payment only	0.34
Other	0.10

The results in Figure 4.9 indicate that respondents rely mainly on the traditional method of payment from medical aids, yet it appears that a large percentage of payments are also being accepted from clients on a monthly

basis. This may be an attempt by the respondents to improve cash flow due to the lengthy time period (often up to six months) taken by medical aids to pay service providers. The results may also be a consequence of fewer clients belonging to medical aid schemes, which would increase the percentage of payment from clients and consequently decrease that of the medical aid schemes. Alternatively, the change in the administration of medical scheme rules or tariffs could have had an effect on the results (Brown, 1994). For example, many medical schemes such as Discovery Health, which has a large client base, have rules that enforce members to pay a percentage of the medical bill when consulting a health care professional such as a speech-language therapist and audiologist. The medical scheme therefore only pays the remainder of the bill. Alternatively, some medical schemes prefer members to pay the medical bill in full and to claim back the funds later. However, with the emergence of managed care in South Africa, the percentage of payments currently accepted by speech-language therapists and audiologists in private practice may undergo substantial changes (Green, 1998).

The respondents' *cash flow problems* were the focus of attention in the following question that determined whether or not the respondents had ever experienced difficulties with cash flow. Although sensitive, this question elicited 125 responses of which 54% (n = 68) of the respondents acknowledged the fact that they had experienced cash flow problems at some time in the history of their existence as a private practitioner. On further analysis it became evident that the respondents who indicated they had experienced cash flow problems received 41% of all payments in cash. In comparison, those who did not have cash flow problems received an average of 53% of all payments in cash within one month of rendering services. It thus appears that there is a correlation between positive cash flow and cash payment for services rendered. This correlation may be considered the reason why respondents only accept cash payments from clients since waiting for medical schemes to pay six months after services are rendered adversely affects cash flow (Wood, 1986). Therefore, in order to avoid cash flow

difficulties, it can be concluded that respondents increase the percentage of payments received by cash from clients.

Since bad debts are considered another possible cause of cash flow problems in a private practice (Flower, 1984; Wood, 1986), the respondents were requested to provide an estimation of bad debts as a percentage of annual income. A total of 122 estimations were provided, which revealed that bad debts ranged between 0% and 40% with a mean of 8.75% (*SD* = 0,095). A comparison was made of the mean bad debts of the respondents who reported using a debtor's analysis (*M* = 9.11) versus respondents who reported not using a debtors analysis (*M* = 7.95). It was interesting to note that the mean bad debts were lower for the respondents who did not use a debtor's summary. Since it seems unlikely that using a debtors analysis should increase bad debts, the reason for this phenomenon may be that respondents who have high bad debts are more compelled to use a debtor's analysis in order to reduce them. An alternative explanation is that it is possible that the respondents who do not use debtor's analyses either do not understand the concept or have good enough control over bad debts not to warrant use thereof. Despite the possible cause for bad debts and the reason for using debtor's analyses, it appears that the respondents may benefit from training with regard to the management of bad debts since bad debts impact on the cash flow in a private practice.

The compilation of the annual tax return in a private practice was studied next by requesting respondents to indicate who compiled the private practice's annual tax return. The respondents indicated that 81% (*n* = 101) of the 124 respondents who answered the question have their tax return completed by a professional in the field of auditing, tax, bookkeeping, or chartered accountancy. Of the remaining respondents, 11% completed the return themselves and 7% had their spouses complete the tax return for them.

These results have three possible explanations. Firstly, the accounting and tax calculations for private practices could be too complicated for a non-financial person. Secondly, practitioners do not have the time to complete tax

returns themselves. Thirdly, the private practitioners have little or no experience or training in completing a tax return. The third reason creates an opportunity for training private practitioners to complete their own tax returns or as Wood (1986) suggests, to be familiar with tax information in order to make suitable financial decisions. This statement is consistent with the result in section 4.3.4 which revealed that the respondents indicated that tax should be included in a training course for private practitioners (see 4.3.4).

Next, the respondents were requested to indicate which *financial records* were used in their private practices. Of the 122 respondents who answered this question, some only used an income statement whereas others used all seven of the financial records available in the answer choices, the results of which are displayed in Figure 4.10.

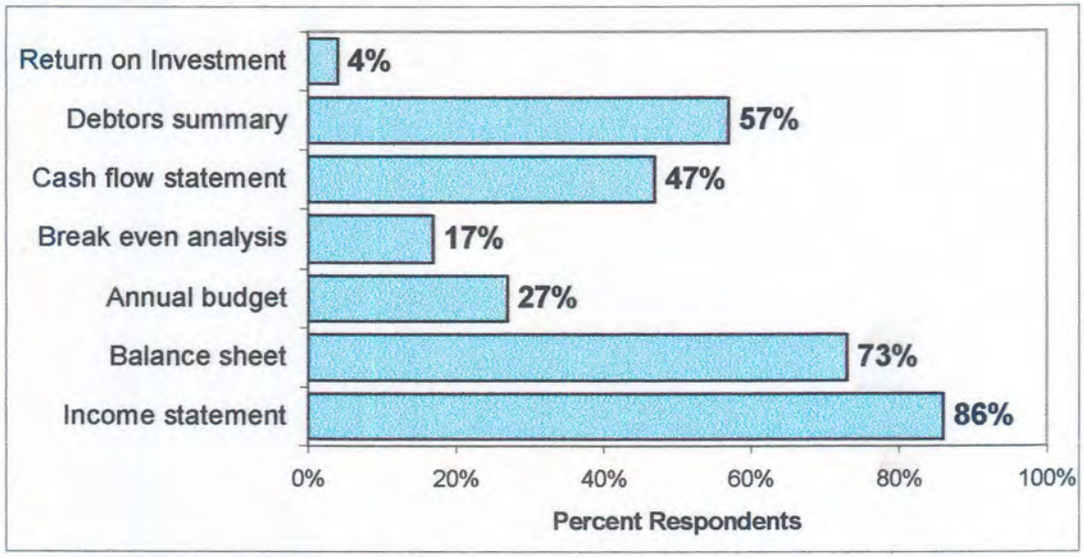

Figure 4.10 Number of respondents using various financial records (n = 122)

It is interesting to note that the most important financial statement, the income statement, is only used by 86% of the respondents. Non-response or the lack of knowledge of financial terms or financial statements may have influenced this result. However, whilst the income statement might have elicited the highest percentage response, it nevertheless is an essential component of the preparation of accurate tax returns by all taxpayers and should thus be used by all business owners (Wood, 1986). The lack of certain essential financial

statements in a private practice imply a lack of financial management on the respondent's behalf and may result in poor financial decisions being made since the relevant data will not be available in a format that facilitates understanding thereof. The implications of poor financial decisions are likely to have a negative effect on all aspects of private practice including clinical duties and may even lead to liquidity of a business. It is therefore essential that the respondents be trained to understand the need for financial statements in order to avoid the above consequences.

In addition, respondents who indicated that they had experienced cash flow problems in the past were more inclined to use cash flow statements. This result, as well as the fact that respondents with higher bad debts use debtor's analyses, is an indication that respondents may be more inclined to use financial records after they experience specific financial problems. It therefore appears that, although it is considered unprofessional, that the respondents are learning through their experiences in private practice. There is a strong possibility that the respondents' process of learning through experience could have been eliminated to a large extent if they had received some form of financial training prior to entering private practice.

Finally, the respondents were requested to estimate the percentage of annual income they allocated to four *expenses* in the business, namely marketing, equipment, stationary, and continuing education in question 25. Unfortunately, this question was misunderstood by at least 19 of the respondents, which negated the results and prevented the data from being analysed statistically. The errors made by the 19 respondents were detected when it was found that 100% of their annual income was divided between the above-mentioned expenses. This situation is unlikely in any private practice since the income should also cover many more expenses within a business such as rent, telephone, petrol, consumables, and professional services to name a few. However, it was evident from a broad overview of the results that the largest of the four expenses was equipment, followed by continuing education, stationary, and lastly marketing. These results are not surprising since good quality materials for speech-language therapy practices are expensive and

audiologists require fairly complex and expensive instruments and materials to render their services (Wood, 1986). The low marketing expenditure is in line with the low importance rating given to marketing and the indication that marketing goals are set by fewer respondents than the other business goals (see 4.3.1 and 4.3.2).

In conclusion to the strategic implementation of financial management practices a number of conclusions can be drawn. Firstly, the respondents accept varied methods of payment yet favour medical aid payments and monthly payment by clients. Secondly, more than half of them have experienced cash flow problems. Thirdly, their practices' average bad debts are approximately 9%. Fourthly, their annual tax returns are mostly completed by accounting professionals, and fifthly they do not all compile essential financial records. Furthermore it appears that many of the respondents rely upon learning about financial practices through experience. A number of the above conclusions indicate that the respondents have insufficient financial knowledge and financial practices and could therefore benefit from financial management training. The consequence of respondents continuing to run businesses without the necessary financial knowledge and skills is that their practices will never reach their full potential in terms of efficiency or profit which is likely to impact on the satisfaction of private practitioners and clients.

- **Information Technology (IT)**

The third area of focus of strategic implementation concerned the respondents' use of *information technology* in their private practices. This was accomplished by determining their use of *computers* and the *Internet* and was completed by 129 of the respondents. The results, which are presented in Figure 4.11, indicate that 97% (n = 124) of the respondents used a computer in their private practices. Amongst the useful properties of computers, it is expected that the overwhelming majority of respondents use computers since they save time, improve efficiency, and are cost-effective.

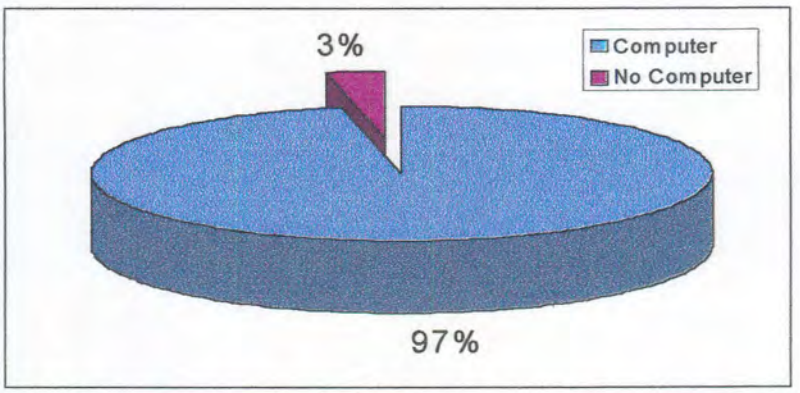

Figure 4.11 Percent of respondents using computers (n = 129)

Figure 4.12 reveals the results of an investigation into the respondents' use of computers in private practice. The results indicate that computers are mostly used by the respondents for report writing (96%, *n* = 123) and generating invoices (81%, *n* = 104). Since question 27 mainly probed the responses to the administration functions of a computer, it is not surprising that only 26% (n = 33) of the respondents reported using computers for assessment and treatment (indicated under "Other"). Furthermore, the results in Figure 4.12 were anticipated since most computers are purchased with basic software installed such as Microsoft Word and Excel, which renders them generally inexpensive and easy to use for administration purposes. However, computers and software specifically designed for more complex functions such as assessment and treatment are relatively expensive for private practitioners to purchase and usually require some form of training, which can be costly.

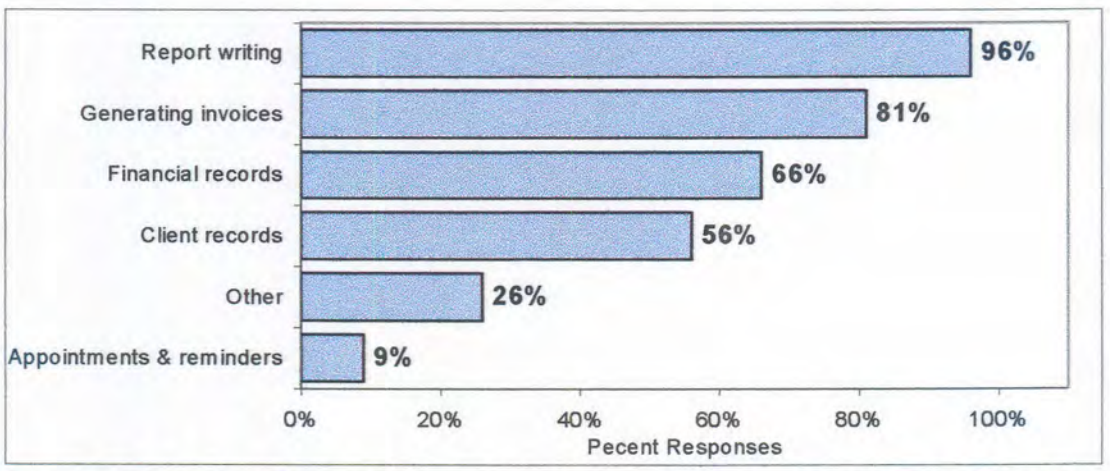

Figure 4.12 Respondents' use of a computer in the private practice (n = 129)

The respondents' access to and use of the Internet was explored in the following two questions, which revealed that 83% of the 129 respondents had Internet access available to them and that a further 10% would like to have access (see Figure 4.13). This indicates the willingness of respondents to learn about information technology regardless of whether or not they have access. The implication of having access to the Internet is that it provides the respondents with a wide variety of learning opportunities, links respondents to the latest information and research, and enables them to participate in discussion groups on speech-language therapy and audiology topics. The Internet therefore offers subscribers many opportunities to stay abreast of developments in the profession yet the onus rests upon subscribers to use the available resources.

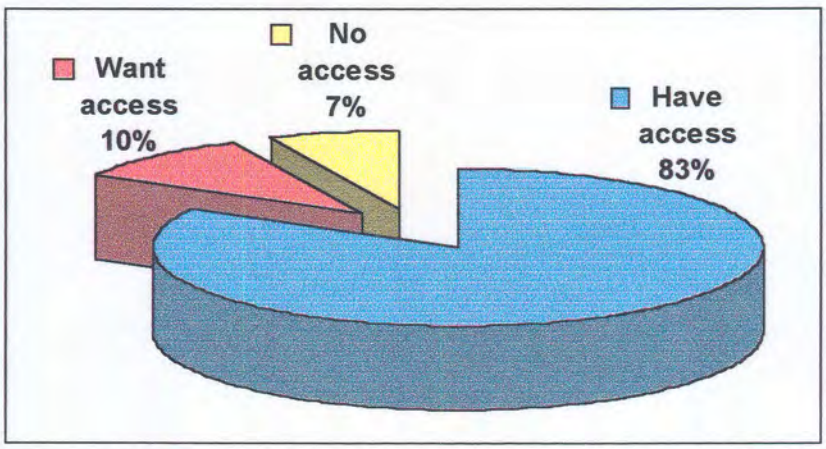

Figure 4.13 Respondents' access to the Internet (n = 129)

The respondents were consequently requested to indicate whether or not they search the Internet for topics relating to speech-language therapy and or audiology. The results indicated that 75% of them (n = 96) do so. This implies that 8% of the respondents have access to the Internet yet do not make use of it to further their speech-language therapy and audiology knowledge.

