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TRAINING FOR ADMINISTRATION IN HEALTH
IDM HEALTH SURVEY

A Preliminary Report
The Institute of Development Management
Botswana, Lesotho, Swaziland

by

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TRAINING FOR ADMINISTRATION IN HEALTHI.D.M. HEALTH SURVEYI. INTRODUCTION

Since 1979 the Institute for Development Management has been offering 8-month courses in Health Care and Nursing Administration at the Certificate level. The two courses were introduced as a result of a recognition by Botswana, Lesotho and Swaziland that efficient health administration was necessary to improve the delivery of health services at all levels, viz hospital and other health facilities and services, both in urban and rural areas.

The aim of the course in Health Care Administration is to provide hospital administrators and senior health care personnel involved in the planning and operation of health care services with the knowledge, skill and competency required for the management of health care delivery systems in Africa, and more specifically in Central and Southern Africa. The aim of the Nursing Administration course is to provide matrons and senior nursing personnel involved in the planning and operation of health services in hospitals and other health facilities, in both public or private sectors, with the knowledge, skills, and managerial abilities to administer nursing services in Africa, especially Botswana, Lesotho and Swaziland.

Since the inception of these courses, a total of 65 individuals from the three countries have been graduated: 31 in Health Care Administration, and 34 in Nursing Administration (cf Table 1.).

Health Care Administration is a fairly new profession, not only in Africa but in the Western world as well, and like any new cadre, finds itself having problems of acceptance and

TABLE 1.

I.D.M. GRADUATES IN HEALTH ADMINISTRATION

COUNTRY	1979		1980-81		1981-82		Totals		
	CNA ¹	CHA ²	CNA	CHA	CNA	CHA	CNA	CHA	Total
Botswana	-	8	7	2	8	8	15	18	33
Lesotho	-	11	1	1	4	-	5	12	17
Swaziland	-	1	5	-	9	-	14	1	25
Total	-	20	13	3	21	8	34	31	65
<p>1 Certificate in Nursing Administration</p> <p>2 Certificate in Health Care Administration</p>									

recognition by the traditional health professions, particularly the doctors and nurses. A recent evaluation of the health programmes at the I.D.M. recommended that a study be undertaken to analyze how health administrators are currently being utilized in the BLS countries, to identify the roles they might play, and to outline future training needs. This paper is a preliminary report of the results of the study carried out in accordance with that recommendation. It consists of four sections: a description of the survey itself, a summary of the results, a description of those results, and the conclusions stemming from them, and recommendations concerning the allocation of administrative tasks and for training.

II. DESCRIPTION OF THE STUDY

Objectives:

The objectives of the study were:

1. To determine the actual tasks of health services administrators currently working in the field, identifying those administrative tasks currently performed by service providers which could be carried out by the administrative cadre, thus freeing nurses and doctors for improved supervision of patient care.
2. To identify factors which facilitate or impede the effective functioning of Health Care Administrators as members of the health team.
3. To describe the tasks for which IDM training should prepare participants in health administration.
4. To estimate the potential demand for different levels of health administrators according to the size and scope of health facilities and services (including ministries, etc.), and to outline the educational and/or experience qualifications for each level.
5. To identify the training needs for administrators in health over the next five years.

Survey Plan:

The study plan called for a survey of as many as possible of the 53 members of the first three graduating classes.¹ In addition, in order to see how the administrative load was shared

¹ Two sets of classes graduated in 1982; the second was not included in the study as it finished after the field work had been completed.

within the health team, one or two others working with the graduate were also to be surveyed at each facility; where possible, these were to include the graduate's supervisor.

Out of the 53 former I.D.M. participants only 37 were available for the study while the others could not be reached for various reasons, e.g. out of the country, or no longer working, etc. These 37 plus their supervisors and colleagues resulted in a total of 71 respondents.

Analyses have been carried out primarily on the 63 respondents actively involved in health administration at hospital or community level. Table 2 shows the distribution of respondents by practice setting, position and country.

Field work in this study was undertaken in the BLS countries between 14th September, 1982 and 15th December, 1982. Interviewing began in Botswana on the 14th of September, 1982 (pilot study in August, 1982), and continued through October 5th, 1982. In Swaziland and Lesotho it was carried out during the period 11th October, 1982, through November 15th, 1982. A list of places covered in the 3 countries appears as Appendix 1.

Survey Instruments:

Four instruments were designed for the study, three of which were used with all respondents; the fourth, given to IDM graduates only, was optional. The first consisted of a detailed listing of 80 administrative and managerial tasks carried out by someone on the health team. For each task the respondent was asked to tick off four items: 1) whether the task was included in her/his job; 2) how frequently the task must be done; 3) whether she/he had delegated it to anyone else; and if so 4) to whom (position).

After the task check-off list had been completed by

Table 2. DISTRIBUTION OF RESPONDENTS BY PRACTICE SETTING, POSITION AND COUNTRY

HEALTH SERVICE ADMINISTRATORS	Total	Botswana	Lesotho	Swaziland
Hospital Administrators:				
Medical Superintendents	14	5	6	3
Matrons, Asst. Matrons, etc.	23	7	8	8
Health Care Administrators	19	6	11	2
<u>Total</u>	<u>56</u>	<u>18</u>	<u>25</u>	<u>13</u>
Community Health Administrators:				
Nursing Administrators	5	4	-	1
Health Care Administrators	2	2	-	-
<u>Total</u>	<u>7</u>	<u>6</u>	<u>-</u>	<u>1</u>
Others	8	7	1	-
<u>Total</u>	<u>71</u>	<u>31</u>	<u>26</u>	<u>14</u>
IDM Graduates	37	14	14	9
Other	34	17	12	5
<u>Total</u>	<u>71</u>	<u>31</u>	<u>26</u>	<u>14</u>

the respondent, a semi-structured interview was conducted in which the respondent was asked to rate satisfaction with her/his job and with the administrative work of others; reasons for the ratings were queried. Specific tasks liked or disliked; ideas about reallocation of tasks and about ways of improving administration; innovations implemented, promotions and/or salary increases since graduation from IDM; opportunities for advancement; and suggestions for improving the IDM courses were also obtained, along with a small number of personal items: age, education, and salary.

Following the interview, each respondent was observed at 2 minute intervals throughout the remainder of the working day, usually for 6 - 8 hours. At each observation two items were ticked: the kind of observable activity (patient care, paper work, telephone, rounds, issuing stores, meeting with others, etc.) and where it was being carried out (office, wards, storeroom, other location in the health facility, elsewhere). Because of the large number of observations, work sampling gives a statistically valid description of the pattern of an individual's, not necessarily typical, working day, and supplements information on the distribution of activities reported by the respondent through the task check-off list. No attempt was made to record the specific purposes of the activities observed. The exercise also provided the interviewers with the opportunity to observe the flow of administrative work among the members of the health team, and the quality of their interaction.

Finally, a diary was left with IDM graduates, in which they were asked to record each activity, location, broad administrative purpose (personnel, management of physical resources, finance, etc.), and the time devoted to each during six different working days over a 2-3 week period. Diaries have been received from twenty respondents; they have yet to be fully analyzed.

Copies of these instruments appear as Appendix II.

III. RESULTS The Nature of Managerial Work in Health

Job profiles showing the relative amounts of time spent in different broad areas of administration responsibility were developed from both the task analysis and work sampling exercises, for each of the five cadre of health administrators: Hospital Superintendent, Hospital Matron/Assistant Matron, Hospital/Health Care Administrator, Community Nursing Administrator and Community Health Care Administrator. Profiles from the work sampling are constructed as simple percent distributions of activities and of their location (Figures 1-6. See also Tables 1 and 2, Appendix III). The profiles of annual administrative load (Figures 5, 6, 7, and see also Tables 3-6, in Appendix III) are constructed from the task check-off list, weighted by the natural logarithm of the frequency with which the task is performed, and to make comparisons easier, are expressed as a ratio of the index for all administrative tasks.¹

Proportions of tasks delegated were also computed for each cadre, for all tasks and for load areas of administrative responsibility (see Table 3).

For each of the cadres the most frequently cited tasks liked and disliked, those which staff felt unqualified to do and those they wanted to see allocated to someone else were identified; suggestions for ways to improve administration were tabulated (Table 4). Scores were constructed for satisfaction with one's own adminis-

¹ This measure gives a lower weight to each performance of tasks which occur daily (and therefore a relatively higher weight to each performance of those, such as planning budgeting or staff appraisal, which occur infrequently), than would an index constructed from the simple frequencies. It makes the distribution somewhat easier to chart, and it does not affect comparisons among the several cadres.

trative role and that of others, from a simple weighted average of the categories checked by each respondent on a satisfaction scale (Table 5); the reasons given were tabulated Tables 6 and 7). For IDM graduates, three items indicating their successful utilization since graduation, and another three indicating their expectation for future advancement, were also tabulated (Table 8), as were their recommendations to IDM for improvement in the current courses in health administration.

Results of these analyses are discussed separately for each cadre. The Tables and Figures appear at the end of this Chapter.

A. The Hospital Superintendent

Data from both the task check-off list and the work sampling exercise show that doctors give a major proportion of effort to direct patient care. On an annual basis, they give far more effort to patient care than to any area of administration (see Figure 5, and also Table 2 in Appendix III). On a single day of observation, close to 40% of their time was spent in patient care, either directly or on rounds (see Figure 1); nearly 50% of their activities were carried out in the wards or clinics (Figure 3).

Communication, by telephone, mail, conversation, or meetings, is an important aspect of the work of the Medical Superintendent. On an annual basis, it is the single most frequent category of administrative work reported. On the day of observation, conversations, direct and by telephone, and meetings constituted close to a quarter of the observations, while an additional but unknown fraction of the surprisingly large 33% of time spent on paper work undoubtedly must be counted as communication.

In an annual basis considerable effort too goes into personnel management, much of it in conflict resolution. Relatively little attention is devoted to the management of either physical or financial resources, or to planning; an important proportion of these tasks is delegated, often to the Health Care Administrator (see Table 3). And there is a hint in the data that the more paper work the HCA does, the greater the amount of time the doctor spends in patient care.

From the interview, too, it is clear that the doctors are concerned and conscientious about patient care. Many feel inadequate in their administrative role, and do not enjoy it. Personnel management, especially conflict resolution, was frequently mentioned among the tasks they disliked or felt inadequately prepared for. Several expressed a desire to delegate this to someone else, although they had not been successful in doing so. They do not like to prepare statistical reports or other written materials, nor to make annual estimates and plans. Some have successfully delegated much of this work to the Health Care Administrator; others would like to delegate but have not been able to do so.

