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Making sense of stakeholder responses to impending major policy reform in the private healthcare sector

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ABSTRACT

Implementing policy change is notoriously difficult, often marred by chronic delays or outright failure to achieve its originally desired mandate. This challenge drew the attention of many scholars who, over the years, published many studies attempting to describe and analyse what the policy change process looks like and most notably, strategies on how to better manage it. However, most of these studies tacitly committed themselves to strategic issues of managing change from a policy-maker's perspective, with very little consideration of what the change process actually looks and feels like from the perspective of the change recipients. Yet, it goes without saying that responses of these change recipients directly affect the outcomes of the change process.

This study sought to address this gap in literature by exploring South Africa's prevailing National Healthcare Insurance (NHI) policy reform. Using a qualitative design and theoretical insights from political sciences, social sciences and organisational studies, the study analysed how the relevant stakeholders in the private healthcare industry were variously thinking about and responding to the proposed reforms.

The findings of the study emphasised the critical role of temporally sequenced historical events in shaping an industry and influencing its change orientation. The study also weighed in on scholarly debates that challenged general characterisation of any recipients' contradictory opinions as 'resistance to change'. In this study, the stakeholders' seemingly antagonistic attitudes and responses to the NHI policy were not necessarily a contestation against change in itself. Instead, the conflict was over compatibility with the policy's implicit secondary goals. This contestation evoked opinions and responses so strong that it overshadowed the stakeholders' initial felt need for change. From this perspective, this research argued for a distinction to be drawn between diagnostic congruence and goal congruence. It further proposed that paying diligent attention to formulating an accurate diagnosis of the problems to be addressed through policy change could attenuate haggling and achieve far better results than finding the best way to attain an agreed upon goal across all relevant stakeholders.

KEY WORDS

Healthcare policy

National Health Insurance

Policy reform

Policy Change

Policy implementation

Recipient response to change

Change inertia

DECLARATION

I declare that this research project is my own work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration at the Gordon Institute of Business Science, University of Pretoria. It has not been submitted previously for any degree or examination in any other University. I further declare that I have obtained the necessary authorisation and consent to perform this research.

09 November 2015

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1 PROBLEM DEFINITION

1.1 Introduction

Planned change, be it organisational, social, or policy change is notoriously difficult and in most cases may not necessarily result in full implementation of its originally desired mandate (McDermott, Fitzgerald, & Buchanan, 2013). Although not all such departures are necessarily problematic (Ford & Ford, 2010; Thomas & Hardy, 2011), it is more common than not that change initiatives result in very slow progress than originally planned, or result outright failure to achieve their original mandates (Beer & Nohria, 2000; Burnes, 2011; By, Oswick, & Burnes, 2014). Many reasons have been put forward to explain such departures and resistance to change is one of the most commonly cited (Burnes, 2014).

This view drew a lot of attention in academia and over the years several studies were undertaken seeking to describe characteristics of this resistance, how it evolves over time and most notably, strategies and models on how to manage or overcome it (Bareil, 2013; Burnes, 2014). However, in organisational studies and political sciences, the greater majority of these studies committed themselves almost exclusively to strategic issues of managing change from the perspective of instigators of the change initiative, “with little more than a passing notice to what (the change process actually) looks and feels like from the perspective of the change recipient” (Oreg, Michael, & By, 2013, p. 6). It is against this backdrop that this study was designed.

South Africa’s prevailing healthcare policy reform provided an ample platform for this inquiry. South Africa is undergoing a major healthcare policy reform process through the introduction of the National Health Insurance (NHI) policy. At the centre of this reform are several real challenges in South Africa’s healthcare system that require change. These include, amongst other issues: South Africa’s poor healthcare outcomes relative to its endowment of resources, the inequitable distribution of healthcare resources that is skewed towards the more affluent, systems inefficiencies and fragmentation in its delivery structures (Department of Health, 2011). However, in spite of industry-wide acknowledgement of most of these challenges, the policy proposal has attracted mixed reactions, mostly adversarial, amongst stakeholders. The implementation of the reforms has also progressed much slower than originally planned, if not completely stagnated.

This study's primary objective was not an attempt to explore the reasons for this lack of progress in implementation of the reforms, neither was it an attempt to construct another prescriptive model on how to better implement policy change. Instead, the study focused purely on comprehending the change process from the perspective of the recipients within the context of their world and what they are trying to achieve in it. On a secondary level, the study also sought to investigate transcendental processes that influence recipients' behaviours in response to change, also viewed from their perspectives of the change agenda and the world around them. Such an exploration of a previously well researched subject, but relooking at it from an alternative perspective has potential to illuminate new insights previously overlooked, or provide empirical support to previously held beliefs (By et al., 2014).

Theoretically, conceptualisation of a change process from recipients' perspective is even more relevant in policy change. According to McDermott *et al* (2013), effective policy change requires change recipients, those whom the change is primarily meant to influence, to translate the policy mandates into their local contexts. In so doing, "first order change recipients" become "second order change agents" as they interpret, tailor, adapt and embellish policy mandates to fit their local contexts. This perspective brings to the fore a frequently overlooked dimension in the change process – the role of the recipients, not as victims of a change process that is thrust upon them, but as active participants in an evolving business environment. This consideration has far more implications than management tactics of how to deal with recipients' responses to change. It emphasises the importance of recipients' interpretation of the world around them, their active role in it and what they are trying to achieve in it, in driving the change process.

Oreg and colleagues (2013) weighed in on this perspective by proposing that recipients' perspective of a policy change process is equally as important even if it were not consequential for change's success. They argued that policy reform has a tremendous effect on organisations that are direct recipients of the change initiative. These organisations, among other things, contribute to the economy of the country, they employ people and sustain livelihoods of specific communities. This reason alone is sufficient enough to compel instigators of a change process to seek to understand recipients' outlook. And if this understanding can benefit the change process, all the better (Oreg et al., 2013).

Three useful analytical concepts were employed to help explore this subject: the population ecology perspective, social science theories and political science theories.

First, the stakeholder approach and the population ecology perspective was used to analyse the organisations-environment, that is: the macro-environment that organisations form part of and coexist in. These two perspectives draw insights from biological and social sciences in an attempt to understand dynamics of environments in which organisations coexist and interact with each other (Hannan & Freeman, 1977).

Second, political science theories were used to illuminate the policy processes occurring in the industry. This theme paid particular attention to empirical theories in political sciences on how political systems turn ideas into policy, and policy into reality. These theories are however more concerned with political tactics of how to implement policy change. Consideration of recipients' perspective of a change process is only referred to where relevant for implementation strategies.

The third theme sought to frame a lens through which recipients' perspective of the change process was analysed. However, there is scant literature in political sciences explicitly focused on recipient perspectives. To create a theoretical base for this study, the literature review explored theoretical conjectures in social science and organisational studies. Organisational literature is saturated with studies on how recipients respond to change, with a lot of focus placed on examining the concept of resistance to change. Although much of this literature is focused on examining intra-organisational change, it is also important to note that most of its dictums are grounded in social sciences, particularly Lewin's seminal theories on individual and group behaviour in response to social change (Schein, 1999). It is for this reason that this theme examined both organisational and social change perspectives, largely to the extent they helped to illuminate group behaviour in response to change.

1.2 Context of Study

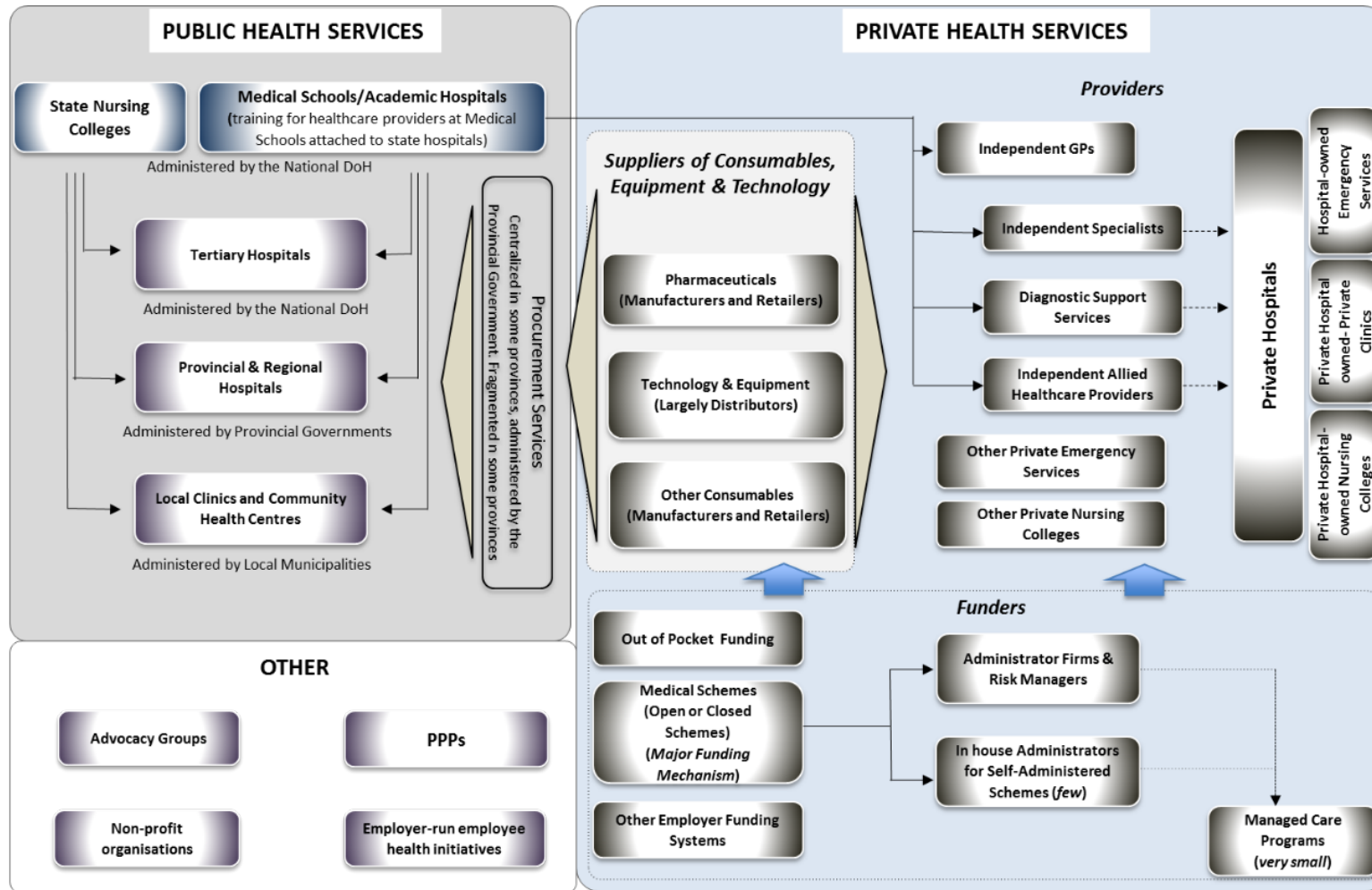
This study examined recipients' experiences of the policy reform process occurring in South Africa's healthcare sector. This section provides a high-level overview of this industry as well as an overview of the proposed policy reforms.