It is evident from the above results that the majority of the respondents use information technology to some extent. However, their limited use of the computer and Internet indicates that they may not be aware of all the advantages and functions available to them, which may facilitate the management of their practices and enable them to deliver more efficient

clinical services. According to Wynn et al. (1993), computers can yield great profits when the private practice is restructured to take advantage of them. However, the respondents firstly need to be made aware of the wide range of functions, software, tools, and equipment available to them in order to fully understand the potential of IT in a private practice setting. Secondly, they need to understand how IT can enable them to be better prepared to respond to the demands of the dynamic changes in the health care industry by providing them with, for example, the most recent information about a client or the most appropriate hearing aid for a client (Leven, 1998; Goldberg, 1996).

Finally, it can be concluded that the respondents require a basic form of computer training in order to make more use of the functions and opportunities available to them. The consequences of not utilising computers and the Internet to their full extent is that the respondents will never take full advantage of the potentially rich learning environment and the potentially efficient and time saving qualities that IT has to offer the private practitioner.

- **Personnel Management**

The final area of focus in the strategic implementation process pertains to personnel management or human resource management. To determine the respondents' personnel management knowledge and practices, respondents were requested to complete question 30 only if they employed one or more staff member in their private practices. Of the 46 respondents who indicated in the biographical information section of the questionnaire that they employed staff, only 91% (n = 42) responded to the question on personnel management. Figure 4.14 presents the results, which indicate that the most popular forms of personnel management used by respondents were job descriptions (72%, *n* = 33) and staff training (72%, *n* = 33). Figure 4.14 also indicates that two respondents did not use any form of personnel management whatsoever.

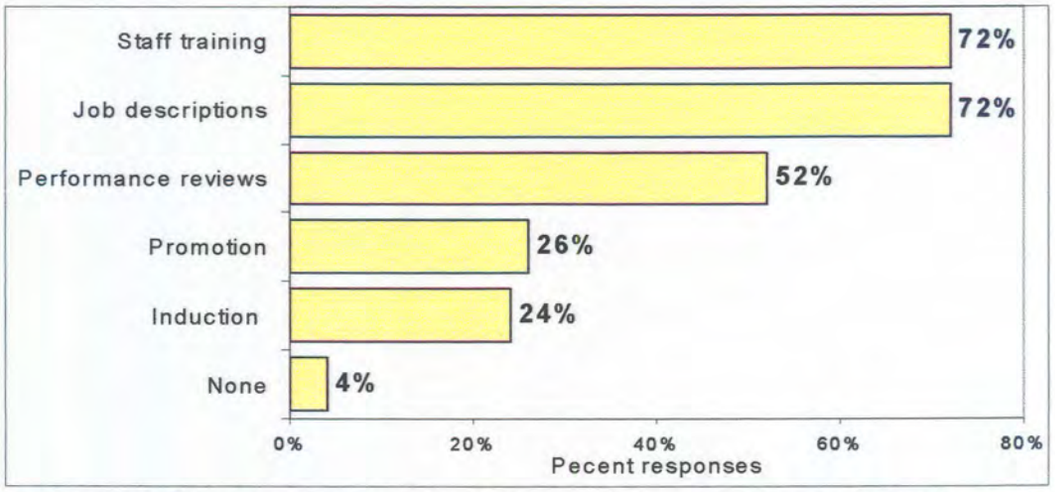

Figure 4.14 Personnel management practices used by respondents (n = 46)

Since it is in a private practitioner's own interests to ensure that her clients receive services from well-trained staff that are competent in the procedures of the business and know the limitations of their abilities, it is expected that staff training, induction and performance reviews should be used by a greater percentage of respondents. Furthermore, it is interesting to note that performance reviews, which were given an importance rating of 3.21 by the entire group of respondents (see Figure 4.2), were only used by 52% (*n* = 24) of the respondents with employees. It therefore appears that despite respondents knowing and rating performance reviews as important, they seldom use this personnel management tool in their private practices. This implies that the respondents are not applying the knowledge that they have of business management to their private practices. According to Wood (1986), this is a dangerous practice since the clinical success of employees reflects on the private practitioner's reputation. This result is therefore even more surprising since many respondents indicated that they rely upon their reputation as a form of competitive advantage (see 4.3.2.2). Furthermore, Brooks (1994) has proved that performance reviews help to identify the self-development and training needs of employees, which was rated in this study as the second most important management activity in a private practice (see Figure 4.2).

The results presented in Figure 4.14 as well as those referred to in the ensuing discussion thereof are incongruent with one another. This implies that

the respondents' intentions are inconsistent with their practices with regard to personnel management practices. A possible explanation for the respondents' incongruent and inconsistent responses is that they have not acquired the necessary skills to fulfil their intentions. It is therefore expected that the respondents would benefit from training in personnel management techniques and human resource management.

In conclusion, the results of the strategic implementation of business management and tools reveals that the importance ratings assigned by respondents to business management activities far outweigh the actual management behaviour and practices within the various private clinical settings of the respondents. It therefore appears that the respondents have *adequate knowledge of business management principles yet do not appear to put this knowledge to use* in the management of their private practices with the appropriate use of management practices, techniques and tools.

4.2.2.3 Strategic Control

Strategic control refers to a combination of components that act together to ensure that the level of actual performance in a private practice comes as close as possible to the private practitioner's desired performance specifications (Duncan et al., 1992). Strategic control systems provide the private practitioner with as early detection system that indicates when conditions or progress is not satisfactory, and provides a method for correcting these conditions. Since many of the factors within a private practice's management control system are closely linked with methods used as proof of accountability, these two factors are examined conjointly. The final area of business management, strategic control, therefore explored the respondents' *knowledge of strategic control concepts* and examined which of the *accountability practices* and *methods of control* described in the literature were *used* by the respondents in their private practices. Four areas of strategic control and accountability were probed, namely *cost analysis*, *time management*, *record keeping*, and *client satisfaction*. The results from each of these areas are presented and discussed separately.

- **Cost analysis**

The *analysis of costs* in a private practice has been described as an important component of managing a business in the literature (Trulove & Fitch, 1998; Ashby, 1995; Wood, 1986) and was the topic of three questions in the questionnaire. The first question concerning cost analysis was completed by 128 of the respondents. Only 51% (n = 65) of those who responded indicated that they had actually determined the cost of their speech-language therapy or audiological services in terms of money or time spent. This result is similar to that obtained by Trulove & Fitch (1998) in their study of private practitioners in the USA and is also consistent with the fact that respondents gave cost containment the lowest mean importance rating of all the business management activities (M = 3.13, SD = 0.83) (see Figure 4.2).

However, the respondents' lack of awareness of costs contrasts with the literature which is abundant with information regarding the importance of cost-effectiveness and cost containment as a measure of accountability, particularly in determining whether or not to continue treatment (Trulove & Fitch, 1998; Metz, 1996; Ashby, 1995). It is thus presumed that the majority of respondents are either unaware of the focus on cost analysis in the literature or that they have not heeded the advice and recommendations made in the literature to focus on costs within their own private practices.

The need for cost analysis is not only for sound financial management of a business but also to prove that the costs of services are justifiable to the client and to the medical scheme. In other words, the respondents must be accountable for the cost of services. It is expected that cost accountability will become increasingly important in the future as medical schemes and managed care companies endeavour to decrease their own costs by putting pressure on the speech-language therapist and audiologist to prove the cost of her services. It is therefore concluded that the respondents require training that will enable them to acknowledge and understand the need for cost analysis as it pertains to financial management as well as accountability. In addition, the respondents require practical training to enable them to analyse

the cost of their services in order to prove to the relevant third parties that their costs can be satisfactorily justified.

A comparison was made between audiology clinics and speech-language therapy clinics to determine which group is more likely to perform cost analysis. The results indicated that 57% of audiology clinics analysed the cost of their services in comparison with 44% of speech-language therapy clinics. A possible explanation for this result could be that audiology clinics have more expensive equipment and are thus more inclined to monitor the return on investment for equipment purchased which in turn puts greater emphasis on cost analysis. An additional reason is that the costing of services may be easier in audiology since each test in an audiological test battery has a specific price. However, in speech-language therapy there is one category for therapy costing as services are provided in therapy units (time controlled units) and fewer tests are performed in such practices. An alternative explanation provided by Metz (1996) is that the dispensing of hearing aids opened up the profession of audiology to the retail arena and in this way exposed audiologists to a more business-like work environment in which costs had to be contained.

The respondents' knowledge of the *cost-effectiveness* of their speech-language therapy and audiology services was probed in question 32. The results, which are graphically displayed in Figure 4.15, indicate that of the 123 respondents who answered this question, 64% (n = 79) believed that their services were cost effective. A further 28% (n = 34) reported that they did not know the answer to the question and 8% (n = 10) indicated that their services were, in fact, not cost effective to the business. However, only 53% of the respondents indicated that they had actually measured the cost of their services. Therefore, the 11% difference between those who believed that their services were cost effective (64%) and those who actually measured their cost effectiveness (53%) may be an indication that some respondents *assume* that their services are cost effective. According to Collins (1994), a private practitioner is a person who operates with the ultimate and relatively clear objective of maximising profits. Therefore, it does not make business sense to

only assume the cost effectiveness of services provided. The implications thereof are that the respondent's net profit may be significantly less than expected, which implies poor financial planning on the respondent's behalf. Furthermore, respondents that assume the cost-effectiveness of their services put the profession at risk with regard to remuneration levels and fee schedules developed by medical schemes or managed care companies.

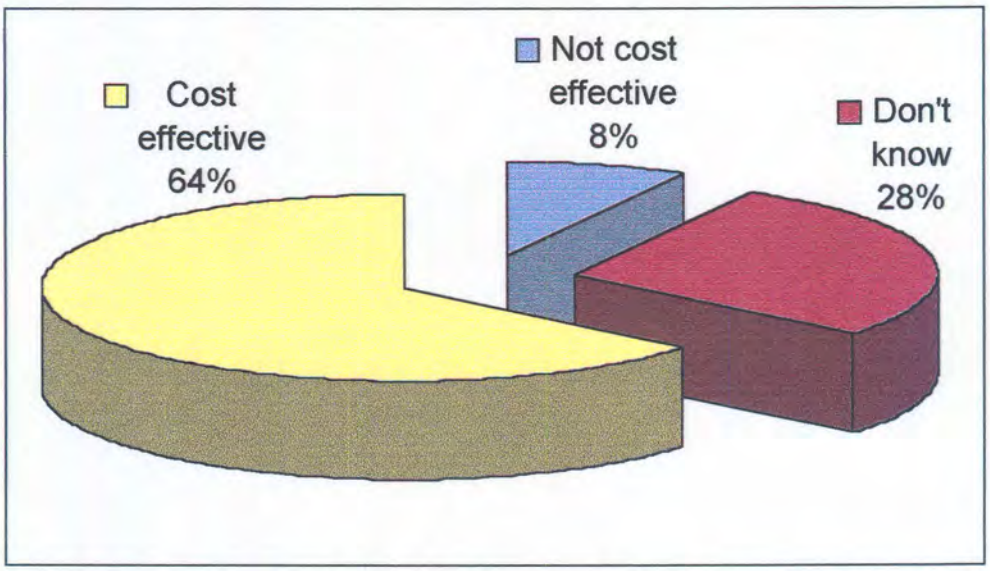

Figure 4.15 Respondents' opinions regarding the cost-effectiveness of their services (n =123)

It is also concerning that 8% of the respondents believe that their services are not cost-effective. It could therefore be assumed that the respondents would rate cost containment as relatively important in comparison with other business management tasks. However, the mean importance rating for cost containment was the lowest of all the categories rated (M = 3.13, SD = 0.83) (see Figure 4.2). Wood (1986) states that the implications of services that are not cost-effective is that the overheads of the practice cannot be paid and the personal income needs of the private practitioner cannot be met which will ultimately result in the practitioner being unable to afford to extend services to clients. Furthermore, Metz (1996) states that in no other work environment is profit and loss more crucial than in a private practice. Even though many practitioners entered the field to provide help to others, it will always remain necessary that they help themselves and remain financially healthy (Metz, 1996). Therefore, the fact that 36% of the respondents either don't know if

their services are cost-effective or believe their services are not cost-effective substantiates the need for training that will enable the respondents to ensure the cost-effectiveness of their services.

The respondents revealed that they use a variety of innovative methods to *contain costs* in a private practice environment. The 87 responses to question 35 were analysed and placed into one of five categories that encompassed the most popular cost saving methods and ideas amongst the respondents. The results of this process are revealed in Table 4.7.

Table 4.7 Respondents' use of cost saving methods and ideas

COST SAVING METHODS AND IDEAS	***Percentage Respondents***
Budgeting, financial planning and financial management	*26%*
Clinical and non-clinical duties carried out solely by respondent without employing or contracting other professionals	*25%*
Decrease indirect expenses such as stationary and telephone	*23%*
Focus on prompt payment of accounts and collection of bad debts	*17%*
Work from home to avoid paying rent	*17%*

It was interesting to notice that most of the reasons given above related to direct and indirect expenses, whereas none of the respondents mentioned productivity improvement or efficient time management as means of containing costs. This may be an indication of a lack of knowledge among respondents of alternative ways to contain costs within a private practice. This implies that cost containment efforts may always be limited and the opportunities within cost containment methods such as productivity improvement and efficient time management will be wasted.

In conclusion to the strategic control of costs and accountability of cost-effectiveness a number of conclusions can be drawn. Firstly, it appears that approximately half of the respondents have never determined the cost of their services which is consistent with their earlier rating of cost containment as the least important of all business management activities. Secondly, 36% of the respondents either did not know whether their services were cost-effective or

believed their services were not cost-effective. Furthermore, a small percentage of the respondents assumed their services to be cost-effective without ever having analysed or measured them. Thirdly, the respondents appear to rely upon a limited number of methods for cost containment. These factors all indicate that the respondents' control over costs and cost accountability is insufficient. Since private practitioners will increasingly rely upon managed care companies for remuneration it is essential that they comply with the cost containment efforts currently pervading the health care industry. Furthermore, it appears that the respondents will benefit from training, which will educate them in cost analysis procedures, cost containment and ensuring cost-effectiveness.

