

**A REVIEW OF THE RE-STRUCTURING OF THE NELSON MANDELA ACADEMIC HOSPITAL  
THROUGH THE CHANGE MANAGEMENT APPROACH**

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By

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## **DECLARATION**

I hereby declare that this thesis, submitted to Rhodes Business School in partial fulfillment of the requirements for the degree of Masters in Business Administration is my own work and has not been previously submitted for a degree except as fully acknowledged within the text.

Dr Mzulungile Nodikida

**RESEARCH SITE: THE NELSON MANDELA ACADEMIC HOSPITAL**



**Figure 1: Nelson Mandela Academic Hospital**  
Source: (Sakhiwo Health Solutions, 2013)

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## ABSTRACT

The research used a change management approach to analyze the restructuring of the Nelson Mandela Academic Hospital from a tertiary to a central hospital. The study was underpinned by two objectives. Firstly, to analyze the restructuring of the Nelson Mandela Academic Hospital from a tertiary to a “central” hospital using the Core Elements Framework of change management developed by Antwi and Kale (2014). Secondly, to use the knowledge gained through literature review combined with the experiences of the managers at Nelson Mandela Academic Hospital to inform future healthcare reforms in general and particularly in the restructuring of hospitals.

The Core Elements Framework by Antwi and Kale (2014) identifies six fundamental change elements from both emergent and planned change management approaches. The six elements are regarded by theorists from the two different schools of thought i.e. emergent change and planned change as key for successful change. The Core Elements Framework by Antwi and Kale, (2014) demonstrates the strength of not viewing the two approaches to change management as mutually exclusive but as complementing each other when the other is falling short.

### **The study identified the following:**

- The change was prompted by clearly identifiable external factors more than internal factors.
- There was notable lack of organizational harmony which may have negatively impacted the change process.
- The Private Public Partnership (PPP) funding model which was aimed at delivering the central hospital collapsed, after a study discovered that it benefited the private sector more than the public sector.
- There was no proper consultation of major stakeholders for preparation of the change.
- Resources in all material forms were not made available for the change to take off, this means that there was no organizational capacity to execute the change.

The study draws the conclusion that lack of organizational capacity, organizational harmony and a proper consultation process for stakeholders are the main reasons why the restructuring of the Nelson Mandela Academic Hospital is not yielding the desired results. The study recommends that organizations should implement a multidimensional approach for any change initiative to be successful and that organizations must ensure the availability of the necessary resources when embarking on change.

## **CHAPTER ONE: PROBLEM STATEMENT AND PURPOSE**

### **1.1 INTRODUCTION**

This chapter provides the field of study in which the research was conducted, what the research problem is about and the importance thereof. The chapter further comprehensively describes the following aspects of the research: the research site, context of the research, research problem, justification of the study, the limitations and delimitations of the study. The chapter concludes with an overview of what each chapter of the research will entail.

The field of study is change management and strategy, using the restructuring of the Nelson Mandela Academic Hospital (NMAH) from tertiary to a central hospital as a research site. The study seeks to use the information available on change management especially the Core Elements framework to analyse the change that took place at the NMAH. According to Pollit (1993) and Dawson (1999) cited in Qwesha (2014), it is important to note that naturally the health system is a complex organisation with many different cultures and norms arising from a number of factors including but not limited to professional autonomy of many of the health staff.

The Nelson Mandela Academic Hospital is found in Mthatha in the Eastern Cape Province and was opened in 2004 by former president Thabo Mbeki (Mpalatshane, 2014). The initial funds towards building the hospital were facilitated by the late president Nelson Mandela, who injected an amount of about R 100 million into the project (Mpalatshane, 2014). The hospital was built to improve health care of the mostly rural communities in the former Transkei (Mpalatshane, 2014). The Nelson Mandela Academic Hospital has operated as a tertiary hospital since it opened in 2004.

In 2011 the Health Minister gazetted a policy for management of public hospitals and the following year he announced that Nelson Mandela Academic Hospital was to become a “central” hospital offering quaternary services such as kidney transplants, oncology and a burns unit (National Department of Health, 2011). This change and its implementation forms the basis of the research.

### **1.2 RESEARCH CONTEXT**

The research reviewed the restructuring of the Nelson Mandela Academic Hospital in Mthatha from tertiary hospital to a “central” hospital through the change management approach. Lorenz and Riley (2007: pp 116-124) define change management as the method that an organization uses to achieve its desired future state.

## 1.2.2 Theories of Change Management

There are two major theories of change management in the literature and these are planned change and emergent change (Bamford and Forrester, 2003).

### Planned Change Management

Planned change can be defined as a deliberate process to transform the way an organization operates, directed at improving its functionality in fundamental ways (Ford and Greer, 2005). Kurt Lewin is regarded as the intellectual father of the planned change research (Barnes, 2004a). According to Burnes (2004b) Lewin's planned approach to change is made up of four important elements: Field Theory, Group Dynamics, Action Research and the Three Step Model and these four elements are treated as separate themes of Lewin's work, although the author intended them to be viewed as a unified whole with all of them necessary to bring about planned change. Lewin's 1951 seminal work has been elaborated by many theorists, especially the three step model, among these theories are Lippitt's seven phase model, Kotter's 8 step model and Bullock and Batten's four phase model (Burnes, 2004a).

- i) **Field Theory**-This represents an approach to comprehension of group behaviour by clearly pointing out in full the complex field in which the behaviour takes place (Lewin, 1947).
- ii) **Group Dynamics**-On this one, Lewin puts group behaviour as opposed to individual behaviour at the centre and the main focus for change (Lewin, 1947).
- iii) **Action Research**- This is an approach that represents a circle that involves a planning stage, acting and observing the change and its consequences, reflecting on the change and consequences and lastly re-planning to repeat the circle (Burnes, 2004b).
- iv) **The Three Step Model**- In 1951, Lewin perceived the change process as made up of three phases: Unfreezing, Moving and Refreezing (Lewin, 1951a). According to Cummings and Worley (2014: p43), Lewin viewed change as a result of two groups of forces; those seeking change and those aiming at maintaining the status quo.

### Emergent Change

According to Antwi and Kale (2014) emergent change management approach, unlike the planned change lacks sound historic foundation and the models in this approach include among others: Hinings and Greenwood's (1989) Model of Change Dynamics, Kanter's "Big Three" model of organizational change and Pettigrew's (1987) process/content/context model.

- i) **Hinings and Greenwood of Change Dynamics**- the model talks of the relationship between five vital organisational factors: situational constraints, interpretive schemes, interests, dependence of power and

- organizational capacity (Hinings and Greenwood, 1989).
- ii) **Kanter’s “Big Three” model of organizational change-** the emphasis is on the three forms of change and three motions in an organisation and those are: motion of the organisation as it relates to its environment; the motion of the organisational components as they relate to each other and lastly the motion of individuals as they struggle for power and control (Kanter, Stein, and Jick 1992).
  - iii) **Pettigrew’s Context, Content, and Process-** this model suggests that change must be viewed from the three dimensions of context, content, and process (Pettigrew, 1987).

### **Change Management in Healthcare**

Balje, Carter and Velthuijzen (2012) suggest that it is challenging to introduce change in the health sector. According to Skinner, Roche, O’Connor, Polland and Tod (2005) it is wishful to expect healthcare professionals to be familiar with the change management literature in addition to their professional knowledge base.

There are frameworks that have been developed for change management in health and these are:

- i) **Lukas’s Organizational Model for Transformational Change in Healthcare Systems:** This model talks of five critical elements that drive change: sense of urgency, leadership to drive and facilitate change, improvement initiatives and lastly align and integrate of efforts (Lukas, Holmes, Cohen, Restuccia, Cramer, Shwartz, and Charns, 2007)
- ii) **Canadian Health Service Research Foundation’s Evidence Informed Change Management Approach:** this approach emphasizes on four key elements: preparing for change; implementing change; spreading change and sustaining change (Dickson, Lindstrom, Black and Van der Gucht, 2012).
- iii) **Canada Health Infoway’s Change Management:** This model emphasis on six key elements: governance and leadership, stakeholder engagement, communications, workflow analysis and integration, training and education, and evaluation (Antwi and Kale, 2014).

These are established frameworks of change management in health and have in them, elements from both emergent and planned change management. This demonstrates the strength of not viewing the two approaches as mutually exclusive but as complementing each other when the other is falling short. Hence the researcher will use the Antwi and Kale (2014)’s Framework of Core Elements of change management from the literature to analyse the restructuring of the Nelson Mandela Academic Hospital (NMAH).

The researcher is of the view that the rich theoretical background combined with the practical experiences of the managers who experienced the change at the Nelson Mandela Academic Hospital could help inform future healthcare reforms especially in the light of changes that are inherent with the new National Health Policy in South Africa. Using the Antwi and Kale (2014) Framework of Core Elements of change management as lenses; the researcher will analyse what was done versus what should have been done.

### **1.2.2 The National Department of Health and the Eastern Cape Department of Health**

The National Department of health has according to the Constitution of South Africa, the responsibility to ensure access to healthcare services to the people of South Africa. In an attempt to fulfil the above mentioned responsibility enshrined in Section 27 of the Bill of Rights. The department has embarked on a lot of programs including but not limited to the Hospital Revitalisation Program and Modernisation of Tertiary Services.

The Eastern Cape Department of Health in line with the National Health Policy has the responsibility of providing access to healthcare for the people of the Eastern Cape. The restructuring of the Nelson Mandela Academic Hospital was envisaged on the Modernisation of Tertiary Services Program.

### **1.2.3 The Nelson Mandela Academic Hospital**

The Nelson Mandela Academic Hospital was built in 2004 to provide tertiary services to the Eastern Cape population. The late president Dr Nelson Rholihlahla Mandela decreed that there must be an academic hospital in the Eastern Cape, named Nelson Mandela Academic Hospital (Mpalatshane, 2014). The 2010 National Department of Health strategic plan, determines that a central tertiary hospital is needed in Mthatha adjacent to the Faculty of Health Sciences to provide adequate medical training and education to all health workers in the province (Department of Health, 2010).

Indeed, in 2012 the hospital was categorised as a Central Hospital by the health minister Dr Aron Motsoaledi (Department of Health, 2012). Its core business is constitutionally enshrined i.e. to offer quality and best care services to the people of OR Tambo, Alfred Nzo, Joe Gqabi and Chris Hani districts as enjoined by the Health Act 61 of 2003.

Currently the Nelson Mandela Academic Hospital is registered as a central hospital providing Level 2 and 3 healthcare services to the population in and around Mthatha and the catchment area. It is also a training platform for the training of all categories of health care professionals. The Academic Hospital is also linked to the Faculty of Health Sciences at Walter Sisulu University (WSU), providing in-service training and specialist infrastructure with medical equipment to render fully fledged tertiary services (Sakhiwo Health Solutions, 2015).

#### **1.2.4 The Hospital Revitalization Program and the Modernization of Tertiary Services and their importance**

In 1996, the National Department of Health embarked on an audit of all its facilities. The findings of the audit led to the development of the Hospital Revitalization Program (Mphaphuli, 2009). According to Lourens (2015) the National Health Department implemented the Hospital Revitalization Grant to modernize and transform the infrastructure and health technology of hospitals as well as to improve the quality of care. According to the Department of Health (2003) the National department of health also conducted workshops and invited specialists to discuss the Modernization of Tertiary Services. The specialists report from the workshops resulted in the development of the framework for Modernization of Tertiary Services. The importance of these two programs: Hospital Revitalization Program and Modernization of Tertiary Services program rest in that it provided clear guidelines on fundamental issues for the improvement of Hospital infrastructure especially tertiary services. The restructuring of the Nelson Mandela Academic Hospital came as the result of the Modernization of Tertiary Services. The main objective of the Modernization of Tertiary Services as it relates to the Nelson Mandela Academic Hospital was to transform the hospital from tertiary hospital to a “central hospital”. According to National Department of Health (2012) a central hospital must:

- a) provide tertiary hospital services and central referral services and may provide national referral services;
- b) provide training of health care providers;
- c) conduct research;
- d) receives patients referred from more than one province;
- e) be attached to a medical school as the main teaching platform and
- f) must have a maximum of 1200 beds.

The primary goal of the restructuring was to have a central hospital in the Eastern Cape. The Department had aimed at achieving the above goals but little progress has been made since the announcement and publishing of the gazette.

### **1.2.5 The Current Situation/ Outcomes of the Change**

According to the Department of Health (2016) there are 10 central hospitals in the country namely:

- i. Charlotte Maxeke Academic Hospital (Gauteng)
- ii. Steve Biko Academic Hospital (Gauteng)
- iii. Dr George Mukhari Academic Hospital (Gauteng)
- iv. Chris Hani Baragwanath Hospital (Gauteng)
- v. Universitas Hospital (Free State)
- vi. King Edward VIII Hospital (KwaZulu-Natal)
- vii. Inkosi Albert Luthuli Hospital (KwaZulu-Natal)
- viii. NMAH (Eastern Cape)
- ix. Tygerberg Hospital (Western Cape)
- x. Groote Schuur Hospital (Western Cape)

The NMAH has the least number of beds with 512 beds which is far below than the stipulated 1200 on the policy of categorization of hospitals. The hospital still operates at the level of a regional or tertiary service not yet offering the desired package of a central hospital.

### **1.3 RESEARCH PROBLEM**

According to Carter (2015) from the Office of Core Standards Progress Report on Central hospitals, the implementation of restructuring NMAH from tertiary to central hospital seem not to have yielded the desired results.

#### **1.3.1 The Primary Objectives of the research are:**

- i) RO1: To use the Antwi and Kale (2014) Framework of Core Elements of change management to analyze the change at NMAH from a tertiary to a central hospital.
- ii) RO2: To inform future health reforms in general and hospital reforms in particular.

#### **1.3.2 The Secondary Objectives of the research in order to attain the Primary Objectives are:**

- i) Change Management literature review
- ii) Interviews of the managers who were involved in the change process at NMAH
- iii) Analysis of the documents that relates to the change at the NMAH

#### **1.4 JUSTIFICATION OF THE STUDY**

The health system is going through major changes at the moment with the introduction of the National Health Insurance (NHI) which will result in South Africans receiving universal health coverage. These changes need to be managed properly and with research based frameworks that are tailor made to suit the unique South African setting. The study is important in that the researcher is employed by the Eastern Cape Health Department and will be able to assist with future change management projects in the Province.

According to Skinner, Roche, O'Connor, Polland and Todd (2005) cited in Qwesha (2009), change management is challenging in healthcare because it is wishful to expect healthcare professionals to be conversant with the change management literature in addition to their personal professional knowledgebase. The study will use the experiences of the managers who were involved with the change and the rich literature available on change management in order to inform future similar healthcare reforms in general and hospital reforms in particular.

#### **1.5 LIMITATIONS**

The study is limited by the fact that out of the 12 managers who were involved in the change only 9 of them were available for interviews. One of the 3 managers not available for interviews was the former Superintendent General for Health in the Eastern Cape, as he has relocated and it has since been difficult to reach him for an interview for the research.

#### **1.6 DELIMITATIONS**

The study only focused mainly on the managers who were part of the change management initiative by the Department of Health. An opportunity for a further study focusing on secondary participants, being the patients and staff members at NMAH, could be explored at a later stage.