On balance, the doctors are fairly dissatisfied with present administrative roles, their own and those of others, particularly in Swaziland (see Table 5). They would prefer to do less administration but are not confident of the administrative abilities of their colleagues. Shortages of staff and other resources constitute the second most important set of factors contributing to their dissatisfaction. They do not share a consensus, however, on what might be done to improve administration.

B. The Hospital Matron

Both the task analysis and the work sampling exercise

show that Matrons, although bearing a major responsibility for supervising patient care, are spending a considerably smaller proportion of their time on this than are the physicians. A great deal of their time is spent in paper work, personnel management, and communication, and far more time is spent in the office than in the wards or clinics, on rounds or in the direct supervision of care (see Figures 2, 4 and 6). Some very frankly express enjoyment of every aspect of administration, preferring this to patient care.

Much of the time spent on personnel management and in direct communication is on conflict resolution, which they do not enjoy. They are very much aware that many of the problems they are having in personnel management demand greater skills in communication, and rate this as one of their most important training needs. Many do not enjoy and feel unqualified for the management of financial and physical resources (notably housekeeping and office management), and feel that these tasks should be allocated to others. A number have been successful in delegating these to other staff, including the Health Care Administrator. Again, many recognize a need for more training in budgeting and finance, estimating future needs, and programme planning and evaluation, if they are to fulfill their responsibilities in these areas.

Since graduation 70-75% have been given new responsibilities or have successfully initiated change. Only 40% have received promotion or salary increases, but 40% expect promotion in the future, while 50% expect to have opportunity for further training. A number would like to see IDM's course in Nursing Administration upgraded to Diploma level.

Generally the Matrons are fairly satisfied with their own administrative role and that of others, although

most recognize the need for improved working relationships among the members of the team of health administrators, and for additional training in communication and in certain administration skills.

C. The Hospital Health Care Administrator

From both task analysis and work sampling, it is clear that the health care administrator spends a great deal of time dealing with others - on the telephone, in conversation and meetings, and through letters and reports. She/he also spends most of her/his time in the office, doing paper work, although a reasonable amount of time is spent away from the facility on errands of various kinds. Finances and physical resources management are considerably more important in the work of this cadre than in that of either the physician or the nurse administrator. Personnel management of clerical and industrial staff is also fairly important. As this cadre is able to delegate very little of this administrative load, there was much complaint about over work.

Most of the Health Care Administrators enjoy the general nature of their duties, although a number found specific tasks onerous. Many felt unqualified for the level of financial administration, and of estimating, planning and budgeting which was expected of them. Some wanted these handled by someone else; others wanted additional training to equip them in these areas. Discipline and conflict resolution, too, were aspects of personnel management for which many expressed the need for additional training.

Since graduation a large proportion in all three countries have been given new responsibilities, and have successfully initiated changes, but relatively few report

receiving promotions or salary increases. This is particularly true in Lesotho. Moreover, few expect promotion in the future, although approximately 40% do expect opportunities for further training. A number would like to see better selection and preparation of participants in the Health Care Administrators' course, and more effective follow-up of the graduates by IDM faculty, to facilitate their acceptance as respected members of the health administration team. Some want to see the course upgraded to Diploma level.

Morale among this cadre is very low; they report considerable dissatisfaction with their own administrative role, and with the administrative roles of others, particularly in Lesotho. Poor working relationships, poor delegation and/or division of responsibility, and little opportunity for advancement are the reasons most often given for this dissatisfaction. In addition a small number feel unqualified for or incompetent in their present job. To improve administration they suggested training in administration for all members of the health administration team, an improved organizational structure, and better communication and human relations.

D. Community Nursing Administrator

Only seven of this cadre were among the survey respondents, reflecting the concentration of IDM training in the early years on hospital management. The greater emphasis on community health proposed for the coming years should lead to a larger fraction of IDM graduates in community/District/Regional posts.

The pattern of activities of the nursing administrator differs from that of the Hospital Matron in several respects, the most notable of which is the small fraction

of time spent in direct contact with patient care in the clinics and health centers. On an annual basis, they report spending approximately as much time in communication as do the Hospital Matrons, but communication represented by far the largest single activity observed in the work sampling exercise; as would be expected, much of this communication took place many from the nurse's office, out in the community. Compared to the Hospital Matron, relatively little time is spent on paper work or in the management of financial and physical resources. Much of their work, both in the supervision of patient care and in administration, is delegated to others, in the clinic and health centers.

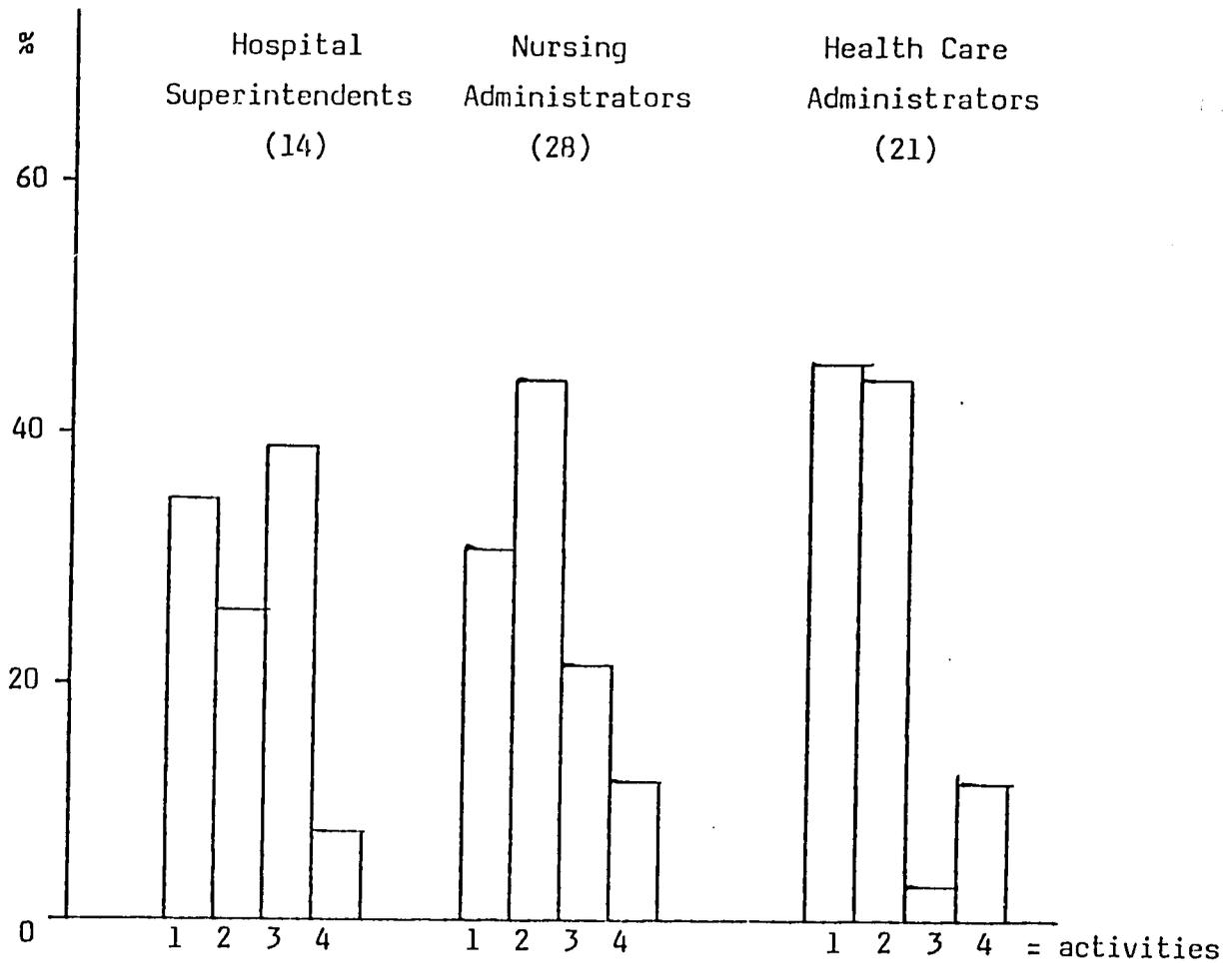
Like the Hospital Matrons, they tend to enjoy personnel management and communication; they do not like to deal with disciplinary problems or conflict. They do not like nor feel qualified to handle finances, and are more successful at getting someone else to relieve them of much of this function. They too feel that administration would be improved by additional training for all members of the health administration team. However, they also stress the need for a greater allocation of resources to rural health, and for greater decentralization in decision-making.

Since graduation they have had considerable success in implementing change and in undertaking new responsibilities. Relatively few have received promotion or salary increases, but nearly all expect promotion in the future. On the whole they are well satisfied with their own administrative role, and very satisfied with that of others with whom they work.

E. Community Health Administrator

With only two respondents this cadre is too small for detailed analysis, although both task analysis and work sampling show clearly the importance of paper work and communication in this position. Compared to the Hospital Health Care Administrator they spend relatively less time in the management of finance and considerably more in the management of physical resources. They report the highest level of satisfaction with their own roles of any of the cadre, and are very pleased with the administrative roles of those with whom they work.

Figure 1. PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION:
HOSPITAL SUPERINTENDENTS, NURSING ADMINISTRATORS,
HEALTH CARE ADMINISTRATORS. BOTSWANA, LESOTHO,
SWAZILAND