1.2.1 *Overview of South Africa's Healthcare System*

The prevailing healthcare environment in South Africa is comprised of multiple players operating in different segments of the system. These all broadly fall into two main sectors, which coexist in parallel - the public sector and the private sector as depicted in Figure 1 below.

Figure 1: Broad focus on stakeholders in the healthcare industry in South Africa

(Author's own diagram)



The public sector is a state-owned system structured to provide open access healthcare to all. This system is largely state funded. Clinics provide services for free, while public hospitals charge fees for their services but these are largely small nominal fees, tiered according to patients' ability to pay. The private sector, on the other hand, is an interdependent network of autonomous private organisations broadly operating in three subsectors namely, healthcare financing, healthcare services delivery (providers) and supply of consumables and technology. There is also a third sector in the healthcare industry that is very small but worth mentioning here. It is made up of non-profit organisations, advocacy groups and Private Public Partnerships (PPPs).

In 2013, the private healthcare sector accounted for healthcare of approximately 7 million people, primarily those with medical insurance covered by a medical scheme. Meanwhile, the public sector accounted for over 43million (Council for Medical Schemes, 2014). Most people generally view the private healthcare system as a provider of better quality of care when compared to the public system (Hassim, Heywood, & Berger, 2007). However, private healthcare services are prohibitively expensive and as a result only accessible to middle and high-income earners, who are a small proportion of the population. The public sector on the other hand caters for the greater majority of the population. It is usually overcrowded, suffers long queues and chronically under-staffed and (Hassim et al., 2007). As a consequence, the public system mainly caters for the indigent population who cannot afford the private healthcare.

Although on the surface there appears to be a clear separation between the private and public sector, there are several important overlaps between the two. First, all the doctors and most allied service providers driving healthcare services in the private sector are trained in the public system, at public expense (Hassim et al., 2007). The private sector is legally not allowed to train healthcare practitioners, except for nurses and emergency care services. Second, full-time public sector employees often work part-time (*'moonlighting'*) in the private sector to supplement their income. Third, in an indirect way, the public system supports the private sector through tax benefits given to individuals for medical aid contributions or out of pocket private healthcare expenditures. The state also provides tax benefits to companies for providing healthcare benefits to employees (Hassim et al., 2007). Fourth, the state also has a medical aid scheme for its employees, the Government Employees Medical Scheme (GEMS) that covers government employees' private healthcare needs.

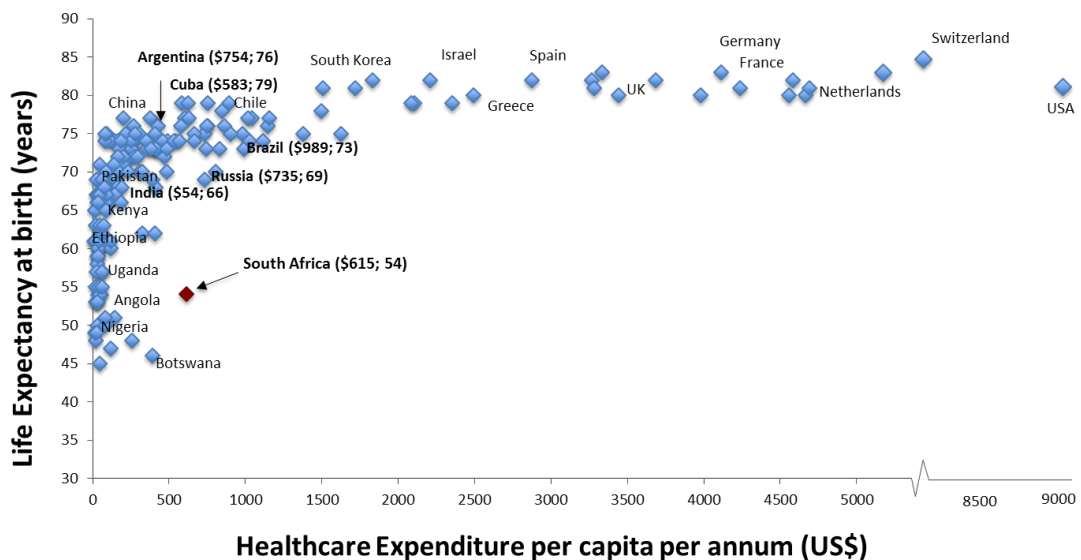
1.2.2 Need for Change

At the heart of many change initiatives is a compelling need for change, either because of a deep commitment to respond to a situation posing threat to the existing system or a response to a new identified opportunity. The healthcare reform in South Africa is by no means different. In recent years, there has been increased spotlight on South Africa's healthcare challenges and its structural failures. Central to the problem is the country's poor health outcomes relative to its wealth and endowment of healthcare resources (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

Figure 2 demonstrates this. The chart plotted over 175 countries' life expectancies against their healthcare expenditures. Each country's life expectancy was used as the closest proxy to the country's healthcare outcomes and this was plotted against healthcare expenditure. It is evident in this chart that South Africa spends a lot more money per capita on healthcare than many countries of the same level of development, yet it has lower life expectancy comparable to some of the poorest countries in the world that spend substantially less.

Figure 2: Healthcare Expenditure vs. Life Expectancy by Country in 2010

(Author's own, data sourced from World Bank (2015))



Of course there are several limitations to this assumption. For instance, a country's reported life expectancy is a function of other factors outside of mainstream healthcare services. Also using average expenditures and average life expectancies masks wide

variances within population groups in each country. However, this chart is still relevant. It is not necessarily being used here to compare healthcare outcomes for each country. Instead, the relevance of this chart is simply to demonstrate gross macro-level inefficiencies in South Africa's healthcare delivery system.

In 2009, *The Lancet* published a series of 6 publications, commissioned by the World Health Organisation (WHO), detailing a micro-level analysis of the state of South Africa's healthcare. The full details of these reports' findings are beyond the scope of this study. However, this study will discuss only three of the findings, detailed in Coovadia *et al.* (2009), relevant to the structural problems in the healthcare system that the NHI policy proposal seeks to address.

a) Poor health outcomes relative to the country's wealth and health expenditure:

In 2008, South Africa spent 8.1% of the country's GDP on healthcare financing (Health Systems Trust, 2013), equivalent to many middle and high-income countries but has healthcare outcomes worse than many lower income countries that spend substantially less.

b) A fragmented systems and institutional failures in the health sector

South Africa has a two-tiered healthcare system that the Department of Health (DoH) refers to as "neither rational nor fair" (Department of Health, 2011). On one hand is a functional but very expensive private healthcare system accessible to only 15% of the country's population (those with healthcare insurance), while on the other is an overwhelmed public healthcare system carrying the burden of predominantly the indigent, confounded by serious staff shortages, underfunding and poor management.

c) Uncontrolled commercialism of healthcare

The current healthcare services structure is inefficient. A lot of healthcare expenditure is wasted on non-health related costs along the delivery chain. The system also promotes excessive utilisation of more expensive hospital-based and specialist services, and the reimbursement model in the private sector incentivises over-servicing of the patients. This has contributed to driving the cost of healthcare beyond control

These structural challenges framed the basis for the NHI policy proposal, which is discussed below.

1.2.3 *The Proposed Policy Reform*

In August 2011, the DoH released the NHI Green Paper (policy proposal) with a range of proposed reforms for public commentary. The discussion below is a high-level overview of the key elements of this proposal. A fuller evaluation or thorough discussion of the proposal is out of the scope of this study. Instead, this overview serves as a summary of the policy proposal to the extent that it helps shape the context and scope of study.

Key in the Green Paper on the NHI is that South Africa has poor healthcare outcomes relative to its endowment of resources. Although presented as the National Health Insurance policy, the proposal presented a range of reforms, part of which would be the introduction of a universal insurance system, the NHI. As described by van den Heever (2011, p. vii) in his evaluation of the Green Paper, “(the proposal) implicitly seeks to address the institutional architecture of the health system,” rather than it being purely about healthcare financing. He further argues that NHI appears to be just a name given to a policy reform framework with much broader terms of reference (van den Heever, 2011).

The Green Paper recommended the centralisation of the public health system under the control of a mandatory ‘national funding system’, which will operate with regional offices. Pertaining to the public sector, the Green Paper recommended various programs for process improvements such as development of additional infrastructure capacity, address human resource deficits, improve quality of service, address drug stock-outs etc.