## **1.7 OUTLINE OF THE STUDY**

### **Chapter One: Introduction**

This chapter describes the background of the research and identifies the problem.

### **Chapter Two: Literature Review**

This chapter reviews, critically analyze the literature on Change Management and examines the framework of Core Elements of Change Management.

### **Chapter Three: Methodology**

This chapter explains and justifies the methodology adopted for the study. It also explains the procedures followed to collect and analyze the empirical data.

### **Chapter Four: Findings Presentation**

This chapter presents the results acquired from the interviews.

### **Chapter Five: Discussion of the Findings**

This chapter discusses the findings. The analysis of the findings also leads to the testing of the hypotheses.

### **Chapter Six: Recommendation and Conclusion**

This chapter draws the conclusions of the study and gives recommendations. It also suggests areas of further research.

## CHAPTERTWO: LITERATURE REVIEW

### 2.1 INTRODUCTION

In the previous chapter, a background of the research was provided which covered briefly change management models and an overview of the NMAH restructuring. This chapter will review and critically analyse the literature on change management. The first part of this chapter focused on an analysis of change management models from the two dominant approaches; the **planned change** and the **emergent change**. This was followed by a discussion of frameworks of change management in healthcare. A critical analysis of change management approaches was carried out. The critical analysis clearly identified strengths and weakness from each of the two approaches. The chapter concludes by discussing framework of core elements develop which incorporates key elements of change management.

The change management literature has significant disagreements in terms of which approach to follow for managers to achieve organizational change (Bamford and Forrester, 2003). According to Appelbaum, Habashy, Malo and Shafiq (2012) research suggests that over 70% of change initiative efforts do not succeed due lack of empiric evidence and the conflicting views on the approaches.

### 2.2 CHANGE MANAGEMENT THEORIES

Moran and Brightman, (2001: p111) cited in Todem, (2005) define change management “as the process of continually renewing an organization’s direction, structure, and capabilities to serve the ever-changing needs of external and internal customers”. There are two main approaches to change; the **planned change** and the **emergent change**. The chapter will focus on the two opposing schools of thought and then review change management frameworks that have been applied in healthcare.

## 2.2.1 Planned Approach to Change

Planned change can be defined as a deliberate process to transform the way an organization operates, directed at improving its functionality in fundamental ways (Ford and Greer, 2005). Kurt Lewin is regarded as the intellectual father of the planned change research (Burnes, 2004a).

Lewin's (1951) seminal work has been elaborated by many theorists especially the three step model. Qwasha (2009: p12) argues that "the three steps of Lewin's framework has been elaborated by ten other theoretical models in literature, these provide more steps in application and design details". These models according to Qwasha (2009: p12) include but are not limited to: "(1) Lewin's (1951) Change Model (Alda and Kuzuhara, 2002; Cummings and Worley 2001; Senior 2002); through to contemporary models such as (2) Action Research Model, (Cummings and Worley, 2001); (3) Contemporary Action Research (Cummings and Worley, 2001); (4) General Model of Planned Change, (Cummings and Worley, 2001); (5) Gardner's Action Training and Research, (Cummings and Worley, 2001); (6) Burke-Litwin Model (1992), (Burke 2002); (7) Kotter –Eight Stage Process (Kotter, 1996); (8) Dunphy-Stace Contingency Model (Dunphy and Stace 1993); (9) Patching (Eisenhardt and Brown, 1999) and (10) Soft Systems Models for Change (Senior, 2000)".

The most prevailing academic literature in change management is planned change; this is largely due to the work that was done by Kurt Lewin (Antwi and Kale, 2014). There are many models for planned change management as indicated by the list above. For the purpose of this study, focus will be on four models of the planned approach to change. These four models of planned change are: **Kurt Lewin's planned change approach, Lipitt's seven phase model, Kotter's 8 step model and Bullock and Batten's four phase model.**

### 2.2.1.1 Kurt Lewin's Planned Change Approach

Lewin was a philanthropic who held the view that only through solving social conflicts of whatever nature, be it religious, racial, marital or industrial, could social development take place. He was convinced that fundamental to resolving a social ill was the facilitation of the empowerment of individuals through knowledge to appreciate and reform their views of the world around them (Burnes, 2004). According to Kaminski (2011: p1210) "Lewin's Change Management Theory, is time tested, easily applied field theory that is often considered the epitome of change models, suitable for personal, group and organizational change". Lewin's model dominated from the 1950s until the economic instability of the 1970s called it into question, it however, continues to underscore many change efforts today (Burnes, 2006 cited in Liebhart and Lorenzo, 2010).

According to Burnes(2004b) Lewin's planned approach to change is made up of four important elements: **Field Theory, Group Dynamics, Action Research and the Three Step Model** and these four elements are treated as separate themes of Lewin's work but he intended them to be viewed as a unified whole with all of them necessary to bring about planned change. He has been recognized as the "father of social change theories" since numerous modern-day models are at least loosely built on Lewin's work. He is also acclaimed as the creator of social psychology, action research, as well as organizational development (Kaminski, 2011).

#### **a) Field Theory**

This represents a tactic for comprehension of group behaviour by clearly pointing out in full the complex field (environment) in which the behaviour takes place (Lewin,1947). According to Burnes (2004) Lewin believed that in order for one to fully comprehend a situation, one should view the status quo as being maintained by certain forces or conditions. Lewin further argues that group behaviour is a result of intricate set of symbolic interactions and forces that do not only impact the group structures but also modify on individuals behaviour. Therefore, a change on the individuals is a direct result of the change in the environment or the field as he terms it (Burnes, 2004). Antwi and Kale (2014) postulate that, if a manager is able to pinpoint, plan, and define the potency of these forces, they will then be able to comprehend an individual's behaviour and appreciate the forces required to change this behaviour. Lewin believed that there must be something in the design and distinguishing factors of particular group which instigates the group to respond (behave) in a certain way to the forces which encroach on it, and he was particularly interested on how these forces can be modified in order to reduce a more desired form of behaviour. For this, he then developed his work of Group Dynamics (Burnes, 2004).

#### **b) Group Dynamics**

Here Lewin puts group behaviour as opposed to individual behaviour at the centre and the main focus for change (Lewin, 1947). According to Lewin (1947) cited in Burnes (2004) it is futile to focus on changing the behaviour of individuals because the individual in seclusion is compelled by group pressures to conform. Thus, the emphasis of change must be at the group level and should focus on factors such as group norms, roles, inter- actions and socialization processes to create 'disequilibrium' and change (Antwi and Kale, 2014). According to Burnes (2004) Lewin was aware that grasping the core dynamics of a group is by itself not enough to generate change, he also realized that it was necessary to develop a process that could allow for members to be engaged and committed into changing their behaviour. This led Lewin to develop Action Research and the 3-Step model of change (Burnes, 2004). These two important models of Lewin's work are discussed in the next section.

### c) Action Research

This is an approach that represents a circle that involves a planning stage, acting and observing the process of change and its consequences, reflecting on the process of change and its consequences and lastly re-planning to repeat the circle (Burnes,2004b).According to Antwi and Kale (2014: p5) action research relates to both Field theory and Group dynamics in that, it “draws on field theory to understand the forces and context in which the group operates, as well as group dynamics to understand the nature of individual group members and the sources of their behaviours” hence the emphasis to view Lewin’s work as unified whole. Lastly the most popular of Lewin’s work is the 3 step model.

### d) The Three Step Model

Lewin’s three-step model is founded on the organism metaphor of organizations; the metaphor sees the organization as a living, adaptive system (Cameron and Green, 2014). According to Gareth Morgan (1986) cited Cameron and Green (2014), the metaphor insinuates that different environments favours different types of organizations based on diverse methods of organizing. Uniformity with the environment is therefore key to success. Cameron and Green (2014) further argue that the metaphor therefore implies that in steady environments a stricter bureaucratic organization would thrive while in more flowing, fluctuating environments a looser, less organized type of organization would be more likely to endure.

In 1951, Lewin perceived the change process as made of three phases: **Unfreezing**, **Moving** and **Refreezing** (Lewin, 1951a). According to Cummings and Worley (2014), Lewin viewed change as a result of two groups of forces; those seeking change and those aiming at maintaining the status quo.

**Unfreezing**-this stage refers to the appreciation by the organization of a need for change in the status quo and can only takes place when prevailing practices and conducts are questioned and dissatisfaction with the status quo such as current management practices and organizational performance arises (Kaminski, 2011). This dissatisfaction gives impetus to change and forces that hinder change are consequently reduced while forces that drive change are reinforced (Kaminski, 2011). An illustration of these forces is shown in figure 2.1 below.

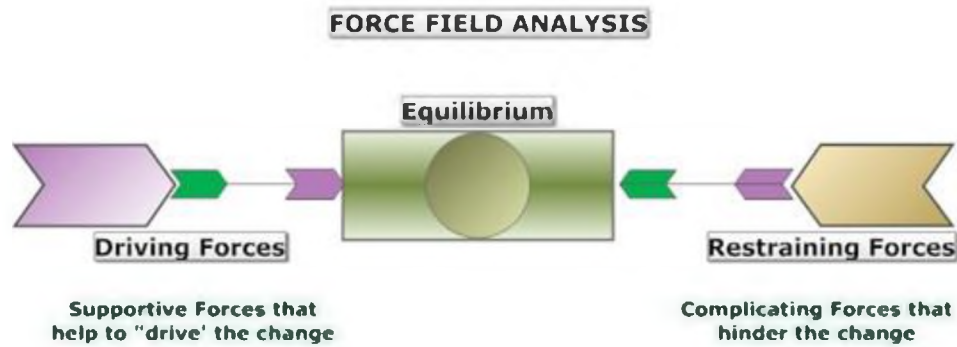


Figure 2.1: Force Field Analysis (Kaminski, 2011: p 1210)

According to Kitsonis (2005) there are fundamental activities that need to be embarked on at the unfreezing stage and these are also confirmed by Qwesha (2009) as being the following:

- i) Making a clear and a convincing case for change
- ii) Engage employees through change readiness activities encourage effective communication and participation in decision;
- iii) Providing resources to support the change process;
- iv) Empower and skill employees in accordance with the new work practices and
- v) Inherent change uncertainty must be managed very well.

According to Cameron and Green (2014) the second stage referred to as **moving**, involves a process of change in thoughts, feelings, behaviour, or all three that is in some way more beneficial or more productive than doing things the old way. During this stage, the people involved (change target group) are convinced that the new way is better than the old. During this stage, various organizational practices and processes are changed or transformed (Qwesha, 2009). One of the most critical priorities at the moving stage comprise of managers clearly communicating and articulating explicit information with regards to how the change will impact workers' job roles and responsibilities. This stage must represent the desired state in order to move to the last stage which is the refreezing.

The third stage focuses on sustainability of the new equilibrium, it is referred to as the **Refreezing stage**. It basically talks to stabilization of the new state of affairs by setting policy, rewarding success and establishing new standards (Kaminski, 2011). According to Kitronis (2005) without this final stage, it is highly possible that the change will not be sustained and the employees will regress to their old equilibrium (behaviours). Kitronis (2005) further argues that this refreezing stage is so important in that it represents the real incorporation of the new ideals into the organizational belief system. Critics of the Lewinian model argue that this stage fails to appreciate that the prevailing context at refreezing is not necessarily the same as it was at the unfreezing stage. This will be discussed later in the chapter.

Lewin's work on change management has formed the basis of many models as indicated earlier, and though criticized by some, others have chosen to expand it in more elaborate steps. Next we look at three of these models; Lippitt, Watson and Westley (1958)'s seven phase model, Kotter's 8 step model and Bullock and Batten's four phase model.

### **2.2.1.2 Lippitt et al (1958)'s Seven Phase Model**

Lippitt, Watson, and Westley (1958) cited Kitronis (2005) expands Lewin's Three-Step Change Theory. The emphasis of the seven-step model that Lippitt, Watson, and Westley developed is more on the role and duty of the change agent than on the culmination of the change itself. Information is continuously exchanged throughout the process (Kitronis, 2005). The seven steps according to (cited Mitchell, 2013) are:

- i) Establish the problem.
- ii) Measure the capability and the drive for change.
- iii) Assess the capacity in terms of resources and the enthusiasm of the change agent. This must cover the assurance by the change agent to change, power, and stamina.
- iv) Identify progressive change objects. In this step, action plans are developed and strategies are established.
- v) The role of the change agents should be selected and clearly understood by all parties so that expectations are clear. Examples of roles are: cheerleader, facilitator, and expert.
- vi) Maintain the change. Communication, feedback, and group coordination are essential elements in this step of the change process.
- vii) Gradually terminate from the helping relationship. The change agent should gradually withdraw from their role over time. This will occur when the change becomes part of the organizational culture.

Lippitt et al (1958) Seven Phase Model differs from Lewin's three step model; on the number of steps – main focus being the force field analysis while Lippitt et al (1958)'s Seven Phase Model pays particular attention on the role of the change agent. There is a fundamental belief which is almost constant among theorists of the planned approach is that change can be predesigned and be progressed towards through a number of step of phases.

### 2.2.1.3 Kotter's (1995) 8 Step Model

Kotter's eight-step model originates from the study that the author conducted of 100 diverse organizations that were going through transformation at his consulting practice. The study underlined eight key lessons, which he converted into a valuable eight-step model. The resulting model speaks to the key authority issues that relate to making change possible, stresses the significance of a 'felt need' for change in the organization, and accentuates the necessity to communicate the vision and maintain high levels of communication throughout the process (Cameron and Green, 2014).

#### KOTTER'S EIGHT-STEP MODEL

- 1) **Establish a sense of urgency-** Deliberating today's competitive advantage, looking at potential future scenarios. Increasing the 'felt-need' for change.
- 2) **Form a powerful guiding coalition-** Building a strong leading team that complements each other.
- 3) **Create a vision-** Developing a compelling vision which gives clear direction in terms of how to successfully execute the change.
- 4) **Communicate the vision-** Kotter emphasizes the need to effectively communicate the vision as many times as humanly possible. Different mediums of communication must be used to communicate and entrench the new ways of doing things and the team must act as role models of the new order.
- 5) **Empower others to act on the vision-** Transform systems and structures in the organization in line with the change initiative and give space for experimentation.
- 6) **Plan for and create short-term wins-** Look for low-hanging fruits which represent quick wins and publicly honour those who have achieved these short term improvements.
- 7) **Consolidate improvements and produce still more change-** individuals who are working hard towards achieving the vision must be encouraged and compensated accordingly. The change initiative must be kept exciting with creativity and sufficient resources.
- 8) **Institutionalize new approaches-** it is crucial that every member of the team has a clear understanding that the change initiative is the way to improve and make the organization successful.

Source: Kotter (1995) cited in Cameron and Green (2014).

The last model that will be discussed is the Bullock and Batten's four phase model.