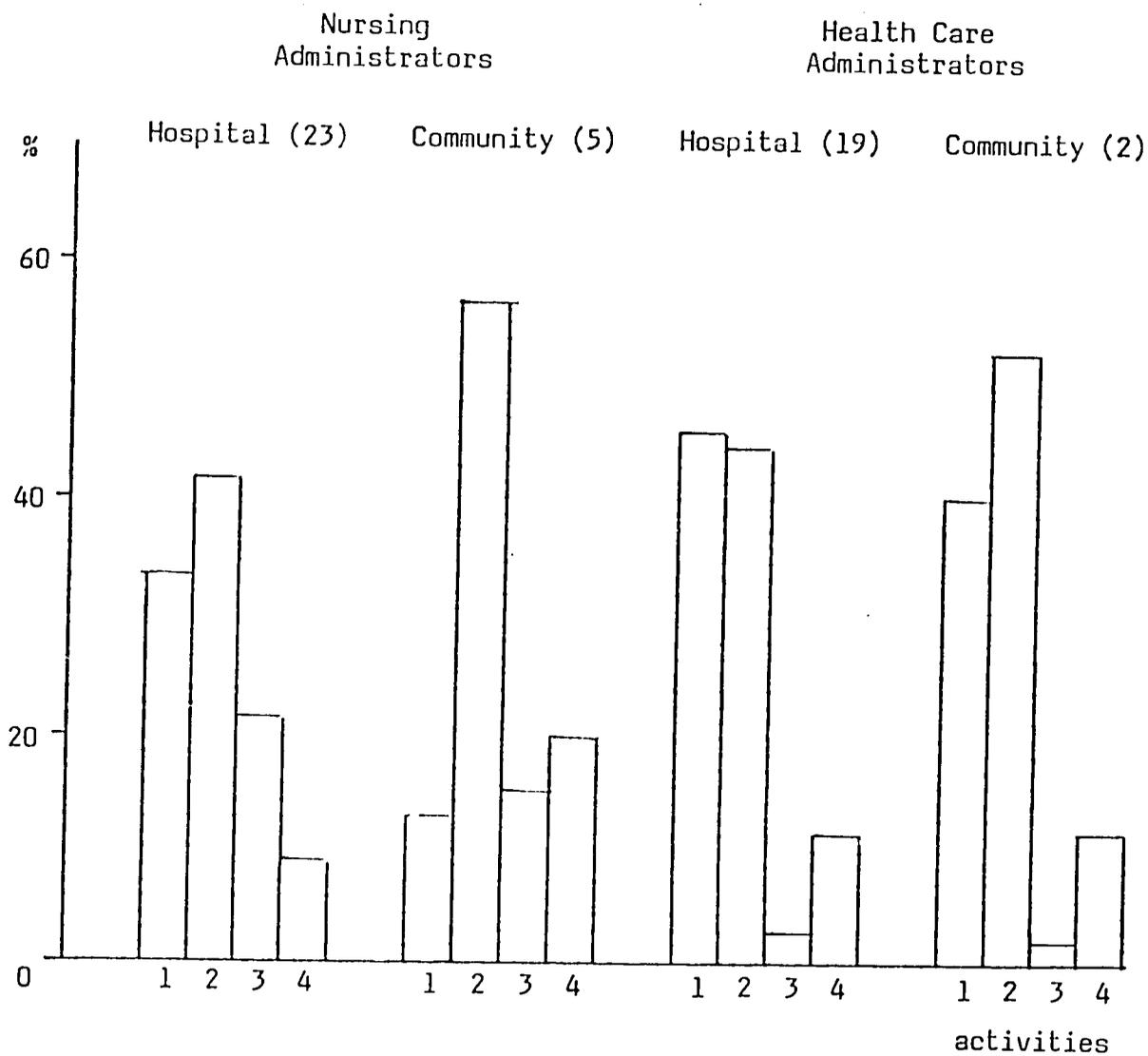


Nr. observations: 10,410

Activities:

1. Paper work
2. Communication: telephone, meetings
3. Service: patient care, rounds (Hospital Superintendent, Nursing Administrator) issuing stores, vehicles, etc. (Health Care Administrator)
4. Other, including travel.

Figure 2. PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION AND PRACTICE SETTING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND

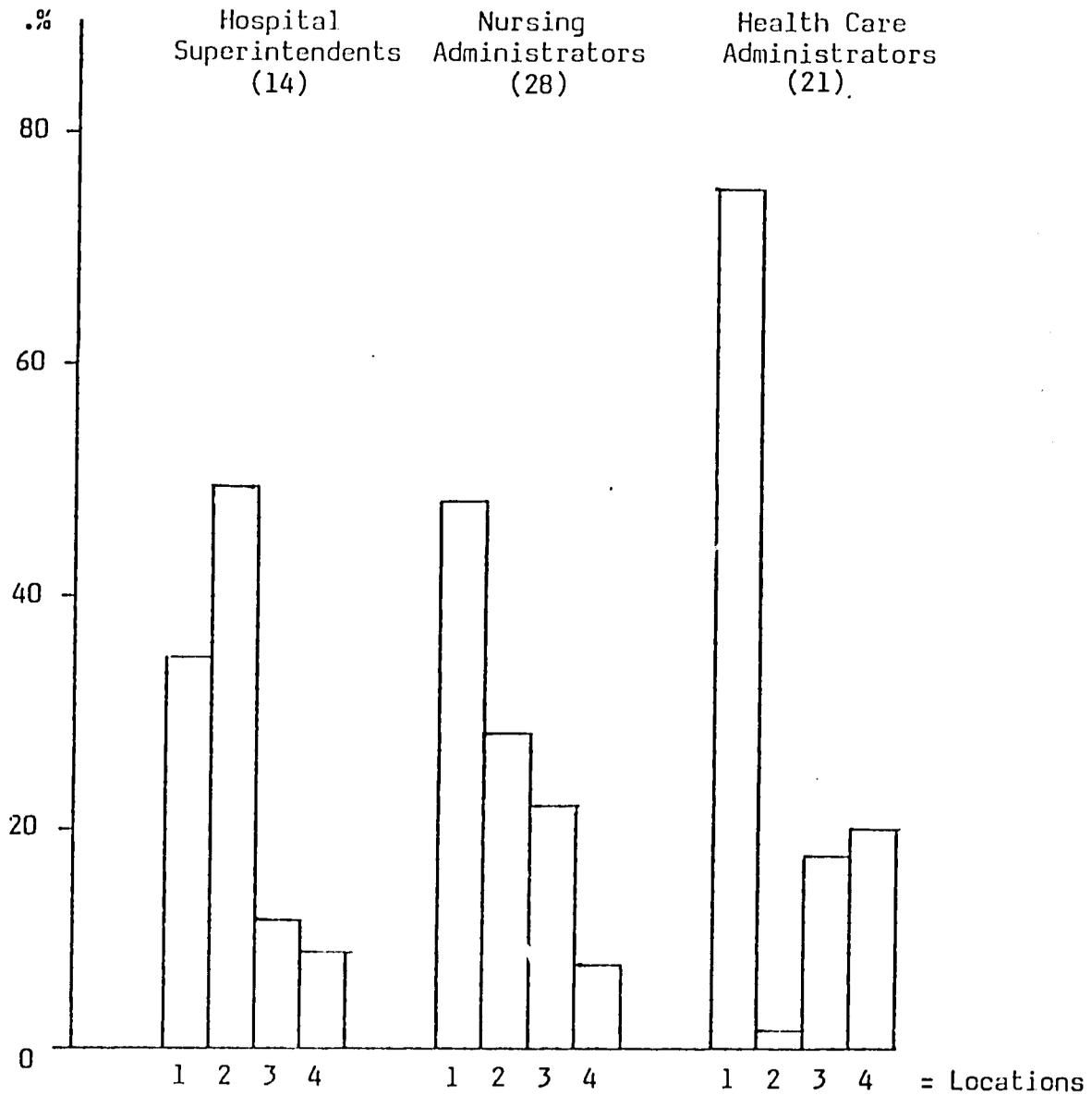


Nr. observations: 7,950

Activities:

1. Paper work
2. Communication
3. Service
4. Other

Figure 3 . PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION: HOSPITAL SUPERINTENDENT, NURSING ADMINISTRATOR, HEALTH CARE ADMINISTRATOR. BOTSWANA, LESOTHO, SWAZILAND

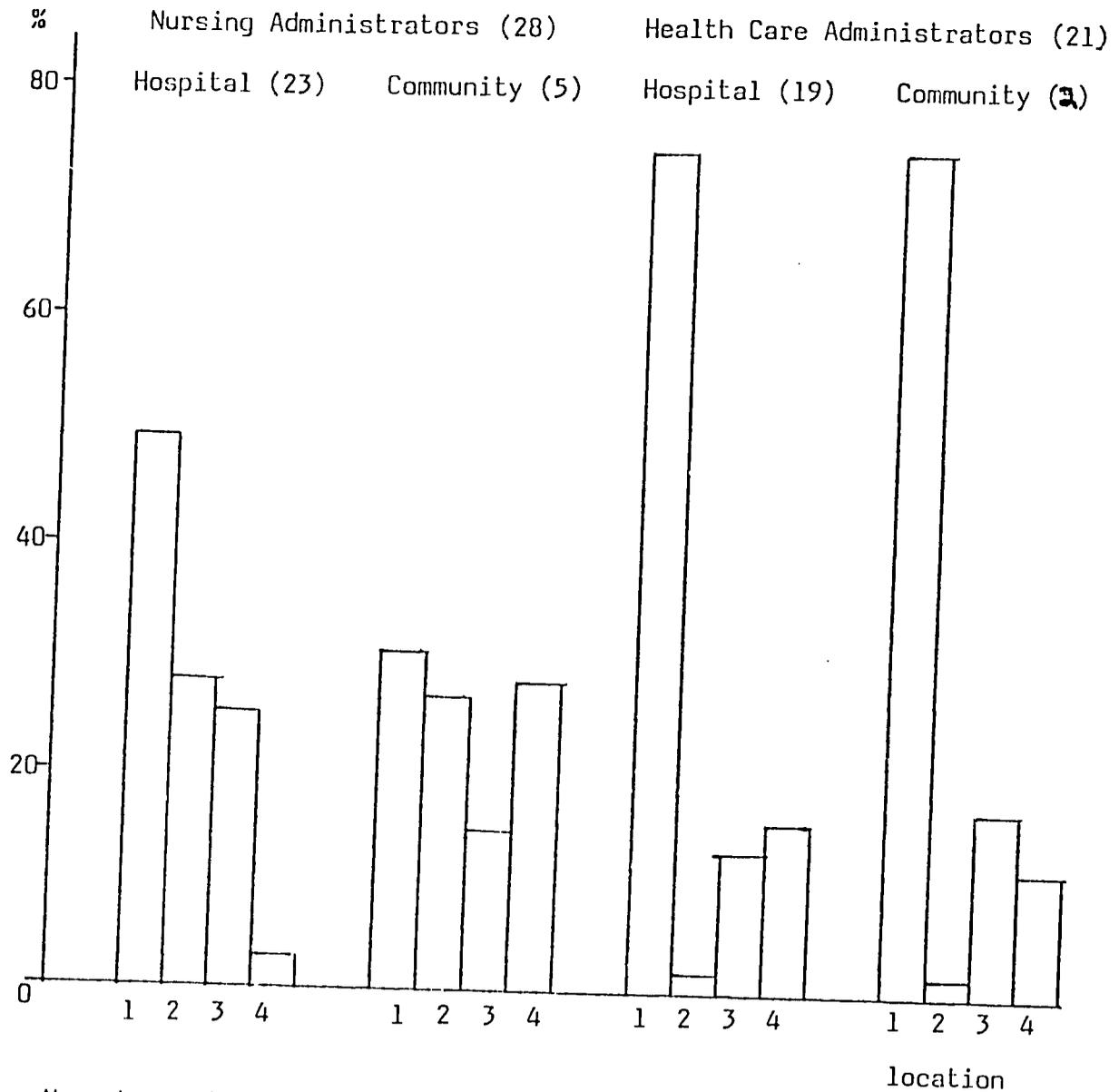


Nr. observations: 10,410

Locations:

1. Office, desk
2. Service point: wards, clinic (Hospital Superintendent, Nursing Administrator); storeroom, depot, etc. (Health Care Administrator)
3. Other location in the facility
4. Elsewhere

Figure 4. PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION AND PRACTICE SETTING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND



Nr. observations: 7950

Locations:

1. Office
2. Service point
3. Other-in facility
4. Elsewhere.

Figure 5 . JOB PROFILES: DISTRIBUTION OF ADMINISTRATIVE LOAD BY POSITION:
HOSPITAL SUPERINTENDENT, PRINCIPAL NURSING OFFICER, HEALTH
CARE ADMINISTRATOR. (LOG-FREQUENCY WEIGHTED INDEX)

Areas of Responsibility:

1. Patient care
2. Personnel
3. Physical resources
4. Finances
5. Communication
6. Planning

Log-frequency
weighted index

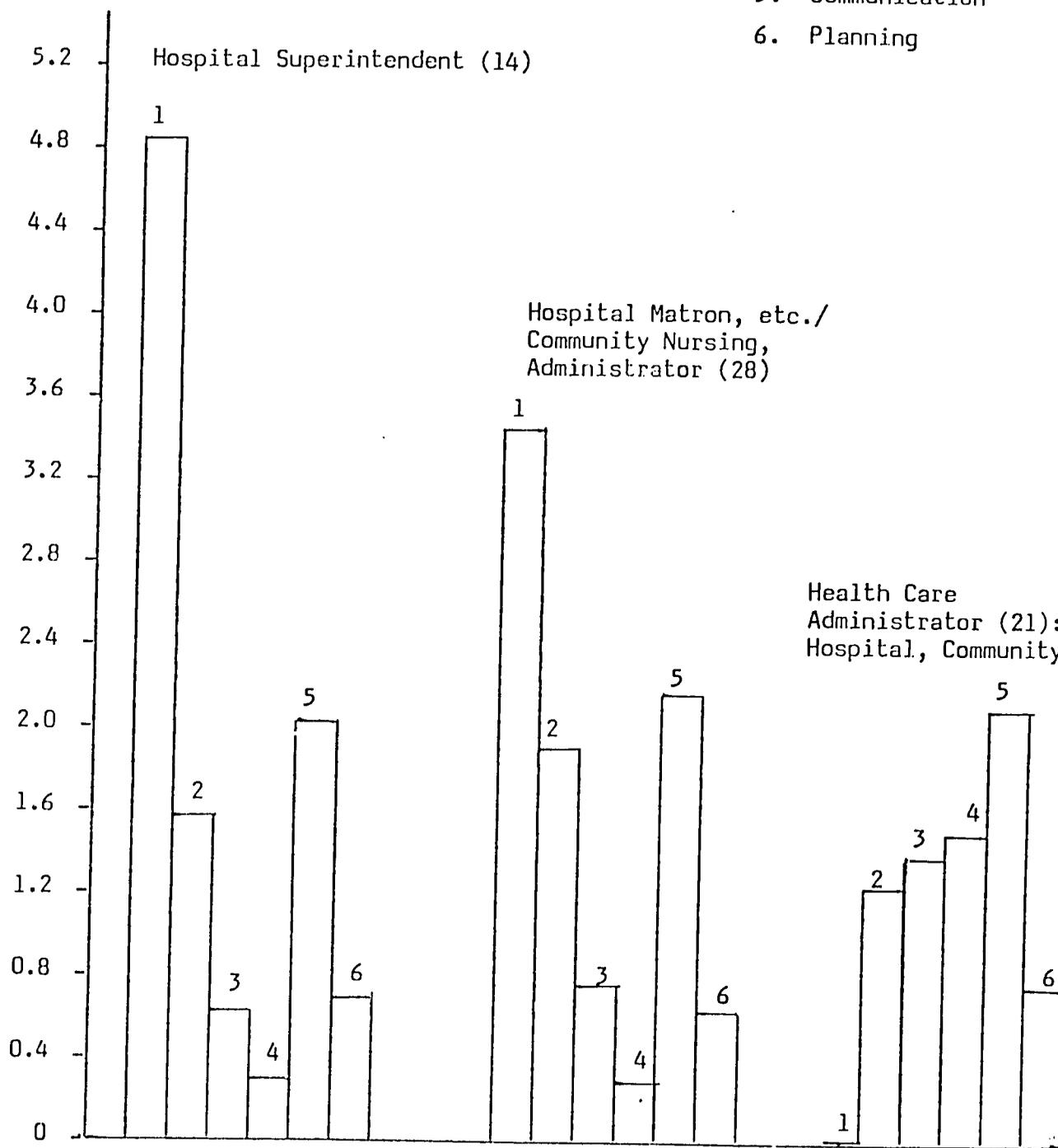


Figure 6. JOB PROFILES: DISTRIBUTION OF ADMINISTRATIVE LOAD BY PRACTICE SETTING: HOSPITAL, COMMUNITY (LOG-FREQUENCY INDEX)

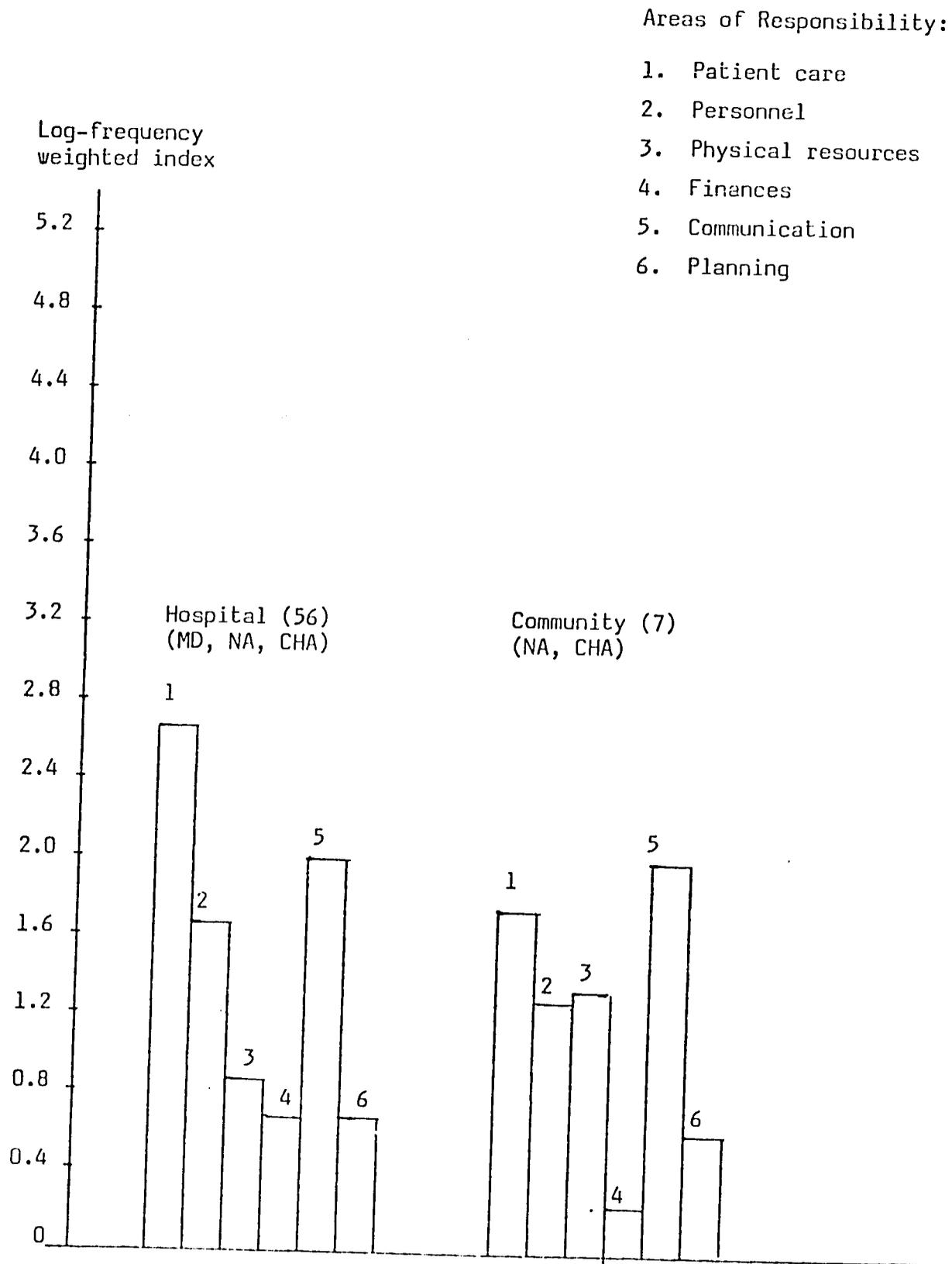


Figure 7. JOB PROFILES: DESCRIPTION OF ADMINISTRATIVE LOAD BY PRACTICE SETTING AND POSITION: NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS ONLY. (LOG-FREQUENCY WEIGHTED INDEX)