Pertaining to the private sector, on the other hand, the proposal implicitly recommended radical reforms with an aim to consolidate various healthcare funding mechanisms to a mandatory ‘single-tier’ government controlled system that procures healthcare services on behalf of all citizens based on defined benefit packages at accredited facilities (Department of Health, 2011). This ‘national funding system’ (the NHI) will be funded through mandatory taxation on all residents of South Africa with taxable earnings. Effectively, this implies restructuring of the entire private healthcare system, which currently has a ‘mature’ funding structure and autonomous providers.

According to the Green Paper, the reform process would be rolled over a 14-year phased process, which would include assessment of existing infrastructure, improvement of public health facilities and establishment of relevant enabling legislations and institutions for a centralised “single-tier” system.

1.3 The Research Problem

As of October 2015, four years since the release of the Green Paper, the implementation of the healthcare reforms had not progressed much. Despite political will and the DoH’s stated commitment that the reforms will still be implemented, there is an acknowledgement that the progress has been a lot slower than originally planned, if there is any progress at all. On the part of the recipients, despite widespread acknowledgement of the need for change, their responses to the policy proposal have also not necessarily been supportive, or at the very least positive. And, this raises the same age-old questions that have troubled policy scholars for years such as: “*why is change so difficult?*”, “*why do people fight change so hard?*” and “*where do inertial pressures on a change process come from?*”.

There are obviously many reasons contributing to the delays on the NHI policy reform process. This study is not necessarily concerned with exploring these reasons. There is also a lot of literature, both in political sciences and organisational studies written on the subject of change, to answer some of the questions on why change fails or why change is so hard. However, most of this literature is written with bias towards the instigators of the change agenda (Oreg et al., 2013), often written with a primary objective of developing prescriptive models and tactics to help change agents better manage the process.

This study, however, departed from this premise. Instead, it sought to examine the change process from the perspective of those whom the change agenda is meant to influence, the change recipients. This re-examination of such an age-old subject, but stemming from a different angle sought to illuminate possible insights previously overlooked. From this perspective, there are two identified questions that have not been thoroughly explored in literature and these formed the main objectives of this study:

First, what does the change process actually look and feel like from the perspective of the change recipients?

Second, how do recipients' narratives – their histories, their interpretation of the world around them and what they are trying to achieve in it – influence the change process?

1.4 Research Aims

This research sought to explore the experience of early phases of a policy reform process from the perspective of the recipients. The aims of this research were:

1. To fully understand the private healthcare industry in South Africa – how the industry is structured, who the major stakeholders are, what are the major challenges that the NHI policy trying to solve for
2. Explore the stakeholders' perspectives of the change process within the context of their environment – their views of challenges in the industry, changes required and their views of the proposed NHI policy.
3. Analyse stakeholders' responses to the change initiative within the context of their environment and what they are trying to achieve in it.

1.5 Research Scope

The scope of this study was confined to South Africa's private healthcare sector. This was mainly to ensure homogeneity of context and subject matter. Although the NHI policy is proposing transforming the entire healthcare value chain, the proposed changes targeting the private sector are different from those targeting the public system. This is partly because the private sector business environment is uniquely different from the public sector, hence the problems that the policy reform intends to address in each are inherently different. In the public sector, the policy proposal is largely focused on incremental changes such as process improvement, infrastructure development, improve management and administrative structures and introduce a financing structure. On the other hand, in the private sector the policy proposes radical changes that are likely to overhaul the entire sector such as restructuring of the healthcare funding system and centralising procurement of healthcare services for all citizens. It is inevitable that give these differences in contexts, business environments and the type of looming changes, the recipient responses would be widely different and

would best be analysed separately. And, given the limited time and resources, this research focused on the private sector only.

Also, this research was conducted four years after the release of the Green Paper on the Policy on National Health Insurance, published in August 2011. The Green Paper provided some detail of the proposed reforms together with an overview of reasons behind its key recommendations for public commentary. The DoH was then due to release the final policy paper (the White Paper) and Draft Bill thereafter. However, 4 years later, the White Paper has not been released yet. The government has however maintained that it is determined to establish the reforms (M. P. Matsoso & Fryatt, 2013; P. M. Matsoso, Fryatt, & Andrews, 2015). As a result, this study was limited to events occurring during a period of impending change.

1.6 Relevance of Study

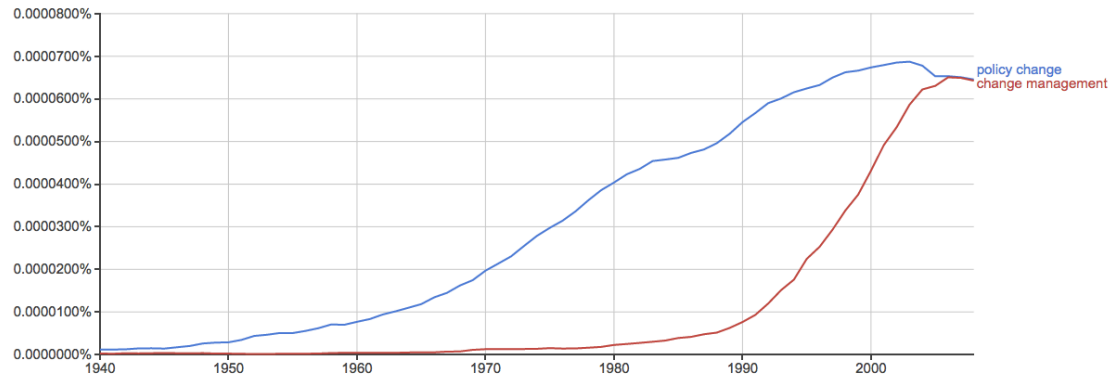
The subject of this study trends on two themes, namely; policy reform and change management. It is worth noting that although much of the literature on the latter theme is largely found in organisational change literature, which is different from policy change, the fundamental theories that guided much of the thinking on both subjects emanate from the same scholarship – the social science of how individuals and groups respond to change. It is therefore not uncommon to find reference to the same fundamental theories in either subject, particularly Lewin’s work, which is largely believed to be the foundation of most of the contemporary thinking on managing change (Burnes, 2004).

The subjects of policy change and change management have featured prominently in literature since the 1970s. To demonstrate this, Google’s Ngram Viewer was used to show a meta-level analysis of how ‘policy change’ and ‘change management’ trended in literature since 1940. Ngram Viewer is Google’s application that allows usage of a phrase to be charted according to yearly frequency of usage of the phrase or words within Google’s large body of indexed literature.

Figure 3 demonstrates the sustained growing frequency of the two phrases in literature, which still remains prominent today.

Figure 3: Google Ngram Viewer trend chart: policy change and change management

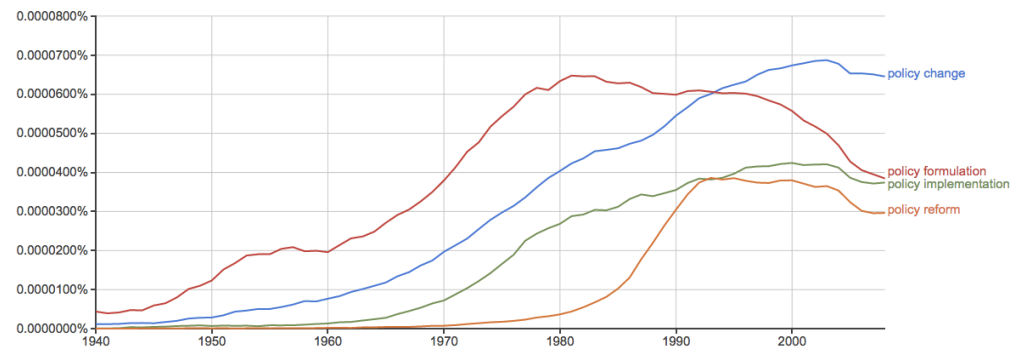
(Created on Google Ngram Viewer)



The phrase ‘policy change’ was also plotted against other related themes on the subject, such as ‘policy formulation’ and ‘policy implementation’. The result is shown in the chart in Figure 4. It shows that over the years, there has been different phases of rise and decline of various approaches to policy change.

Figure 4: Google Ngram Viewer trend chart: Citation levels for different approaches to policy change

(Created on Google Ngram Viewer)



In describing these lexical patterns, By, Oswick and Burnes (2014) argued that a citation profile that shows such rises and declines resonates with the pattern found in fads and fashions. They argue that the patterns follow a bell-shaped curve where, at the start of the fashion craze, only a few pioneers take interest in it. These early adopters are later joined by a tide of imitators and the fashion becomes popular for a while, until this fashion is ‘out’ and new fashions emerge. Such lexical shifts give an impression of differentiation and create a sense of novelty and progress of one fashion from its predecessor (By et al., 2014).

This observation is important for few reasons. First, it opens up scope for reflection into a subject that may have been researched over many years. Second, it compels anyone intending to revisit such a subject that has been researched for many years, to examine how the ideas and the practices developed and changed over time. Third, it necessitates one to account for tacit assumptions that could have been carried along through these transformations. These considerations render this research pertinent to academia.

The other reason why this research is relevant to academia is that it examined a previously well-researched subject but approached it different light – analysing the change process from the recipients’ perspectives. Although most of the debates in policy change and policy implementation literature may seem to have been resolved, a relook into the subject from an alternative perspective has potential to illuminate important insights previously overlooked.

This research is also important for business and politics. For the business of healthcare in South Africa, the study sheds more light into the way different organisations in the industry are variously responding to impending policy reforms. For politics, it provides more insight into recipient factors that influence the progress and outcomes of a policy reform process.