- **Time management**

The second area of determining the respondents' accountability and control measures pertained to *time management* and the *use* thereof in the private practice, which was probed in questions 34 and 35. The results, which are presented in Figure 4.16, indicate that, of the 101 respondents who use time management systems in their private practices, the largest group reports doing so either on a daily (62%) or weekly basis (59%) or both (34%). These results were surprising since it was anticipated that all of the respondents would use a daily time management tool such as a diary to schedule appointments. However, the results in Figure 4.16 as well as the fact that 28 non-responses were recorded for this question may be an indication that the respondents misunderstood the concept of time management. A further possible explanation is that the respondents consider time management not to be a great concern in their private practices. However, this finding is inconsistent with the fact that the respondents rated time management as the fourth most important business management activity (M = 3.66, SD = 0.54) (see Figure 4.2). The results in this section, however, were consistent with the findings of Trulove & Fitch (1998) who investigated time management issues amongst private practitioners in the USA and found that the majority of them did not use time management either. Time management is also closely linked to accountability since private practitioners should be able to justify the length of assessment and treatment sessions as well as the period of treatment to

medical schemes and managed care companies. Therefore, one of the implications of not having a reliable time management system is that the respondents will not be able to justify the length of treatment sessions. In addition, respondents and their employees may be less productive without a reliable time management system (Stanbridge, 1999).

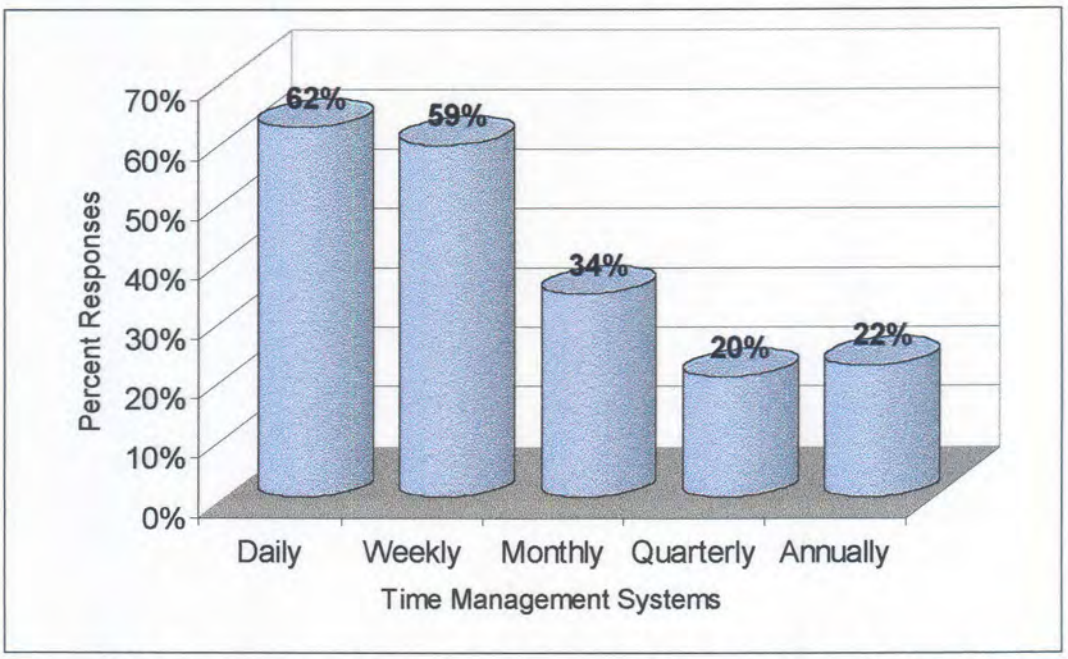

Figure 4.16 Time management system used by respondents (n = 101)

To determine the respondents' *knowledge* of the *factors* that *impacted* on their *time management* they were requested to report their frustrations and problems with time management in private practice. This question elicited a great deal of interest since 105 respondents were eager to provide written comments regarding the problems they encountered with time management. Table 4.8 presents the most common problems reported by the respondents. The results in Table 4.8 reveal that an overwhelming 80% of the respondents complained of excess administration, which included report writing, handling of accounts, and follow-up of bad debts and medical aid claims. Since most administration tasks are essential to ensure payment, accountability, and to keep adequate records, they are necessary and therefore cannot be avoided. However, respondents have a number of options available to them to alleviate the administration burden such as hiring or contracting staff, outsourcing the

administration or bookkeeping duties, and implementing an integrated office management system.

Table 4.8 Respondents' time management problems

PROBLEM	*Percentage Respondents*
Excessive administration at week, month and term-end (report writing, bookkeeping, payments & expenses)	*80%*
Late cancellation of appointments	*12%*
Telephone calls to parents, teachers and significant others	*10%*
Consultations with parents after assessment or treatment sessions	*10%*
Preparation for assessment and treatment	*5%*

Wood (1986) believes that private practitioners are faced with an unusual combination of professional and business demands in a private practice. Therefore, the fact that administrative duties are the most common problems reported is an indication that the majority of the respondents do their own administration. This was anticipated since the majority of the respondents (64%) indicated that they have solo practices and stated this as one of the ways in which they contained costs (see 4.2.2.2). However, computers offer the respondents many time saving opportunities to ease the burden of administration tasks (Ashby, 1995). As stated previously, respondents should therefore be trained to take advantage of information technology to assist them with tasks that can be done automatically and thus save time.

In conclusion to the strategic control of time management, it appears that the respondents do not all use time management systems in their private practices which may be the result of insufficient knowledge regarding time management systems. Furthermore, the respondents inexorably agreed that excess administration was the most common time management problem in private practice. Since there are tools and methods available for alleviating this problem it is assumed that the respondents would benefit from training pertaining to time management, yet it remains their responsibility to implement time saving devices into their respective private practices.

- **Record Keeping**

Record keeping was investigated as an important component of accountability and strategic control. The respondents rated record keeping as the second most important business activity following clinical duties (*SD* = 0.41) (see Figure 4.2) and it was therefore expected that their *record keeping knowledge and practices* would be consistent with this rating. The origin of respondents' clinical record keeping systems was probed in question 36, the results of which of displayed in Figure 4.17. The 128 respondents who completed this question indicated a variety of origins for their record keeping systems. Figure 4.17 indicates that the highest percentage of respondents (64%) reported using a record keeping system that they had developed themselves. It is interesting to note that 16% of the respondents reported using a combination of systems, for example: a self-developed system based on a system learnt from a private practitioner as well as the system they were exposed to in university.

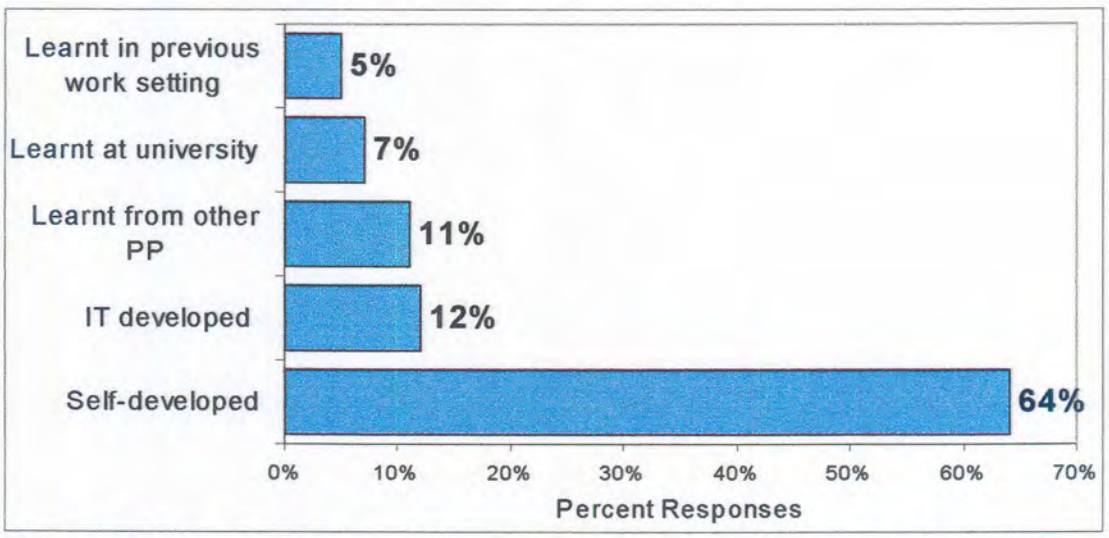

Figure 4.17 Origin of record keeping system used by respondents (n = 128)

The fact that only 12% of the respondents used IT developed record keeping system contrasts with the fact that 56% of the respondents used the computer for record keeping (see 4.2.2.3). The reason for this inconsistency could be that most of the respondents tailor general software packages such as Microsoft Word and Excel to their record keeping requirements whereas the

12% in Figure 4.17 use specially designed and purchased IT record keeping systems.

Delving deeper into the respondents' clinical record keeping habits, they were requested to report what type of information they used to describe client progress and how often they used it (Q.37). Table 4.9 presents the results which indicate that descriptive and quantitative information was rated by the respondents as being used most regularly (97% and 87% respectively). It is concerning that such a large percentage of respondents never used graphs (44%) or tables (46%) when recording client progress since these tools are useful in tracking client progress and representing outcome data. The above result implies that the respondents may not be recording essential outcome data. Since recording outcome data is one of the most important ways of proving accountability (Frattali, 1998), respondents should go to great lengths to prove, with the use of every type of information available, that they are accountable. As stated previously, proving accountability to medical schemes and managed care companies is essential in order to justify remuneration for services rendered.

Table 4.9 Respondents use of information to describe client progress (n=128)

Type of Information	*Regularly Used*	*Never Used*
Descriptive	**97%**	**3%**
Quantitative	**87%**	**6%**
Graphs	**36%**	**44%**
Tables	**26%**	**46%**

Therefore, despite the high rating respondents assigned to record keeping in section 4.2.2.3, it appears that they mainly used uncomplicated, traditional methods of record keeping which they have observed in use in other clinical practice settings. These results are consistent with the findings of Trulove & Fitch (1998:79) who stated that "...the most commonly reported accountability practice was describing client progress through use of quantitative data and narrative information." In addition, Trulove & Fitch (1998) reported that the majority of private practitioners sampled did not use graphs or tables in their

description of client progress or for maintaining accountability in their practices.

It can therefore be concluded, with regards to record keeping as a measure of strategic control and accountability, that the respondents generally use self-developed record keeping systems and that they use limited types of information in their description of client progress. This demonstrates the respondents' need for training with regard to how they can improve accountability through record keeping since the majority of the respondents agreed with the statement that they need to be more accountable (see 4.2.2.3). The consequences of not keeping adequate records is that the respondents may not satisfy the requirements of the managed care companies in terms of accountability.

- **Client Satisfaction**

The third method of strategic control and accountability used in private practice is the respondents' *measurement of client satisfaction*, which was assigned a mean importance rating of 3.62 (*SD* = 0.61) by the respondents (see Figure 4.2). Despite this high importance rating the results to question 38 indicate that, out of a total of 124 responses, 59% (*n* = 73) of the respondents reported *never* having measured client satisfaction (see Figure 4.18).

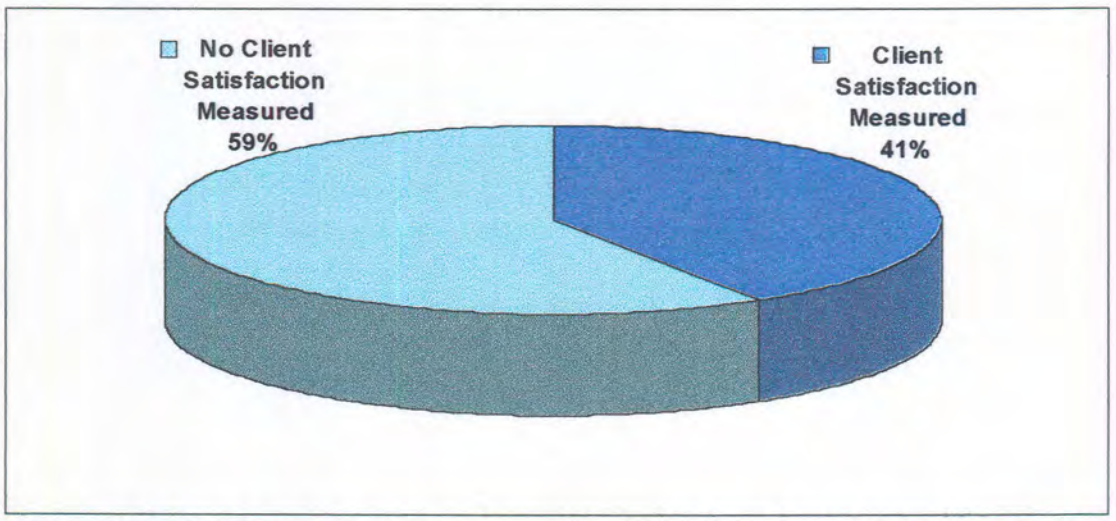

Figure 4.18 Respondents' measurement of client satisfaction (n=124)

This result is alarming since the measurement of client satisfaction is an essential component of determining clients' needs in order to respond to the way quality service is delivered to the client (Klop, 1998). Furthermore, Crosby (1994) states that a satisfied client is a successful client. It is therefore in the respondents' best interests to ensure clients are satisfied. One of the most useful ways of doing so is by measuring whether or not clients are satisfied with the quality and delivery of services. The implications of not measuring client satisfaction is that the respondents may keep losing dissatisfied clients, as they have yet to discover the reason for their dissatisfaction. It is possible that the reason for the results in Figure 4.18 is that the respondents are unaware of the potential benefits of measuring client satisfaction. It is therefore likely that they will gain the necessary insight and skills through training in the measurement of client satisfaction.

Among those respondents who have measured client satisfaction, interviews appear to be the most prevalent method used (see Table 4.10). However, as discussed previously, the most significant results were the high percentage of respondents that had never used any of the client satisfaction tools listed in the questionnaire.