#### **2.2.1.4 Bullock and Batten's (1985) Four Phase Model**

According to Cameron and Green (2014) "Bullock and Batten's (1985) stages of planned change derives from the project management discipline. Bullock and Batten's (1985) phase are:

- Exploration
- Planning
- Action
- Integration

The similarity between Bullock and Batten (1985) model of change and the other models of planned change, resides in that it also describes change as a step by step process (Paul, 2015). The planned approach to change when used appropriately has proven to provide crucial tools in the management of organizational change, for instance Lewin's notions offer a helpful device for those contemplating organizational change, especially his "force field analysis" which is an exceptional approach to empower and enable management teams to deliberate and concur on the "driving and resisting forces" that presently exist in any change situation (Cameron and Green, 2014).

According to Cameron and Green (2014), Kotter's 8 step model is said to be very popular with managers. The eight steps provide an exceptional preparatory idea for those involved in initiating large or small-scale organizational change. Other models like Bullock and Batten's (1985) four phase model are also hailed as useful in small scale and non-complex organizational changes (Cameron and Green, 2014).

Cameron and Green (2014) warn that these models simplify change, by accepting that change can be outlined and progressed towards a planned way. This view present one of the major limitation of the planned approach to change and brings to question the planned approach's relevance in the future of organizational change models, but for now, according to Paul (2015) it is still Lewin and Bullock and Batten that currently best describe approach to organizational change, she however warns that the future might belong to the emergent approach to change.

## 2.2.2 The Emergent Approach to Change

According to Burnes (1996) cited in Liu (2009: p234) “Emergent change involves continuous adjustments, adaptations, and fluctuations that yield fundamental change without a priori intention to do so. Emergent change happens once individuals re-accomplish routines and when they sort out eventualities, breakdowns, and prospects in everyday work”.

The characteristics of emergent approach to change according to Burnes (1996) cited in Strôh (2005) are:

- change is viewed as an on-going process of obtaining knowledge and investigation with a goal to acclimatize and be in synergy with the turbulent environment;
- small-scale changes over time can lead to larger changes in the organizations;
- managers should create a climate of risk-taking and empower employees through participative management of the change process;
- managers should create a collective vision to direct the change process; and key activities should be information-gathering, communication and learning.

Strôh (2005) continues and argues that the Harvard Business School conference in 1998 identified key characteristics of the emergent approach to change which are directly opposed to planned change approach and these are:

- purpose: creation of sustainable organizational capabilities;
- inclusive leadership style and the value of interaction;
- focusing cultural transformation;
- change initiative are not schedule and they emerge;
- importance is not place on financial incentives as a driver for change; and
- involving small process-oriented consulting firms.

The emergent change management approach, unlike the planned change lacks sound historic foundation. In an attempt to illuminate the organization as a holistic entity and organizational change as a phenomenon that affects the entire organization, some theorists have put together more comprehensive models of understanding change. Hinings and Greenwood’s (1988) model of change dynamics, Kanter (2003), “Big Three” model of organizational change and Pettigrew’s (1985) process/content/context model are in this category (Bamford and Forrester, 2003).

### 2.2.2.1 Hinings and Greenwood's Model of Change Dynamics

Hinings and Greenwood's model of change dynamics like other emergent change models suggests that change emerge as direct result of intricate interaction of organizational context and internal organizational processes. According to this model, change is an enlightening progression of conditions and deeds originating from unforeseen effects and an evolving environment. The model postulates that change arises through the interaction of five factors:

- i) **Situational constraints**-this can be environmental, technological and size related
- ii) **Interpretive schemes**-this relates to the founding ideas and principles of the organization
- iii) **Interests**- different interests of the subunits with the organization may lead to disruptive competition within the organization
- iv) **Dependence of power**-this talks to power dynamics main actors in decision making
- v) **Organizational capacity**-leadership style ability to generate enthusiasm around the vision.

Each of these factors are crucial to change and managers must be knowledgeable and well prepared to respond appropriately to each of them (Antwi and Kale, 2014). Next we look at Kanter's "Big Three" model of organizational change.

### 2.2.2.2 Kanter's Big Three Model of Organizational Change

According to Antwi and Kale (2014: p8) "The Big Three model suggest that there are three kinds, of motion, three forms of change and three roles in the change process".

#### Three Kinds of Motion

- **Organization-environment motion**-relation between organization and its environment
- **Intra-organizational components motion**- relation between internal components of the organization
- **Intra-organizational individuals motion**-power relations between individuals

#### Three Forms of Change

- **Identity change**- results from pressures and opportunities in the environment
- **Coordination change**-results from the interdependence of internal units of the organization

- **Control change**- this results from power relations within the organization.

### Three Roles in the Change Process

- **Change Strategist**- takes part at development of the change and senior in the organization
- **Change Implementer**-takes part in the middle and mostly middle manager
- **Change Recipient**- has the least role on the change but is most impacted

This model demonstrates fundamental aspects of change that need to be well understood in order for the organization to prosper. It emphasizes the fact that managers must be very clear of the nature of change being undertaken, moreover they must appreciate and take into account the views and interests of all three change roles – strategists, implementers, and recipients (Antwi and Kale, 2014). Lastly we look at Pettigrew’s process/content/context model.

#### 2.2.2.3 Pettigrew’s Process/ Content/ Context Model

Pettigrew et al (1992) cited in Brignall and Ballantine (2003: p230) defines “**Context** as the “why and when” of change, and distinguishes between the inner and outer contexts. Outer context signifies aspects such as current macro-economic circumstances, the specific competitive environment faced by an organization and social and political environments, whereas inner context is concerned with internal influences such as organizational resources, capabilities, structure, culture, and organizational politics. **Content** is defined as the “what” of change and is concerned with the areas of transformation and the tools and techniques used to effect change. Finally, **Process** is described as the “how” of change and refers to actions and interactions of the various stakeholders as they negotiate proposals for change”.

Antwi and Kale 2014 posits that Pettigrew’s Context/Content/Process model implores those leading change to be acutely cognizant of the organizational context, including internal configurations and external constraints, in order to improve the chances of leading successful change initiatives. Moreover, managers must ensure that the content of change makes sense to all those involved in the change process. These are prerequisites that need to be met before the initiation of the change process.

On the following section presents the change management models in health and provide a critical analysis of the literature.

### 2.3 CHANGE MANAGEMENT IN HEALTH

The planned and emergent change management approaches are derived largely from the business literature; some work has gone into developing other change management models from a healthcare context. Three such models are Lukas et al (2007)’s Organizational Model

for Transformational Change in Healthcare Systems, Canadian Health Services Research Foundation (CHSRF)'s Evidence- Informed Change Management Approach, and Canada Health Infoway's Change Management Framework (Antwi and Kale 2014).

### **2.3.1 Lukas et al (2007) Organizational Model for Transformation Change in Healthcare Systems**

According to Antwi and Kale (2014) Lukas et al (2007)'s Organizational Model for Transformational Change in Healthcare Systems provides a theoretical model for assisting healthcare organizations towards sustained organization-wide patient care improvements. To facilitate this process, the model proposes five essential elements of transformational change in healthcare organizations:

- a) Impetus to transform
- b) Leadership commitment to quality
- c) Improvement initiatives that actively engage staff in meaningful problem solving
- d) Alignment to achieve consistency of organization-wide goals with resource allocation and actions at all levels of the organization
- e) Integration to bridge traditional intra-organizational boundaries between individual components

Lukas et al (2007) argues that those who are leading change must guarantee that these proposals are aligned with broader organizational goals and that organizational sub-components are integrated and function as coherent units.

### **2.3.2 Canadian Health Service Research Foundation's Evidence Informed Change Management Approach**

This is a model developed by the Canadian Health Service Research Foundation targeted the Canadian healthcare organizations and its main objective is leadership development to support change. The fundamental benefit of this document is that it addresses change in a way that is specific and pertinent to a Canadian context (Antwi and Kale, 2014).

The model emphasizes four key elements:

- a) Preparing for change;
- b) Implementing change;
- c) Spreading change and
- d) Sustaining change (Dickson, Lindstrom, Black and Van der Gucht, 2012).

This model presents a relevant guide for the Canadian healthcare organizations embarking on change initiatives because it takes into account the specific conditions of their environment.

### **2.3.3 Canadian Health Infoway's Change Management**

The Health Infoway's Change Management Framework was created to establish a set of common priorities and develop a unified plan to guide e-health change management efforts in Canada. The framework has six key elements of the change management process that should be addressed throughout the course of a change initiative. These elements are:

- a) governance and leadership,
- b) stakeholder engagement,
- c) communications,
- d) workflow analysis and integration,
- e) training and education, and
- f) monitoring and evaluation (Antwi and Kale, 2014).

It must be noted that even though this framework was globally welcomed and successful, at its tenth year review, Canada was found to still be lagging behind as compared to other Western countries in the area of the electronic patients' documents (Antwi and Kale, 2014).

## **2.4 CRITICAL ANALYSIS AND DISCUSSION**

According to Cameron and Green (2014) cited in Paula (2015), there are three fundamental elements to consider when one analyses organizational change process and these are; process, people and principles. The elements basically answer the three critical questions during a change process in an organization namely:

- Process →how is organizational change tackled?
- People →who is responsible for organizational change?
- Principles →what are the guiding principles?

According to Paula (2015), to be able to answer these questions, one has to plot an approach of the change models against the metaphors of organization change developed by Gareth Morgan (1996). The metaphors are:

- Organization as Machines- change is planned and centralized.
- Organization as Political system-powerful individuals key to change initiatives.

- Organization as Organisms-the entire organization must be cognizant of the need to change and must participate in the change process.
- Organization as flux or transformation-in turbulent times change emerges and cannot be planned for, managed or controlled (Cameron and Green, 2014).

According to Kansal and Chandani (2014: p208) cited in Paula (2015) "Change is the only thing that will never change so let's learn to adopt by change management".

The above quotation brings to the fore the importance of the organization's ability to manage change in today's world where change is a constant and organization's survival and competitive edge depends almost on how the organization deals with change (Pettigrew and Hinings, 1996 cited in Paula, 2015).

The planned approach dominates academic literature and since the other models in this approach are an elaboration of Lewin's work, he is hailed as the intellectual father of planned change and organizational development.

All the four models of the planned change approach covered in this study (Kurt Lewin's planned change approach, Lippitt's seven phase model, Kotter's 8 step model and Bullock and Batten's (2007) four phase model) can be associated with the machine metaphor because of the assumption that change can be planned and moved towards a goal with predetermined steps (Paula, 2015).

Cameron and Green (2014) and Morgan (2006) cited in Paula (2015) outline a synopsis of some of the fundamental principles of the machine metaphor of organization: each worker should take orders from only one line manager, division of labour into specific roles results to high levels of efficacy, the executive should design, organize and govern.

The planned change approach relates to above synopsis in that:

Firstly, it views change as a provisional process between permanent states. It also creates the idea that the individuals and groups within the organization will concur with the management's vision of change and the steps to be taken thereof. In practice this is rarely the case and this reality makes the state of complete convergence almost impossible (Antwi and Kale, 2014).

Secondly, the planned change approach endorses the rigid top-down approach, in that it emphasises the role of management and disregards the inputs of employees in the change process. The influence that workers have on change initiatives is completely obliterated by this approach, because of its focus on pre-planned processes, schedules and goals all of which are generated by management (Antwi and Kale, 2014).

The major limitation of mechanistic view and by implication of the planned change approach is that it thrives in stable conditions and it struggles to cope in turbulent and

uncertain conditions (Cameron and Green, 2014). This limitation leads to the belief by some theorists that the over 70% of failed organizational change initiatives (Sackmann et al., 2009 cited in Liebhart and Lorenzo, 2010) are directly linked to the misfit between the slow and rigid models of change management that these organizations use and the unstable and rapid changing technological driven environment within which they operate, hence require the opposite (Guest, 2004 cited in Paula, 2015). Wheatley (2005) concurs with the above view when she argues that the approach of viewing organization as machines is directly responsible for the large numbers of organizational change failures. Snowden (2005: p48) also warns against the planned approach and postulate that “ordered systems are prone to catastrophic failure, especially in human systems where complacency and the human capacity to ignore or re-interpret unpleasant facts increases the probability that change will be forced catastrophically rather than through gradual change.”

The constant presence of change combine with, the continuous need to adapt and seize opportunities that come with change require a more robust and complex way of dealing with change.

Emergent change approach position itself as solution to today’s fast changing environment which Stacey (2005) cited in Lorenzo (2010) describes as the “edge of chaos and far from equilibrium” with instability and stability intertwined and difficult to separate.

One of the prominent characteristic of the emergent approach to change is that organizational change is not viewed dependent on detailed proposals and forecasts by managers, but on gaining deeper comprehension of the complexity of the matters involved and determining the scope of potential alternative (Bamford and Forrester, 2014). Furthermore, emergent change places a great deal of emphasis on the external environment and suggests that these external forces effectively deprive management of the power to control change and prearranged organizational trajectories (Antwi and Kale, 2014).

Proponents of the emergent approach dismiss the planned approach to change as inappropriate. They argue that in turbulent and ever changing environment, it is unreasonable to conceive of change as a process of moving from one relatively stable state to another. Accordingly, for these theorists, the instability and uncertainty nature of the environment within which organizations operate renders planned change inappropriate and emergent change more pertinent (Bamford and Forrester, 2003).

Given the above arguments, an association between the emergent approach and metaphor of the organization as flux and transformation can be drawn, because the emergent approach agrees that change cannot be planned, it emerges. According to Cameron and Green (2014), the flux and transformation metaphor is the only one that attempts to explain change in turbulent environment. Cameron and Green (2014: p105) further argue that the metaphor suggests that “managers can nudge and shape progress, but cannot ever be in control of change”. Gareth Morgan (1986) cited in Cameron and Green (2014:p105) suggest that “in

complex systems no one is ever in a position to control or design system operations in a comprehensive way change emerges. It cannot be imposed”.

The emergent approach is not without critics, Bamford and Forrester (2003) argues that proponents of the emergent approach seem to be more unified in their viewpoint against planned change than agreeing on a specific alternative. This is notable on the difference of their proposed models.

The other key limitation to this approach is inherent with the metaphor of organization as a flux and transformation. The metaphor does not provide a guide or a roadmap for action to be embarked on. It argues that direction will appear as you go along and can only be clear afterwards (Cameron and Green, 2014).

It becomes clear as ones goes through literature that there is no one approach that is perfect for change management (Bamford and Forrester 2004). Kritsonis (2005: p5) confirm this when she affirms that “there is no right or wrong theory to change management. It is not an exact science”. Though the planned and emergent approaches to change are frequently presented as sharply opposing views and as if they are mutually exclusive, it is critical to appreciate that these are theoretical approaches. Occasionally, the greatest approach for organizations to effectively manage change lie in between the two theories; this necessitate astute integration of the two based on the specific context of an organization (Antwi and Kale 2014). The Antwi and Kale (2014) framework of core elements of change management is presented together with the conclusion.

## **2.5 THE CORE ELEMENTS FRAMEWORK OF CHANGE MANAGEMENT**

In the critical analysis of the literature on organizational change, there are two different schools of thought with different point of views. There are factors that are constantly endorsed for consideration emerging from the change management theorists. These are referred to as core element. These core elements are further divided into two categories; the essential elements and the useful elements. Essential elements are those elements that are cited by four or five models of change management. The Useful elements are those elements cited by two or three models of change management (Antwi and Kale, 2014). There are four Essential elements and two Useful elements. See table 2.1

Table 2.1 below outline the Theoretical Change Management Models from which the Antwi and Kale (2014)'s Framework of Core Elements were derived.