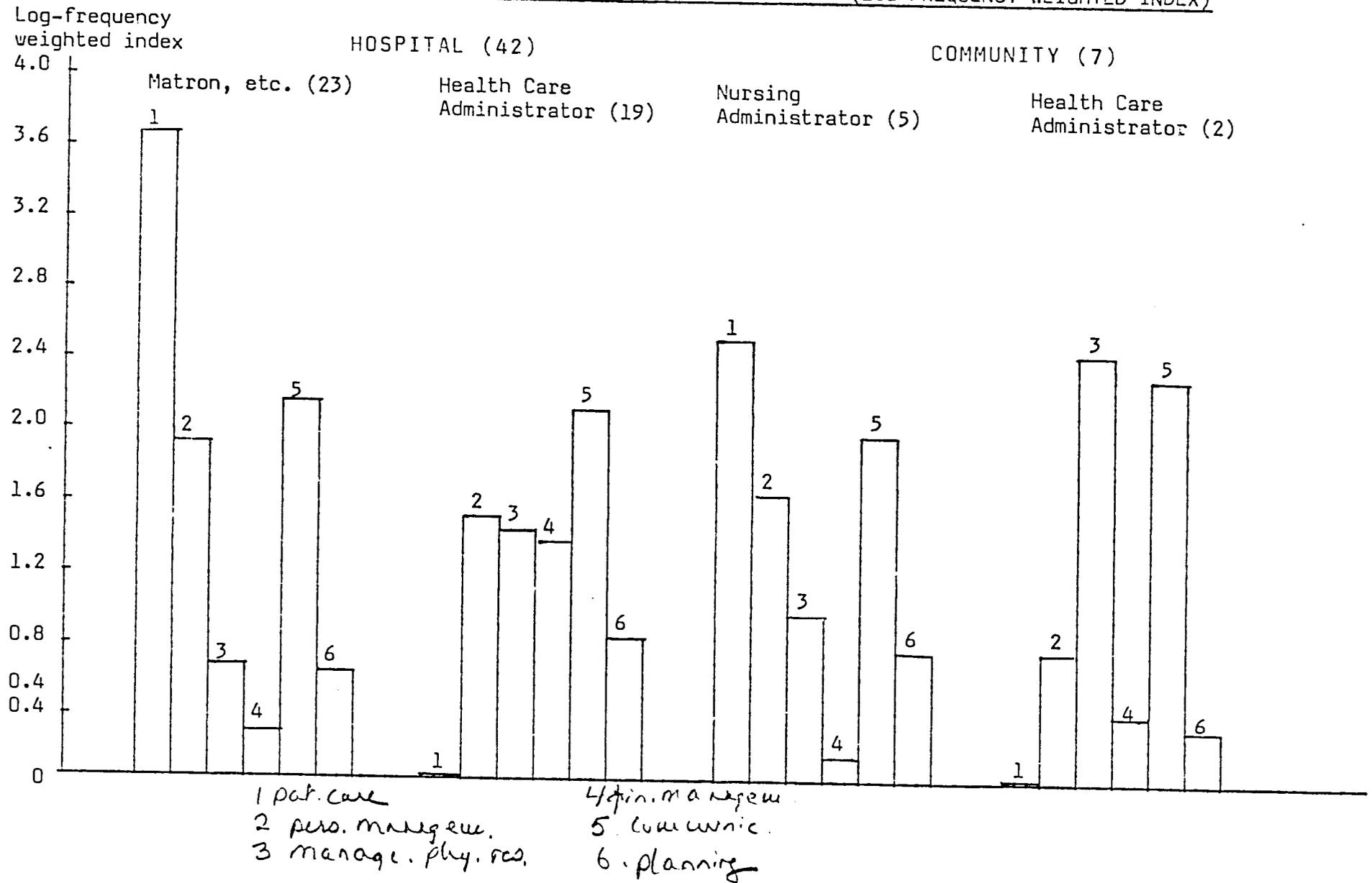


Table 3 . PROPORTION OF TASKS DELEGATED TO ANOTHER, BY BROAD AREA OF ADMINISTRATIVE RESPONSIBILITY

Responsibility	Total	Medical Supt.	Matron Nurs.Ad.	Health Care Ad.	Hospital		Community	
					Matron, etc.	HCA	Nurs.Ad.	HCA
Patient Care	0.49	0.29	0.62	0.0	0.56	0.0	1.00	0.0
Administration:								
Personnel	0.31	0.28	0.44	0.12	0.40	0.11	0.61	0.50
Physical resources	0.46	0.67	0.57	0.32	0.50	0.35	0.74	0.08
Finances	0.36	0.78	0.37	0.26	0.35	0.27	0.43	0.0
Communication	0.26	0.24	0.28	0.25	0.25	0.26	0.43	0.20
Planning	0.30	0.44	0.32	0.13	0.22	0.15	0.64	0.0
Total	0.36	0.43	0.41	0.26	0.36	0.26	0.58	0.27
RELATIVE PROPORTION ¹								
Patient Care	1.36	0.81	1.72	0.0	1.56	0.0	2.78	0.0
Administration:								
Personnel	0.81	0.78	1.22	0.33	1.11	0.31	1.69	1.39
Physical resources	1.28	1.86	1.58	0.89	1.39	0.97	2.06	0.22
Finances	1.00	2.17	1.03	0.72	0.97	0.75	1.19	0.0
Communication	0.72	0.67	0.78	0.69	0.69	0.72	1.19	0.56
Planning	0.83	1.22	0.89	0.36	0.61	0.42	1.78	0.0
Total	1.00	1.99	1.14	0.72	1.00	0.72	1.61	0.75
Number of Respondents	63	14	28	21	23	19	5	2

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¹ This expresses the ratio of the proportion of a given task delegated to the proportion of all administrative tasks delegated, e.g. total proportion of patient care delegated is 0.49, and total proportion of all administrative tasks delegated is 0.36. The ratio is 0.36, which means that patient is delegated 1.36 times as often as all administrative tasks.

Table 4. SUGGESTIONS FOR IMPROVING ADMINISTRATION

SUGGESTIONS:	Nr.
<u>Additional training in administration for Colleagues:</u>	31
Refresher courses for senior officers (19)	
Workshops, in-service training for senior officers (7)	
Adequate orientation to staff roles (4)	
Evaluation and feedback by supervisors (1)	
<u>Improved working relationships:</u>	28
Better cooperation, coordination, communication, teamwork (13)	
Clear job descriptions, adherence to job descriptions, improved delegation of tasks, allocation of duties (8)	
Involvement of all senior staff in administration (1)	
Time for meetings, discussion, problem-solving (3)	
Change in attitudes, professional respect, recognition (3)	
<u>Organizational structure:</u>	5
Clear organizational structure (1)	
Decentralization (5)	
<u>Staffing:</u>	14
More staff, reduced work load (7)	
More qualified administrative personnel (3)	
Specific staff needs: Personnel Officer, Health Care Administrator, Housekeeper, etc. (4)	
<u>Facilities, material resources:</u>	4
Better transport (4)	
Improved facilities for patient care (1)	
Increased resources (2)	
<u>Don't Know:</u>	1
All Suggestions	83

Table 5. JOB SATISFACTION SCORES¹ BY PRACTICE, SETTING, POSITIONS AND COUNTRY

PRACTICE, SETTING POSITION	PERSONAL SATISFACTION				SATISFACTION WITH OTHERS			
	Total	Botswana	Lesotho	Swazi- land	Total	Botswana	Lesotho	Swazi- land
<u>Hospital:</u>								
Superintendent	1.7	2.0	1.8	1.5	2.0	1.8	2.4	1.5
Matron, Asst. Matron, etc.	2.0	2.4	2.1	2.5	2.1	2.0	2.0	2.3
Health Care Administrator	1.6	2.0	1.1	2.0	1.8	2.0	1.7	2.0
<u>Total</u>	1.9	2.2	1.6	2.3	2.0	1.9	2.0	2.1
<u>Community:</u>								
Nursing Administrator	2.2	-	-	-	2.6	3.0	-	-
Health Care Administrator	3.0	-	-	-	2.5	2.5	-	-
<u>Total</u>	2.4	2.5	-	-	2.6	2.8	-	-
TOTAL	2.0	2.3	1.6	2.3	2.0	2.2	2.0	2.1

¹ Weighted average of satisfaction category (administrative tasks only):

- 3 = Very satisfied
- 2 = Fairly satisfied
- 1 = Somewhat dissatisfied
- 0 = Very dissatisfied

Table 6. REASONS GIVEN FOR SATISFACTION OR DISSATISFACTION WITH OWN ADMINISTRATIVE ROLE

SATISFACTION ¹		DISSATISFACTION	
Reasons:	Nr.	Reasons:	Nr.
<u>Working Relationships:</u>		<u>Working Relationships:</u>	
Good cooperation, communication	3	Poor communication, cooperation	3
Good support from supervision	2	Poor supervision, no feedback	2
<u>Division of Responsibility, Job Description</u>		<u>Division of Responsibility, Job Description</u>	
Independence, initiative, decision-making role	3	Role not understood by others; no or inadequate job description; recognition wanted; additional responsibilities, participation in decisions wanted.	16
<u>Personal Competence, qualifications:</u>		<u>Personal Competence, Qualifications:</u>	
Confident in applying skills	3	More training, additional qualification needed, not prepared for present job	6
<u>Opportunity for Advancement</u>		<u>Opportunity for Advancement</u>	
No barriers to advancement	1	Promotion, salary increase wanted	13
<u>Other:</u>		<u>Other:</u>	
None given	0	Heavy work load, staff shortages, inadequate resources, travel demands, time pressures, etc.	14
All Reasons	12		54

¹ Relatively fewer respondents who were satisfied gave reasons.

Table 7. REASONS GIVEN FOR SATISFACTION OR DISSATISFACTION WITH ADMINISTRATIVE ROLES OF OTHERS

SATISFACTION ¹		DISSATISFACTION	
Reasons:	Nr.	Reasons:	Nr.
<u>Working Relationships:</u>		<u>Working Relationships:</u>	
Good human relations, good communication, cooperation.	8	Poor communication, cooperation, dislike of colleagues.	11
Good supervision	1	Poor supervision	1
<u>Division of Responsibility, Job Description:</u>		<u>Division of Responsibility, Job Description:</u>	
Good division of responsibility, good delegation, understanding of role by others	5	Poor division of responsibility, inadequate delegation, lack of job description, lack of challenge, lack of independence	12
<u>Competence, Qualification of Colleagues:</u>		<u>Competence, Qualification of Colleagues:</u>	
Competent colleagues, respect for ability of colleagues	4	Colleagues poorly qualified, not trained in administration, not responsible in carrying out duties, resistant to change, without vision	9
<u>Other:</u>		<u>Other:</u>	
None given	0	Time pressures, staff shortages, lack of trained support staff, overwork, crisis management, lack of continuity in leadership, circumstances beyond control, etc.	9
All Reasons	18		42

¹ Relatively fewer respondents who were satisfied gave reasons.

Table 8. PERCEPTION OF CAREER PROSPECTS OF I.D.M. GRADUATES, BY POSITION, COUNTRY

Position, Country	No. of respondents	Success Since IDM Graduation			Expectation of Advancement		
		New respon- sibilities	Successful changes	Promotion/ salary increase	Promotion	Further training	Other, un- specified
<u>Numbers</u>							
<u>Position:</u>							
Matron/Nurse Administrator	20	14	15	8	8	10	2
Health Care Administrator	17	14	12	7	2	7	1
Total	37	28	27	15	10	17	3
<u>Country:</u>							
Botswana	14	8	10	7	5	8	1
Lesotho	14	13	11	4	1	5	-
Swaziland	9	7	7	4	4	4	2
Total	37	28	27	15	10	17	3
<u>Percentages</u>							
<u>Position:</u>							
Matron/Nurse Administrator	20	70	75	40	40	50	10
Health Care Administrator	17	82	71	41	12	41	6
Total	37	78	75	42	28	47	8
<u>Country:</u>							
Botswana	14	57	71	50	36	57	7
Lesotho	14	93	79	29	7	36	-
Swaziland	9	78	78	44	44	44	22
Total	37	76	73	41	27	46	8

IV. POTENTIAL DEMAND FOR TRAINED PERSONNEL IN THE BLS COUNTRIES

The study has clearly shown that there is a definite need for training of administrative personnel in health. This need was also identified in the former studies done in health in the BLS countries, e.g. Cote (1978). The BLS countries are all working towards achieving the WHO objective of 'health for all by the year 2000'. The countries hope to achieve the said objective by expanding their health services, especially in rural areas where most of their populations live.