2 LITERATURE REVIEW

2.1 Introduction

This literature review frames the theoretical lenses through which this subject was interrogated. The study sought to examine the policy change processes from the perspective of the change recipients. The subjects of policy implementation and policy change have previously been researched for many decades, but this study intends to revisit them in different light. As would be expected, a subject that has undergone research over many years is bound to have also undergone many shifts and transformations through those years. A review of such a subject can therefore not be dealt justice if its examination is limited to perspectives at a particular point in time. It is imperative to take a historical and contextual perspective. This concept, also referred to as a 'historic turn' by Clark & Rowlinson (2004) or 'long view' by Burnes (2014), looks at how ideas and practices developed and changed over time rather than just examining them at a specific point in time. This 'long view' helps clarify fundamentals of what we now know, but also, which is more, potentially controls for tacit assumptions that have been carried over time without real interrogation into their validity or basis. The literature review in this study adopted this 'long view' approach.

There are three themes relevant to this investigation. The first theme explores two theories, the stakeholder theory and the organisations ecology theory to the extent they help to contextualise the interactions between key stakeholders in South Africa's healthcare system. The second theme explores various theoretical frameworks of how policy change occurs and models of implementing policy reforms. The last theme is an overview on the concepts of recipient responses to change, particularly seminal studies in social science literature on collective 'behaviour' of groups as they deal with change.

Stakeholder theory and business ecosystems will be discussed first.

2.2 Theoretical Frameworks for Analysing South Africa's Healthcare Environment

The primary aim of this study is to explore a change process from recipients' perspectives, within the context of their environments. To do this, an important point of departure would be a full appreciation of who the 'recipients' are as well as

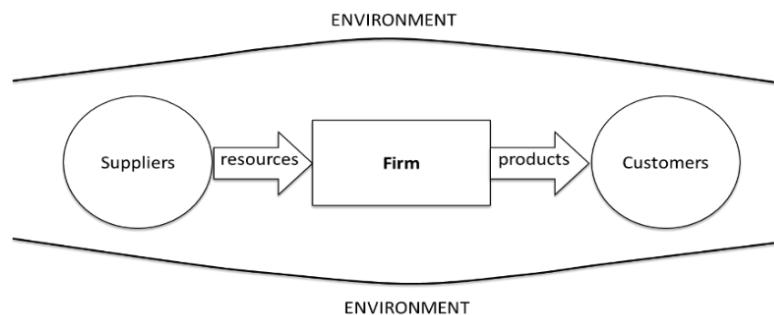
contextualise the world around them and what they are trying to achieve in it. This study used the stakeholder approach to identify the relevant recipients as well as the theoretical framework of business ecosystems to analyse the context of the world that these various stakeholders interact in and form part of. The stakeholder theory will be discussed first.

2.2.1 Stakeholder Perspective

The stakeholder approach cannot be attributed to a single academic as it has had contributions from many academics over the years. However, Edward Freeman in his landmark book, *Strategic Management: A stakeholder approach* (1984) presented one of the earliest and most concise description of the concept which remains its definitional cornerstone today. The concept primarily sought to answer the question, ‘*who or what really matters to an organisation?*’ To answer this question, Freeman described the evolution of a firm to present his argument.

He first presented a traditional view of a business looked at an owner-managed firm with suppliers and customers surrounded by an environment that is out there, as depicted in Figure 5 below. He called this a “*Production View*” of a firm.

Figure 5: The Production View of a Firm (Freeman, 1984)

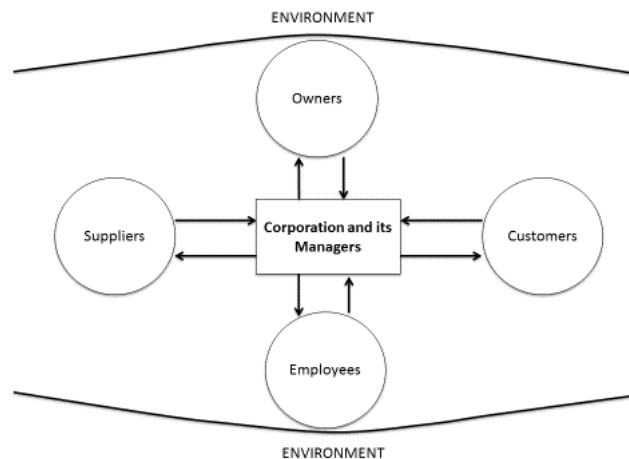


In this simple and narrow paradigm, a firm buys raw materials from a supplier, converts them into products and sells to a consumer. From this perspective, the firm’s primary responsibility would be the customer – satisfying the customer with superior value for money to make the business successful.

But then, a number of factors coalesce to make larger, more economical firms – *organisations* –, which have more efficient production processes. This demands large amounts of capital that may need to be sourced externally resulting in separation of ownership and control of the firm. Ownership suddenly becomes more disbursed, including banks, shareholders and institutions that financed the emergence of the

modern corporation. All of a sudden, the management of the firm is no longer accountable only to customers. Instead, leaders of organisations have a larger employee base to manage in order for them to deliver the firm’s promises to the customer and are also accountable to owners of the organisation who seek a return on their investment. Freeman (1984) called this, the “*Managerial View*” of a modern corporation, depicted in Figure 6 below.

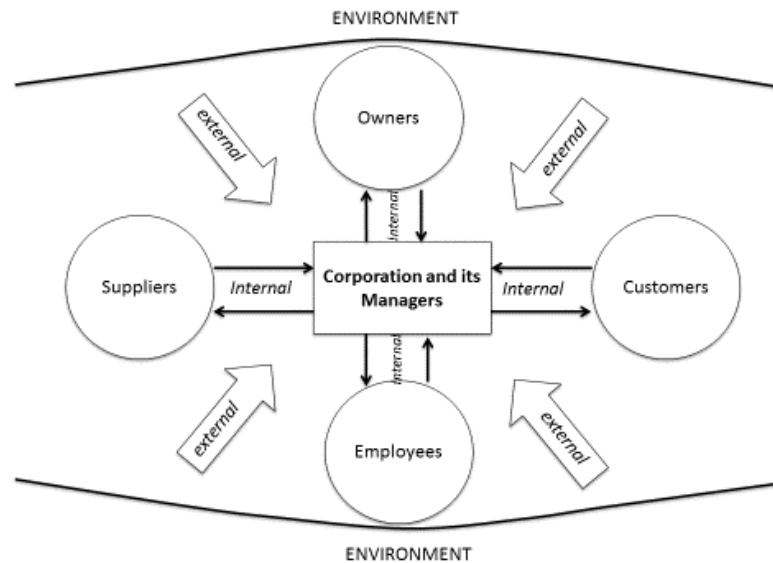
Figure 6: The Managerial View of a Firm (Freeman, 1984)



Freeman (1984) however further argued that this view is still narrow as it still assumes a static and stable operating environment that does not have demands on the organisation. He proposed a conceptual shift towards a construct that considers the external environment more closely. He argued that the “*Managerial View*” did not encompass the unpredictable nature of the corporate’s external environment and is inconsistent with the quantity and type of pressures that impinge on a firm. This gave birth to his stakeholder approach.

In this proposed framework, he considered two forces acting on a firm with potential to cause turbulence – internal change, which primarily appropriates the relationships a firm has with its internal environment as depicted in Figure 6 and external change, which considers turbulence thrust upon a firm from factors in its broader environment, as depicted in Figure 7 below. This view expanded cognisance of the broader boundaries of a firm’s relations with its external environment.

Figure 7: Internal and external change (Freeman, 1984)



Freeman (1984) proposed that internal change requires management to constantly reassess an organisation's objectives and policies in light of evolving demands by each of the four groups; customers, employees, suppliers and shareholders. However, external change produces another layer of uncomfortable uncertainty that cannot readily be assimilated into the relatively more stable relationships management has with its employees, customers, suppliers and shareholders. "External change can be understood in terms of the emergence of several groups and the structuring of old relationships of lesser importance, who have come to have a stake in the actions or inactions of the corporation" (Freeman, 1984, p. 13). These include governments, civil society, unions, pressure groups etc.

Many studies that followed this work by Freeman have only served to advance and justify the descriptive influence and normative validity of this paradigm (Donaldson & Preston, 1995; Freeman, Harrison, Wicks, Parmar, & De Cole, 2010). However, most of them committed much effort to defining means through which management can give due regard to interests of various groups that can claim stake on the corporation using this approach (Freeman et al., 2010). This limited view of the model has, as would be expected, attracted much criticism from other scholars. Those contesting its usefulness have questioned its lack of definitional clarity of 'exactly who or what really matters', as anyone and anything can possibly be considered to claim a stake on a firm (Miles, 2012; Mitchell, Agle, & Wood, 1997). In his more recent book, *Stakeholder theory: The state of the art*, Freeman (2010, p. 63) acknowledges this "ambiguity in the definition of the central term" and this limits the prospects for the approach "to ever be admitted to the status of (a) theory." However, in defence of the approach, he argues for specific

problems that the stakeholder approach tries to solve, which is primarily to counter previously held conceptions used to understand business. That is, promote a mind-set shift from a view of a business seen as a monolithic organisation concerned only with its customers, suppliers, owners and employees to a broader view that acknowledges other external factors and parties that impinge on it.

From this perspective, the stakeholder approach is relevant in this study to the extent it helps to build a case for the role of external pressures that impinge on an organisation beyond its own internal structures. However, identifying these relevant stakeholders only is not enough to understand the macro-environment that these organisations exist in and form part of. A more robust approach would have to consider the interrelatedness of these stakeholders as they interact with each other in their environment as well as give due regard to the valence of external forces that variously impinge on them. An ecological perspective helps in this regard.

2.2.2 *Business Ecosystems*

Ecological perspectives in the study of organisations-environment build on insights gained from biological and social sciences to help examine dynamics of organisations within their environments. Although, for the most part, the scholarship on business ecosystems is committed to understanding circumstances under which organisations emerge, grow and die, (Hannan & Freeman, 1989) it still provides some useful insights to help better understand the macro-environment in which organisations coexist and form a part.