Table 4.10 Respondents' use of client satisfaction tools (n = 124)

Client Satisfaction Tool	*Used*	*Never Used*
Interviews	**43%**	**42%**
Standardised questionnaires	**18%**	**64%**
Self-developed questionnaires	**14%**	**64%**

The questionnaire did not ascertain whether or not the methods of client satisfaction used by the respondents were formal or systematic as suggested by the literature (Klop, 1998). Nevertheless, the literature recommends the use of questionnaires as an appropriate tool for measuring client satisfaction (Lacap, 1994). In comparison, interviews are considered inappropriate unless they are administered by an independent organisation or person because clients usually prefer anonymity when providing honest feedback about services (Beckwith, 1997). Since interview methods were the most popular method of client satisfaction used and taking into account that the majority of

private practices are single-therapist practices, it follows that the interviews were likely to have been carried out by the private practitioners themselves. Therefore, the results obtained from the client satisfaction interviews may not have revealed the degree of honest feedback required by the respondents since the client may have been inhibited in his or her responses. The consequence of this is that the client's true satisfaction with the respondent's services may never be revealed. This eliminates the opportunity for the respondent to make meaningful changes to improve client satisfaction in her private practice. To prevent this from occurring respondents should be trained in the selection of the most appropriate tools to measure client satisfaction and be warned against the potential shortfalls of each tool.

With regard to using the information and feedback collected from client satisfaction tools (Q.40), only 72% of the 60 respondents who answered this question agreed that they had actually acted upon the suggestions made by their clients. This is surprising if one considers Klop's (1998) belief that the measurement of client satisfaction means that the practitioner is committed to act upon the results thereof and should only include questions about aspects that she is willing to change. Furthermore, Klop (1998:51) states that the "*...inability or unwillingness to respond to client feedback will impair the credibility of the practitioner and raise questions about his or her commitment to the needs of clients.*" The respondents would, therefore, be well advised to heed the needs and wishes of clients if they want to continue providing a service in the increasingly competitive health care service industry (Harrison & Frattali, 1994; Lacap 1994).

Since a private practitioner is held accountable to her clients, she will need to justify her actions as well as her inaction with regard to making the suggested changes to service delivery. However, in view of the above result, which indicates that only 72% of the respondents acted upon clients' suggestions, it appears that not all of the respondents are as accountable to their clients as they ought to be. This is consistent with the respondents' earlier admission that private practitioners need to be more accountable.

In conclusion to the strategic control and accountability of client satisfaction it appears that more than half the respondents have never measured client satisfaction. Furthermore, those who have elicited clients' suggestions through formal means have not all acted upon the suggestions made indicating a lack of general accountability towards the client. It is presumed that these results are the consequence of a lack of knowledge and training involving client satisfaction measures.

In conclusion to the respondents' level of *strategic control and accountability* it appears that *some* degree of these skills is present and used in most of the private practices in the research sample. However, the cost analysis, record keeping, client satisfaction and time management controls used by the majority of the respondents lack complexity, innovation and are often not used to their full extent. The attitude of the respondents to accountability is nevertheless consistent with these results if one considers that only 79% of the respondents agreed with the opinion that private practitioners should be more accountable (see 4.2.2.3). It therefore appears that the respondents are aware of the need for control and accountability methods yet lack the necessary skills in the management of their private practices.

The final conclusions regarding the business management knowledge and practices of the respondents' is that they generally understand the need for planning, management and control of their businesses yet do not make full use of the management tools available to them. It is assumed that this result is the consequence of lack of business management knowledge and understanding of the importance of these three factors within a business. Furthermore, the importance ratings previously assigned to the business activities were inconsistent with the management practices actually used by the respondents. Possible explanations for the inconsistency is that the respondents appear to understand the importance of the various business management activities yet lack the knowledge of how to apply specific management principles to achieve their business aims due to a lack of training in business management.

4.2.3 PRIVATE PRACTITIONERS' NEED FOR BUSINESS MANAGEMENT TRAINING

The fourth objective was to determine the respondents' need for training and education in the principles of private practice management. In order to achieve this aim, the respondents were requested to provide details of their previous training and to give their opinions on various matters relating to the logistics of future business management training. It appears that the respondents were greatly interested in this topic since 99% of them (n = 128) willingly imparted their opinions to the various questions. The respondents' previous attendance of business management training in small business or private practice management was probed in question 42. The results, which are illustrated in Figure 4.19, indicate that 60% of the respondents (n = 78) had never received any form of training. This result is consistent with earlier results that indicated a general lack of business management knowledge and skills amongst the respondents. Furthermore, it supports the researcher's assumptions and conclusions drawn from the data presented earlier in the chapter.

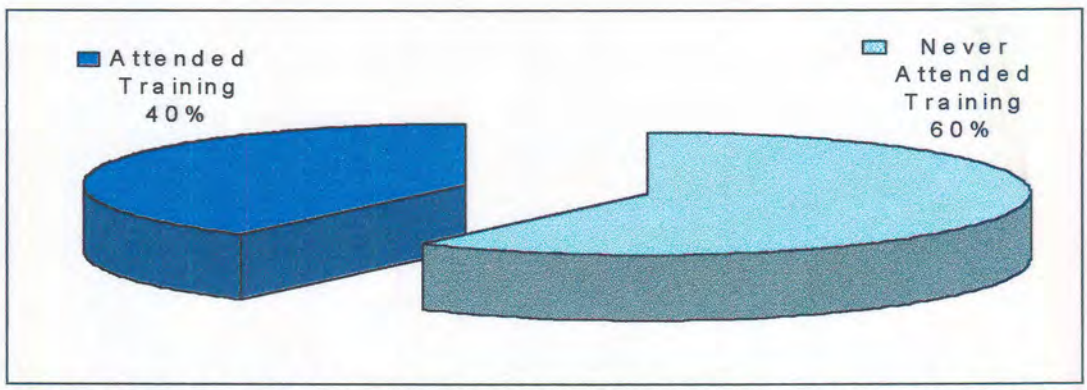

Figure 4.19 Respondents' previous business management training experience (n = 128)

Figure 4.19 also indicates that the remaining 40% of the respondents (n = 50) reported attending at least one training course applicable to business management. Among this group, approximately 45% indicated that the content of the courses included private practice management or small business management training, including university lectures on practice

management. A very small percentage of respondents also reported having attended financial and accounting courses, marketing seminars, computer courses, and time management training. It therefore appears that general management training is more popular amongst the respondents than training courses focusing on one particular aspect of management. The fact that some respondents have of their own accord attended training courses on business management implies that they acknowledge their lack of knowledge and skill in business management. Furthermore, it indicates that they are willing to learn more about the topic.

The respondents' willingness to attend a course on business management was the following area to be explored. Figure 4.20 illustrates the results of 99% of the respondents (n = 128) who answered question 44. The general opinion amongst respondents is that 68% of them (n = 87) would like to attend business management training. The fact that 68% of the respondents are interested in attending a business management course is not entirely consistent with the fact that respondents assigned self-development the third highest importance rating of all business activities (M = 3.77, SD = 0.44) (see Figure 4.2). However, it is assumed that this lower than expected response rate is due to certain private practitioners not being interested in the issue of business management. Furthermore, the term self-development may have been ambiguous to some of the respondents since it can be interpreted in terms of therapy and not in terms of management. The result in Figure 4.20 is a positive sign for future business training initiatives since the respondents' general willingness to attend business management training can be portrayed as an admission that they lack the necessary knowledge and skills in this regard.

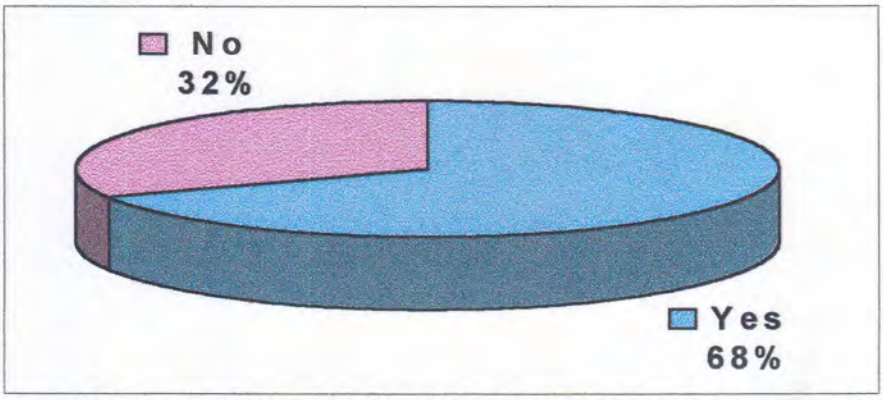

Figure 4.20 Respondents' willingness to attend business management training (n = 128)

Respondents' attitudes towards receiving assistance or advice from people outside the profession, in particular business professionals was explored in order to determine whether they rely upon their own experience or seek the advice of others. The results, which as displayed in Table 4.11, reveal that the groups most sought for advice on business, financial or management information are friends and colleagues (64%, *n* = 82) followed by family and relatives (57%, *n* = 74). In comparison, it is surprising that only 33% of the respondents (*n* = 43) have approached business professionals and even fewer have approached financial institutions (26%, *n* = 34) for business, financial or management advice. However, 27% and 19% of the respondents respectively reported that they would consider approaching these groups of people for advice.

Table 4.11 Respondents' willingness to seek advice from others (n = 129)

Advice received from:	*Percent respondents that have approached*	*Percent respondents willing to approach*
Friends and Colleagues	64%	8%
Family & Relatives	57%	8%
Professionals	33%	27%
Financial Institutions	26%	19%

The results in Table 4.11 are an indication that the respondents are less likely to have sought the advice of business and financial professionals, however it is more likely for them to do so in the future than to seek the advice of friends and family members. This result is disappointing since much relevant and

appropriate business management information can be gleaned from professionals. Nevertheless, the results are consistent with earlier findings that many of the respondents generally learn from experience.

Finally, the respondents' opinions regarding future business management training were analysed to reveal a number of interesting results, which are presented in Figures 4.21 and 4.22. With regards to respondents' opinions regarding the most appropriate time for training in business management to be introduced into the career of the speech-language therapist and audiologist, it appears that the majority of respondents are in unanimous agreement. The agreement is that business management training should be available at both undergraduate level (78%, *n* = 100) and as part of continued education (73%, *n* = 94) (see Figure 4.21).

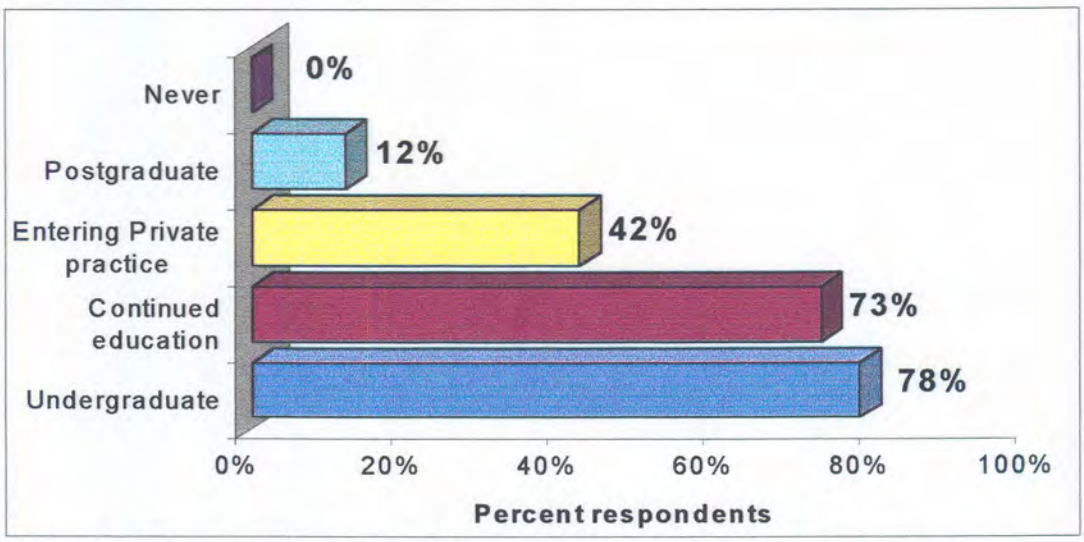

Figure 4.21 Respondents' opinions regarding the most appropriate time to learn business management (n = 128)

From the results in Figure 4.21 it appears that the respondents are seeking business management training at similar times to those which are provided in the USA and the UK, namely at undergraduate level and as part of continued education (Clausen, 1998; Van der Gaag, 1996). The merit of providing training at undergraduate level is that all speech-language therapists and audiologists will be trained regardless of whether or not they may enter private practice in the future. Therefore, every practitioner will have learnt the basic

management skills required in private practice. In comparison, providing training as part of continued professional development is appropriate since some practitioners may only enter private practice after many years of experience and may therefore need to enhance their basic skills learnt at undergraduate level. Furthermore, many practitioners have passed through university without basic business management skills and would thus only be included in training as part of continued education.

Respondents' opinions were divided, however, on the question concerning who is responsible for providing business management training for speech-language therapists and audiologists. The results in Figure 4.22 indicate that 56% of the respondents (n = 72) claim that SASLHA is responsible, whereas 43% (n = 55) believe that the universities are responsible. There was also strong support for the various other parties listed in question 46 to provide the training. The respondents' divided opinions can nevertheless be understood since training can be provided by any organisation. One explanation for the high percentage of respondents considering SASLHA to be responsible is that all of the respondents are affiliated to SASLHA and they therefore have a better chance of being informed about training courses. The indication that 56% of the respondents believe SASLHA is responsible for training is further evidence that there is a need for business management training amongst practitioners who have completed their university training. This is supported by the findings earlier in this chapter that indicate there is a definite need for the respondents to learn business management skills since there is overwhelming evidence of their lack of business management knowledge and skills.