**Table 2.1: Deriving Core Elements of Change Management from the Theoretical Models**

Common Themes / Core Elements of Change Management	Lewin's Change Management Models	Hinings and Greenwood's Model of Change Dynamics	Kanter et al.'s "Big Three" Model	Pettigrew's Context/Content/Process Model	Lukas et al.'s Organizational Model
<i>External Circumstance</i>	<i>Field Theory</i>	<i>Situational Constraints</i>	<i>Organization – Environmental Motion</i>	<i>Context</i>	<i>Impetus to Transform</i>
<i>Power Distributions</i>	<i>Group Dynamics</i>	<i>Dependencies of Power</i>	<i>Intra-organizational Individuals' Motion</i> <i>Control Changes</i>		
<i>Organizational Harmony</i>	<i>Group Dynamics</i>	<i>Interests</i>	<i>Intra organizational Components' Movements</i>	<i>Context/Process</i>	<i>Integration to Bridge</i> <i>Traditional Intra-Organizational Boundaries /</i> <i>Alignment to Achieve</i> <i>Consistency</i>
<i>Organizational Capacity</i>		<i>Organizational Capacity</i>	<i>Change Strategist</i> <i>Change Implementer</i> <i>Change Strategist</i>		<i>Leadership Commitment</i>

Table 2.1 (continued) – Deriving Core Elements of Change Management from Theoretical Models

Common Themes / Core Elements of Change Management	Lewin's Change Management Models	Hinings and Greenwood's Model of Change Dynamics	Kanter et al.'s "Big Three" Model	Pettigrew's Context/Content/Process Model	Lukas et al.'s Organizational Model
<i>Nature of Change to be Implemented</i>	<i>Action Research</i>		<i>Identity Change (Organizational identity vis-à-vis external environment) / Coordination Change (Organizational structural makeup)</i>	<i>Content</i>	
<i>Process for Change</i>	<i>Action Research</i>			<i>Process (Operational activities to materialize change)</i>	

Source: (Antwi and Kale, 2014)

### 2.5.1 Essential Elements

- a) **Environmental Factors:** this refers to factors that are external to the organization that forces the organization to change or disappear.
- b) **Organizational Harmony:** this refers to different interests of individuals and units within the organization as well as the plans and processes of the organization to be compatible with the change.
- c) **Power Dynamics:** this refers to the importance of the acceptance of the change process by the influential actors within the organization.
- d) **Organizational Capacity:** this refers to the availability of resources and the necessary skills to achieve the change.

## 2.5.2 Useful Elements

- a) ***Nature of change***: this refers to the components of and the rationale behind the change. This argues that any change proposal should take into account the external and the internal realities of the organization.
- b) ***Process of Change***: this refers to the practical part of the change. This refers to ensuring that there is a common understanding of the necessary steps to be taken to achieve the change and its objective.

The Antwi and Kale (2014) Framework of Core Elements of change management offers a solution to the challenges posed throughout the literature review relating to the complexity of the change process and the limitations inherent with viewing change from one dimension.

The literature review clearly points out the complexity of the change process, it also emphasises the major limitations that comes with adopting a one-dimensional approach to change. The literature suggests that, however different the views on the theoretical frameworks for change are, one needs to be able to learn from the different sides. In-depth analysis of the two approaches in change management demonstrates that even though it's comforting to plan for change it's equally important to be prepared to learn from disruptive/unintended changes. This allows the organization to deal with unforeseen issues that may arise.

## 2.6 CONCLUSION

This chapter has captured in detail the two approaches to change management and the key principles within these approaches. While critically analysing these principles, it became clear that the old way of looking at change is fast becoming outdated. Another observation was that there is no one approach to change.

The chapter concludes with the framework of core elements of change management which incorporates principles from both the emergent and planned change approaches. The chapter points out the complex nature of a change initiative and the limitations of looking at change in a unidimensional way. Recent research on the future of change management (Paula, 2015) alluded that by 2025 the organizational models that will dominate will be those models that are aligned to the Cameron and Green (2014)'s Organism, Flux and Transformation Metaphor. The Cameron and Green (2014)'s Organism, Flux and Transformation Metaphor are discussed further in chapter six of the study as part of the recommendations.

## CHAPTER THREE: METHODOLOGY

### 3.1 INTRODUCTION

The purpose of this chapter is to define the research design and the process followed to conduct the research. Initially, aspects of the research objectives and the related research objectives are explained. Subsequently a narrative of the qualitative methodology used for the data-gathering phases covering of research paradigm and design; a description of who the participants were; how these participants were obtained, and their characteristics will also be provided. Lastly, data analysis and the process followed for data-collection will be explained including how issues that relate to confidentiality and ethics were dealt with.

### 3.2 RESEARCH AIM AND OBJECTIVES

Given the fact that the NMAH was categorized as a central hospital and pronounced as such by the Minister of health Dr Aron Motsoaledi in 2012; the purpose of the research is to analyze the restructuring of the NMAH through a change management approach. This afforded an opportunity to the answer of the research question and provides the foundation to the main problem: "Why is the restructuring of NMAH not yielding the desired results? To resolve the stated problem, the purpose was broken down in the following research objectives:

- RO1: To use the Antwi and Kale (2014) Framework of Core Elements of change management to analyze the change at NMAH from a tertiary to a central hospital.
- RO2: To inform future healthcare reforms, particularly hospitals restructuring.

### 3.3 RESEARCH DESIGN

This part details the research paradigm and its applicability to the overall research objective and the research design.

#### 3.3.1 Research Paradigm

Guba and Lincoln (1994) define the research paradigm as the basic belief system or world outlook that guides the researcher, not only in choices of method, but in ontologically and epistemologically fundamental ways. The research was conducted within the scope of the interpretivist paradigm (Cohen, Morrison and Marion, 2000; Guba and Lincoln, 1994) which is also referred to as constructivist paradigm. This paradigm affords the researcher an opportunity to generate an understanding through words of what happened (Yin, 2004).

According to Pearse (2014) one of the key features of the interpretivist paradigm is the emphasis on understanding the subjective experience of individuals. It is concerned about the meaning that people ascribe to the phenomena. This paradigm acknowledges that there are

multiple realities (Pearse, 2014). The interpretivist paradigm is also concerned with understand particular contexts, as opposed to coming up with universal principles. The managers shared their experience of the change process with the researcher.

### **3.3.2 Research Method**

The case study method was used in order to understand the change through the lens of the Antwi and Kale's (2014) Framework of Core Elements. The case study method is very useful in that it allows for numerous data collection methods (Yin, 2004). The researcher in this case analysed all hospital restructuring project plan documents and minutes of steering committee meetings that relate to the restructuring process. Secondly interviews were conducted with senior managers in the organogram of the hospital and the department of health. Yin (2004: p18) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context especially when the boundaries between phenomenon and context are not clearly evident".

According to Yin (2003) this method is recommended when:

- a) the focal point of the study is to answer "how" and "why" questions;
- b) you cannot influence the behaviour of those involved in the study;
- c) you want to cover contextual conditions because you believe they are relevant to the phenomenon under study; or
- d) the boundaries are not clear between the phenomenon and context.

It is also recommended for research purposes when examining a single instance of a phenomenon of interest (Yin, 2004). A general case study can provide a rich understanding of the organization. Qualitative methods such as case studies usually observe realistic approaches of analysis where the principal intention is to determine new relationships of realities and develop an appreciation of the significances of experiences rather than prove predetermined hypothesis (Riege, 2003 cited in Qwasha, 2009). Baxter and Jack (2008) make the observation that when the approach is used appropriately, it becomes a respected method for health science research to develop theory, evaluate programs, and develop interventions.

### **3.3.3 Methods of Data Collection**

#### **3.3.3.1 In-depth interviews**

Data was collected mainly through semi-structured one-on-one interviews. The interview questions were based on the Antwi and Kale (2014) Framework of Core Elements of change management. The style of questioning was an open-ended approach with nine managers. An interview is a social connection devised for an interchange of information between the participant and the researcher. The amount and value of information shared during an interview depends mainly on the innovative abilities of the interviewer to comprehend and handle the relationship and how innovative the interviewer is at understanding and managing the relationship. The interviews were audio-recorded with the participant's consent. An interview guide, which assisted as broad investigative tactic (Babbie and Mouton 2001 cited Qwasha, 2009) was used. The interview guide guarantee that each interview is kept on the same basic lines, but also allowed for flexibility to investigate matters as they arise (Patton, 2002 cited in Qwasha, 2009)

The interview guide, together with the letter for participation was sent in advance to participants. This allowed participants to research and informed them that they could opt out of the research at any stage. The interviews covered the core elements of change management. The interview guide is provided in Appendix A.

#### **3.3.3.2 Other data gathering methods**

In addition to this, a large amount of written material produced by the hospital was used, namely:

- Feasibility studies for NMAH
- The Master Plan for Mthatha Hospital Complex
- Minutes of Steering Committee Meetings
- Business Plan for the NMAH
- Act No. 61 of 2003: National Health Act, 2004
- The White Paper on NHI
- Constitution of the Republic of South Africa No. 108 of 1996.

The researcher was given access to the documentation by the hospital management. The information gathered was then utilized to complement to the information already gained during the interviews. The benefit of documentation is that it does not change and can be checked over and over again (Yin, 2004).

### **3.3.3.3 Participant Selection**

Interviews were conducted with nine managers out of the population of twelve managers who were involved in the change initiative. The researcher had intended to interview all twelve managers but only nine were available. Non-probability sampling was used by selecting middle and senior managers to interview (Palys, 2008). Palys (2008) postulates that engaging in purposive sampling means that, the researcher views sampling as one of many strategic choices with whom, where, and how he/she conducts his/her study. The list of interviewees consists of middle and senior managers who were involved with the restructuring process at the NMAH led by the CEO.

### **3.3.3.4 Data analysis**

The thematic code for understanding the restructuring was built on the Antwi and Kale's (2014) Framework of Core Elements of change management. In accordance with the literature, six themes were utilized. Both pattern-matching and explanation-building was used with a focus on relying on theoretical propositions. Pattern matching is according to Hak and Dul (2009) relating two patterns with an intention to establish whether they match (i.e. that they are alike) or do not match (i.e. that they are not the same). All the analyses were conducted in accordance with the theoretical proposals of the Antwi and Kale's (2014) Framework of Core Elements of change management.

## **3.4 RESEARCH PROCEDURE FOLLOWED**

This part deals with the tests applicable to the research method employed and their application to this research. Lincoln and Guba (1985) argue that crucial to assessing research studies, merit is the study's level of fidelity. There was a general willingness to take part in the study among participants, especially when it was explained to them what the study was about, their role and how the information from the study would be disseminated. The participants were guaranteed of the confidentiality of their contribution and they were made aware of the fact that they are free to withdraw at any stage of the research. The researcher has in particular for this study, looked at the tests designs developed for qualitative research which include credibility, transferability, dependability and conformability.

### **3.4.1 Credibility**

Credibility is an equivalent of internal validity of the study. In accordance with the fundamental measure to ensure credibility advocated for by Russell, Gregory, Ploeg, DiCenso, and Guyatt (2005) cited in Baxter and Jack (2008) and confirmed by Yin (2009), the researcher in this study has utilized multiple sources of evidence, and has maintained a chain of evidence.

The research also achieved credibility of the study by self-monitoring and understanding the concepts of the health field.

### **3.4.2 Transferability**

Transferability is an equivalent of generalization in quantitative research. This test is achieved when the researcher demonstrates comparable or diverse findings of a phenomenon amongst comparable or diverse respondents (Baxter and Jack, 2003). The findings comprised “thick descriptions” to empower the readers to measure the transferability suitability for their own circumstances and this was achieved by putting into words; the meaning of the experience for the participants (Qwesha, 2009).

### **3.4.3 Dependability**

Dependability is an equivalent of reliability in quantitative research. This test is achieved when the researcher demonstrates signs of stability and consistency in the process of inquiry. In other words, other researcher ought to in principle, be able to arrive at the same results if they were to use the same process of inquiry (Baškarada, 2014). The researcher in this study has clearly defined the process of inquiry and has traceable documentation including audio recording that can be rechecked.

### **3.4.4 Conformability**

Conformability is an equivalent of objectivity in quantitative research. This test is achieved when the researcher demonstrates reduction of researcher biases through multiple data sources and admission of researcher’s principles and suppositions. Limitations of the study process in terms of the research method and their adverse potential impacts must be clearly identified and lastly clear description of the process of inquiry for scrutiny purposes must be done with a clear audit trail (Baškarada, 2014). The researcher in this study has clearly identified limitations and has taken reasonable care to avoid being bias and used a framework of core elements of change management by Antwi and Kale (2014) to inform the interviews.

In accordance with the principle advocated for by Strauss and Corbin (1998) cited in Qwesha (2009: p45) and confirmed by Baškarada (2014) that “supporting theories should be traceable to the data that gave rise to them and thus it is incumbent upon the researcher to leave a trail of evidence for any interested reader to follow up”. The objective use of the Core Elements Framework of change management together with an audit trail that has been kept has upheld the objectivity of this study.

## **3.5 ETHICAL CONSIDERATIONS**

The researcher in fulfilling his ethical obligations to the participants has attained approval of the research proposal from the Higher Degrees Committee of Rhodes University (see Appendix C). Authorization to commence with the study was obtained from the chief executive officer of the NMAH (see Appendix D). Lastly an ethical clearance from the Rhodes Business School ethics committee (ethical application number: 2016\_10\_37 Mzu Nodikida (see Appendix E)) and the Eastern Cape Department of Health Research Committee were

secured (see Appendix F).

The general schedule of enquiry (see Appendix A and B) and an informed consent form was provided to participants. The schedule clearly states that the participants' participation was completely voluntary and they could withdraw at any time and at any stage of the study. Preservation of confidentiality was fundamental to the researcher in line with the ethical guidelines of the research. Even though the participants did not raise concerns about their names being mentioned, it was clearly explained to the participants that their individual data would be kept anonymous and that a general discussion of the results from an organizational level would only be reported in total and summary form without disclosing any individual participant by name. Contact details of the researcher were provided in the general plan of enquiry.

### **3.6 SUMMARY**

This chapter looked at the aims and objectives of the research, and the research question. A case study approach was identified as an ideal approach for this study. The study was conducted within an interpretive research paradigm. The chapter also described clearly what research procedure was followed to address the research question. The researcher described how the level of trustworthiness for the study was ensured and also pointed out the limitations of the approach used. Reasonable care was taken by the research to ensure that ethically considerations were covered. The next chapter covers in detail, the research findings as gathered in the process of inquiry.

## CHAPTER FOUR: RESEARCH FINDINGS

### 4.1 INTRODUCTION

The current chapter concerns itself with research findings. The data collection was a two-pronged process with the analyses of documents that relate to the change management and structured interviews. This chapter will present the findings of the research in the following order: an overview, findings and summary. The key findings of the study include; the fact that the restructuring process of the NMAH enjoyed political support and had clear environmental factors that necessitated the change. Among these factors that prompted the change was the association of the hospital with Walter Sisulu University (WSU) medical school mentioned by most respondents. The second key factor that prompted the change was the need to improve healthcare service in response to the growing diseases profile of the population. These two seem to have been the drivers of the change initiation process. The study also found that though the need for change was clear and well supported politically, lack of organizational capacity, organizational harmony and a proper consultation process for stakeholders hindered the change process.