The proponents of this theory criticise most routine models of analysing the macrosociology of organisations. They argue that most scholars approach the subject from the point of view of a monolithic organisation, with its own internal structures, facing an environment that is out there (Hannan & Carroll, 2000; Hannan & Freeman, 1977) – its competitors, buyers and suppliers, collaborators, shareholders, communities etc. Instead, an ecosystems approach places central the role of the environmental effects on the structure of organisations. It takes an outside-in perspective (Hannan & Carroll, 2000). It attempts to conceptualise forces that shape and maintain the communities of organisations over long periods of time as well as frame the context of the evolution of organisational diversity within those communities (Hannan & Freeman, 1989).

There are a wide variety of perspectives on this concept. However, only two of these perspectives, relevant to this study, will be discussed here – the adaptation perspective and the structural inertia perspective.

2.2.2.1 Adaptation Perspective

Most literature in management scholarship attributes patterns in nature to what Hannan and Freeman (1977) called the ‘adaptation perspective’. This view purports that, in order to survive, organisation leaders constantly scan their environment for opportunities and threats. They then formulate strategies and adjust their modus operandi and organisational structures accordingly to suit the changing environment (Hannan & Freeman, 1977). Clearly this view features quite prominently management literature and is the basis for a corpus of models on Organisational Design (OD). Consequently, viewed from this perspective, successful leaders and managers are those that are able to constantly model their organisations to buffer themselves from environmental disturbances or able to arrange smooth adjustments to accommodate environmental changes.

This view however, makes an important tacit assumption. It assumes a hierarchical view of control and places decisions concerning the organisation as a whole at the top (Hannan & Freeman, 1977). Of course leaders and managers of organisations do formulate strategies and adjust organisational designs to adapt to environmental contingencies, but Hannan and Freeman (1977) argued on the limitations to this adaptive flexibility. They proposed that the organisational structure contains an inertial component that curtails its ability to adapt.

2.2.2.2 Structural Inertia Perspective

Structural inertia is the tendency of an organisation to maintain its current trajectory despite external pressures to change. Forces that create inertial pressures vary in complexity and valence. They arise from internal structural constraints within the organisation as well as from environmental constraints.

Internal constraints may include propensity to over commit to a given structure because of sunk costs, bounded rationality due to limited information an organisation has, internal political constraints and normative agreements that may be held as a consequence of the organisation’s history (Hannan & Freeman, 1989). On the last

point, any firm holds normative agreements within its own structures such as standards of procedure, allocation of tasks, and lines of authority. These become the subject of some form of 'psychological contracts' and the cost of altering such 'contracts' cannot be understated (Robinson, 1996).

External constraints may include availability of information relevant to the organisation, social and political legitimacy constraints, legal and fiscal barriers as well as limitations of collective rationality. According to Hannan and Freeman (1977), any legitimacy an organisation attains constitutes an asset that enables it to manipulate the environment. Conversely, an attempt to change its structure may violate those legitimacy claims and this may constrain an organisations' ability to adapt.

The question of collective rationality also warrants additional emphasis. This accession emphasises the powerful constraint that an organisations-environment places on the autonomy of organisations in strategic decision making and highlights the importance of collective aspects of inter-organisational life (Astley & Fombrun, 1983). It argues that if one decision maker finds an optimum strategy for himself or herself in a competitive market, it does not follow that such a position is rational to a large number of other decision makers within its environment. Furthermore, any choice that appears rational to one party has potential to evoke reactions of counter-reactions from other parties affected by such a move. In essence, it is therefore difficult to achieve general equilibrium that suits all parties in the environment (Hannan & Freeman, 1977). And, until such equilibrium is achieved, it cannot be assumed that the adaptive response of a single organisation facing a changing environment would equally be a strategic position for any other organisation competing or coexisting with it in that environment.

This view has far-reaching implications on conceptualisation of how organisations, and an industry at large 'behave' in the face of change. It brings to the fore two important perspectives. First it highlights the importance of carefully interrogating units of analysis when investigating organisations-environments. Events at an individual level have consequences on an organisational level and events in an organisation have consequences on the population of organisations and the community at large. Second, it reignites a frequently overlooked aspect of organisational studies, that of the force field that shapes and maintains these communities of organisations. This second perspective is not new. In fact, it has its roots in social science literature, particularly Lewin's foundational work on analysing group behaviour, which is addressed in more detail below. However, organisational literature has not paid it the attention it deserves.

2.3 Policy Processes

This section explores different models of analysing the policy process. These include various approaches to formulating policy, various models of implementing policy and theories of how policy reform unfolds in practice. As it has long been established, some policy changes are radical, new and innovative while some are incremental shifts and refinements to existing policies (Bennett & Howlett, 1992). It is however not uncommon to find an overlap between the two, as some radical reforms are often preceded by smaller incremental shifts. This section will address both shifts.

Models of formulating and implementing change will be discussed first.

2.3.1 *Theories of Policy Implementation and Policy Formulation*

In literature there are generally two schools of thought that have long been debated as effective lenses for studying and describing policy reform, the top-down approach and the bottom-up approach (Cerna, 2013). The top-down approach emphasises the role of central government in crafting and implementing policy change while the bottom up approach advocates for consideration of recipients' views when both crafting and implementing policy change. However, many contemporary scholars find this dichotomous view problematic arguing that the two approaches are not necessarily distinct from each other. Instead, they overlap or at least complement each other (Hill & Hupe, 2014).

One such scholar is Matland. This section will pay particular attention to the authoritative model that he developed to solve for the complexity of trying to synthesise the two approaches. However, in order to best appreciate Matland's model, a brief overview of the top-down and bottom-up models are presented first.

2.3.1.1 *Top-down Approach*

This approach sees policy formulation and policy implementation as distinct activities and emphasises the role of setting up goals and means to achieve them (Hill & Hupe, 2014). Its central argument is anchored on the view that policy designers, often central government, in order to control the policy implementation process should concentrate on factors that can be manipulated at central level to drive action of the target recipients towards desired outcomes (Matland, 1995). The starting point is the

authoritative decision from the centrally located actors and their views seen as the most relevant to produce the desired mandate.

There have been many contributors to this theory but the most notable authorities on the subject are Sabatier and Mazmanian. They described variety of legal and political variables affecting the different stages of policy implementation and synthesised them into six general conditions (Sabatier & Mazmanian, 1979):

- a) Having clear and consistent objectives
- b) Formulating an adequate causal theory
- c) Developing legally structured implementation processes to enhance compliance
- d) Having committed and skilful implementing agents
- e) Ensuring support of interest groups
- f) Nonappearance of changes in socio-economic conditions which could substantially undermine political support or causal theory

Sabatier and Mazmanian (1989) later build on their argument proposing three general sets of factors which they hypothesised to determine predictability of successful implementation and influence compliance to the mandate of the reform process (Matland, 1995):

- a) Tractability of the problem,
- b) Ability of statute to structure implementation
- c) Non-statutory variables affecting implementation

There have been further attempts to expand on these factors to increase the theory's rigor (Sabatier & Mazmanian, 1989). But, as Matland (1995) argued, this has only served to increase the complexity and concentration of variables that need to be manipulated at the central level. In summarising many other contributors to the theory, Matland (1995) concluded that the common top-down advice is:

- a) Make policy goals clear and consistent
- b) Minimise number of actors
- c) Limit the extent of change necessary

- d) Place implementation responsibility in an agency sympathetic with the policy goals

The theory has been subjected to a lot of criticisms for its lack of parsimony. Some of the criticisms include that it is a futile desire to develop generalisable prescriptive advice for a complex and very dynamic challenge (Matland, 1995). Further, that the theory does not consider events preceding the policy change. In addition, the theory is criticised for its focus on administrative processes while neglecting institutional and political factors and its emphasis on top-level policy framers as key actors while undermining implementers (Cerna, 2013).

2.3.1.2 Bottom-up Approach

An alternative perspective, the bottom-up approach argues in favour of seriously considering the influence “street-level bureaucrats” have on the outcome change initiative (Lipsky, 2013). Proponents of this approach propose that a more realistic view of change implementation can be gained employing the views of the target population in the implementation process (Matland, 1995). Implementation occurs at two levels, at a macro-level where centrally located policy framers develop the program and at an institutional or micro-level where local implementers develop their own interpretations of the policy and then devise their own actionable plans for implementation (Matland, 1995). Central actors cannot control the implementation process but can only indirectly influence micro-level factors. As a result, a wide variety of outcomes at a local level can be expected from the same national policy. McDermott and his colleagues (2013) referred to this phenomenon as “entrepreneurial change agency responses.” In their study, they argued that micro-level implementers are “first order recipients”, but in response to imposed change they become locally contextualised into “second order agents” who then tailor and embellish policy mandate to suit local contexts (McDermott et al., 2013).

An alternative take on the bottom-up approach was proposed by Hjen (1982). His strategy involved engaging targeted policy recipients at policy planning phase asking them about their goals, plans, interactions and problems (Hjern, 1982). This enables the centrally acting policy framers to identify relevant implementation structure, key coalitions and specify policy for local, regional and national levels (Matland, 1995).

There are two common criticisms levelled against bottom-up approaches. The first is that too much discretion is left in the hands of the recipients whose interests may not necessarily be aligned with those of the centrally located policy framers i.e. the government. Those who find this problematic argue that policy control should instead remain in the hands of the government, which is accountable to its sovereign voters (Matland, 1995). The second is concerned with evaluation of effects of the policy which become difficult given a variety of possible localised outcomes due to increased local autonomy (Cerna, 2013).