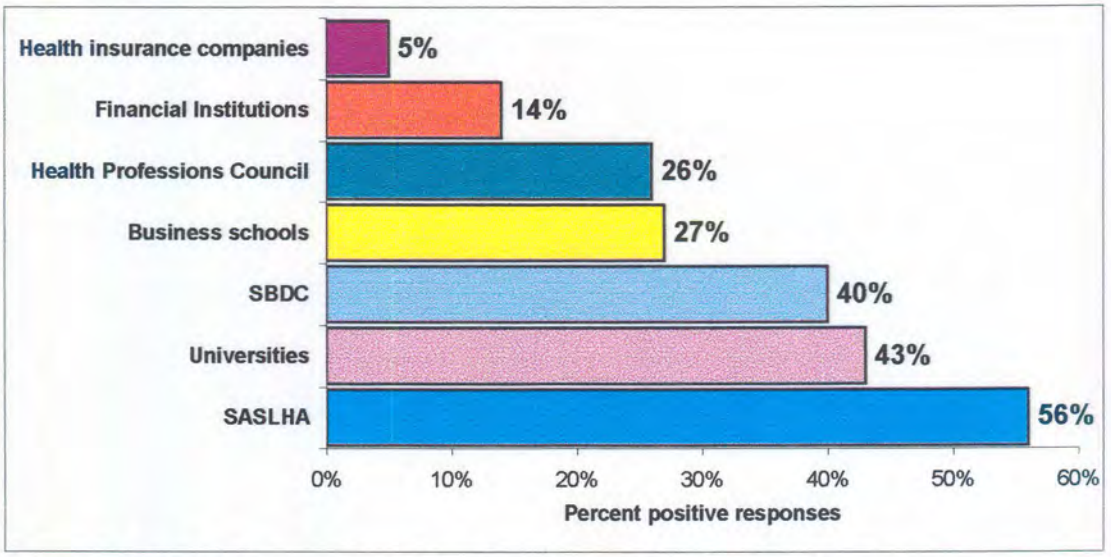

Figure 4.22 Parties considered responsible for business management training (n = 128)

The results of Figures 4.21 and 4.22 appear to be inconsistent with one another since, if business management training is to be completed at undergraduate level, it makes sense for the universities to be responsible for providing the training. However, the majority of the respondents claimed that SASHLA should be responsible for the training. These results are, however, consistent with the dichotomous view of Metz (1996) that university training programmes should start responding to the needs of the private practitioner but should make use of supplemental courses in order to accommodate both the clinical and non-clinical aspects of training. It could be argued that the clinical training programmes at universities are not able to accommodate the supplemental courses in their curricula due to time constraints. Metz (1996) therefore suggests that the best solution might be to allocate specialisation to a time following general clinical certification.

The results of the respondents' opinions regarding private practitioners' need for business management training serve as evidence that there is a definite willingness amongst private practitioners to attend business management training. Furthermore, it can be concluded that *training is required at undergraduate level* as well as part of *continued education* and should be the responsibility of SASLHA and the relevant universities that train speech-

language therapists and audiologists. However, the groups considered responsible for business management training are of lesser importance since the level at which training is required is likely to dictate this responsibility.

4.2.4 RECOMMENDATIONS FOR BUSINESS MANAGEMENT TRAINING OF PRIVATE PRACTITIONERS

The final objective in the research process was to make recommendations for *future business management training of private practitioners*. The earlier findings in this chapter, the respondents' opinions, and the literature were drawn upon to make appropriate recommendations.

It has already been established and confirmed that the respondents would certainly benefit from business management training at *undergraduate level* and as part of *continuing professional development* (Trulove & Fitch, 1998; Goldberg, 1996; Metz, 1996). Business management training at undergraduate level is necessary since there is a strong indication in the results that many speech-language therapists and audiologists enter private practice with limited clinical experience (see Figure 3.4). In addition, Figure 3.4 also indicates that some speech-language therapists and audiologists enter private practice long after they have completed their undergraduate training. In order to accommodate these practitioners, it is therefore recommended that business management training should also be provided on a continuing education basis. If higher levels of experience or qualification are imposed on practitioners before they are able to enter private practice in the future, undergraduate training in business management may be unnecessary. However, if such limitations are imposed, it will be essential to ensure that clinical experience is not the only factor taken into consideration, but that the business management skills and abilities of the practitioners also form part of the criteria (Metz, 1996; Goldberg, 1995).

Furthermore, some respondents expressed the need for in-service training prior to setting up a private practice as is evident in the following narrative from one of the respondents: *"I believe that some practical experience is necessary before being let loose on the public. At least 6 months internship in*

a private practice. This alternative, however, if the in-service training or internship is to be administered and conducted correctly it will require accreditation of private practices. Furthermore, it will require predetermined goals for the development of new graduates, strict adherence to them and a governing body to ensure adherence. These criteria are likely to take many years to come into effect. Internship may thus be a viable long-term solution for the profession of speech-language therapy and audiology in South Africa, however, immediate changes are required to address the current business management needs of the private practitioners in the short term.

Many respondents expressed the need for someone competent in and informed on speech-language therapy and audiology private practice issues to present business management training courses. The following comment from a respondent provides support for this view: *"We need a competent private practitioner who knows speech therapy inside out and the client base we treat."* It is therefore recommended that persons who present the business management training courses must understand the difficult relationship between patient and profit yet understand business from a financial and management viewpoint (Metz, 1996).

To ascertain the most appropriate content for future training courses on business management for private practitioners, the respondents' opinions were requested. Suggestions were elicited from 76% of the respondents, which is an indication that most of them were eager to give advice on what to include in future training courses. The value of their responses lies in the fact that the results may also be an indication of the areas of business management in which the respondents have the least knowledge or skills. The various suggestions from the respondents were sorted into seven categories to reveal the most prominent ideas amongst respondents. Figure 4.23 illustrates the respondents support for the seven categories of business management course content.

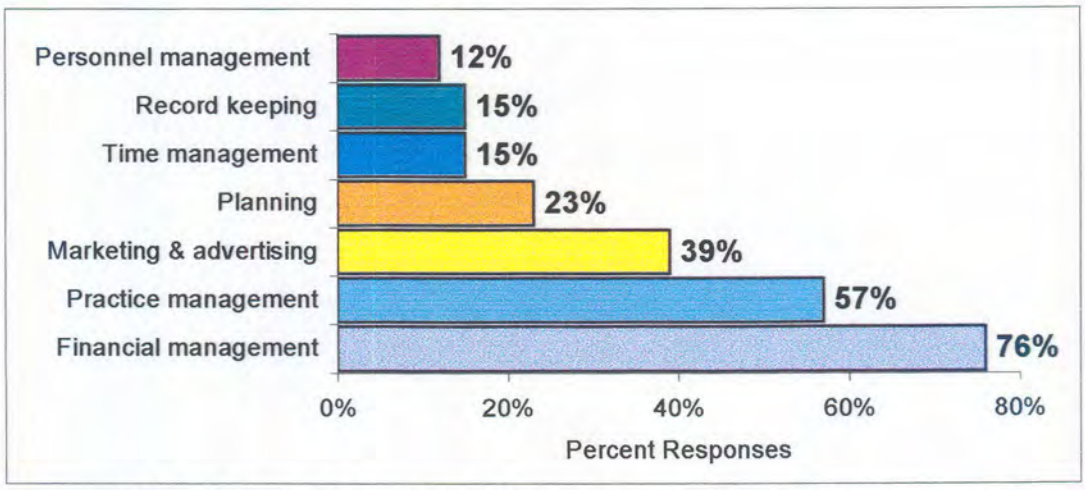

Figure 4.23 Suggested categories of course content for private practitioners

Figure 4.23 indicates that the greatest need for training amongst respondents is in financial management since 76% of the respondents (n = 74) suggested that private practitioners would benefit from such training. This is consistent with earlier findings, which indicated the extent of the respondents' lack of financial management knowledge and skills (see 4.2.2.2). Since financial issues are likely to have an effect on all aspects of private practice it can be understood that this would be one of the respondents' first priorities. However, financial management was assigned an importance rating that placed it sixth out of ten business management activities, which does not support the respondents above priorities in Figure 4.23.

Practice management was also considered a priority since 57% (n = 56) of the respondents suggested it should form part of future training courses. Practice management generally includes all the basic management skills that a private practitioner would require to run a small business. This result supports the earlier findings in this chapter, namely that the respondents generally lack all forms of business management knowledge and skills that prevent them from planning, implementing, and controlling crucial aspects of the business and from being accountable to clients and medical schemes. In addition, the literature recommends that private practitioners should learn the basic aspects of business management in order to ensure success in the competitive marketplace (Stanbridge, 1999; Metz, 1996).

The remaining five categories of course content were less well supported by the majority of respondents. Additional course content that was not included in the seven categories but was nevertheless suggested by a small percentage of respondents concerned tax, business ethics, and labour law training. Cost containment was conspicuous by its absence from the respondents' suggestions for training content yet is consistent with their low rating thereof earlier in the chapter. It is expected that the respondents need for cost containment training will increase in future when the private sector of speech-language therapists and audiologists are put under pressure by managed care companies to be more accountable in terms of costs. Furthermore, cost containment may not feature in its own category since the respondents may have categorised it under financial management. All the above comments and suggestions from the respondents are consistent with many of the recommendations in the literature for improving particular aspects of business management knowledge and skills such as record keeping (Trulove & Fitch, 1998), private practice management (Metz, 1996), finance (Brooks, 1995; Moskovitz, 1995) and marketing (Smith, 1996).

The respondents' comments not only included suggestions for course content but also statements and motivations for their attitudes towards business management training. Their comments support the fact that the majority of the respondents need to learn about the various aspects of business management. Furthermore, the comments support earlier findings that many respondents are compelled to learn on the job and gain experience from their own mistakes. Since this is unprofessional and is likely to tarnish the image of the profession in the eyes of the public and other health care professionals it can be stated that many unnecessary lessons could have been avoided by attending a comprehensive business management training programme. Examples of the respondents' comments were as follows:

- *" I've had to learn the hard way - through many years in the profession - I think new PP's (private practitioners) should be given the basics involved in setting up a practice and then develop it from there."*
- *"...basic business management (is needed), as nothing was provided during training!"*

- *"Most of the above aspects (are required) - it took me 7 years to learn the hard and often demotivating way..."*
- *"Finance issues - how to deal with money issues with clients, I spent first 5 years of PP losing money because I had a pro-deo practice - didn't know how to say no."*

In conclusion, the final recommendations are presented in Table 4.12. These recommendations for business management training of private practitioners are based upon the findings of this study, the suggestions and needs of the respondents, as well as the current literature.

Table 4.12 Recommendations for future business management training

	TRAINING ISSUE	***TRAINING RECOMMENDATION***
1	Necessity for training	It is recommended that the respondents attend business management training since they generally lack the necessary business management knowledge and skills to successfully manage a private practice.
2	Optimal time for training	Private practitioners should receive business management training at undergraduate level and as part of continuing education.
3	Organisers of training	It is recommended that universities are held responsible for undergraduate business management training and SASLHA be held accountable for sourcing and providing continuing professional business management development.
4	Course content	Practice management training should include the following: - Management of money - Management and prevention of bad debt - Financial statements and personal tax - Marketing and practice development - Medical aids and managed care - Record keeping and data capturing - Time management - Personnel selection, appointment, management & motivation - Computers in private practice - General management information

It is presumed that the recommendations in Table 4.12 will be applicable to all speech-language therapy and audiology private practitioners in South Africa since the basic management principles in all private practices are similar (Stanbridge, 1999). Furthermore, these recommendations are based upon the current needs of the respondents in the sample and may therefore be adapted in the future if private practitioners' future circumstances or needs change.

4.3 CONCLUSION

New and interesting information on the topic of business management in speech-language therapy and audiology private practice was obtained in the analysis and discussion of the results. The results of the data collected from the questionnaires also yielded many interesting yet divided opinions on the subject of business management. The respondents' business management knowledge and behaviour was generally consistent with that of the subjects in a similar study conducted by Trulove & Fitch (1998). There were, however, a number of contrasts when one compares the abundance of available literature on the topic with the current knowledge and behaviour of the respondents as determined by the questionnaire. It therefore appears that the respondents have not heeded the advice in the literature and brought about the necessary changes in their private practices.

A number of conclusions were drawn from the analysed results in this chapter. Since the results were presented in a manner corresponding with the objectives in this study, the conclusions in Table 4.13 refer to the relevant results in the questionnaire as they pertained to the five objectives.

Table 4.13 Conclusions drawn from the results in chapter four

OBJECTIVE	***CONCLUSION***
Objective 1: Private practitioners' **opinions** regarding the management of their businesses.	The general opinion amongst the respondents was that the management of their businesses was important yet not as important as clinical duties. This was evident in their importance ratings, which ranged between quite important and extremely important. However, many of the ratings were inconsistent with the management practices actually used by the respondents.
Objective 2: Private practitioners' **knowledge** of business management concepts.	The respondents generally lacked knowledge regarding business management issues. This lack of knowledge manifested itself in the respondents' strategic planning, implementation and control management behaviour. Most notable amongst the results was that the respondents were uncertain of their proportion of market share, appeared neither to understand the need to determine cost effectiveness, nor the need for an annual budget to plan for future business initiatives. Respondents were also not aware of the need and importance of considering and reviewing important factors about the environment, which affect and influence their private practices.

Table 4.13 continued

Objective 3: Private practitioners **management practices** and **behaviour**.	The general trend amongst private practices in the study was that the management control systems and practices used by the majority of respondents were basic, traditional management controls, which mostly lacked complexity, innovation and were not used to their full potential. Evidence of this trend could be found in the all of the management practices used by the respondents and is attributed to a lack of business knowledge and understanding.
Objective 4: Private practitioners' **opinions** regarding the **need** for business management training	The respondents indicated much interest in training courses on private practice management, particularly in the financial, marketing, tax, planning, and administrative aspects of business. Furthermore, the respondents indicated that training is necessary at undergraduate level as well as part on continued professional development. They were divided however as to who should be responsible for providing the training.
Objective 5: Recommendations for **future training** based on the results of the research	Based on the respondents' opinions and the literature it is recommended that adequate business management training be included in undergraduate curricula and form part of continued education seminars and workshops. Universities and SASLHA should be held responsible for this training, which should include the following content: management of money, management and prevention of bad debt, financial statements and personal tax, marketing and practice development, medical aids and managed care, record keeping and data capturing, time management, personnel selection, appointment, management & motivation, computers in private practice, and general management information.
Final objective: How do South African speech-language therapists and audiologists manage their private practices in the transforming health care environment with limited business management training?	In conclusion, the large majority of private practitioners in this study manage their businesses with insufficient knowledge of business management, which is evident in their limited application of business management systems, tools and practices. The degree of their unawareness of the need for business management practices is also apparent in their total lack of use of certain forms of management. Despite their general lack of training in this regard, most of them are eager to learn more about the various forms of business management in order to improve their businesses.

The conclusions reached in Table 4.13 thus provide a brief overview of the most salient findings in the current study and indicate that the main aim of the study was achieved. Furthermore, the large base of information gathered during the analysis of the questionnaire data provides a broad and comprehensive view of how SASHLA speech-language therapists and

audiologists in South Africa manage their private practices. The respondents' need to learn business management principles is further substantiated by Metz (1996) who believes that practitioners will have to rely on their own educational and skill level in order to be profitable within the private sector. This is of great importance since one of the most important skills required in achieving profitability and success in private clinical settings is astute business practices.