The countries also hope to give quality care to their populations and this can only be achieved if all the health experts concentrate on areas of their greatest competence and training. Because the work load is enormous in the BLS countries, the need for supportive staff cannot be over emphasized. For example, Swift (1974), showed the population per physician and per nurse as follows for the BLS countries:

COUNTRY	POPULATION PER PHYSICIAN	POPULATION PER NURSE
Botswana	12,500	1,624
Lesotho	22,000	3,341
Swaziland	9,000	1,161

The foregoing clearly shows that the doctors and nurses in these countries cannot efficiently manage health care facilities without the help of other administrative personnel in health. Moreover, the countries themselves

have recognised the need for such assistance, hence their utilization of IDM's training courses in health care and nursing administration, established in 1979-80. The need for continued training of personnel in health administration remains crucial.

V. RECOMMENDATIONS

Recommendations arising from this study of health services administration are presented below, organized around four themes:

- A) The allocation of administrative responsibilities within the health team;
- B) Organizational structure and career paths in health administration;
- C) Training needs in administration for the health sector;
- D) Specific modifications and/or additions to IDM training courses in administration for health care.

A. Allocation of Administrative Responsibilities

In these recommendations, no attempt is made to specify the allocation of individual tasks nor to propose detailed job descriptions for the several members of the administrative team. The focus is, rather, on the allocation of responsibility among broad areas of administration and on the over-all pattern of administrative duties of each of the three principal cadres of the health team: the Medical Superintendent, the Hospital Matron/Community Nursing Administrator, and those called, for want of a more appropriate title, Health Care Administrators, in both hospital and community.

1. Medical Superintendent

- 1.1 The survey shows that Medical Superintendents tend to be concerned and conscientious in giving high

priority to patient care. It is recommended that they be supported in this concern and be encouraged to delegate to the Health Care Administrator, under adequate supervision, as much of the following as is feasible in a given situation:

- 1) the management of physical resources: transport, buildings and grounds, supplies and equipment, etc.
- 2) financial management: accounting, payrolls, annual estimates, etc.;
- 3) the preparation of statistical and other reports, record systems, etc.

1.2 Because the survey shows that many of the Medical Superintendents feel inadequate in their administrative role, it is recommended that the relevant Ministries arrange for programmes of in-service training, workshops, etc., for physician/administrators, to improve skills and increase self-confidence in this role.

2. Matron/Nursing Administrator

2.1 From the survey it appears that many of the Matrons/Nursing Administrators are giving a higher priority to administration than to the supervision of patient care. This cadre should ordinarily be encouraged to give more attention to the supervision of nursing care in hospital and community, and to delegate, under adequate supervision, a greater proportion of the administrative load to the Health Care Administrators. Responsibilities which could be delegated include:

- 1) the management of physical resources: house-keeping, office management, maintaining inventories, maintenance and repair of vehicles and equipment, etc.;
- 2) the preparation of statistical and other reports, record systems, etc.;
- 3) the supervision of clerical and industrial staff, and the routine maintenance of all employee records.

2.2 In those instances, however, where administrative nursing staff show particular interest in and aptitude for administration, a limited number could be encouraged to take further training in health administration, at the Diploma or even the Masters level. (See recommendations concerning organizational structure and career paths in health administration).

2.3 Much of the time of the Matrons/Nursing Administrators is spent in communication, but the relatively high priority they give to conflict resolution and the low morale of many Health Care Administrators suggests that this communication is not as effective as it could be. It is recommended that Matrons/Nursing Administrators be encouraged to take advantage of the existing 2-week IDM course in communication, with emphasis upon human relations. It is also recommended that the relevant Ministries organize in-service training and/or workshops in conflict resolution for ^{all} members of the health administration team.

3. Health Care Administrators

The survey has found that, despite wide-spread concern

about the role of Health Care Administrators, the great majority of this cadre, since graduation from IDM, have been given new responsibilities and have successfully implemented new initiatives. Nearly one half have received a salary increase or promotion, except in Lesotho where only one has been promoted. Nevertheless, few anticipate promotion in the future. The level of dissatisfaction is very high among this cadre, stemming from their perception of inadequate professional recognition despite their new responsibilities, and of limited opportunities for advancement, together with poor working relationships among the members of the health team. Although they are currently making a contribution to the improvement of health services in the BLS countries, their full potential cannot be realized unless their morale problem can be solved. The solution will not be easy for the problem has a history which may be difficult to overcome. However, to move toward a solution, it is recommended that:

- 3.1 The nature and scope of their duties and their reporting relationships be clarified, if not for the entire cadre, then in accordance with the realities of a specific position, in order to minimize conflict among the members of the health team.
- 3.2 An identification be made of a clear career path for this cadre, which is parallel to the normal career path for administrative cadre in other sectors (see Recommendation 4.1, 4.2 and 5.1 concerning organizational structure and career paths in administration); the existence of such a path should provide an incentive for improved performance.
- 3.3 As recommended in previous sections, the Medical

Superintendent and Matron/Nursing Administrator should be encouraged to delegate responsibility to this cadre for the management of physical resources, financial management, the preparation of statistical and other reports, the supervision of clerical and industrial staff, and routine personnel matters. Provision should be made for adequate supervision of the Health Care Administrator, and for in-service training where necessary. Workshops and refresher courses, both in technical administration and in human relations, are also recommended for this cadre.

B. Organizational Structure and Career Paths in Health Administration

A definite administrative career structure exists within the civil service of each of the three governments, and prior to their designation as Health Care Administrators, this cadre took its place within that structure. Additional training in the administration of health services, while better preparing them to function in that sector, need not take them outside the existing civil service career structure. Consequently it is recommended that:

- 4.1 An appropriate career path for administrators in the health sector be identified which parallels that of those working in other sectors. Although this could theoretically result in the movement of administrators trained in health care to posts outside the sector, were adequate attention given to factors presently affecting the morale of this cadre, there would be no particular incentive for them to make such a move, while the improved performance which could be expected from the existence of opportunities for advancement could outweigh a small number lost to health.
- 4.2 Titles be given to this cadre which more appropriately

reflect their position within the existing administrative career structure of the civil service. (See Recommendation 5.1 for an outline of the several administrative levels within the health sector and their corresponding levels within the civil service).

- 4.3 The survey shows that the majority of Health Care Administrators are younger, less experienced, and have had less education than the other members of the health administration team, and will in general, therefore, need to be supervised by a more senior person. In the Ministries and in those services and facilities where there is a senior administrative officer, that individual would normally supervise the work of a junior certificate-level Health Care Administrator. However, where no senior officer is present, a condition characterizing by far the majority of the posts filled by HCA's, it is recommended that the HCA be supervised by the Medical Superintendent through the Matron/Nursing Administrator.
- 4.4 Opportunities for further training in Health Services/Hospital Administration, at the graduate, diploma or Masters level, be made available to a limited number of suitably qualified and experienced Health Care Administrators and Nursing Administrators, to fill senior administrative posts in the larger hospitals, special services, and the Ministries as occasion arises.

C. Training Needs in Administration for the Health Sector

5.1 In the light of the structure of health services in the BLS countries and the nature of the administrative load in hospital and community, following is a table showing some of the personnel for whom training in administration is recommended to improve their ability to carry out their duties. The specific level of training would depend upon their background, experience and responsibilities:

PERSONNEL FOR WHOM TRAINING IN ADMINISTRATION IS RECOMMENDED

Level, Scope of service	Position	Suggested Qualifications and level of training	Civil Service Level
Ministerial	1. Senior Administrator in Health	Bachelor in Public Administration/ Bachelor in Health Administration Master in Health Administration/ Master of Public Health	Principal Administrative Officer Senior Administrative Officer Administrative Officer
	2. Administrators for special services/ categorical programmes	Diploma in Health Administration	Administrative Officer Assistant Administrative Officer
	3. Assistant Administrator	Diploma in Health Administration	Assistant Administrative Officer
Hospital: Referral	1. Medical Superintendent	Physician, seminars/workshops on adminis- tration	Principal Administrative Officer Senior Administrative Officer Administrative Officer
	2. Matron/Nursing Administrator	Graduate Nurse plus appropriate experience, plus Certificate, Diploma or Degree in Administration	Senior Administrative Officer Administrative Officer
	3. Hospital Administrator/Secretary	Bachelor in Public Administration/ Bachelor in Health Administration	Administrative Officer
	4. Assistant Administrators, reporting to the Hospital Administrator	Certificate or Diploma in Health Care Administration	Assistant Administrative Officer Senior Administrative Assistant
Hospital: Rural and Speciality	1. Medical Superintendent	Physician, seminars/workshops in adminis- tration	Principal Administrative Officer Senior Administrative Officer Administrative Officer
	2. Matron/Senior Sister	Graduate Nurse plus appropriate experience, plus Certificate, Diploma or Degree in Administration	Senior Administrative Officer Administrative Officer
	3. Assistant Administrator, reporting to the Hospital Superintendent OR Assistant for Administration, reporting through Matron	Bachelor in Administration/ Diploma in Health Administration OR Certificate in Health Care Administration	Administrative Officer Assistant Administrative Officer Senior Administrative Assistant
District/Regional	1. Regional Medical Officer	Physician, seminars/workshops on adminis- tration	Principal Administrative Officer Senior Administrative Officer Administrative Officer
	2. Nursing Administrator/Public Health Nurse	Graduate Nurse plus Public Health Nursing plus experience, plus Certificate, Diploma or Degree in Administration	Senior Administrative Officer Administrative Officer

Level, Scope of service	Position	Suggested Qualification and level of training	Civil Service level
District/Regional (Continued	3. Assistant Administrator	Diploma in Administration	Administrative Officer Assistant Administrative Officer
	4. Assistant for Administration, reporting to Nursing Administrator	Certificate in Health Care Administration	Senior Administrative Assistant
	5. Health Inspector	Certificate in Health Care Administration	Senior Administrative Assistant
Health Centers/ Large Clinics/ Specialty Clinics	1. Senior Sister	Graduate Nurse-Midwife, plus Certificate or Diploma in Administration	Senior Administrative Officer
	2. Assistant for Administration, reporting to the Senior Sister	Certificate in Health Care and Administration .	Senior Administrative Officer
Smaller Clinics	1. Senior Sister, Staff Nurse, Enrolled Nurse	Certificate in Nursing Administration	Senior Administrative Assistant

5.2 In the light of the need and potential demand for trained administrative personnel in health in the BLS countries, it is recommended that as a minimum the three countries plan to train the following numbers of Nursing and Health Care Administrators at the Certificate level at IDM over the next five years.