2.3.1.3 Combination of the Two Approaches

Over the years there have been attempts to combine the two approaches. At the heart of most of these attempts is an acknowledgement that there are other situational parameters that define policy context that the implementation designer cannot readily control for (Hill & Hupe, 2014). These may include scope of change, goal conflict, institutional setting and environmental stability (Matland, 1995). To solve this, there are scholars who have proposed a synthesis of the two models, while other scholars advocate for policy maker's discretion of an appropriate model to use given each situation

The proponents for the synthesis approach advocate for the views of policy designers, implementers and the target groups to be incorporated in planning an implementation strategy. One such proponent is Sabatier (1986). He proposed a synthesis model building on his earlier top-down view, by introducing the role of a network of advocacy coalitions. In this theory he proposed that policy change should be approached with a long-term perspective allowing for periods of policy learning. Learning is achieved through advocacy coalitions – groups of policy advocates from different organisations that share the same vision for change. His advocacy coalition framework is discussed in more detail below.

Mischen and Sinclair (2007) suggested an alternative approach to democratising the policy formulation process. Building on Lewin's action research approach (also discussed in more detail below), they proposed that the implementing agent develops and initiates policy implementation in a top-down manner but once the implementation process starts, they constantly refine the policy depending on feedback received from the implementation programs.

Matland (1995) and other scholars, on the other hand, have argued against a generic synthesis approach to the two models. Matland (1995) argues that many of the contributors to the study of policy implementation based their assertions on single case studies. Most proponents of the top-down approach based their studies on relatively clear policies while supporters of the bottom-up approach studied policies with greater uncertainty. As would be expected, each of these two schools of thought consequently presented long lists of quite justifiable variables that are important and affect implementation given their peculiar situations. However, an attempt to simply assimilate the two into a single model is not only difficult, but also serves to add complexity with a prodigious number of variables that do not necessarily talk to each other (Hupe, 2014).

To solve for this, Matland proposed a model to guide selection of the most appropriate approach for a given situation. He suggested that when change is incremental, scope of change is low, goal conflict is minimal, the environment is stable and institutional setting is well controlled, the plan should therefore favour a top-down approach (Matland, 1995). However, when implementing policy in which uncertainty is high, with a variety of conflicting goals and an unstable loosely coupled environment, then bottom up approaches maybe more appropriate (Matland, 1995). To factor this approach into a model, Matland (1995) went further to develop a matrix that attempts to explain when each of the two approaches would be more appropriate, the conflict-ambiguity matrix. His matrix was based on two variables, conflict and ambiguity, discussed in more detail below.

2.3.1.3.1 Policy Conflict

Conflict plays a central role in this decision-making matrix. This notion builds from an assumption that individual actors are rationally self-interested and this has potential to create conflict. Conflict develops when there is failure to agree on a set of goals for the proposed policy reform. Even when a set of goals is clearly written and well communicated, the degree of goal congruence may be problematic. The challenge for the policy maker lies in finding the best way to attain an agreed upon goal across all parties directly affected by the reform, particularly the most influential. When such conflicts exists, actions change and actors may resort to bargaining mechanisms (Matland, 1995). Matland (1995) further posits that unfortunately bargaining may not necessarily lead to goal congruity. Rather focus is placed entirely on negotiating action

plans and often culminates in no action when actors fail to reach an agreement or derailment of the policy agenda in the direction of the most powerful coalition.

For conflict to exist, there must be interdependence of fate amongst actors, incompatible objectives, and a perceived zero-sum element to the interactions (Matland, 1995). Policy conflict therefore would exist if there is at least one organisation that sees the policy action as directly relevant to its interests and when this or these organisation(s) involved have incongruous views with the proposed policy agenda. Such differences can arise either from differences of opinion on the professed goals of the policy, or substance of programmatic activities that the policy plan intends to action out to achieve the professed goals (Matland, 1995). Matland (1995) argued further that the intensity of the conflict increases with an increase in incompatibility of concerns and with an increase in perceived stakes for each stakeholder.

2.3.1.3.2 Policy Ambiguity

Policy ambiguity in implementation, on the other hand arises from a number of sources and can broadly be characterised into two categories: ambiguity of goals and ambiguity of means (Matland, 1995). Goal ambiguity leads to misunderstanding of the policy agenda and creates a lot of uncertainty. This is foundational to top-downers and most contemporary change models, that the goals of a change initiative must be clear and well communicated. Goal ambiguity is seen as a root cause of a lot of misunderstanding, uncertainty and anxiety. It is therefore often deemed culpable in many implementation failures (Matland, 1995). However, Matland (1995) also argues that the converse, goal clarity can potentially lead to dysfunctional effects. Clear goals can lead to more conflict as existing actors become more aware of existing or impending threats to their environments. From this perspective, it would come as no surprise why some contemporary change models advocate for concealing details of change goals in order to limit conflict.

Ambiguity of means, on the other hand, may manifest when there are uncertainties of the various roles different organisations play in the implementation process or when the complexity of the policy itself makes it difficult to know exactly what tools to employ, how to use them and the effects of their use would be (Matland, 1995). There have been calls in some academic circles to always limit ambiguity in policy goals. For instance, Kotter (1996) in his 8-step model, which is still very popular today, asserts the importance of communication as the fourth step in order to “engage” and “enable” the organisation during a change process. There have also been calls to eliminate ambiguity in policy means by limiting policy change to those areas where the centrally

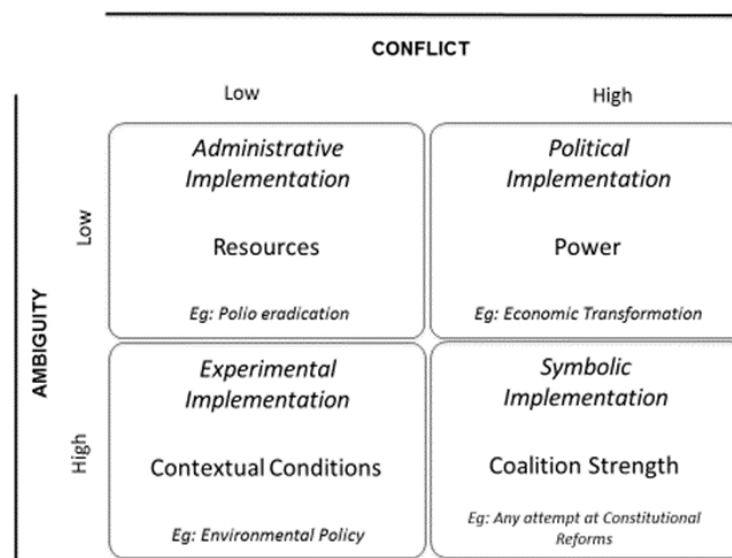
acting policy instigators understand how actions occur and those areas with known instrumental means to attain desired goals (Matland, 1995). Advocates for this view, in contemporary change literature argue for minimising the extent of required change or implementing incremental changes in piece-meals.

However, Matland (1995) argues that it is sometimes not always easy to find the right solution or pathway to answer problems that the policy maker may be faced with. In such cases, a degree of ambiguity is inherent in the policy process. “Sometimes finding a right answer requires a learning and experimenting process,” (Matland, 1995, p. 157). He also further argues that politicians almost always attempt to react to the demands of their supporters by producing some form of tangible action. As a result, it is reasonable to expect that the system will routinely produce policies that have ambiguous goals and ambiguous means (Matland, 1995).

2.3.1.3.3 The Policy Ambiguity Matrix

To remedy the challenges highlighted above, while harnessing the advantages of both top-down and bottom-up approaches, Matland synthesised these two variables into a matrix, illustrated in Figure 8 below.

Figure 8: Conflict Ambiguity Matrix: Adapted from Matland (1995)



a) Low policy ambiguity and low policy conflict

This set-up, where goals are clear means for solving existing problems are known, provides an ample environment to rational decision-making, the outcomes of the

process are determined by resources. Information flows from the top down explicitly outlining the goals of the policy agenda, responsibilities at each level, deliverables and measurement of outcomes (Matland, 1995). Incentives for compliance and disincentives for non-compliance can easily be structured and communicated at each level of implementation.

b) Low policy ambiguity and high policy conflict

This occurs when various stakeholders have clearly defined goals, but these goals are incompatible with each other's. Consequently, conflict battles will also arise over means because the different stakeholder goals are likely to have completely different pathways to follow. So while there is an explicit, well-communicated policy hold-ups can potentially emanate from powerful stakeholders that control resources outside of the implementing body. As would be expected, such conflicts would erupt early on, at the policy proposal stage. According to Matland (1995), implementation outcomes under such circumstances are decided by power. Stakeholders or a coalition of stakeholders with sufficient power will enforce their will on other participants. Alternatively they will resort to bargaining or lobbying.

On the part of the implementing body, the solution might be stamping of authority using coercive, remunerative and punishment mechanisms. Where such power does not exist, activities are normally directed towards haggling or a negotiated agreement. There are various forms of bargaining techniques in literature worth a passing mention here, but are outside the scope of this discussion. These may include side payments (compensation for unequal exchanges), logrolling (exchange of favours), cronyism, oversight or constructive ambiguity (Harstad, 2008; Holcombe, 2006).

c) High policy ambiguity, low policy conflict

Matland (1995) proposed that if a policy exhibits high levels of ambiguity but low conflict, this implies that the goals of the policy are clear and generally well accepted but there is no clarity on the role of each stakeholder, the tools required, how to use the tools, pathway to follow or possible outcomes of the chosen process. Under such circumstances, Matland (1995) argues that outcomes will largely depend on which actors are active and most involved. The lack of conflict opens the arena for experimentation. But then, the active participants, depending on their level and orientation of interest, they are likely to mould the policy significantly. This process is more prone to environmental influences than other processes and is likely to take a bottom-up approach.

d) High policy ambiguity, high policy conflict

As noted above, policy ambiguity may be strategic on the part of the implementer in limiting the levels of conflict among interested stakeholders. However, Matland (1995) also argues that policies that evoke highly salient symbols also often produce high levels of anxiety and conflict among recipients even when the policy is vague. Matland (1995) further asserts that a policy with vague goals, or as he called them – “referential goals”, breeds differing perspectives as to how to translate abstract goals into instrumental actions. This leads to multiple interpretations and debate over the appropriate pathway to follow. Stakeholders see their futures directly tied to the policy direction, and therefore coalitions are likely to form on the basis of dependence of fate. Under such circumstances, policy course is determined by the strength of coalitions at the level of stakeholders who control the available resources (Bryant, 2015; Matland, 1995).