4.4 SUMMARY

The aim of this chapter was to present the results for each of the research objectives in a meaningful way, to interpret the results against the current literature, and to draw meaningful conclusions and extrapolate the findings so that recommendations could be made. In order to achieve this aim the results from the questionnaires were analyzed and graphically illustrated to facilitate comprehension. The results were discussed and interpreted in view of the literature, compared with one another and similarities drawn where necessary. In addition, the need for practitioners to acquire business management skills and knowledge was discussed throughout the chapter. Finally, recommendations were made for the future business management training of speech-language therapists and audiologists in private practice.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

***Aim**: To present the general conclusions and implications of this empirical research, critically evaluate the findings, and make recommendations for future research.*

5.1 INTRODUCTION

This research study has identified a general lack of business management knowledge and skills amongst SASLHA-affiliated speech-language therapists and audiologists in private practice in South Africa. These findings are consistent with other studies of speech-language therapists and or audiologists (Trulove & Fitch, 1998; Metz, 1996). In the pursuit of clinical excellence in undergraduate training courses speech-language therapists and audiologists are seldom afforded the opportunity to develop business management skills since this would use up critical clinical learning time. However, with an increasing number of newly graduated professionals entering the private sector as the preferred work environment (Pickering et al., 1998; Tuomi, 1994), the need for business management skills at undergraduate level has increased significantly (Smith, 1998). Furthermore, from the results of this study it is evident that those professionals that have been in private practice for some years are also lacking in business management skills.

The speech-language therapist and audiologist entering private practice without essential business management skills will find it increasingly difficult to successfully manage her business through the dynamic transformation within the profession as well as the transformation period in South Africa (Jamieson, 1998; Brown, 1994). This study was therefore undertaken to determine how speech-language therapists and audiologists in South Africa manage their private practices in a transforming environment with a limited degree of business management training.

In order to obtain the relevant information from private practitioners a questionnaire was designed. Utilising the results and data obtained from the questionnaire it was evident that the majority of private practitioners in the study lacked business management knowledge and skills. The implication of these empirical results is that business management training is definitely required by undergraduate speech-language therapists and audiologists as well as those professionals who are currently in private practice. This is of particular importance with the onset of managed care in South Africa, which is expected to have severe consequences for private practitioners (Jackson, 1999; Kadish, 1999; Green, 1998).

The importance of and applicability of business management in a private practice setting is usually underestimated by many health care professionals (Stanbridge, 1999). However, since the future of speech-language therapy and audiology as a profession depends on the ability to stand alone in the business community as a profitable, valuable private practice, business management skills are essential (Metz, 1996). A lack of adequate business management knowledge and skill can result in professional and financial ruin for a private practitioner who relies solely on her expertise for a living (Metz, 1996; Flower, 1984). Although astute business practices are critical, success will not occur because of these only, but more importantly because the speech-language therapist and audiologist in private practice will offer benefits and a high level of quality and technologically advanced service that is unavailable elsewhere to clients with communication disorders or delays (Masterson et al., 1999; Klop, 1998). The future of the profession therefore depends on how well speech-language therapists and audiologists are able to take their clinical training and business management skills to the marketplace (Metz, 1996). Consequently, training in both clinical and business management skills is essential to ensure the growth and future of the profession of speech-language therapy and audiology in the transforming health care market.

This chapter provides an organised summary of the main conclusions drawn and a discussion of the theoretical and clinical implications of the study. This is followed by a critical evaluation of the research study. Recommendations are made regarding future research opportunities and a curriculum for business management training for speech-language therapists and audiologists in South Africa is also recommended.

5.2 CONCLUSIONS AND IMPLICATIONS

Research is inherently linked with teaching and service delivery and the conclusions drawn should thus have theoretical and clinical implications for the profession (Uys & Hugo, 1997). The clinical and theoretical implications that arose from this research study generally pertain to private practitioners in the profession of speech-language therapy and audiology, however, they can also be extrapolated to various other disciplines such as occupational therapy or physiotherapy private if necessary.

Prior to presenting the general conclusions and implications of this study it is imperative to commend private practitioners for the manner in which they have created their own employment opportunities in a country where resources are limited and unemployment is rife. Moreover, the fact that they have created their own employment in the difficult health care economy indicates a certain measure of will, self-motivation and tenacity. However, in this new century private practitioners will not survive as professionals without a commitment to quality, an understanding of business management principles, and an appetite for success. The high response rate achieved in this study (65%) may be an indication that speech-language therapists and audiologists in private practice are aware of these factors and consequently rate the importance of business management highly. Furthermore, the fact that 68% of practitioners showed interest in attending a business management training course may be an indication that they believe their knowledge and experience in this area to be limited.

The numerous conclusions and implications of this research study are discussed under three sections, namely, the impact of health care transformation in South Africa, private practitioners' business management knowledge and skills, and business management training for private practitioners. Each of these sections are discussed forthwith.

5.2.1 The impact of health care transformation in South Africa

In highlighting the effect of all the factors that impact on the speech-language therapist and audiologist in private practice, it is evident that the role of transformation in health care in South Africa will continue to influence private practices in the future. Of particular importance is the lack of financial resources in the public health care sector (Tuomi, 1994). The implication of the disintegration and transformation of the traditional public health care system in South Africa is that the private health care sector is experiencing continual growth with an increasing number of professionals entering private practice (Pickering et al, 1998; Tuomi, 1994).

With limited incentives to lure speech-language therapists and audiologists back into the public sector, it is expected that the public health departments may eventually start to employ private practitioners on a contractual basis to ensure that the demand for speech-language therapy and audiology services is satisfied (Smith, 1998). The value and relevance of private practitioners in the future of health care in South Africa will therefore become more apparent and will need to be encouraged within specific guidelines such as best operating practices, peer review and continued education. It is evident that the Professional Board for Speech, Language and Hearing Professions has made deliberate attempts to develop best operating practices and a continued education programme which commences this year. This committee has also included the transformation strategy of the profession in their list of strategic initiatives to be completed by the year 2004.

The results of this study have indicated that many speech-language therapists and audiologists enter private practice with limited clinical experience. This has various implications for the image of the profession and for the well-being

of clients. There is thus an opportunity for regulating bodies such as the HPCSA and SASLHA to determine the extent of this occurrence and to develop practice management guidelines or standards for private practitioners including a minimum number of years experience in the field prior to entry into private practice (Clausen, 1998; Van der Gaag, 1996). Furthermore, these guidelines may include a list of best operating practices and minimum performance standards to regulate the quality of speech-language therapy and audiology services within the private sector (Clausen, 1998).

The fact that there is not an accurate and reliable database profiling speech-language therapists and audiologists in private practice in South Africa (Smith, 1998) makes it impossible to determine whether or not the trends and tendencies within the private sector of the profession are transient. For example, it is well accepted in the literature that professionals are entering private practice at an earlier stage in their careers due to limited public sector positions (Tuomi, 1994), however, there is little factual evidence of this trend. Furthermore, there may be a tendency of practitioners inclining towards audiology practices instead of speech-language therapy practices because dispensing hearing aids to the public has become a profitable and popular source of income (Metz, 1996). Therefore, the clinical implication of the information collected in this study is that it serves as a useful source of statistical data on the profiles of South African speech-language therapists and audiologists in private practice, which can be used in future research studies to make comparisons between data and to plot or monitor trends.

The changes brought about by managed care in the health care system in South Africa has a implication for private practitioners in that they would most likely benefit from receiving information regarding managed care, the consequences thereof and the possible impact it will have on their businesses in the future (Jamieson, 1998; Sunter, 1998). Practicing in the private sector without this essential information may well be to the detriment of private practitioners as managed care will certainly have an impact on the administration and autonomy of health care professionals in the near future (Green, 1998; Jamieson, 1998). This information might also encourage private

practitioners to understand the necessity of improving their record keeping systems and accountability practices in their businesses (Isenberg, 1998).

5.2.2 Private practitioners' business management knowledge and skills

The *main conclusion* that can be drawn from this research study is that there is a need amongst private practitioners for training and education in business management. The rationale for this is that the results of this survey, conducted on a sample of SASLHA-affiliated private practitioners in South Africa, indicate that they generally lack the necessary business management knowledge and skills.

The study showed that the majority of respondents were aware of some of the management concepts, principles and practices included in the questionnaire, however, they failed to use this awareness in the management of their practices. One explanation for this trend is that practitioners lack sufficient business management knowledge, which originates from insufficient and limited business management training available to speech-language therapists and audiologists. However, many health care journals and publications, for example GP Bulletin, and the South African Medical Journal, advertise business or private practice management courses, which offer private practitioners many opportunities to gain the necessary skills required to manage a practice with confidence and expertise. The results of this study may thus be an indication that respondents are either not making use of these opportunities for acquiring knowledge and skills or are unaware of the need for business management skills in private practice.

An alternative explanation for the results of this study is that many speech-language therapists and audiologists have entered private practice to be self-sufficient and thus feel it is unnecessary to have or to use business management practices such as visions, budgets, business plans, or marketing (Flower, 1984). Further support for this explanation is that there are varied opinions regarding the usefulness and applicability of certain business management practices to small businesses such as private practices (Wood, 1986). Nevertheless, private practitioners may be content with the current size

and client base of their practices as well as their referral sources. This could be an indication that private practitioners are not profit-orientated as some believe, but rather appear to be content with their self-sufficient businesses and the remuneration received for the number of hours they work. However, the current changes in legislation and the health care system (Jamieson, 1998; Green, 1998), compulsory continuing professional development (Communiphon, 2000), and the regulations of the managed care organisations in the future (Green, 1998; Sunter, 1998) will affect all speech-language therapists and audiologists, including private practitioners. Therefore, despite some practitioners wanting to remain self-sufficient in their practices without implementing formal business principles, it is unlikely that they will be able to continue doing so in the new health care environment.

The study also found that approximately 20% of the private practitioners appeared to understand some of the business management concepts and reported using some advanced management controls and practices in their businesses. It is assumed that these practitioners have received some form of business management training, have learnt through experience or from the advice of professionals. The fact that there are private practitioners who use many of the business management concepts and tools recommended in the literature further substantiates the fact that business management practices are relevant and applicable to speech-language therapy and audiology private practices (Stanbridge, 1999; Metz, 1996; Flower, 1984).

The results also indicate that the private sector may benefit from peer review since there are currently few regulations for the development and management of private practices. If peer review had been in place, the respondents in this study could have benefited from it in the early stages of establishing their businesses since they received little training in business management (Flower, 1984). Furthermore, peer review could be an appropriate way to regulate the quality of services provided by private practitioners to ensure that clients continuously receive the highest quality of service delivery (Van der Gaag, 1996). The fact that speech-language therapy and audiology professions in the USA and UK have developed and

implemented peer review systems in the private sector indicates that a peer review system is necessary and appropriate to monitor service delivery in South African private practices (Van der Gaag, 1996; Clausen, 1998). The development and implementation of a peer review system is therefore an additional clinical implication of this study.

5.2.3 Business management training for private practitioners

The need for business management training amongst the private practitioners who participated in the survey was confirmed by all the private practitioners, including those who had recently graduated. This is consistent with the researcher's belief that the content of the current training for private practitioners at undergraduate level is insufficient and limited in scope. The private practitioners in the study provided the researcher with their opinions on business management training, which proved to be very useful in making recommendations for future training, which would be appropriate and relevant to the private practitioner's specific management needs.

Speech-language therapists and audiologists in South Africa need better business management training that will enable them to make better business decisions and make use of improved business management practices that will ensure the future success of their business endeavours. Furthermore, training of this nature is likely to improve the autonomy and the image of the profession since business management practices impact on all aspects of service delivery including client satisfaction, communication with referral agents and medical schemes, as well as financial efficiency.

The results of this study have indicated that speech-language therapists and audiologists currently in private practice need business management training that is tailored to their specific private practice needs. The general conclusion of the respondents' suggestions and recommendations for the course content is that more *comprehensive business management training* should be developed, and implemented at undergraduate level in order to equip students to manage their own private practices in the future so that they can improve the efficiency of their service delivery to the community. The clinical

implication of this is that the relevant personnel at the speech-language therapy and audiology departments at the universities need to review the current curricula for undergraduate students and adapt them to include additional and more relevant aspects of private practice management that will benefit future private practitioners. One university, the University of Pretoria, has already adapted its curriculum to included business management lectures and is currently in its fourth year of the new curriculum (Louw, 2001).

In summary, there are numerous theoretical and clinical implications of the findings of this research study. It is incumbent upon the practitioners in the profession of speech-language therapy and audiology to use this information to directly benefit themselves as well as the profession. It is hoped that this will lead to more empowered private practitioners, a more autonomous profession, and a more satisfied client base.

5.3 CRITICAL EVALUATION OF THE STUDY

A critical evaluation of a research study is imperative because it helps to establish the value of the research project undertaken as well as the clinical implications thereof. It is also useful in guiding similar research efforts in the field of business management for private practitioners in the future. For example, certain lessons learnt during the course of this study may be of benefit to future researchers. The advantages of and drawbacks to the current study are consequently discussed.

The high response rate (65%) achieved in this study is considered very good for a postal survey (Welman & Kruger, 1999) and can be attributed to the extra effort taken to ensure that the majority of respondents participated in the study. These efforts included the telephone calls requesting participation prior to despatching the questionnaires and providing an incentive to participation in the study. In addition, it could be postulated that the research objective was considered interesting to the majority of respondents since the eventual outcome of the study could have an impact on private practice in the future.

The good response rate also serves as evidence that the results of the study are representative of the population and its characteristics. However, the criteria for the population in this study excluded all those private practitioners who were not affiliated to SASLHA. The rational for this decision was the general lack of statistical information or a database which lists the number of speech-language therapy and audiology private practitioners in South Africa. The only database that was considered by the researcher to be recently updated and functional was that of SASLHA. Consequently, the sample of private practitioners was limited. The results are thus limited by the fact that they are only representative of SASLHA-affiliated private practitioners. Opportunities therefore exist for repeating this study on a wider section of the population of private practitioners.

The results obtained in this study reflect the specific opinions, knowledge and behaviour of a particular group of speech-language therapy and audiology private practitioners in South Africa who participated in the study. Therefore, the second limitation is that, despite the high response rate attained in the study (Welman & Kruger, 1999), it is impossible to generalise all of the findings to the remaining private practitioners in South Africa who were excluded in the sampling process or who refused participation through non-response. Nevertheless, private practitioners are considered to be a relatively homogeneous group of professionals, as the statistics in the study revealed that there were very small standard deviations with regard to the respondents' opinions and importance ratings of business management activities. It is therefore presumed to be unlikely that the remaining private practitioners' opinions and management behaviour should be vastly different from those measured in this study.