### 4.2 OVERVIEW

The study analyzed the re-structuring of the NMAH from the perspective of the Antwi and Kale's (2014) Framework of Core Elements of change management. Valuable information related to the restructuring of the NMAH was identified as the researcher scrutinized the documents and pieces of legislation that relate to the change. Some of the findings demonstrate clearly that the intention to upgrade the hospital dates back to 2009, three years before it was gazette as a central hospital.

The NMAH in Mthatha was built as a tertiary hospital and commissioned in 2004. The Health Minister, Aaron Motsoaledi had announced the hospital as one of the flagship Public-Private Partnership projects in late 2009. In 2012 it was categorized as a central hospital in accordance with the Department of Health (2012)'s Government Notice, Regulations Relating to Categories of Hospitals.

According to Sakhiwo Health Solutions (2013), the NMAH was identified by both the National Department of Health and the Eastern Cape Provincial Department of Health as a priority project and 2014 was set as the year in which the hospital was to be fully developed. The hospital was offering tertiary services and now it was to offer quaternary services and become a central hospital. The basic package of care at the Provincial Tertiary and Central hospitals are almost similar in that both offer tertiary services like anesthesiology, general surgery and obstetrics. These services are basic tertiary services. The difference between a tertiary and central hospital is that the central hospital should go beyond tertiary services and be able to offer super-specialized quaternary services such as: Nuclear Medicine, Cardiology complex

and interventional cardiology to mention but a few. Medical complications that cannot be sorted at Provincial tertiary hospital must be referred immediately to a central hospital to receive care. National referral centers only deal with quaternary services that could not be treated at a central hospital. NMAH is a central hospital by implication should render over and above tertiary services and offer quaternary services. Table 4.1 shows these different categories of hospitals and the services that they render.

The NMAH lacks some of the services that are listed here in Table 4.1 under central hospitals services like: Nuclear Medicine, Burns Unit, Pediatrics Cardiology Complex, and Renal Transplant as a result a patient who requires one above mentioned services will have to be referred outside of the province at a huge cost.

**Table 4.1: Hospital Categories**

T3 services provided in National Referral Centres	T2 services provided at Central Hospitals (including Specialised Psychiatric Hospital Units (SP2))	T1 services provided at Provincial Tertiary Hospitals (including Specialised Psychiatric Hospital Units)
Anaesthesiology	Anaesthesiology	Anaesthesiology
Cardiothoracic surgery Complex	Burns Unit	Cardiothoracic Surgery
Cardiothoracic surgery Complex	Cardiothoracic Surgery	Maxillofacial Surgery
Otorhinolaryngology (ENT)	Maxillofacial Surgery	Otorhinolaryngology (ENT)
Medical Genetics	Otorhinolaryngology (ENT)	Endocrine Surgery
Medical Oncology	Endocrine Surgery	Surgical Gastroenterology
<b>Surgical Gastroenterology - Complex (Liver transplant)</b>	Surgical Gastroenterology	Neurosurgery
Medical Oncology	Neurosurgery	Obstetrics & Gynaecology Complex
Radiation Oncology	Obstetrics & Gynaecology Complex	Ophthalmology Complex
Neurosurgery	Ophthalmology Complex	Orthopaedic Complex
	Orthopaedic Complex	Trauma Surgery
		Urology

Urology	<b>Plastic &amp; Reconstructive Surgery</b>	Vascular surgery
Urology		Cardiology Complex and
Clinical Haematology (BM transplant)	<b>Spinal Injury Management</b>	interventional
Neurology	Trauma Surgery	Dermatology
Psychiatry - National Maximum	<b>Urology</b>	Endocrinology
Security	<b>Renal transplant</b>	Medical Gastroenterology
Psychiatry Complex - Child and Adolescent	<b>Vascular surgery</b>	Hepatology
Paediatric Surgery	Cardiology Complex and interventional	Geriatric Medicine
	<b>Clinical Haematology</b>	Infectious diseases
	Dermatology	Medical Oncology
	Endocrinology	Radiation Oncology
	Medical Gastroenterology	Nephrology
	Hepatology	Nephrology (Renal Dialysis)
	Geriatric Medicine	Neurology
	Human Genetics	Pulmonology
	Medical Oncology	Rheumatology
	Radiation Oncology	Medical Physics
	Nephrology	Critical Care
	Neurology	Psychiatry
	<b>Rheumatology</b>	Neonatology
	<b>Nuclear Medicine</b>	Paediatric Cardiology
	Psychiatry	Paediatric Surgery
	Neonatology	Dentistry Complex -
	Paediatric Cardiology - General	Orthodontics
		<b>Dentistry Complex - Maxillofacial</b>

	Paediatric Cardiology - Complex & interventional  <b>Neonatal Surgery</b>  Paediatric Surgery	and oral Radiology
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Source: (Sakhiwo Health Solutions, 2013)

The researcher used information from the change management literature and from the document analysis to prepare the structured interviews and with questions based on a framework by Antwi and Kale (2014) of the core elements of change management. The interviews were later transcribed for onward translation, analysis and interpretation. The analysis was done according to the interview schedules in the order of the recordings. In the sections that follow, the researcher will provide the findings which have been organized according to the concepts from the core elements of change management by Antwi and Kale (2014). Each question with the exception of the last one is built on one of the core elements of change management.

#### **4.3 THE FINDINGS OF THE INTERVIEW:**

##### ***4.3.1 Concept 1: Factors (both internal & external) that prompted the initiation of the change of the NMAH to a central hospital (Environmental factors).***

###### **Response by respondent 1**

According to the information provided by this respondent, one of the factors that prompted the initiation of the change of the NMAH from a provincial hospital to a central hospital was the need to link the medical school at the Walter Sisulu University (WSU) to a central hospital for professional operations as a basic requirement of any medical school. This allowed the WSU medical school to operate at the same level with other medical schools in the country and elsewhere. Furthermore, there was a need to upgrade the hospital to attain the central level status directed at improving health care of the mostly rural communities in the former Transkei homeland (Mpalatshane, 2014). The NMAH had been operating as a tertiary hospital since its inception in 2004.

## **Respondent 2**

The second respondent, a senior member of the management team; started by clarifying the different roles played by any medical system where he specified the existence of different categories of health service. The researcher was made aware of the functionalities of community clinics, district hospitals, regional hospitals and central hospitals. The respondent was quite categorical that a central hospital, unlike other hospitals, functions at a national level.

Some of the factors that led to the creation of the NMAH were stated as follows:

- The NMAH as a central hospital was intended to deal with specialized medical services that arose within the province and provide specialized health services to a priority of diseases;
- In addition, the central hospital was intended to serve as strong referral unit within the province with a national mandate;
- The central hospital was meant to be a national asset which acted as a super specialist hospital;
- Further to the above, the creation of the central hospital was to strengthen medical training facilities which worked in collaboration with the WSU's Faculty of Health Sciences. The WSU's medical training programme has been a big beneficiary of the NMAH.

These noble ideas were echoed and supported by Antwi and Kale (2014) who claimed that changes in healthcare are initiated and carried out in line with the needs of the target populations in mind.

## **Respondent 3**

The commissioning of the hospital was a clarification brought forward by Respondent 3. According to this respondent, the hospital was commissioned in 2004.

The creation of a new model to be adopted by the management of the NMAH as desired by the National Department of Health was one of the factors that contributed to this commissioning. Another factor was the attachment of the NMAH to WSU 's Faculty of Health. The need was for improvement of specialized personal medical services and as well as to improve the medical fraternity within the community. This was with particular reference to direct the attention of the hospital management into the training of clinicians, particularly doctors and equally identify those special areas which the university could offer to take care of the envisaged improved service delivery.

Furthermore, support services linked to the development of personnel management had to be taken into consideration. This will fairly be proportional to the expected change since a change in professional clinical services had to go hand in hand with improved personnel

services as a component of personnel management in view of the changing hospital environment.

#### **Respondent 4**

According to the information received by the researcher, the change from a general hospital to a central hospital was necessitated by the need to create NMAH as one of the academic hospitals in the country. As required by law that all central hospital must be attached to a medical school, the national government intended to properly designate the NMAH hospital as a training center and further planned to properly resource the NMAH. The fact that the hospital was already linked to a university which ran medical training, WSU was an added convenience. All ten facilities in the country were so designated that they became central specialist hospitals.

#### **Respondent 5**

The respondent argued that the hospital was regarded as a medical complex providing tertiary services including; tertiary health services, mental health services, orthopedic services, maternity services, obstetric services at a tertiary level as well as an academic hospital. It was added that factors that contributed to gazetting it as a central hospital were a national government requirement for a central hospital in every province in the country. It was a national requirement that a central hospital which provided academic services and tertiary services be attached to a university which ran medical training.

#### **Respondent 6**

According to the information received from the 6<sup>th</sup> respondent, it was a ministerial prerogative to categorize different hospitals in the country according to the different functions each rendered. This was applied to all the provinces. This was necessitated by the high degree of fragmentation of different categories of hospitals existing in different provinces. The initial step was a scrutiny of deciding on the type and size of hospital followed by a categorization of different hospitals for proper service delivery. This was necessary for the protection of the government from spending huge sums of money on hospitals which had as few as 8 beds. It was decided that a district hospital must have a minimum of 50 beds. There were also medium size hospitals. Another designation was “tertiary hospital”. Tertiary hospitals were to provide level 1 and level 2 hospital services with the objective of serving people within a province. The other category was “central hospitals” which were to provide specialized services. Four centers were identified for specialist services.

On the question of “why NMAH was selected against other hospitals”, the respondent, like other respondents, claimed NMAH was selected because of its attachment to WSU, which had an existing medical school. It was thus made a medical training institute attached to university medical school. Other institutions of similar category were to be utilized as extended services of the WSU as this was a provincial service. NMAH was an academic

hospital.

### **Respondent 7**

The respondent confirmed having been a member of the top management team of the NMAH between 2009 and 2012.

The respondent informed the researcher that the plan for the decision to change the general hospital to a central hospital took about five years of preparation. The change was necessitated by the need for a broader health platform of the province. One supporting reason was that the location of the hospital was found to be the most convenient, ideal and proper site for the construction of a central hospital. Besides, the site is situated in a densely populated area within the province. It has been estimated that the great majority of the workforce in the Eastern Cape resides in this community. The respondent further claimed that there was room for the development of the hospital in order for it to comply with the norms of a central hospital.

### **Respondent 8**

The researcher was informed that varied perceptions were expressed by different stakeholders. While some people expressed a high degree of acceptance, a few were resistant to the change. The main problem was the key issue revolved around the availability of resources. The respondent, however, added that the opposing views were so overpowered by the proponents that the programme was affected.

### **Respondent 9**

The researcher was explained the different stages which the central hospital went through before being recognized as a central hospital. First it was a tertiary hospital known as Mthatha General Hospital, and later renamed to Nelson Mandela Academic Hospital. It was understood that the respondent played a significant role in the conceptualization and the subsequent implementation of the creation of the new hospital. The Mthatha General Hospital was later to be named the NMAH without designating the type of services the NMAH was to provide. The hospital provided services at the two levels of tertiary hospitals (tertiary 1 & 2). At some stage, the hospital had to treat ordinary cases as well. This included cases such as harvesting of tumors, cochlear implants which require ordinary medical services. It was understood that, earlier on, there was no hospital in the Eastern Cape that provided these services.

There came the need to digest and create the idea of a central hospital. This was done to diagnose and treat specialist cases. The creation of a central hospital was to recognize the international icon "Nelson R. Mandela" in whose name and honour the hospital was named. This recognition was due to his having steered its creation and made sure it was a reality.

In the absence of which, the hospital would have been named "Walter Sisulu Academic

Hospital” after another South African political icon. An additional motivation was the closeness and nearness of the hospital to the WSU medical school which had been running medical training at the academic hospital. The creation of the NMAH was not only an administrative move but also a politically motivated idea by the national government. It was a political move to balance the specialist medical attention in the country by creating a specialist high ranking unit within the Eastern Cape Province and Mthatha was the obvious choice due to its association with the WSU medical school.

#### **4.3.2 Concept 2: *The mutual agreement among the hospital stakeholders for the re-structuring of the NMAH at the time of initiation (Organizational Harmony).***

##### **Respondent 1**

According to the information gathered by the researcher from the first respondent on the issue of mutual agreement among stakeholders, the respondent first identified the following as the official stakeholders of the NMAH as a central hospital: The Department of Health in the Eastern Cape Province, WSU and the community (who happen to be the beneficiaries of the medical facility). It was noted that the Department of Health within the province did not resist the change to a central hospital because the entire province had no central hospital. Thus, it was a welcome idea which had negligible opposition and the national department had to immediately gazette the implementation based on facts that supported the creation of the only central hospital in the Eastern Cape Province for improvement of medical services. Furthermore, the researcher was informed that the university management warmly welcomed the idea of a central hospital with a view to improving its training programs by equipping medical trainees with more practical knowledge and skills and so, the university management similarly welcomed the idea of re-structuring the hospital. The third stakeholder; the community, strongly welcomed the idea for the improvement of training of the hospital staff to offer better quality services as well as receiving higher level medical care given the presence of a central hospital within their reach.

##### **Respondent 2**

The information conveyed by this respondent discussed the functionalities of a central hospital with particular reference to the requirements of the community served by the central hospital. Further to this, the respondent mentioned the superior functions of a central hospital and claimed that the NMAH as a central hospital should aspire to cover all aspects of specialized health care services within the physical setup of the hospital and in consideration of the resource requirements. Furthermore, consideration should be given to the burden of disease setup within the Eastern Cape community, where emphasis must be given to the existence of the prevalent communicable diseases in addition to the following prevalent cases:

- Maternal problems;

- Neonatal problems;
- Child disease problems;
- Nutritional problems and;
- Environmental medical problem.

The respondent estimated that the above medical cases consume approximately 50% of the financial budget allocated to the province and thus, the NMAH was well-intended as a central hospital to put greater emphasis on these cases in addition to identifiable communicable diseases. The academic hospital was made aware not to neglect the existing social issues within the province.

The NMAH management at the time made sure that the hospital provided top level medical services.

In conclusion, the respondent, a high-ranking official within the management of NMAH felt that all the requirements were summed as follows:

- The idea of a central hospital had good rationale;
- A medical school was available;
- The medical training platform was conducive;
- The medical teaching platform was practical as a result of the availability of the necessary resources and personnel.

Coupled with the above conditions, there was realization that the Eastern Cape Province did not, at the time, have a highly specialized central hospital. Having the blessings of the national government was an additional advantage. All the above analysis justified the creation of a central hospital and led to the upgrading to the current NMAH.