Recommended Numbers for Certificate Training in Health Administration ¹						
Country and Cadre	1982-1983	1983-1984	1984-1985	1985-1986	1986-1987	Total
Botswana						
Nursing Administrator	6	6	6	6	6	30
Admin. Asst. for Health Care	4	4	4	4	4	20
Total	10	10	10	10	10	50
Lesotho						
Nursing Administrator	5 5	5	5	5	5	25 25
Admin. Asst. for Health Care	12	2	2	2	2	20
Total	17	7	7	7	7	45
Swaziland						
Nursing Administrator	6	6	6	6	6	30
Admin. Asst. for Health Care	3	3	3	3	3	15
Total	9	9	9	9	9	45
Total						
Nursing Administrator	17 27	17	17	17	17	85 85
Admin. Asst. for Health Care	19	9	9	9	9	55
Total	36	26	26	26	26	140

¹ These numbers represent estimated demand for the types of nursing and Health Care Administrators that are currently being trained, and do not include the additional categories of health personnel suggested for training. If it were available, some of these potential candidates would qualify for a diploma level course.

D. Modification to the IDM Administrative Training Programme

The research showed that there were wide disparities in the background and experience of participants and in their performance on the job after graduation. Respondents suggested that candidates with no experience in the health sector should be given more preparation. There was a strong demand for a diploma course and for further training in specialized areas. Many expressed a need for more emphasis on certain aspects of the training programme.

Curriculum modification and expansion

- 6.1 In order to provide an administration training course that is appropriate for persons with higher qualifications and to qualify health and nursing administrators for positions of greater administrative responsibility, it is recommended that diploma courses in Nursing and Health Services Administration be established. Both certificate and diploma courses should have a common core, plus appropriate numbers and levels of additional short courses or modules. Those completing the certificate would be able to qualify for the diploma on completion of the required additional modules. However, candidates with appropriate backgrounds could enter the diploma course directly.

- 6.2 In order to accommodate the diverse backgrounds and responsibilities of the health administration cadre, it is recommended that, in addition to the core, participants be offered a choice among the modules they take in order to qualify for a certificate or diploma. The choice would include modules that are outside the health administration programme, such as

financial management. The participants should receive a paper qualification for the successful completion of a module so that a person requiring training in only one specialized area would be encouraged to attend even if she/he were not aspiring to a certificate or diploma.

6.3 It is recommended that some new short courses, or modules, be established, such as hospital records, pharmaceutical management, health team operations and inter-relationships, etc. It is suggested that not every module be offered every year. Special attention should be given to identifying either new or on-going courses that are needed to upgrade the skills of HCA graduates.

6.4 Certain areas need to receive greater emphasis in the health administration training programme. In some areas, it will require a new course or additions to an existing course, in others, a different orientation. It is recommended that the following areas be strengthened: community health organization and management, finance and budgeting, human relations, planning and evaluation, including health statistics and epidemiology. In recruiting staff the IDM should make a special effort to seek ^{additional} personnel with a strong background in the organization and delivery of community health services.

Selection of Candidates

6.5 It is recommended that participants coming into the certificate course who have minimal or no background in health should be given a pre-induction course. This would enable them to benefit more from the programme and would reduce the need for providing this compensation in classes that are also attended by

persons already familiar with health services.

- 6.6 It is recommended that persons with administrative responsibilities at the levels of enrolled nurses, health assistants and pharmaceutical technicians also be considered for admission to training for the certificate course. For either the certificate or diploma course, admission of special services administrators (EPI, family planning, handicapped services, laboratory management, etc.) and Health Inspectors should be considered.
- 6.7 In order to ensure that the IDM programme supports the potential for a career ladder for the health administration cadre, it is recommended that the qualification for entry into the diploma course be either CHA/CNA plus experience and recommendation, or the equivalent background in health and administration, or the appropriate academic qualifications.

REFERENCES

- Cote, M. The Health Systems of Swaziland, Lesotho and Botswana. Gaborone. 1978.
- Swift, J.L. et al. "A Programme for Comprehensive Health Care Development". Gaborone. 1974.

APPENDIX I

FIELD WORK UNDERTAKEN IN THE ELS COUNTRIES BETWEEN
14TH SEPTEMBER, 1982 and 15TH DECEMBER, 1982

BOTSWANA

<u>Date</u>	<u>Place</u>	<u>No. Interviewed</u>
14. 9.1982	Molepolole	2
15. 9.1982	Molepolole	3
16. 9.1982	Mochudi	3
17. 9.1982	Mochudi	3
20. 9.1982	Kanye	3
21. 9.1982	Kanye	3
22. 9.1982	Gaborone	2
23. 9.1982	Molepolole	1
24. 9.1982	Gaborone	1
27. 9.1982	Mahalapye	3
28. 9.1982	Selebi-Phikwe	3
29. 9.1982	Francistown	2
4.10.1982	Ramotswa	2
5.10.1982	Ramotswa	1
		<u>31</u>

SWAZILAND

11.10.1982	Mbabane	2
12.10.1982	Mbabane	2
13.10.1982	Mankanyane	2
14.10.1982	Manzini	2
18.10.1982	Siteki	2
19.10.1982	Hlalakulu	3
20.10.1982	Manzini	1
21.10.1982	Mbabane	2
		<u>14</u>

Field Work Undertaken in the BLS Countries between
14th September, 1982 and 15th December, 1982

LESOTHO

Date	Place	No. Interviewed

27.10.1982	Maseru	2
28.10.1982	Maseru	2
29.10.1982	Maseru	2
1.11.1982	Quthing	2
2.11.1982	Mohale's Hoek	2
4.11.1982	Maseru	2
5.11.1982	Morija	2
8.11.1982	Leribe	2
9.11.1982	Leribe	2
10.11.1982	Mapoteng	2
11.11.1982	Berea (Ty)	2
12.11.1982	Roma	2
15.11.1982	Morija	2
		<u>26</u>

APPENDIX III.

Table 1. ADMINISTRATIVE¹ LOAD (LOG-FREQUENCY WEIGHTED INDEX)² BY PRACTICE SETTING AND POSITION

Practice Setting, Position	Number of Respondents	Number of Administrative tasks checked	Proportion of Maximum number of tasks (x 100)	Log-frequency weighted index ($\div 1.24$) ³
<u>Hospital:</u>				
Superintendent	14	450	40	0.81
Matron, Asst. Matron, etc.	23	732	40	0.87
Health Care Administrator	19	816	54	1.27
Total	56	1998	45	0.99
<u>Community:</u>				
Nursing Administrator	5	221	55	0.94
Health Care Administrator	2	83	52	1.43
Total	7	304	54	1.07
Total	63	2302	46	1.00
<u>Medical Superintendent</u>				
Matron, Nursing Admin.	14	450	40	0.81
Health Care Administrator	28	953	43	0.89
	21	899	54	1.28
Total	63	2302	46	1.00
<u>Hospital Administrator</u>				
Community Health Admin.	56	1998	45	0.99
	7	304	54	1.07
Total	63	2302	46	1.00

1 Administrative tasks only; does not include patient care.

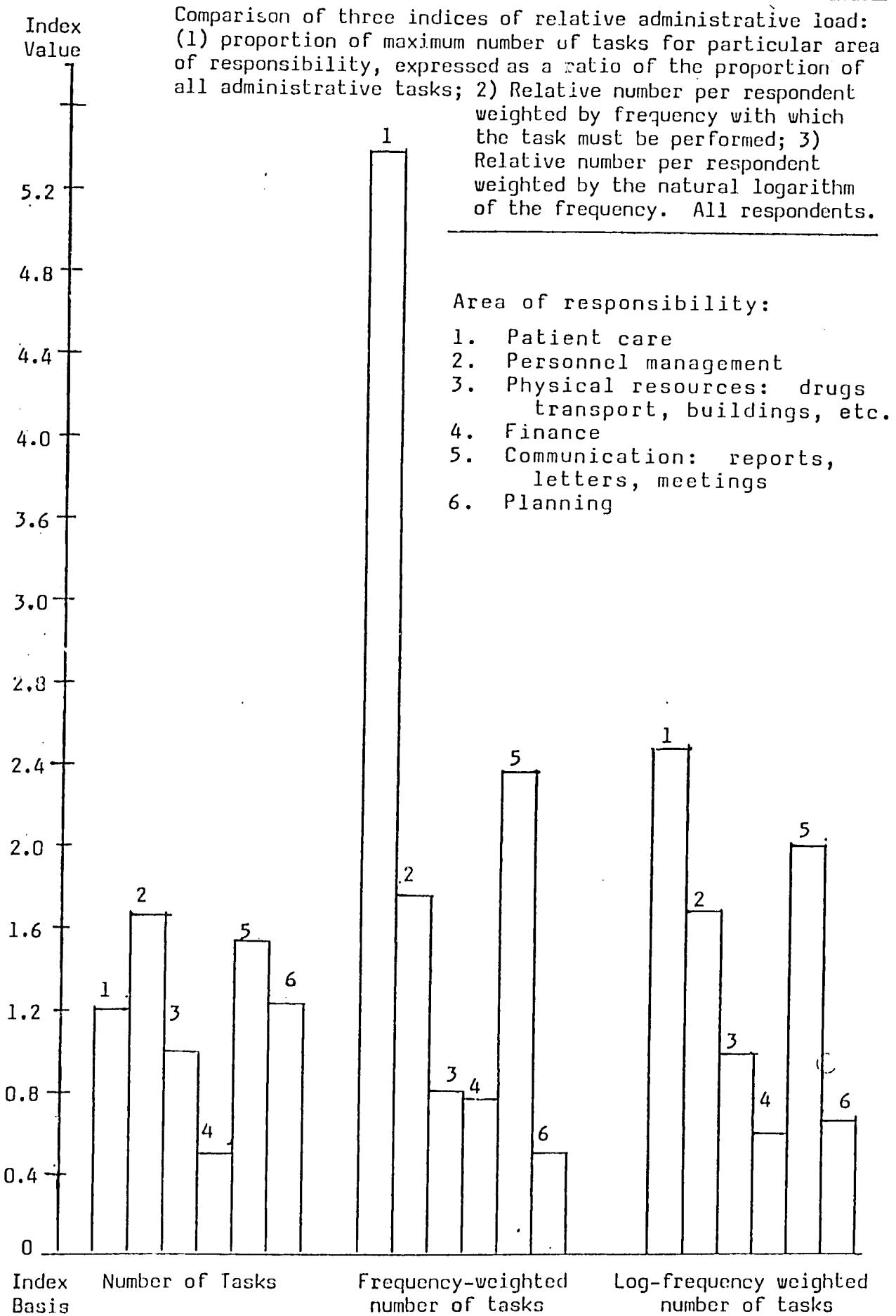
2 The log-frequency weighted index is the sum of the number of tasks performed, weighted by the natural logarithm of the annual frequency with which each is undertaken. This procedure reduces the weight given to each performance of a daily task, such as bookkeeping, thus giving relatively greater weight to tasks such as budgeting which are carried out only a few times per year.