2.3.2 Theories of Policy Change

Section 2.3.1 above discussed the commonly debated approaches of how ideas or desired goals can be translated into actionable policy. It also reviewed potential strengths and weaknesses of each approach. However, these models tell us very little about how policy change actually unfolds. That is where the theories discussed in this section come into play. These theories help frame various lenses through which the micro-environment of a policy reform process can be analysed as well as provide a theoretical framework of how and why a change process adopts a particular shape.

Three theories relevant to this study will be discussed, namely: historical institutionalism, the advocacy coalition framework and punctuated equilibrium.

2.3.2.1 Historical Institutionalism

In this section an overview of two perspectives on historical institutionalism will be discussed, namely path dependence and the critical junction theory. These theories take a historical perspective to describe mechanisms of how prior events influence the outcome of change initiatives. As one of the leading proponents of this school of thought, Pierson (1993) aptly explains, historical institutionalism “is based on a few key claims: that political processes can best be understood if they are studied over time.” He further asserts that “structural constraints on individual actions ...are important sources of political (behaviour); and that the detailed investigation of carefully chosen,

comparatively informed case studies is a powerful tool for uncovering the sources of political change.” This renders historical institutionalism theories particularly relevant to this study.

Path dependence will be discussed first.

2.3.2.1.1 Path Dependence

It is not uncommon to find reference to path dependence in political literature, however in most cases, the concept is often employed without careful elaboration (Pierson, 2000). In many cases, the concept is used to vaguely support a few key claims such as: “history matters”; “the past influences the future”; “large consequences may result from relatively small or contingent events”; or that a “particular course of action, once introduced can be virtually impossible to reverse” (Pierson, 2000). Such perspectives are by no means flawed. Instead, they employ various modes of “path analysis” in which relations between temporally sequenced events are considered (Mahoney, 2000). However, they fail to do justice to the concept of path-dependence and why it deserves special attention in political sciences.

“Path dependence specifically (characterises) those historical sequences in which contingent events set into motion institutional patterns or event chains that have deterministic properties” (Mahoney, 2000). In other words, under a set of initial conditions conducive for self-reinforcing sequences, a number of relatively small events occurring in a particular sequence can set into motion event chains that produce large outcomes with enduring consequences (Pierson, 2000). There are many possible outcomes that can emerge, attributable to timing and sequencing of these contingent events. Earlier parts of the sequence matter more than the later parts (Mahoney, 2000).

Pierson (2000) further reinforces the role of increasing returns. He asserts that this is critical in explaining how large eventual consequences can evolve from these relatively small, temporally sequenced events. Once one path of several path-dependent processes realises self-reinforcing sequences, each step along that particular path produces societal commitments, which make that path more attractive than its alternatives (Mahoney, 2000). As such effects begin to accumulate, they generate a powerful vicious cycle of self-reinforcing activities that may lead to a single equilibrium that is generally resistant to change (Pierson, 2000). Drawing on Arthur, Pierson (2000)

proposes that these increasing returns processes have peculiar features that he summarises as:

- a) Unpredictable – early event, albeit relatively small, have large effects and are partly random and many outcomes are possible
- b) Inflexible – the farther one is in the process the more difficult it is to shift from one path to another
- c) Non-ergodic – accidental events early in the sequence cannot be ignored as noise because they feedback into future choices. And the system will not return to its original state
- d) Potentially path-inefficient – in the long run, the path that becomes locked in may generate lower payoffs that foregone alternatives would have.

2.3.2.1.2 *Critical Junctures*

Another alternative conception of history's role in political studies, also popular amongst historical institutionalists, is the theory of critical junctures. This conception is by no means incompatible with path dependence. While path dependence proposes that appropriately sequenced, relatively small events at one point in time have large eventual consequences owing to increasing returns (Mahoney, 2000; Pierson, 2000), critical juncture theory calls more attention towards periods of significant change that typically occur in distinct ways and are hypothesised to produce distinct legacies (Hacker, 1998). The fundamental logic behind this argument emphasises the lasting impact of choices made during the critical juncture in history, rather than simply long history to path dependent institutional evolution that suddenly accelerates in a particular direction (Capoccia & Kelemen, 2007). These choices or junctures are critical because they close off alternative options and lead to the establishment of institutional arrangements that generate a particular path dependent trajectory that is often difficult to alter. (Capoccia & Kelemen, 2007)

It is common to find scholars in historical institutionalism linking critical juncture to the theory of path dependence. For instance, Capoccia and Kelemen (2007) suggested that path dependence is a crucial causal mechanism for historical institutionalism, and critical junctures constitute the starting point for many path-dependent processes. In other words, they propose that critical junctures play the crucial role of setting into motion processes of increasing returns. Classic examples for a critical junctures include changes in governments, war, natural disasters, major protests, radical policy reforms and significant legally binding judgments.

2.3.2.2 *The Advocacy Coalition Framework*

Another perspective, totally separate from historical institutionalism is the advocacy coalition framework. Developed by Sabatier (1988), the advocacy coalition framework proposes that people have deeply held beliefs about policy areas, including ideas about causation, intensity of the problem and promising solutions to solve the problem. Stemming from this, groups with common beliefs form coalitions around certain interests that are linked to them. Sabatier (1988) asserts that it is possible to map these networks within a policy sector. Policy change therefore occurs through interactions between external changes to a political system and the success of the ideas within the most powerful coalitions, which may cause actors in other coalitions to shift (Cerna, 2013).

The contribution of the theory is that it uses policy sub-systems as basis for developing a theory of policy change, using coalitions as key units of the internal structure (Cerna, 2013). It is especially useful in circumstances where there is high goal conflict and high uncertainty about the nature and the cause of the problem.

This theory makes a few key assumptions. It assumes that coalitions are held together by agreement over core beliefs, not interests because, as Sabatier (1988) argues, beliefs are more inclusive and variable. Another assumption is that coalitions may have diverse members, but because the groups already share common beliefs, they would effectively coordinate themselves because of need to reach common understanding. Also, this theory assumes that core beliefs are unlikely to change unless major external events are skilfully manipulated by proponents of change or new learning about policies is thrust upon coalitions that shifts its previously held beliefs.

2.3.2.3 *Punctuated Equilibrium*

This theory seeks to explain a simple observation that “although generally marked by stability and incrementalism, political processes occasionally produce large scale departures from the past,” (Baumgartner, Jones, & Mortensen, 2014, p. 59). Punctuated equilibrium therefore seeks to conceptualise this alteration between long periods of stable infrastructure that only allow small incremental adaptations, *punctuated* by brief periods of revolutionary upheaval (Gersick, 1991).

The theory asserts that there are always many ideas are constantly competing for attention but then something happens at some point in time that generates attention on

some specific idea and it will expand rapidly and become unstoppable (Cerna, 2013). This may be because the idea gets defined differently, new dimensions of the issue get attention, new actors get involved or the issue becomes more salient and gains heightened media and public attention (Stachowiak, 2009). These conditions then set up an environment within which large leaps of path dependent processes can occur, but they do not predict direction or guarantee it.

There is one major assumption held in this theory. The theory suggests that government institutions (which Baumgartener *et al.* (2014) termed “venues of policy action”) are typically inclined towards maintaining status quo and have a monopoly over the way issues are defined (termed “policy images”) as well as the way decisions are made. Actors seeking change within these institutional constraints search for new “venues” inclined to their beliefs or views such as the media, legal system or lobby groups. Each “venue” carries some form of decisional bias (Cerna, 2013). Support is therefore typically mobilised through redefinitions or reframing of the issue at hand – altering the “policy image” to create an alignment of beliefs within a particular “venue”. In most instances, media can play a particularly important role in mobilising public support and directing public attention to specific aspects of the “policy image”. The culmination of a combination of these factors results in large “image” and “venue” shifts.

This theory in action suggests that a strategic move for political actors involve a dual role. First, they need to control the image of the policy problem through the use of rhetoric, symbols and policy analysis (Stachowiak, 2009). Second, they need to seek out the most favourable “venue” for consideration of their issues either through venue shifts or control appointment of participants in charge of the relevant venues (Cerna, 2013). It also highlights the strategic role of institutions, or “venues” in triggering chains of events with lasting legacies, especially the possibility that a relatively small minority group can manipulate and leverage on the influence of these venues to create change.

2.3.3 *Outcomes of a Policy Change Process*

One issue that has become a subject of debate among scholars in political science is defining successful change. According to Matland (1995), the pivotal question is whether attention should be focused on fidelity of the change process to the designer’s plan or on the general consequences of the implementation actions. Advocates for “fidelity to the designer’s plans”, measure success of a policy reform process in terms of specific outcomes that are tied directly to the statutes that are the source of the

policy reform program (Matland, 1995). It would therefore come as no surprise that supporters of this view perceive recipients' responses to a policy reform as either 'resistance' or 'acceptance'.

Advocates for general "consequences of the implementation actions", prefer a much broader evaluation in which a reform process that leads "positive effects" can be labelled a success (Palumbo et al. in Matland, 1995). In other words, outcomes of a change process need not necessarily be what the change instigator intended, but any positive effects in the direction of the desired outcome is a success. However, this school of thought also acknowledges that the implementation of a policy reform cannot necessarily be surrendered to natural evolutionary processes. While accommodating lessons gained from change recipients, there is still need to maintain control of the process towards a desired goal.

Both of these views raise an important premise, the role of recipients' responses towards the change process. This section (Section 2.3) looked at strategic issues of policy change process from a planners' perspective – how ideas turn into actionable policy and how the policy change unfolds. The next section will reflect on some of the dicta on recipient response to change. The reflection will pay particular attention to perspectives on recipient factors with potential to create inertial pressure on a change process.