### **Respondent 3**

The respondent was of the view that given the circumstances that have taken place during his working tenure, there was no proper coordinated mutual agreement among the hospital stakeholders for the re-structuring of the NMAH at the time of its initiation. One supporting reason for this view was that the services which are supposed to be rendered at the primary care level are attended to by central hospital. This has caused heavy congestion which has negatively affected the services which are supposed to be offered at the central hospital. Accordingly, this has interfered with the prioritization process at the NMAH. One such priority is the speed of treatment provided by the academic hospital when attending to cases requiring specialist attention. The respondent was of the view that the interference had to stop. This will only be achieved if there are frequent management meetings between the District Department of Health to speed up attending to matters relating to specialist referral cases at the NMAH. Another function of such management meetings would be to clarify which cases have to be attended to by which hospital and in particular, specify the referral procedure by districts to the NMAH.

#### **Respondent 4**

The stakeholders were delighted with the information of transformation of the facility to a central institution. This was an upgrade to a higher institution and all contributors were ready to contribute towards the success of the new institution. Another motivation was the support that was based on the fact that the Eastern Cape was comparatively least developed among the provinces. There was a strong show of harmony. There was a workload agreement which was signed to show the workers' commitment as most of them were to be made aware of the additional workload. There was a lot of opposition particularly from the other two hospitals in Port Elizabeth and East London this led to Port Elizabeth even announcing that they were going to open a medical school. This eventually all settled down through a working agreement. In summary, there was a strong opposition because of the fear that NMAH was going to get a larger share of the budget than the other two hospitals.

#### **Respondent 5**

Three designation categories were outlined by this respondent referring to hospitals within the province as either: T1, T2 or T3. Here T1 was referred to as a Provincial Tertiary Service Center while T2 as a Training Facility. It was noted further that the budgets for the two centers were slightly different, with T2 having a higher package than T1. There were, of course, challenges arising from some centers with reference to the type of service rendered.

Such resistance challenges were quashed off by citing the fact that the NMAH was the only one central hospital in the province that was designated to offer the special services as stipulated by the Department of Health. This was a sort of recognition for the NMAH which created some comparative resistance on grounds that the other two centers (East London and Port Elizabeth) had been more developed than NMAH. One of the fears was associated with the possible shift of resource allocation to (possibly) NMAH.

#### **Respondent 6**

The respondent informed the researcher of positive discussions which led to an agreement for the initiation of the central hospital. The researcher was further made to know that it was a tradition that all central hospitals in the country had always been attached to a medical school. The only big difference between Mthatha and other central hospitals was the size of the cities in which the hospitals exist, whereas Mthatha was/is still regarded as a rural town. Of course NMAH did not have the many and advanced facilities like other central hospitals elsewhere. This is why it was referred to as being at its development stage. It has difficulties with regard to attraction of specialist personnel but notwithstanding this, it was a rare opportunity for the community to have in its midst a medical institution such as NMAH. The respondent hypothesized a situation where the institution would go a long way in developing the rural community of Mthatha. Furthermore, the central hospital status of the hospital would assist the WSU medical school to develop to a higher level. In addition, the NMAH was one of the five national hospitals to qualify for the Flagship programme. The flagship

programme meant that the five identified hospitals were to be improved, restructured, and even elevated to higher status to take care of advanced medical procedures. The Mthatha choice was meant to greatly benefit many people because it did not have most of the services available in other similar hospitals such as the oncology unit and other specialist areas that did not exist before the creation of the central hospital. The government had intentions of using the PPP model for funding hospital operations. Other funding procedures were infrastructure type which depended on the position of the institution. The basic approach was to ensure that all institutions had to receive equal funding for institutional development.

#### **Respondent 7**

The researcher was informed by this respondent that the agreement among the official stakeholders was very encouraging. It was stated that there was no opposition to the construction of the central hospital. In spite of the diversity of views of the stakeholders, there was no opposition of any significant nature. All the stakeholders were properly managed by discussion and through a feedback report to contribute to the successful implementation of the envisaged hospital.

#### **Respondent 8**

A number of issues were considered. First, there were concerns ranging from disease risk reduction to the rating of the performance of the stakeholders. The reality of the health status on the ground was so overwhelming that the stakeholders had to increase the speed of change process. The need to create the change was enforced by the practical truth pertaining to the suffering of the people in the community.

#### **Respondent 9**

The researcher was clarified as to who the stakeholders were. According to the respondent, the hospital stakeholders were: Department of Health at all levels including; district, provincial and the national, the workers, the community which stood to benefit from the facility and the traditional leadership. A unique understanding of the real stakeholders was the addition of other dependent hospitals (feed hospitals) within the central hospital complex as stakeholders. It may be put generally that there was overwhelming agreement among the stakeholders, notwithstanding the insignificant opposition which was experienced. Different views and ideas were expressed. Ideas referring to the rural status of the Mthatha area were to be considered and it was challenged in consideration of the view that it was too far from resources and thus running medical facilities would not be easy. Another idea was centered on the lack of recreation facilities as compared to other hospitals which were well equipped. The overriding decision originated from the international icon, Mandela whose decision was final and binding. Right now, when a reflection is made, the number of beneficiaries from the existence of the hospital is so huge that it has improved that economic condition of the community. It has generated employment either directly or indirectly for the community and made specialist treatment easily available within the community. It can be summarized that

the Mthatha area has developed partly because of the NMAH. Considering all these, all stakeholders ultimately agreed on the creation of the NMAH.

**4.3.3 Concept 3: *The level of cooperation of influential personalities such as the political lead within the organization (Power Dynamics).***

**Respondent 1**

The political and the traditional leadership within the community strongly supported the initiation of the change. Coupled with this, the provincial leadership found the establishment of a central hospital as an asset which would improve the health services of the community. It was on record that the community had shown a desire for their own medical school within the province to improve the health services in the community.

**Respondent 2**

The respondent says there was general cooperation from the leadership in the province and from the traditional leadership as well. This was to benefit the population and improve services.

**Respondent 3**

The respondent was not directly involved in the discussions at the time of initiation of the NMAH. The respondent requested for pardon as he was not able to contribute to this topic due to his failure to be within the NMAH setup at the time of planning for the hospital. In addition, most of the people who participated in the planning and those who were in the management at the time of initiation have either long left the institution or they are no longer alive. There have been several administrative changes within the management of the hospital since its inception. A lot of information has been either been displaced or even lost.

**Respondent 4**

The respondent claimed there was a significant buy-in from the leadership. This was supported by the fact that the political setup in South Africa enables the national government to take decisions whereas the provincial administrations just implement decisions taken at the national level. The influential contributors were the national department of health, the provincial and district administrations. This means the leadership played a significant role. The strong support was enforced by the non-existence of a medical facility within the province that would offer similar services. After the decision, all resources meant for a central hospital were directed towards the development of the NMAH.

### **Respondent 5**

The researcher was informed that it is normal that when a new ideology is to be introduced by any organization, there was to be some form of opposition which, given human nature, was inevitable. There are always those society elements who don't welcome change be it well-intended. This opposition was minimal in this instance and was so insignificant that within a very short time, there was overwhelming support for the creation and development of the NMAH as a central hospital in Mthatha.

### **Respondent 6**

The respondent claimed that the management of the NMAH hospital received the initiative of hospital change with enthusiasm regarding the flagship programme which was only meant for the NMAH and not the whole province as had been misunderstood.

### **Respondent 7**

The researcher was informed that the community was so excited that there were higher level expectations than normal due to the creation of the central hospital. This was seen as an upgrade of the general hospital. The portfolio of clinical services that were to be offered by the new hospital was much wider than before. The community was quite hopeful for better health services particularly that the new hospital was to offer specialist services which were to be made available locally. Additionally, another school of thought was the expected economic growth resulting from the new hospital. This was strongly supported by the community as the most immediate beneficiary. The economic element was observed to be encouraging as the hospital would receive referrals from other provinces and hospitals which would ultimately generate revenue for the hospital.

Another advantage was the recruitment of specialist personnel including specialist physicians, specialist nurses, and the introduction of advanced medical facilities to measure to the requirements of a specialist hospital. Other avenues of significant nature were the physical expansion of the hospital to accommodate the envisaged operations which meant a more modern medical structure and an improvement in terms of development. The political leadership was very proud and it was a flagship which created positive sentiments.

### **Respondent 8**

The responded pondered for a few minutes and replied in the affirmative claiming the shortage of financial resources influenced the shortage of professional personnel such as doctors and nurses which limited the general community's access to appropriate healthcare. It was a suggestion for an optimization procedure of hospital funding to reduce financial shortages experienced by the management. This suggestion was made with the awareness that the improvement was a long-term process.

### **Respondent 9**

It was observed that some of the influential people within the province were not happy. The expectation of the influential people within the province was that the central hospital was to be either located in East London or in Port Elizabeth. Due to these differences, the budget did not reflect the central hospital status of the NMAH. The researcher pressed the respondent as to whether there were very influential people at the national level who were not supportive of the creation of the new hospital. The respondent's answer was in the affirmative, and quite a number.

#### **4.3.4 Concept 4: *The availability of sufficient human, financial and environmental resources (Organizational capacity).***

### **Respondent 1**

At this point, the researcher was made to know that a project of the level of NMAH was such a huge project that it was understood that it would take a number of years to reach finality. The reason for this was voiced to be the implication of the different complicated dynamics facing different aspects of the development of the hospital. One other setback was the non-availability of sufficient financial resources which at some stages, culminated into numerous complications – which is a normal phenomenon in any operation of the kind in discussion.

Other problems experienced were related to the well-known issue of the level of development of the community where the hospital was to be developed. The community had a high level of rural features which many prospective personnel were not willing to assume employment opportunities. This meant that the practical attraction of personnel was not an easy task to handle and further that it was clear at some point in time that this was going to take a long time.

### **Respondent 2**

The respondent informed the researcher that, the fact that the decision was rational at the time depended on what was available at that time, hindsight is better but the decision was a good one at that time. The process should have been a bottom up approach. The level of expectations was very high and might have overstated what was expected.

### **Respondent 3**

Responding to the availability of sufficient human, financial and environmental resources, the third respondent claimed that from his personal view point of observation, it appears there was no proper project plan for the proper guidance of institutional management for one to make follow-ups in order to understand the sufficiency or otherwise of the institution.

With specific reference to human resources, at the point of creation of the central hospital,

the scarcity of nurses (i.e. Professional nurses, assistant nurses and staff nurses) was a very critical issue. This critical need forced the management to hire close to 200 nurses in the year 2013. The appointment of doctors faced a financial constraint which led to hiring a few doctors.

The support services were not satisfaction due mainly to financial scarcity. With regard to other support services, the institution has only seven (7) pharmacies.

There were serious financial issues which resulted into failure by the management to de-complex due to specific legal requirements which did not allow one person to process a complete financial transaction.

At clinical level, currently, there are plans to incorporate oncology, an area which is problematic. It has been noted that the department of human resources does not exist due to non-availability of human resources personnel. There is, therefore, the need to improve the services of the HR department by increasing the available manpower. The challenge here is there was no organizational structure developed to speak to the new hospital.

#### **Respondent 4**

The equitable share funding mechanism is still the current funding model. Funding is resourced by the national tertiary health care plan, the health professionals and training programme. The current approach has put more emphasis on the National Tertiary Services Grant (NTSG) which is intended to develop the central hospital. The NTSG fund, which does not depend on any growth formula but depends on a realignment plan. This has been done without downgrading the services rendered by the other competing hospitals in East London and Port Elizabeth. In summary, currently the NMAH has all the availability of sufficient human, financial and environmental resources. This has been due to the willingness of the stakeholders, the national government and the funding system.

#### **Respondent 5**

The respondent claimed the education of involved human participants is a necessary procedure. This, in a way, will prepare them for positive participation. This action was done. Workers had to show their level of agreement by signing official forms. And in spite of the failure to fulfill all the promises, workers have been performing to required standards.

Financial limitations have affected the operations of many areas of the institution. This has been coupled with staff shortages where as a complex hospital, the demand was quite different. Discussions have been held to create some allocation of duties with the expected workload increase.

### **Respondent 6**

The researcher was informed of the appointment of a programme manager. In addition, funding was either by the PPP or internal funding model. The whole financial issue was under the guidance of the parliamentary committee at the time. The issue of “a funding model” created a delay of proposals in action. One school of thought was that the PPP model would end up being more expensive to handle than others. The funding was problematic as it took so long to determine the funding process. There were expectations that by 2016 the funding issue was to be finally solved but this did not succeed.

There have been rumors going round about the PIP’s being utilized to solve the hospital financial issues. There are now five hospitals to be considered for financial resolution. The question of prioritization now arises as to which among the five should be given priority. It must be borne in mind that the NMAH falls under the national competence and no longer a provincial concern.

### **Respondent 7**

At the time of the decision making there was a PPP funding model which was encouraging but it collapsed and result into the major financial, human and infrastructural problems. So there should have been a bench marking exercise with the private hospitals to learn best practice.

### **Respondent 8**

According to the respondent, external realities pertain to the area of coverage in particular as well as the population expansion that the hospital is expected to service. The researcher was informed of the need for convenient locations of clinics to deal with outpatients in order minimize the demand at the central hospital. At an internal level, the infrastructure requires an upgrade and extensions of the hospital infrastructure with particular reference to buildings. The respondent recommended a strategic move to address the long queues at the hospital resulting from the many patients who seek treatment particularly those who are booked for theatres. Another recommendation for consideration is of a continuous monitoring and evaluation to be put in place as well as feedbacks to the stakeholders. Positive results from the change management process require to be communicated constantly for staff/stakeholders to engage and embrace the changes that have taken place. The researcher was informed of the overwhelming confidence the community had with regard to expected changes whose positive impact will be felt in the medium term.

### **Respondent 9**

With regard to the issue of availability of sufficient human, financial and environmental resources to initiate the envisaged change, the researcher was informed of the categorization of different requirements of a central hospital. Initially, there were available human resources

from the Eastern Cape Province except that they were serving other provinces in similar capacities. It was just a question of creating the relevant positions, appoint them and vacant senior positions were occupied. The theory was depending on the “sons of the soil”. With regard to finances, the national government committed itself to run the financial burden of the new hospital. The big question was the proper allocation of finances to different departments of the new hospital. The natural resource availability of resources such as land was not an issue to grapple with as land was easily available. The surrounding land at the hospital was available for development as it was not individually owned. The truth of the matter was that the land belonged to the apartheid system and after independence, it was available.

**4.3.5 Concept 5: Whether external and internal realities of the hospital were taken into account at the time of change initiation (Nature of Change).**

**Respondent 1**

The respondent was of a strong view that both internal as well as external realities were taken into consideration. To explain his position, the respondent discussed the idea of the delivery of health services having been district-based. Thus, the initiative was the creation of two types of hospitals namely: the central hospital and district hospitals which worked in collaboration under a teamwork approach. Furthermore, it was stated that the envisaged central hospital would receive referrals from district hospitals. In addition, the training would no longer be centralized to the hospital but rather training would operate on a wider scale than expected. Cited was the example given of the Health Resource Centre, which was externally created outside the hospital as extensions to assist with hospital training.

**Respondent 2**

The respondent enumerated the practical services rendered by other central and referral hospitals in other parts of the country and elsewhere. According to the respondent, these hospitals have not lived to the expectations at the planning stage. The respondent estimated that none of them had performed up to 80% of the expectations. Most of them had turned into attending to medical issues meant for clinics and general hospitals rather than attending to issues meant for specialized hospitals. The estimated use of the NMAH was put at 60%, while similarly attending to cases which are supposed to be attended to by lower level hospitals.