All private practitioners, however, are expected to have their own management style, opinion and attitude towards management and the business activities within their private practices (Stanbridge, 1999). This factor could limit the generalisation of the results even further. However, a single research study is not expected to have wide-ranging generalisation, as this is the result of cumulative research on a given topic. As this study is one of the

first studies to determine business management practices in the field of speech-language therapy and audiology in South Africa, there is unfortunately limited local research to draw upon to validate the results (Klop, 1998). However, the research study by Trulove & Fitch (1998) in the USA is a reliable source of reference and serves as a guideline to validate the results in this study. Validation is considered essential since it

A further advantage of this research study is that the content of the questionnaire may have encouraged private practitioners to consider where their business management knowledge and practices may be lacking. With this recent insight they may be more aware of their own personal needs for additional training in business management and may thus be encouraged to seek some form of training. Nevertheless, should they not do so immediately it is hoped that in the future when business management training is offered to speech-language therapists and audiologists that they will acknowledge their shortcomings and accept the training opportunity.

The present study is also considered to benefit and be limited by the fact that the questionnaire included 47 management related questions. The benefit of this many questions is that a wide range of business management factors were evaluated. However, the limitation is that 47 questions are in no way sufficient to accurately measure the wide range of business management activities used within a private practice in much detail (Stanbridge, 1999). The researcher therefore had to weigh up the advantages of keeping the number of questions to a minimum to ensure a good response rate, with the advantages of covering all the relevant aspects of business management in the content of the questionnaire (Leedy, 1997). The results of the study are therefore limited to the aspects of business management that were included in the questionnaire. However, since the results were generally similar across all of the questions and aspects of management, i.e. there was a general lack of knowledge and use of business management practices, extrapolation of these results to other forms of business management in private practice can be done with a reasonable degree of confidence. This benefit is further substantiated by the fact that it is unlikely for private practitioners to have one

particular management skill but be lacking in all other forms of business management knowledge and skills.

The next limitation pertains to the compilation of the questionnaire. Despite the questionnaire having been pre-tested in the pilot study in order to remove all ambiguity there were a number of questions that required more clarity in terms of instructions, wording and structure (Mangione, 1995). This was evident in many of the responses, or non-responses, and respondents' opinions, which indicated that they did not understand what was being requested. In order to overcome the effect of unit and item non-response, the results and discussion thereof was only based upon the actual data available. Furthermore, non-responses were acknowledged in the presentation of the results by stating the number of responses upon which the results were based.

The formulation of questions is a vitally important aspect of a survey research study since all data obtained from the survey rely upon the subjects' responses to the questions (Foddy, 1993). Much care was therefore taken in ensuring that the questions in this survey appropriately and thoroughly assessed the knowledge, opinions and behaviour intended for measurement (Fink, 1995). Despite these efforts as well as a pilot study, which aimed to improve the question content and structure, there were thee questions which required more information, better wording and clearer instructions, namely questions 25, 39, and 41. The question on private practice expenses (Q.25) should have included simpler instructions as well as an example to make it easier to understand and to prevent the respondents from misunderstanding the intent of the question. Question 41 should have been worded differently since it was ambiguous to some of the respondents. Finally, question 39 may have been less ambiguous if fewer categories had been provided in the answer format since three of the categories referred to similar client satisfaction tools namely, self-developed questionnaires, standardised forms, and parent surveys (Fink, 1995a). These three questions may have been interpreted better had their errors been detected in the pilot study or by the researcher prior to execution of the study. The lack of clarity in the three

questions mentioned is thus considered a limitation to the research process since the results to those questions cannot be interpreted with confidence.

Since the questionnaire was developed by the researcher and was not objectively validated or standardised, there was an increased likelihood that the results of the study were biased in favour of the researcher's intended findings. This, however, is a common problem in survey research (Leedy, 1997). One way in which this factor can be eliminated is if the study is repeated and similar results are obtained (Schnetler, 1989). Furthermore, the questionnaire was only printed in English, which could have put second-language English speaking respondents at a disadvantage. Consequently, their actual opinions may not have been recorded as accurately as expected. The decision to print the questionnaire in English only was, however, considered an advantage to the research process since translation often increases the risk of ambiguity and misinterpretation by bilingual respondents (Borque & Fielder, 1995). In order to overcome the potential language constraints of Afrikaans speaking respondents, the terms used throughout the questionnaire were explained in each section.

Finally, an additional limitation of this study was that the postal questionnaire used in the survey limited the researcher to written responses. According to Cox (1996) this is one of the main drawbacks of questionnaire based research studies. In mail survey research there is no opportunity for the researcher to judge the respondents' non-verbal behaviour and spontaneity during the completion of the questionnaire (Mangione, 1995). Therefore, much of this vital information, which may have influenced the conclusions drawn from this study, was lost to the researcher. However, despite these factors the choice of a postal survey was still considered the most appropriate method for the data collection of the business management knowledge and skills of speech-language therapists and audiologists in private practice in South Africa.

The critical evaluation of this study has indicated the benefits and limitations inherent in the research process undertaken to determine the business management needs of private practitioners. The benefits allows one to

appreciate the value of the research and helps one to establish the specific clinical implications of the study. The limitations, however, restrict the conclusions drawn from the study to the private practitioners who took part in the study. Any additional conclusions that venture beyond the actual findings in this study are therefore based upon speculation, inference or assumption.

5.4 RECOMMENDATIONS

Research can only be considered as relevant or effective if there is an outcome or if there are recommendations for the use of the information gained in the research process. One of the most important aspects of research is that the researcher's findings and recommendations are applied and implemented in practice in order to make a difference in the profession. Klop (1998) states that data collected from the private sector can fuel and direct research and the development of appropriate clinical programmes. It was therefore hoped that this study would provide evidence of the need for business management training for speech-language therapists and audiologists and facilitate the development and implementation of business management training courses at undergraduate level in South African universities and as part of continued professional development. The recommendations regarding the outcome of this study, as discussed forthwith, include recommendations for training of future private practitioners, recommendations for speech-language therapists and audiologists currently in private practice, and research recommendations.

5.4.1 Recommendations for training of future private practitioners

There is overwhelming consensus in the literature and amongst the respondents in this study that private practitioners require business management training at undergraduate level or prior to entering private practice (Van der Gaag, 1996; Clausen, 1998; Stanbridge, 1999). With regards to the content of the business management training, the opinions of the respondents as well as those of the authors and researchers in the literature were considered during the development of a curriculum for private practice management training at undergraduate level. This recommended curriculum, as presented in Table 5.1, lists all of the tasks, knowledge and

skills required by future private practitioners and the justification for their inclusion in the curriculum. Particular emphasis was placed in the curriculum on those areas of business management that the respondents in this study either identified as essential to include or where their knowledge or skills were considered to be significantly lacking.

Table 5.1 Recommended curriculum for speech-language therapists' and audiologists' business management training

TASK	SPECIALISED KNOWLEDGE AND SKILL-BASE	JUSTIFICATION AND REFERENCES
General overview of business management	Health care management	To provide practitioners with perspective of the need for management of a private practice. Metz (1996) states that private practitioners should receive training that will add value to the client, including courses that teach practitioners to understand small business affairs, especially the relationship between patient and profit.
	Legislation, regulations and ethics	The HPCSA declares that all private practitioners must abide by the regulations set in terms of advertising, assessing and treating clients, keeping records, and behaving ethically towards the client, amongst others. Practitioners also have ethical obligations towards the profession, the community and to colleagues to ensure that services are accessible and affordable (SASLHA, 1997).
Establishing a business	The process of completing a business plan for a private practice	Brown (1994) recommends that private practitioners prepare their practices for the new South Africa through constantly updating their strategic plans.
	Vision, mission and purpose	Rassi & Fino-Szumski (1994) stress the need for private practitioners having vision, mission and goal statements that provide a firm foundation for current and future management decisions and establish the intent of the business (Harrison & Frattali, 1994).
	Environmental analysis	This information enhances the practitioner's awareness of internal and external environmental factors impacting on their businesses and serves as a useful tool for objectively assessing the practice's strengths, weaknesses, opportunities and threats (White, 1995).

Table 5.1 continued

	Setting of goals and objectives	According to Moskovitz (1994) setting goals and planning enables the practitioner to clarify and identify the practice goals, to strategically position the practice, its services and its resources in such a way that the practice can continue to be profitable and successful.
Managing a business	The principles, systems and tools used to manage three areas of private practice:	The systems, tools, procedures and policies used to facilitate the management of three main functional areas of a business to ensure that the stated goals are attained (Stanbridge, 1999; Wood, 1984).
	Finance	Detailed financial knowledge and skills are not required by private practitioners, yet they must understand what influences profitability in order to adequately manage financial resources, assets and expenses and to diminish the impact of bad debts and poor cash flow through sound financial management practices (Moskovitz, 1994; Dunlop & Martins, 1995).
	Marketing	It is important for private practitioners to take a more business like approach to marketing by recognising the significant role thereof in private practice, particularly as a means to educate the public, to maintain a competitive edge, to increase business opportunities, to increase client base and to advertise new or improved services to referral sources and potential clients (Goldberg, 1995; Ashby, 1995)
	Personnel	Skills to manage staff are required to ensure that the practitioner's reputation is upheld through the conduct of and services provided by staff members. Furthermore, to implement principles to manage the recruitment of staff, their induction, performance, promotion, and remuneration in a consistent manner that is according to the labour law (Stanbridge, 1999; Brooks, 1995).
Accountability and control of the business	Business controls to maintain accountability of all clinical and management practices within the business including:	Control and accountability practices essentially help the practitioner to monitor, evaluate and maintain control of activities undertaken in serving the public. Trulove & Fitch (1998) recommend that enhanced accountability training should begin in university training programmes. Goldberg (1996) recommends that practitioner must take advantage of new technologies and prove - using outcome data - that using the services of a speech-language therapist and audiologist is cost effective.

Table 5.1 continued

	Time management	This information is required since time is closely linked to costs in a service business (Trulove & Fitch, 1998). Moreover, the practitioner needs to keep track of activities through client scheduling, caseloads and productivity analysis in order to maintain optimal organisation and functioning of a private practice.
	Record keeping	Implementing and maintaining adequate clinical and business records is essential to prove accountability to referral sources, medical schemes and the client (Green, 1998; Wood, 1986).
	Client satisfaction	A high level of client service is required to ensure that the clients' needs are met by the practice since a practice exists for its service to clients. Practitioner should learn how to measure client satisfaction because a satisfied client is a valuable marketing tool (Lacap, 1994; Crosby, 1994).
	Quality management	Klop (1998) and Harrison & Frattali (1994) suggest that private practitioners implement quality management into every clinical and management aspect of their private practices to improve accountability, client satisfaction and service delivery.
Other relevant information	Additional aspects of private practice management such as:	Private practitioners in South Africa must stay abreast of changes in the tax and labour laws to avoid confrontations with various parties.
	Labour law	Practitioners should be aware of the basic requirements of employment that their staff are entitled to in order to ensure that they do not contravene the law (Stanbridge, 1999).
	Tax requirements	Practitioners do not need detailed tax knowledge but need to be aware of the following: how to take advantage of benefits in the current tax system to prevent paying unnecessary taxes; to avoid late payment to the Receiver of revenue; and to understand the obligations for municipal and council taxes prior to establishing a private practice (Stanbridge, 1999; Wood, 1986).

The curriculum presented in Table 5.1 is very flexible and can simply be used as a guideline for future business management training at undergraduate level. Furthermore, it may be used to fuel academic discussion groups on the need for more comprehensive small business management training at undergraduate level, the most appropriate content thereof, and the applicability of specific business management practices to the speech-language therapy and audiology profession.

5.4.2 Recommendations for speech-language therapists and audiologists currently in private practice

This study has highlighted a number of issues regarding the current SASLHA-affiliated private practitioners' lack of business management knowledge and skills. The main recommendations to this group of professionals is to seek out and attend training courses on private practice management or business management. Alternatively, the literature has a rich source of relevant articles and books regarding ways in which private practitioners can improve their business "savvy" as well as useful and practical advice on implementing new management techniques into their practices.

Furthermore, many of the respondents in this study indicated that they have already approached professionals for business advice or would be willing to do so in the future. This provides practitioners with useful opportunities to learn more about business management and how simple techniques can be used successfully to aid them in their businesses. Private practitioners could set up discussion groups on topics of business management and use their combined resources to share ideas and solve management dilemmas.

Another vital recommendation is that private practitioners learn more about managed care and the impact that it will have on them in the future. It is suggested that practitioners contact the medical insurance companies and medical aids of their current clientele to determine the future impact on and changes in billing as a result of managed care being introduced.

5.4.3 Research recommendations

There are numerous future research opportunities on the topic of business management in private practice. This study provides a broad outline of the most important business management activities in a private practice yet it only probes the surface of each activity. The aims of this study could be extrapolated to various other settings or specific management activities by exploring in more detail the overall effect of a management practice in a speech-language therapy and audiology clinical setting.

Since the majority of the public relies on speech-language therapy and audiology services from the public sector, an opportunity also exists to determine the business management practices of speech-language therapists and audiologists in management positions in government subsidised clinics, hospitals and schools. This is particularly relevant since human resources are extremely scarce in the public sector in South Africa (Pickering et al., 1998; Tuomi, 1998). These departments are thus likely to benefit from an overall improvement in business management practices, thereby ensuring the allocation of scare resources in the most efficient and beneficial manner (Stanbridge, 1999). Moreover, it may be interesting to determine what the managers' or department heads' needs are regarding business management training in order to manage speech-language therapy and audiology clinics in the public sector. A study of this nature may yield great opportunities for improving the public's perception of the performance, autonomy and image of the profession in South Africa.

With the escalating costs of health care it is possible that the funding and training of speech-language therapists and audiologists may continue to change to reflect the needs of the community. Furthermore, the africanisation of health care in South Africa is likely to infiltrate into many private practices within South Africa, which will result in adaptations to the client base and type of services private practitioners will render to the community. Exploring the ways in which private practitioners can adopt this new concept and adapt their services to better serve the needs of the community will make an interesting and relevant topic for research in the future.

In addition, with the loss of speech-language therapy and audiology posts due to budget cuts in the public sector, it is expected that private practitioners will play a more consultative role within the public health care system in the future. This will definitely require private practitioners to review their priorities and business management skills as well as their contracting and negotiating skills if they are to take advantage of this opportunity. Future research could therefore determine what the private practitioner's most appropriate and relevant consultative role would be in the transformation of health care and of the speech-language therapy and audiology profession in South Africa.

Of particular importance to South Africa in the next few years will be the effect of managed care on the autonomy of speech-language therapists and audiologists in private practice (Jamieson, 1998). Accountability and strategic control measures are therefore likely to receive much attention from private practitioners, as these will be required by the managed care organisations prior to remuneration of health care professionals (Isenberg, 1998; Boston, 1994). The improvement of and need for more sophisticated accountability and outcome measures in private practice thus presents researchers with a number of future research opportunities (Frattali, 1998).