3 Dividing by 1.24, the log-frequency weighted index for all administrative tasks for all respondents, transforms this to a relative measure, for greater ease of interpretation.

Table 2. JOB PROFILES: ADMINISTRATIVE LOAD (LOG-FREQUENCY WEIGHTED INDEX) FOR BROAD AREAS OF RESPONSIBILITY, BY POSITION

Broad Area of Administrative Responsibility	Total	Medical Superintendent	Matron/Nursing Administrator	Health Care Administrator
Patient Care	2.57	4.76	3.41	0
Administration:				
Personnel	1.66	1.56	1.85	1.23
Physical resources	0.92	0.58	0.69	1.44
Finance	0.61	0.29	0.28	1.54
Communication	2.06	2.01	2.08	2.08
Planning	0.65	0.63	0.61	0.73
All Administration	1.00	0.81	0.89	1.28

Figure 1. JOB PROFILES: DISTRIBUTION OF ADMINISTRATIVE
LOAD IN HEALTH SERVICES



APPENDIX III.

Table 3. JOB PROFILES: ADMINISTRATIVE LOAD (LOG-FREQUENCY WEIGHTED INDEX) FOR BROAD AREAS OF RESPONSIBILITY, BY PRACTICE SETTING

Broad Area of Administrative Responsibility	Total	Hospital Administrators (MD, NA, HCA)	Community Health Administrators (NA, HCA)
Patient Care	2.57	2.68	1.75
Administration:			
Personnel	1.66	1.70	1.35
Physical resources	0.92	0.87	1.38
Finance	0.61	0.63	0.24
Communication	2.06	2.07	2.01
Planning	0.65	0.66	0.61
All Administration	1.00	0.99	1.07

Table 4. JOB PROFILES: ADMINISTRATIVE LOAD (LOG-FREQUENCY WEIGHTED INDEX) FOR BROAD AREAS OF RESPONSIBILITY, BY PRACTICE SETTING AND POSITION

Broad Area of Administrative Responsibility	Hospital		Community	
	Matrons, etc.	Health Care Administrators	Nursing Administrators	Health Care Administrators
Patient Care	3.62	0	2.45	0
Administration:				
Personnel	1.91	1.55	1.59	0.73
Physical resources	0.64	1.38	0.96	2.42
Finance	0.31	1.36	0.17	0.43
Communication	2.11	2.06	1.92	2.26
Planning	0.58	0.78	0.75	0.28
All Administration	0.87	1.27	0.94	1.43

Table 5. DISTRIBUTION OF OBSERVATIONS BY LOCATION, POSITION, PRACTICE SETTING AND COUNTRY

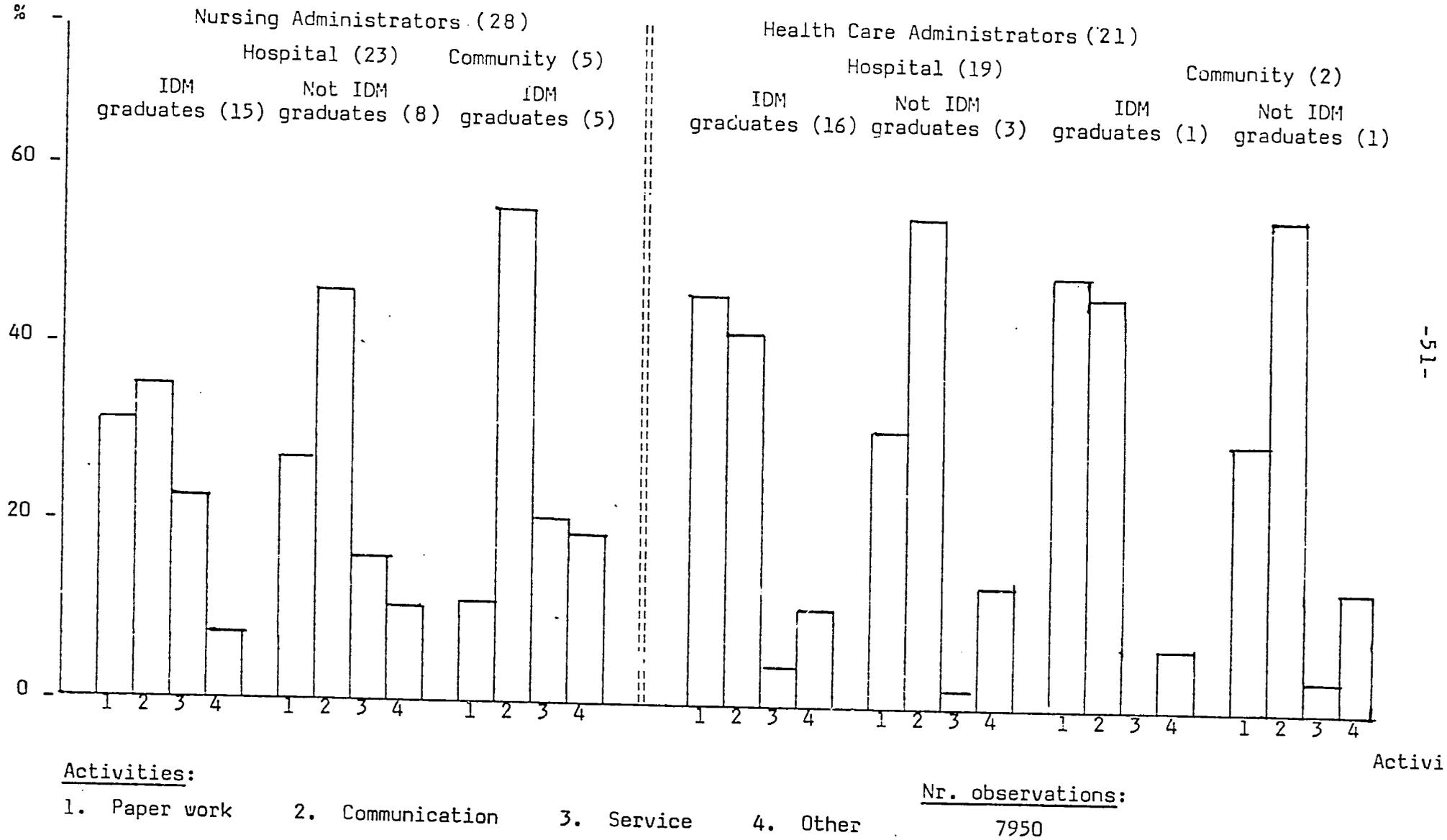
	Total		Botswana		Lesotho		Swaziland	
	Respon- dents Nr.	Observa- tions Nr. %	Nr.	%	Nr.	%	Nr.	%
<u>Hospital:</u>								
Superintendent	14							
Office		814 33	335 38		262 25		217 41	
Service point		1202 48	416 46		700 66		86 16	
Other-in facility		270 11	90 10		42 4		138 26	
Elsewhere		198 8	51 6		55 5		92 17	
Total		2484 100	892 100		1059 100		533 100	
Matron, Asst.Matron, etc.	23							
Office		2044 49	657 56		617 45		663 49	
Service point		1051 26	277 23		423 31		252 19	
Other-in facility		846 21	190 16		303 22		391 29	
Elsewhere		155 4	61 5		28 2		37 3	
Total		4096 100	1185 100		1371 100		1343 100	
Health Care Administrator	19							
Office		2286 73	655 68		1419 81		212 54	
Service point		20 1	4 0		16 1		0 0	
Other-in facility		370 12	128 13		201 11		41 11	
Elsewhere		445 14	188 19		123 7		134 35	
Total		3121 100	975 100		1759 100		387 100	
<u>Community:</u>								
Nursing Administrator	5							
Office		217 29	217 39		na		0 0	
Service point		202 27	122 22				80 42	
Other-in facility		119 16	118 21				1 1	
Elsewhere		207 28	99 18				108 57	
Total		745 100	556 100				189 100	
Health Care Administrator	2							
Office		251 73	251 73		na		na	
Service point		3 1	3 1					
Other-in facility		56 16	56 16					
Elsewhere		33 10	33 10					
Total		343 100	343 100					
Sub Total	65	10410	3951		4007		2452	
Other	8	-	-		-		-	
Total	71	-	-		-		-	

Table 6 . DISTRIBUTION OF OBSERVATIONS BY ACTIVITY, POSITION, PRACTICE SETTING AND COUNTRY

	Respon- dents	Total		Botswana		Lesotho		Swaziland	
		Observa- tions Nr.	%	Nr.	%	Nr.	%	Nr.	%
<u>Hospital:</u>									
Superintendent	14								
Paper work		811	33	249	28	385	36	177	33
Communication		602	24	270	30	126	12	206	39
Service		916	37	303	34	511	49	102	19
Other		155	6	070	8	37	3	48	9
Total		2484	100	892	100	1059	100	533	100
Matron, Asst. Matron, etc.	23								
Paper work		1300	32	294	25	460	34	448	33
Communication		1618	40	563	47	463	34	545	41
Service		839	20	211	18	279	20	292	22
Other		339	8	117	10	169	12	58	4
Total		4096	100	1185	100	1371	100	1343	100
Health Care Administrator	19								
Paper work		1381	44	366	38	934	53	81	21
Communication		1346	43	479	48	655	37	212	54
Service		51	2	15	2	34	2	2	1
Other		343	11	115	12	136	8	92	24
Total		3121	100	975	100	1759	100	387	100
<u>Community:</u>									
Nursing Administrator	5								
Paper work		92	12	92	17	na		0	0
Communication		406	55	325	58			81	43
Service		103	14	75	13			28	15
Other		144	19	64	12			80	42
Total		745	100	556	100			189	100
Health Care Administrator	2								
Paper work		135	39	135	39	na		na	
Communication		170	50	170	50				
Service		4	1	4	1				
Other		34	10	34	10				
Total		343	100	343	100				
Sub Total	63	10410		3951		4007		2452	
Other	8	-		-		-		-	
Total	71	-		-		-		-	

APPENDIX IV.

Figure 1 . PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION, PRACTICE SETTING, AND IDM TRAINING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND



APPENDIX IV.

Figure 2. PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION, PRACTICE SETTING, AND IDM TRAINING
 (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND)