It was, however, justifiable given that in most cases, the functionalities of a hospital are determined by community circumstances and demands which dictate the approach to be adopted. All taken into account, the disease burden such as chronic TB problems, Pneumonia and high HIV prevalence within the province, and given the poverty level of the community, the internal and external realities were taken into account at the time of change initiation.

Overall, the decision to upgrade the regional hospital to a central hospital was a good

decision. This was supported because of the availability of the following:

- The medical professional manpower was available;
- There were sufficient high-class beds and other hospital facilities to rely on as a requirement of a central hospital;
- There were existing general and district hospitals in the province that would be relied on as feed sources for specialized treatment on referral;
- The hospital was associated with a university faculty of health at Walter Sisulu University;
- There were enough teaching personnel and the university had sufficient students to benefit from the programmes of a central hospital.

### **Respondent 3**

The respondent claimed that for an institution that was already in existence, a feasibility study should have been done to understand the situation at the time of commissioning. This would have been linked to the services provided at the primary health care and created the opportunity for the comparison of service provision as time went by. Such a feasibility study report would have been found quite useful by management addressing the problem identified at the primary health care.

### **Respondent 4**

The respondent claimed that from the facilities perspective, the move has been quite positive. This means that the external and internal realities of the hospital were taken into account at the time of change initiation. He supported this claim by citing the example of the Mthatha area being comparatively underdeveloped. However, due to the high degree of willingness, facilities, human resources and other logistics have been established and working well in spite of a disturbing rough beginning. It was further claimed that all the necessary facilities were made available even in the absence of human resources, but after a while, the facility is fully functional. Currently, plans are in the pipeline to establish the oncologist unit, a dream that will come true, though the hospital does not currently have one.

### **Respondent 5**

The respondent was of the opinion that most external and internal realities of the hospital were not taken into account at the time of change initiation due to lack of finances. There have been conflicts which were mainly centered on the budget. The issue of concern was having the central hospital so close to the general hospital whereas the two institutions depended on the same original budget.

### **Respondent 6**

The internal and external realities of were taken into account a lot of work was done in this regard. The processes were running smooth and the fact that area is rural so would serve as a referral centre that would help improve the health outcomes. The community had high hopes as the initiative was presented to them.

### **Respondent 7**

The participant was categorical that the external and internal realities of the hospital were taken into account at the time of change initiation. The reality with respect to the time it would take to reach the expected level of development was understood. There were, of course, challenges which included lack of good schools in terms of capacity, which discouraged specialists who received appointments to assume positions which fell vacant as a result of the new hospital. This resulted in scarce skills in the area. Other challenges were related to the poor infrastructure to accommodate all the departments, development of training and upgrading of skills which turned to be a huge challenge.

### **Respondent 8**

The readiness process was fairly binding and it was well executed. However, when it came to the implementation, challenges were experienced due to the conflicting individual interests of various key stakeholders.

### **Respondent 9**

The researcher was informed of the possibility of the failure to establish the source of resources for the expansion of the infrastructure at the NMAH. This was because there were no long term commitments of continued resource allocation for infrastructural expansion of the NMAH.

### ***4.3.6 Concept 6: Whether there was a clear rational and readiness process to initiate the change***

### **Respondent 1**

With regard to rational and readiness for the process to initiate change, the respondent was of the view that considering the political commitment, the initiatives taken by the national department of Health in collaboration with the national government towards the development of the hospital expressed a high degree of readiness. The provision of the national training grant, the tertiary grant and the hospital re-modernization programme formed contributions by the national government and signaled the degree of commitment and readiness towards the hospital creation initiative. However, due to the Eastern Cape dynamics, the process was seen to take longer than if it would have taken in other parts of

the country.

## **Respondent 2**

It was stated by the respondent that this topic leaves one with mixed feelings. The fact that a central hospital had to be constructed in this part of the province had a well calculated vision. There have been, however, some observed practicalities which have sent some messages in the form of lessons. A clear example has been, that there was a misplacement in the form of planning which lies on the fact that whereas the planning was for the NMAH at a central level, the demand and practical realities on the ground have seen the central hospital providing services which are supposed to be provided by district or general hospitals. This means that the planning should have provided for proper equipping of the lower hospitals to run concurrently with the central hospital in the provision of required medical services. This requires that lower hospitals should be running/functioning properly in order that a central hospital will be fully functional according to the planning of a central hospital and achieve its potential. It must be remembered that a district hospital will function to its required potential when doctors, nurses, beds, equipment and logistics are made available.

With regard to readiness, it must be understood that the decision to create the NMAH was a good one. Based on the principle that developing of health services must start from the bottom, it was observed that at the planning stage, there were local clinics, district hospitals and the Mthatha general hospital whose basic function from the planning level, had to feed into the projected central hospital. The above sentence means that the conditions qualifying the readiness were well satisfied.

On the other hand, one other condition related to readiness was the question of whether the practical operational procedures were to be followed or not. This means that the clear demarcation between the operations of a central hospital and those of district and the Mthatha general hospitals were respected to the letter.

With regard to what the respondent would do differently if the planning of the central hospital were to be repeated, improvement of the lower hospitals was suggested, which, he felt were to be upgraded in order to handle cases that lower hospitals are supposed to handle. A direct implication was that the lower hospitals must also be well resourced to meet both daily demands and routine services. At present, the central hospital treats cases which are supposed to be treated by either district hospitals or the Mthatha General Hospital. This situation has led to inestimable over expenditures resulting from high costs experienced by the central hospital.

### **Respondent 3**

The respondent was of the view that for a change to be effective there has to be some educative processes involving the institutional stakeholders and the prospective workers of the central hospital. There was total lack of communication to stakeholders. Stakeholders should have been informed of the objectives of the new institution in terms of the kind of services that were supposed to be rendered by the institution to the desired level. The cause would have been by the provincial head office and at other levels of the department. All levels would have been informed of the intentions by the district, the provincial and the national offices.

### **Respondent 4**

The respondent agreed to the existence of prior plans in place for a clear rational and readiness process to initiate the hospital change. The position of “CEO” was created and someone was hired on fulltime basis besides the creation of a clinical governance office which was functional at the time of initiation. There were selections which were well facilitated for trainings and other professional undertakings. Management was able to reroute some of the financial resources to the central hospital with great success. All these were running successfully. However, there is a strategy which is being adopted by the NMAH management for a more successful hospital operation than it has been.

### **Respondent 5**

There has been some confusion and the rational wasn't clear. The respondent believes that as far as service reception is concerned there was a challenge. The respondent highlighted the NMAH and Mthatha General Hospital share a site. It was the views of the respondent that this creates confusion with regard to customer care. Patients have always preferred to be treated at the NMAH but not at the Mthatha general hospital because of their proximity to each other. The fact that NMAH is identified with special treatment makes it vulnerable to abuse. A number of patients naturally feel safer under the NMAH than at the Mthatha General Hospital.

### **Respondent 6**

The rational was there in the respondent's view the rational was on point, in terms of readiness a lot was done. The feasibility study was done and the report was presented to the minister. According to the respondent who was very involved with change, the first building was supposed to be built in June 2014. This was the plan until the collapse of the Private-Public-Partnership.

### **Respondent 7**

The respondent agreed to the idea that the change was of an enormous nature but also agreed that there was a good degree of a collective and clear rationale and the existence of a readiness process to initiate the change. It was, however, acknowledged that the health services are by nature a complex exercise. The motivation for the existence of a clear rationale and a process for change was the understanding that the future of the province and the country depended on the growth of the hospital particularly that it had been earmarked for a central hospital status. It was a welcome idea given that the central hospital would attend and treat complicated cases such as heart attacks which had usually been referred to Cape Town. The other convincing reason was the training aspect. This would reduce the SA dependence on foreign medical professionals. However, there was limited resource availability for training. The logic here was that a time will come when the foreign professionals will not be available as their own countries will need their services. One expected a more aggressive approach by the treasury particularly when it came to funding the training. The change readiness was hampered by the failure by the national government to budget for across the board training where all workers were to be trained in readiness for the change to a central hospital. This was part of the change programme. The respondent reminded the researcher that change is a generational issue requirement. There was serious need for a significant staff mix for adequate service delivery. The respondent recommended a continuous annual review to balance on the generational mix where the young and old generations agree for good production.

### **Respondent 8**

According to the respondent the readiness process was thorough and all encompassing. However, when it came to the implementation, challenges were experienced due to the conflicting individual interests of various stakeholders.

### **Respondent 9**

This respondent is of the view that the hospital and the community were ready to take off with the change, but the lack of funding was and still is a major challenge. The rationale according to the respondent was clear and the readiness process was also done very well until the funding model failed.

#### ***4.3.7 Shortcomings of the change process and any suggested improvements***

### **Respondent 1**

According to the analysis of the information received, the researcher was informed that because the university (an important component of the hospital), was already in operation and the Mthatha Regional Hospital was available, there wasn't need for much change. The

other supporting fact was the establishment of such a facility in a densely populated area within the Eastern Cape Province which meant that the whole idea of a central hospital was well considered.

### **Respondent 2**

The respondent responded by saying if he were to do it all over again, he would do this from the bottom up. The respondent believes that it's the lower level hospitals that need to be strong first before the apex. So the respondent believes that 80% of health problems can be dealt with at the lower level of care, in cost effective manner.

### **Respondent 3**

The respondent was committed to the vision that the department had wanted to achieve. This would have been achieved by improved communication in order that the message of change reaches everyone. A clear example is the failure by the majority of the community to utilize the NHI facility. It is known that the NMAH is a specialist hospital which must be understood from the point of view of physicians, nurses and other professionals. The mandate has not been achieved. There should be proper coordination and communication with the department's provincial office. It is time the national government took over and created the hospital autonomy for better operations in terms of decision-making by management. At such a time, the dream for the NMAH will be realized without provincial dependence.

### **Respondent 4**

One of the crucial lessons learned by the management of the NMAH has been the revitalizing of the operations of the hospital to bring the NMAH facilities to the level of a central hospital. This refers to the specialist procedures which have been proposed for a long time.

One approach the management would adopt to improve on the operations of the hospital is to adopt the policy of a PPP plan where the required hospital preparations would be ready and then recruit the necessary personnel to manage/run the concerned facility. On the other hand, if the clock were to be rewound, a PPP plan of getting the infrastructure ready followed by the recruitment of the required hospital staff would have yielded fruits faster than currently. A practical show of the availability of functional facilities would easily convince an interested qualified professional to join the hospital.

### **Respondent 5**

At the beginning, there was supposed to have been a formal introduction of the idea of a central hospital and gauge the willingness of the stakeholders and the workers before introducing the change. This would have had the opportunity to convince those who were opposed to the change by some motivations without approach of force.

### **Respondent 6**

The researcher was told that if the process were to be repeated, then there would have been need to incorporate the private health sector. The reason for this, it was revealed, is because the private sector has huge amounts of information and experience from which the central hospital would have benefited. There was also need to include other institutions at the planning stage. The inclusion was for the purposes of mentoring the new staff of the upgraded central hospital.

### **Respondent 7**

The implementation of the change process could have been managed better. The engagements with the various key stakeholders was hampered by the lack of financial resources with regard to costs of implementing the process, failure to turn up for meetings by key stakeholders and the prioritization of key aspects of the change process.

The respondent suggested a more practical resource provision and management would have gone a long way in getting the change process easily accepted by the stakeholders and which would have led to a smoother change management process.

### **Respondent 8**

The researcher was informed by the respondent, that the implementation process of the change process could have been better. The engagements with the various key stakeholders was hampered by lack of resources with regards to the cost of implementing the process, availability of key stakeholders and prioritization of key aspects of the change process. Better resource provision and management would have gone a long way in getting the change process easily accepted by the stakeholders and thereby having a smoother change management process.

### **Respondent 9**

According to this respondent the funding was and still is the major challenge for this initiative. The respondent would the secure funding for the project first.

## **4.4 CONCLUSION**

The finding of the research conducted with nine participants at management level on the restructuring of the NMAH in line with the research problem and objectives were presented in this chapter. There are notable emerging themes on these concepts, coming from the interviews of the managers. Those themes are: lack of organizational harmony, lack of organizational capacity and poor change readiness programs. The next chapter will discuss the interpretation of the data.

## CHAPTER FIVE: DISCUSSION AND INTERPRETATION

### 5.1 INTRODUCTION

This chapter discusses the findings of the study in line with the research problem and the research objectives. The main objective of the study is to analyze the restructuring of the NMAH in Mthatha from a tertiary hospital to a central hospital. This chapter provides an answer to the research question through contrasting literature and the findings. The Antwi and Kale's (2014) Framework of Core Elements of change management is used in this chapter to discuss, interpret and make sense of the findings. The interview questions were mounted on the Antwi and Kale's (2014) Framework of Core Elements of change management's six elements and these are: environmental circumstance, organizational harmony, power dynamics, organizational capacity, nature of change and process for change.

### 5.2 OVERVIEW OF THE IMPORTANCE OF CHANGE MANAGEMENT APPROACH ON HEALTHCARE CHANGE INITIATIVES

The process of change can be planned or abrupt, and managers must be prepared to deal with change however it comes. This means that at a minimum the manager must at least have a certain level of knowledge concerning change management. The Canadian Health Services Research Foundation's (CHSRF) Evidence-Informed Change Management Approach recommends that the context, dynamics, and readiness for change should form part of the initial phases of any change process. This encourages change leaders to do proper analysis of the environment factors that are necessitating the change and material circumstances (context); the shape and the form of the change and everything that's needed to achieve it; and lastly the ability in terms of resources of the organizational to achieve the change (Dickson, Linstrom, Black and Van der Gucht, 2012).

Change management within health is even more challenging because of three factors that Pollitt (1993) and Dawson (1999) cited in Qwasha (2009) mentions and those are:

- Variety and multiplicity of stakeholders
- Intricate ownership and resources
- Professional independence of many of its staff.

The above were clearly evident in the findings chapter and make the process even more challenging especially for healthcare managers who might not be familiar in the field of change management. The knowledge of the different approaches and models of change management empowers the manager to navigate well in difficult situations. The next section discusses the interpretation of the findings.

## 5.3 DISCUSSION AND INTERPRETATION

Moving from the premises that there was a plan for the restructuring of the NMAH from a tertiary hospital to central, the findings suggest that unforeseen circumstance resulting from the turbulent environment in which the hospital operates impacted on the restructuring process. The discussion and interpretation of the findings are conducted in line with the six themes which derived from the Antwi and Kale's (2014) Framework of Core Elements of change management. The six themes are: environmental circumstance, organizational harmony, power dynamics, organizational capacity, nature of change and process for change.

### 5.3.1 Environmental Circumstance

This according to Antwi and Kale (2014) refers to the conditions outside of the organization forcing it to change. Lukas et al (2007) refers to the environmental circumstances as external pressures forcing the organization to change. In terms of the restructuring of the NMAH, 8 out of 9 respondents mentioned the association of the hospital with the Walter Sisulu University, growing disease profile of the population and the need to upgrade and modernize the hospital. The restructuring of the academic hospital was a policy issue in response to the growing burden of disease and a provision of the best platforms for medical training. These external factors compelled the hospital to change, Pettigrew (1985) confirms this when he argues that when external environment changes, the internal environment must change to accommodate the changes that occurred externally. The fundamental importance of this core element is that these factors create according Lewin (1951) discomfort or disequilibrium in the status quo. The findings in the case of the restructuring of the NMAH, demonstrate that there is enough evidence to argue that the need to change was clearly understood at least by managers who were involved in the initiative. Next is a discussion of the second core element of change management the: *organizational harmony*.