Business management courses present a number of appealing research opportunities available to researchers in the future. The first suggestion is that a pre- and post-experimental study could be undertaken to measure the degree of change or improvement in a private practice subsequent to a private practitioner attending an established business management training course. The second research opportunity is that a module on business management could be developed for implementation at undergraduate level in training institutions. The students' interest in the course content could be measured as well as the applicability and relevance of the course material. The benefit of research of this nature is that business management training could be tailored specifically to the needs of speech-language therapists and audiologists in private practice.

These research opportunities and suggestions are amongst many that could be pursued in the topic of business management in the profession of speech-language therapy and audiology. Despite business management aspects of the profession not being considered very important in comparison with the clinical aspects of the profession, they are nevertheless an essential part of ensuring the continued success and efficiency of the private sector of the profession in South Africa. Therefore, research studies probing business management issues need to be pursued with the same fervour as with those pursuing clinical relevance.

5.5 CONCLUSION

This study has aimed to answer the question of how South African speech-language therapists and audiologists manage their private practices in the transforming health care environment with limited business management training. This question was based on the rationale that private sources of health care are becoming increasingly important in South Africa and that more new graduates are choosing to enter the private sector since the financial rewards are far greater than in the public sector.

It can finally be concluded that the large majority of private practitioners in this study manage their businesses with insufficient knowledge of business management, which is evident in their limited application of business management systems, tools and practices. The degree of their unawareness of the need for business management practices is also apparent in their total lack of use of certain forms of management. Despite their general lack of training in business management, most of the speech-language therapists and audiologists in private practice are eager to learn more about the various forms of business management in order to improve their businesses.

In order to capitalise on this willingness to learn in a practical manner, a curriculum for business management training was developed and presented. It is hoped that this curriculum can be used as a guide in undergraduate business management training or as part of continued education for future or

current private practitioners in the field of speech-language therapy and audiology.

5.6 SUMMARY

The aim of this chapter was to present the general conclusions and implications of the research undertaken and to critically evaluate the study. Furthermore, the aim was to extrapolate the findings so that recommendations could be made for future research, for training at undergraduate level as well as for practitioners currently in private practice. In order to achieve this aim general conclusions were drawn from the study as a whole and the clinical and theoretical implications thereof discussed in order to establish the value of the research study. In addition, a critical evaluation of the study highlighted both the benefits and drawbacks of the methodology and the results obtained in the research process. Finally, the research opportunities available to future researchers were discussed and recommendations regarding a curriculum for undergraduate business management training was presented. Recommendations and training opportunities for speech-language therapists and audiologists currently in private practice were also made.

Appendix A

Transcription of telephonic message

- Good morning Mrs/Mr/Ms _____.
- My name is Mary-Lyn Foxcroft.

- I am doing a research study on the business management aspects of private practice through the University of Pretoria.
- I am calling to find out if you would mind completing a questionnaire that forms part of the study.
- The questionnaire is confidential, contains 47 questions and only pertains to speech-language therapists and audiologists.

- Thank you. I appreciate your assistance.
- Please look out for the envelope in the post in the next few days.
- Goodbye.

Appendix B

Covering Letter to Speech-Language Therapists and Audiologists in Private Practice

21 May 2000

Dear Private Practitioner

In the interests of research and the continuous growth of the profession I are appealing to you as a private practitioner to spend a few minutes of your time assisting me. I am currently examining the business management practices of Speech-Language Therapists and Audiologists in private clinical settings as part of a Masters programme at the University of Pretoria.

Private practice has become an attractive option for many qualified therapists entering the clinical field. It is usually the practitioner's goal for the practice to become a successful, financially independent business. In order to achieve these goals, successful business management practices are required. It is the purpose of this study to examine the business management needs of private practitioners, as well as to ascertain the business practices that are being used to manage them. Private practitioners with experience of managing a practice of their own are in the ideal position of determining their own needs and identifying how their initial business management difficulties can be overcome through training and education. The results of this study will for instance be used in undergraduate training, continued education and professional development.

I appreciate your time and effort in completing the questionnaire as I realize the high demand for your time as a private practitioner. As an enclosure with this letter, you will find a questionnaire and a self-addressed, stamped envelope. I would appreciate it if you could try to respond within a week of receiving the questionnaire. Please be assured of the confidentiality and anonymity of your responses at all times.

If you are interested in the topic of the study and would like to know the outcome of the project, please indicate this in the relevant block at the end of the questionnaire. An abridged version of the results will be sent to you upon completion.

Thank you for the courtesy of your assistance and participation.

Yours sincerely

Mary-Lyn Foxcroft
Researcher

Professor Brenda Louw
Supervisor
Dept. Communication Pathology
University of Pretoria

Appendix C

Instructions for completion of the questionnaire

- Please complete **all the questions**.
- Please indicate your responses clearly with a **cross (X) over** the selection of you choice.
- You are welcome to comment on any question or aspect of the questionnaire.
- Your responses will remain **confidential and anonymous** and will only be used for the purpose of this project.
- If you would like to **fax** the completed questionnaire, please fax to **031 563 8744**. This is a private fax machine and your completed questionnaire will remain confidential.
- If you have any queries or would like to discuss any of the content, feel free to contact me at any time on 082 859 5868.

Business management practices employed by speech-language therapists and audiologists in private clinical settings.

A. BIOGRAPHICAL INFORMATION

This information will be used to account for differences in opinion, no attempt will be made to identify respondents.

1 Where in South Africa is your practice situated?

_____

2 Where and when did you complete your training?

University of:	Year

3 What is your highest professional qualification in Speech Therapy & Audiology?

Bachelors degree
Masters degree
Doctorate

4 How many years of speech-language therapy / audiology experience do you have?

	total years experience
	years private practice experience

5 Please indicate in a percentage how your practice is divided between speech-language therapy & audiology (approximate percentage is sufficient).

Speech-language therapy	%
Audiology	%

6 How many speech-language therapists / audiologists do you employ (excluding yourself)?

_____ total number of Speech-Language Therapists / Audiologists

7 How many hours per day and how many days per week do you work on average?

_____ hours per day _____ days per week

8 Please indicate the percentage of your client base and which services you provide.

Client Base:

Infants & toddlers	%
Pre-school	%
School-aged	%
Adolescents	%
Adults	%
Geriatrics	%
	100%

Services:

Screening
Assessment
Parent groups
Individual therapy
Group therapy
Collaborative consultation
Other:

B. PRIORITIES

9 A scale from 4 = "EXTREMELY IMPORTANT!" to 1 = "NOT AT ALL IMPORTANT!" is shown below. Choose a number that best describes how important you feel the activity is.

4	3	2	1
EXTREMELY IMPORTANT	QUITE IMPORTANT	NOT REALLY IMPORTANT	NOT AT ALL IMPORTANT

	Rating	Description of terms
Planning & setting goals		(Establishing short & long term objectives)
Marketing		(Making the community aware of your services)
Financial management		(Management of the practice's finances)
Staff performance reviews		(Conducting appraisals of employee performance)
Time management		(Effective use of time available)
Record keeping		(Maintaining all client-related data)
Measuring client satisfaction		(Determining satisfaction with services received)
Cost containment		(Reducing the cost of services)
Self development		(Further education & training)
Clinical duties		(All assessment & rehabilitation of clients)

C. STRATEGIC PLANNING

This section explores the direction and purpose of the practice and how it aligns itself with information from the environment in order to plan for the future.

10 Do you have a formal or defined vision for your practice?

YES
NO

If YES, please state it:

_____

_____

_____

11 Does your practice draw up an annual business plan?

YES	NO

12 When you plan, which of the following information do you review about your practice environment? You may mark more than one option.

Client base	Financial position of the practice
Type of sevices offered	Marketing strategy
Geographical area you service	Staff and admin needs
Strengths & weaknesses of the practice	Equipment & facility needs
Opportunities & threats to the practice	Referral sources of the practice
Dominant payers of client's accounts	

13 When you plan, which of the following issues about the community do you review?

Major housing developments in area	Services offered by other practices
Purchasing power of potential clients	New practices opening
No. of private practices in the area	

14 Which of the following chang…ie health care services industry do you reflect upon and align your business with?

New medical centres/hospitals	Changes in admin. of medical schemes
Changes in medical aid membership	Advances in technology (computerization)
Medical aid tariff changes	

15 Which of the following goals do you set for your private practice and how often?

Financial	Monthly	Quarterly	Annually	Never
Marketing	Monthly	Quarterly	Annually	Never
Customer service	Monthly	Quarterly	Annually	Never
Education & training	Monthly	Quarterly	Annually	Never
Quality	Monthly	Quarterly	Annually	Never

16 Do you have long term development plans for your practice?
Eg. increasing practice growth by 10% each year, offering community service, etc.

YES	NO

If YES, please state them. _____

_____

D. STRATEGIC IMPLEMENTATION

Marketing

17 What proportion of the market share do you have in your geographical area?

Unsure	0 - 20%	20 - 40%
40 - 60%	60 - 80%	80 - 100%

18 Does your practice have a competitive advantage over other private practices?

YES	NO

If YES, what is your competitive advantage? _____

_____

19 Please rank the marketing tools that you have used in your practice.
1 = Never 2 = Once/twice 3 = Three/four times 4 = Five or more times
Also indicate whether it was successful in yielding business opportunities.

Pamphlets/brochures	1	2	3	4	successful
Business cards/calling cards	1	2	3	4	successful
Newsletters	1	2	3	4	successful
Word of mouth	1	2	3	4	successful
Presentations to groups	1	2	3	4	successful
Media - advertisements, articles	1	2	3	4	successful
Networking	1	2	3	4	successful

Finance

20 What percentage of payments by clients are made by the following means?

Cash payment directly after treatment	%
Monthly payment by client	%
Client & medical aid each pay their share	%
Medical aid payment (up to 6 months)	%
Other	%
TOTAL	**100%**

(Please provide approximate percentages)

21 Has your practice ever experienced cash flow problems?

YES	NO

22 Please indicate bad debts as a percentage of your annual income?

[ ] % Bad debts (approximately)

23 Who completes your annual tax return?

_____

24 Examples of financial records are listed, mark those that are used in your practice.

Balance sheet	Return on investment	Break even analysis
Income statement	Annual budget	Debtors summary
Cash flow statement		

25 What percentage of your annual gross income do you allocate to the following?

Marketing	Equipment or apparatus	Stationary (Postage)	Continuing education
%	%	%	%

Information Technology

26 Do you use a computer in your practice?

YES	NO

27 If YES, which of the following do you use the computer for?

Generating invoices	Financial records	Record keeping of client files
Report writing	Appointments / Reminders	Other .....

28 Do you have access to the Internet?

YES	NO

If NO, would you like to have access? _____

29 Have you searched the Internet for speech-language therapy/audiology-related topics?

YES	NO

Personnel Management (Only complete question 30 if you have employees)

30 Which of the following forms of personnel management do you use?

Job descriptions	Staff training	Induction of new staff
Performance reviews	Promotion	None

E. ACCOUNTABILITY AND CONTROL MEASURES

Accountability can be described as the means by which control is kept over a business. It allows the practitioner to evaluate the practice's position and make descisions.

Cost analysis

31 Have you determined the cost of your services in terms of money spent or time spent?

YES	NO

32 Are the services you provide ness?

YES	NO	DON'T KNOW

33 How does your practice contain costs?

_____

_____

_____

Time management

Time management refers to how a practitioner manages time to ensure that sufficient time is spent on billable & nonbillable professional activities, clerical & administrative duties.

34 Do you use time management in your practice?

Daily	Weekly	Monthly	Quarterly	Annually
YES	YES	YES	YES	YES
NO	NO	NO	NO	NO

35 Please list the problems you encounter with time management?
For example: waiting lists, excessive administrative work at month/term/year end.

_____

_____

_____

Record keeping

36 What type of record-keeping system do you use?

Self-developed system	System learnt from other private practitioners
Past employers system	System recommended by IT consultant
System used at university	Other.....

37 How often do you record the following information to monitor client progress?

Quantitative data (eg. scores, %)	Always	Sometimes	Seldom	Never
Descriptive information / Perceptions	Always	Sometimes	Seldom	Never
Graphs	Always	Sometimes	Seldom	Never
Tables	Always	Sometimes	Seldom	Never
Other.....	Always	Sometimes	Seldom	Never

Client satisfaction

38 Have you ever measured client satisfaction?

YES	NO

39 Client satisfaction tools are listed below. Tick those you have used.

Parent surveys	Quarterly	Bi-annually	Annually	Never
Parent/family interviews	Quarterly	Bi-annually	Annually	Never
Standardised forms	Quarterly	Bi-annually	Annually	Never
Self-developed questionnaires	Quarterly	Bi-annually	Annually	Never

40 If you have used any of the customer satisfaction tools above, did you act on any of the suggestions and adapt your practice.

NO	YES

If YES, briefly describe adaptations made:_____

_____

_____

Accountability practices

41 Do you think that private practitioners should be more accountable for their choice of assessment and treatment methods and the outcome thereof?

YES
NO

MOTIVATE: _____

_____

F. TRAINING AND EDUCATION IN BUSINESS MANAGEMENT

42 Have you attended any formal lectures, courses or training in small business or private practice management? Please provide details of the training.

No
Yes, 1 lecture/seminar/course on…
Yes, more than 1 lecture/seminar/course on…

43 Are you interested in attending a course or seminar on private practice management?

YES	NO

44 Have you or would you consider approaching the following people for business, financial or management advice?

Family	Have approached	Will consider approaching
Friends & colleagues	Have approached	Will consider approaching
Business or management consultants	Have approached	Will consider approaching
Financial institutions	Have approached	Will consider approaching

45 When do you think it's necessary for therapists to learn about practice management? (You may mark more than one option)

Under graduate level	When entering private practice	Never
Post graduate level	Part of continuing education	

46 Who do you think should run business management courses for therapists?

SASLHA	Financial institutions, e.g. SANLAM
Health Professions Council of SA	Dept. of SLT and Aud. at universities
Business schools	Small Business Development Corporation
Health Insurance companies e.g. Fedsure	

47 What would you like to see covered in a course for private practitioners?

_____

_____

THANK YOU FOR YOUR TIME. Please place the completed form in the enclosed, stamped, self-addressed envelope or **FAX** to **031 563 8744**

[ ] YES, I would like to receive an abridged copy of the results of this study.

Address: _____

Regards
Mary-Lyn Foxcroft

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