### 5.3.2 Organizational Harmony

According to Antwi and Kale (2014) this refers to the ability of the individuals and units within an organization to work as a unit in a cooperative manner in order to achieve the change. The findings in this regard demonstrate that there was resistance to the change initiative of the restructuring of the NMAH. The resistance was mainly from the other two tertiary hospitals in Port Elizabeth and East London. These two institutions believed that with the change, the NMAH was going to receive more in terms of the budget at their expense. Out of the nine respondents 4 cited that there was opposition 2 out of the 4 mentioned that there was strong opposition to the change and the other 2 cited negligible opposition. Five of the respondents felt that there was no opposition to the change. According to Lewin (1951)'s field forces analysis the forces that are for the change must overcome those that are against the change. The success and the pace of the change depend largely on these forces. In the case of this study, judging from numbers in the findings it seems the forces for change were indeed stronger than the ones against the change at the initiation phase of the restructuring. The

forces against the change (no matter how negligible they may be) have a potential to stall the speed with which the change is undertaken. Next is a discussion on the third core elements: ***power dynamics***.

### **5.3.3 Power Dynamics**

This refers to the main actors within an organization, these are units and individuals who have power and influence to swing any decisions their way and literature recommends that any change initiative must have these main actors' approval for it to improve its chances to succeed (Antwi and Kale, 2014). Seven respondents concur that there was generally a buy-in from the influential people in the province and even nationally. The fact that it was named after a struggle icon and that it was situated in the area that is most rural and would therefore serve the underprivileged made it easy for the powers that be to approve of the change initiative. Lewin's Group Dynamics, Hinings and Greenwood's Model of Change Dynamics' Power Dependencies and Kanter's "Big Three" Model's Intra-Organizational Individuals' Motion and Control Change concur on the importance of these power relations in any change initiatives (Antwi and Kale 2014). This is one aspect that the majority of the respondents concurred that there was indeed a buy-in from the main actors within health, political leadership and the traditional leaders. Next is the discussion on the fourth core element: ***organizational capacity***.

### **5.3.4 Organizational Capacity**

Hinings and Greenwood (1989) define organizational capacity as the ability of the organizational leadership to communicate their vision for change in a way that induces commitment and excitement about the change process. Furthermore, Antwi and Kale (2014) argue that organizational capacity refers to the process through which the organization ensures that; the drive to change, the essential skills set and resources (human and financial) are available for the change project to succeed. The findings in terms of this concept were in the main negative, seven out of nine respondents didn't believe that the resources were sufficient for the change project. When the Public Private Partnership (PPP) funding model which was meant to fund the development of the NMAH, there was no clear alternative funding model. The other fundamental aspect in this regard is that the hospital was given an upgrade on services to render which are highly specialized without a corresponding organizational structure that talks to the services to be rendered. The Human Resource is also struggling to recruit specialist in the area of Mthatha as it is still considered rural and lacking in recreation and schooling purposes when compared with other cities with central hospitals. This seems to have been the aspect that impacted on the change project. Next is the discussion on the fifth core element of change management: ***nature of change***.

### 5.3.5 Nature Change

This refers to the analysis behind change and what the change entails; change leaders in this regard are to ensure that the change will result into an existing organizational problem being solved. The change must take both the internal and external realities of the organization (Antwi and Kale, 2014). The findings in this regard are positive as six of nine respondents affirm that a lot of work was done even prior to the announcement of the change. A feasibility study was conducted by Deloitte in 2013 which also looked into the internal and external realities of the hospital. In essence, as far as the nature of change the leaders generated the necessary excitement and the announcement was well received and the idea also well supported. Lastly, the discussion on the sixth core element of change management: ***change process***.

### 5.3.6 Change Process

This refers to the practical component of the change initiative and the process to be followed must be clearly defined and agreed upon by stakeholders in the organization (Antwi and Kale, 2014). Change process is well captured in two of the major change management models; Kurt Lewin's Action Research in that it deals with the actually practical steps to be taken to reach the end goal and with Pettigrew's Context, Content and Process Model in that it refers to operational activities directed to achieving the desired change. In terms of the findings, the views varied: five respondents believed the process was rational and clear until the collapse of the funding model. Three respondents said a lot more could have been achieved had the communicating of the change initiative been stronger. They also raised strong views on how the surrounding hospitals should be strengthened in order for central hospital to admit only those who need super-specialized medical care. There were some who felt the step by step process to follow was not communicated properly.

## 5.4 CONCLUSION

The key research findings as guided by the Antwi and Kale (2014)'s Framework of Core Elements for change management by demonstrate that there was:

- Lack of organizational capacity,
- Lack of organizational harmony and
- Poor change readiness programme

The study draws the conclusion that even though the change process and initiative at NMAH received support and the need for change was understood, the above findings demonstrate why the restructuring of the hospital did not yield the desired results. The next chapter concludes the study with summary of the findings and recommendations for future health reforms and further research

## CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

### 6.1 INTRODUCTION

The study focused at the restructuring of the NMAH from a tertiary hospital to a central hospital. The main objective of the study is to analyze the restructuring of the NMAH through the Antwi and Kale (2014)'s framework of core elements of change management. The research was set to find out the reasons why the restructuring of the NMAH is not yielding the desired results and not fulfilling its mandate as a central hospital. This was further broken down in two primary research objectives:

- RO1: To analyze the restructuring of the hospital from the perspective of Antwi and Kale (2014)'s Framework of Core Elements of change management.
- RO2: To inform future healthcare reforms in particular hospitals restructuring.

### 6.2 SUMMARY OF FINDINGS

During the research process, especially during the analysis of documents, it emerged that the hospital was in fact announced as one of the seven hospitals which were to benefit in a flagship program of Public-Private-Partnership (PPP) between the Development Bank of Southern Africa, The National Treasurer, The National Department of Health and the Eastern Cape Department of Health in 2009. This was three years before the restructuring announcement and gazetting in 2012. The PPP funding model collapsed and negatively impacted the restructuring of the NMAH. According to the research findings, both the financial and human resources were and still a major challenge for the change process.

The current situation at the NMAH as result of the failure in change is as follows:

- A 512-bedded central hospital functioning at the tertiary level.
- A central hospital that still refers cases from tertiary hospital in Port Elizabeth (PE) and East London (EL) instead of receiving patients from these centers.
- A central hospital without an adult Burns unit, Oncology services and Nuclear Medicine; and with an Orthopedic unit situated 9km outside of the main hospital.
- A central hospital without organizational structure that is in line with the services it's supposed to render.

The above challenges represent just a fraction of the challenges at the NMAH and confirm the research problem that the restructuring of the Nelson Mandela Academic Hospital is indeed not yielding the desired results.

The research finding identifies what contributed to the restructuring of the NMAH not yielding the desired results. The study as a response to the research question and in line with Antwi and Kale (2014)'s Framework of Core Elements of change management found that there was:

- In terms of the Environmental factors: there was a compelling need for change, both internal and external.
- Power Dynamics: according to the findings the buy-in was easily secured.
- Organization capacity: this seems to have been and still remains the major challenge, with both human and capital resources.
- Organizational harmony: other tertiary hospitals in Port Elizabeth and East London were concerned that the NMAH was going to get a bigger share of budget allocations, so they reluctantly accepted the change process.
- The nature of change: there was enough evidence to believe that the change project was valid and rational.
- The change process: there was a master plan for Umtata Hospital Complex and a clear business case with monitoring and measurement of milestones, but it is clear that the plan was not followed through, especially after the collapse of the PPP project. There was no alternative dedicated source of funding.
- No approach to deal with unforeseen challenges as they arise.

The above findings explain why the NMAH has not fulfilled its legislated mandate of operating as a central hospital. Next are the recommendations that may help inform future health reforms, particularly hospital reforms and suggestions for further research.

### **6.3 RECOMMENDATIONS**

There is growing global evidence that leaders of organizations can no longer rely on linear planned change models of change, nor can they rely on being reactive in response to emergent change to transform their organizations (Liebhart and Lorenzo, 2014). The idea is to strike a balance between planned change and emergent change instead of viewing these two approaches as mutual exclusive (Antwi and Kale, 2014). According to Liebhart and Lorenzo (2014) planned change almost always lead to unforeseen emergent change, more reason to intelligently plan for change in an emergent way that can withstand the ever-changing environment. The restructuring of the NMAH is a very good example of a planned change that struggled to deal with unintended changes that led to emergent change.

Research on the future of organizational change models emphasizes that change might be difficult to strategically plan (Paula, 2015) and therefore an approach that combines elements from the two approaches as done in this study might be appropriate.

In light of the above, the recommended approach to change going forward; should answer the following three questions:

- Process →how is organizational change tackled?
- People →who is responsible for organizational change?
- Principles →what are the guiding principles?

The answer to these questions even though challenging to achieve, rests at striking that balance between the two approaches to change management. The two metaphors that can help answer the three questions, that is, if an organization is to be competitive in future, is the organization as an **organism** and organization as **flux and transformation**. In these metaphors, you find approaches from different schools of thoughts. According to Paula (2015) the future of organizational change belongs to the change management models that follow **flux and transformation metaphor**. The guiding principle of this metaphor which when combined with the Antwi and Kale (2014)'s Framework of Core Elements for change management can assist with any change process are the following according to Cameron and Green (2014):

- Organization is part of the environment
- Organization has the ability to self-organize and change with the purpose of getting a desired identity
- Change cannot be managed but it emerges.

It is also clear that organizations will have to invest more on research and development (R&D) and knowledge management in order to be successful in the future.

It can be argued that based on the findings that in the context of healthcare change management the following are fundamental for change to succeed.

- Change readiness programme
- Organizational capacity
- Organizational harmony

Lastly study reveals a clear contrast between theory and practice and recommends the above mention three elements as key for health care change management process.

#### **6.4 OPPORTUNITIES FOR FURTHER RESEARCH**

The aspect which might need to be explored further is how the change process at NMAH was experience by the patients and general staff members of NMAH.

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## **APPENDICES**

### **APPENDIX A**

#### **INFORMATION ON THE RESEARCH STUDY TO BE CONDUCTED**

TITLE OF THE STUDY: THE REVIEW OF THE RESTRUCTURING OF THE NELSON MANDELA ACADEMIC HOSPITAL THROUGH THE CHANGE MANAGEMENT APPROACH

RESEARCHER: DR MZULUNGILE NODIKIDA

SUPERVISOR: KEVIN RAFFERTY

INSTITUTION: RHODES UNIVERSITY

#### **1. Background**

The study will be focusing on the restructuring of the Nelson Mandela Academic Hospital from a tertiary to a central hospital using a change management approach. The hospital was opened in 2004 and operated as a tertiary hospital until 2011, when it was gazetted as a central hospital. This change from a tertiary to a central hospital forms the bases of the research.

#### **2. The Objectives**

The objectives of the study are:

- RO1: To use the Antwi and Kale (2014)'s Framework of Core Elements of change management to analyze the change at NMAH from a tertiary to a central hospital.
- RO2: To inform future healthcare reforms in particular hospitals restructuring.

The two objectives will be achieved through interviewing the managers who are/were the change agents.

#### **3. Ethical and Confidentiality Information**

The following are the ethical and confidentiality aspects of the study:

- i) Participation is voluntary and can be withdrawn at anytime
- ii) Participants will have to sign a consent form to participate

- iii) The risk around confidentiality will be minimized by not using participant's real names (respondent 1-9)
- iv) The interviews will be recorded and transcribed and the transcript version will be shown to the participants to confirm if it's a true reflection
- v) The research will have to be given a go ahead by the Rhodes Business School, The Department of Health and the NMAH Hospital.

## APPENDIX B

### INTERVIEW QUESTIONS FOR THE RESEARCH STUDY TITLED: THE REVIEW OF THE RE-STRUCTURING OF THE NELSON MANDELA ACADEMIC HOSPITAL THROUGH THE CHANGE MANAGEMENT APPROACH.

#### 1. BACKGROUND

After reviewing the literature in change management and its application in healthcare, it was discovered that there are some notable trends. The researcher will be using Atwi and Kale (2014) Framework of Core Elements of change management derived from these notable trends in theoretical change management models (see Table 2.1). According to Atwi and Kale (2014) there are Core Elements that are constantly cited by change management theorists from different backgrounds that are fundamental for change to succeed.

These Core Elements are further divided into two categories; the Essential Elements and the Useful Elements. Essential elements are those elements that are cited by four or five models of change management. The useful elements are those elements cited by 2 or 3 models of change management. There are four Essential elements and two Useful elements and the researcher intends to use all six Core elements to evaluate the change that took place at Nelson Mandela Academic Hospital.

#### 1.1 ESSENTIAL ELEMENTS

- a) **Environmental Factors:** factors external to the organizational that forces the organization to change or disappear.
- b) **Organizational Harmony:** this refers to different interests of individuals and units within the organization as well as the plans and processes of the organization to be compatible with the change.
- c) **Power Dynamics:** this refers to the importance of the acceptance of the change process by the influential actors within the organization.
- d) **Organizational Capacity:** this refers to the availability of resources and the necessary skills to achieve the change.

#### 1.2 USEFULL ELEMENTS

- a) **Nature of change:** this refers to the components of and the rationale behind the change. This argues that any change proposal should take into account the external and the internal realities of the organization.
- b) **Process of Change:** this refers to the practical part of the change. It refers to ensuring that there is a common understanding of the necessary steps to be taken to achieve the change and its objective.

The interview questions will thus be informed by the theoretical background.

#### **INTERVIEW QUESTIONS:**

1. Describe what prompted the initiation of the change?
2. Describe what you feel about the convergence/ agreement among stakeholders and units within the organization about the change process. What were the sentiments like?
3. How did the influential people (main actors) within the organization feel about the change process?
4. In your view, do you think there were enough resources (human, financial and environmental) to initiate the change? Discuss your answer.
5. In your opinion were the external and internal realities of the hospital taken into account when the change was initiated? Explain your answer.
6. Do you think there was a clear rational and readiness process to initiate the change? Explain your answer.
7. What in your view was missing in the change process and what could have been done better? Elaborate.



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Rhodes University  
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South Africa


Dear Sir/Madam

**Re: Approval to conduct Research at the Nelson Mandela Academic Hospital**

This is to confirm that Dr Mzulungile Nodikida has been granted permission to conduct his research at the Nelson Mandela Academic Hospital on change management. The research will be analyzing the restructuring of the Nelson Mandela Academic Hospital from a tertiary Hospital to a Central Hospital through the change management approach.

The institution management will support Dr Nodikida with the necessary information, these include documents and minutes of meetings that related to the change. The managers that participated in change process will be available to share their experiences. The hospital views this as a step forward in the development of research into the change management in healthcare and commends the initiative.

Regards

  
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Mrs. NP Makwedini  
CEO: NMAH  
DATE: 28/07/2016