2.4 Response to Change

Failed change efforts have often been blamed on inadequate competence in managing the change process (Griffith, 2001) or on resistance to change (Burnes, 2014). This in turn led to a tide of research in search for either solutions to better manage change – programs, models, set of actions and skills; or tactics on how to avert or manage resistance to change. However, this section will pay attention to scholarship on the behaviour of recipients during a change process, particularly deviant behaviour that has potential to exert inertial pressures on the change process or potential to drive the change process in a particular direction independent of the original change mandate.

2.4.1 *Resistance to Change*

The concept of human 'resistance to change' has featured prominently in management literature since the 1940s and over the years, the concept has undergone significant shifts (Bareil, 2013). At the centre of it is the recurrence of two poignant questions first

proposed by Coch and French (1948) in their seminal article, *Overcoming resistance to change*:

1. Why do people resist change so strongly?
2. What can be done to overcome this resistance?

A lot of research that followed devoted energy to unpacking causes of this resistance to change. Fuelling this avenue of research has been a general appreciation that change is an inevitable part of organisational life and *successful* change is essential if organisations are to survive. This placed prime responsibility on those who lead organisations to be better managers of the change process (Beer & Nohria, 2000; Cummings & Worley, 2009; Kotter, 1996). Over the years, several models to help better manage the change process emerged. However, despite all this research, a majority of change initiatives still failed to achieve their intended objectives (Beer & Nohria, 2000; Burnes, 2011). Many reasons for such failure have been presented, and 'resistance to change' emerged as one of the most frequently mentioned (Burnes, 2014; Erwin & Garman, 2010). This provoked research into this 'resistance' coupled with proposed models of how to overcome it.

In the six decades of researching 'resistance', two paradigms have become apparent (Bareil, 2013). Some scholars viewed resistance as baffling pathological counter-forces that obstructs necessary change and needs to be minimised or managed (Goodstein & Burke, 1991; Kotter & Schlesinger, 1979; Lawrence, 1970; Recardo, 1995). While others challenged this view, promoting a 'productive resistance' paradigm. Instead of interpreting resistance as an organisational ill, proponents of 'productive resistance' have suggested decoding it (Ford & Ford, 2009; Miguel, Clegg, Rego, & Story, 2013; Piderit, 2000) and start using it as a source of feedback to improve change management processes (Dent & Goldberg, 1999; Ford, Ford, & Amelio, 2008; Thomas & Hardy, 2011) or enhance creativity (Ford & Ford, 2010). However, most of this literature maintained a biased view that favours change agents' perspectives with very little attempt to conceptualise what change looks like from the perspective of change recipients, the very people whom the change initiative is meant to influence (Oreg, Vakola, & Armenakis, 2011).

McDermott and colleagues weighed in an alternative perspective to this debate. They argued that in policy reform, 'first order' change recipients - those whom the policy reform is primarily meant to influence-, inevitably become 'second order' change agents as they attempt to tailor and embellish the change mandate to suit their

contexts (McDermott et al., 2013). They further proposed that among these second order change agents, there are ‘adapters’ – those who make appropriate local adjustments to the policy mandate and ‘extrapreneurs’ – those who add extra dimensions to the change mandate. This argument sort of deviates from the traditional dichotomous view of responses to change which sees responses as either acceptance or resistance. Instead, it points towards a continuum responses that range from direct impedance and avoidance to adoption, adaptation and manipulating the change agenda (McDermott et al., 2013).

Burnes raised another important premise as he reflected on the subject of organisational change. Burnes (2014) notes that a lot of change literature seems to be firmly focused on individuals as sources of resistance. However, if one explores the foundations of the subject on resistance to change, it paint a different picture. Reflecting on Coch and French’s 1948 article, *Overcoming resistance to change*, Burnes asserts the need to acknowledge the broader context of this work in order help to inform current debates on resistance to change and recipient response to change. He argues that Coch and French’s article was not a result of a single study, but a culmination of more than a decade of field experiments conducted by Kurt Lewin into social dynamics of collective behaviour in both organisational and social settings (Burnes, 2014). The next section reflects on this work to help fully comprehend this subject of recipient response to change.

2.4.2 *Lewin on Understanding Recipient Response to Change*

A few people have had more profound impact on the theory and practice of change as Kurt Lewin (Schein, 1999). Although most of his pioneering work was primarily committed to solving social conflict, be it religious, ethnic or industrial, in order to improve human condition (Burke, Lake, & Paine, 2008), his theories have found relevance within the broader sociological aspect of planned change. This section is a brief re-appraisal of his work to the extent it helps to provide a framework to analyse drivers of the ‘behaviour’ of organisations in response to change.

This reflection is primarily based on the appraisal of Lewin’s work by Burnes (2004). Four of Lewin’s theories, relevant to this study will be discussed here. These theories are the field theory, group dynamics theory, action research and the 3-step model. The four will be dealt with in the way “Lewin saw them, as a unified whole with each element supporting and reinforcing the others and all of them necessary to understand

and bring about planned change, whether it be at the level of the individual, group, organization or even society” (Burnes, 2004, p. 981).

2.4.2.1 The Field Theory

“Field theory was central to Kurt Lewin’s work yet, after his death, interest in it declined significantly until the 1990s when a variant, force field analysis, became widely used,” (Burnes & Cooke, 2013, p. 412). The role of field theory in his theorising was primarily an attempt to understand how particular social groupings were formed, motivated and maintained. Burnes & Cooke (2013) further argue that the foundation on which Lewin’s other contributions to planned change was built primarily on the field theory. Without it, it is not possible to understand the forces that maintain current behaviour and identify those that would have to be modified in order to bring about change (Lewin, 1943). It is however unfortunate that the concept has not received in academia as much rigorous attention it deserves as other elements of his work (Gold, 1992).

In this approach, Lewin sought to understand group behaviour by trying to map out the “totality” and the “complexity” of the environment in which the behaviour takes place (Burnes, 2004). In an essay titled *Field Theory in Social Science*, Lewin (1943) argued that in order to fully understand any social setting, one should view any present situation as being maintained by certain conditions or forces. He further proposed that group behaviour is an intricate set of symbolic interactions and forces that not only affect group structures, but also have the ability to modify individual behaviour (Burnes, 2004). Lewin believed that if one could identify, plot and establish the potency of this force field in an environment at a particular point in time, then it will be possible not only to comprehend individual, group or organisations behaviour, but also understand forces that, if altered, can bring about lasting change (Burnes, 2004).

Figure 9: Lewin's Field Model: Adapted from Burnes & Cooke (2013)

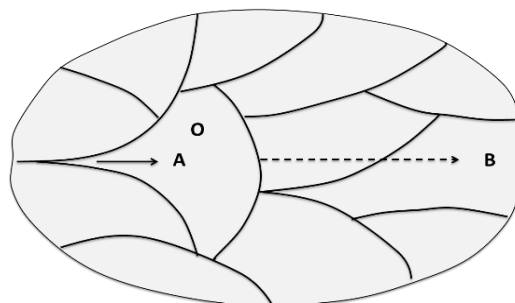
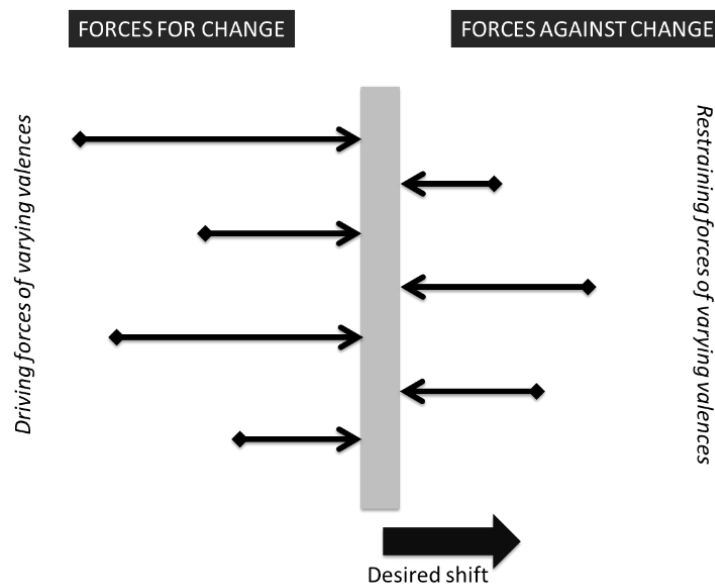


Figure 9 above shows a simplified example of a Lewinian force field, or 'life space' as he called it. O represents the person, group or organisation. A is their current situation and B is the goal they wish to achieve or change they wish to make. The dotted arrow shows the quickest and shortest path that can be taken to move from where they are to where they want to be. Each of the segments within this 'life space' represents different existing forces of a varying valence and orientation impinging on the organisation. The forces directly above, below and behind A represent forces for change. Those between A and B represent forces responsible for resisting change or at least maintaining the status quo (or as Lewin called it, a 'quasi-stationary equilibrium') (Schein, 1999). The other forces will also exert influence on the change and will also be affected by the change.

Lewin argued that it is not sufficient to identify one or two of these forces impinging on the individual or group, let alone identify them in isolation. Instead it is essential to account for all the forces in their "totality", and their interrelatedness to one another (Burnes & Cooke, 2013). Therefore, this "life space" represents a holistic view of the group or individual in relation to their environment. As all these parts are interdependent, changes in one part of the field has the propensity to change the entire landscape, depending on the valence of the forces affected (Burnes & Cooke, 2013).

This theoretical framework has since been applied by other more recent scholars, albeit in isolation, primarily to analyse sources of individual resistance to change (Dent & Goldberg, 1999; Schein, 1999). Also, a variation of the field theory, usually referred to as the "force field analysis", demonstrated in Figure 10 gained popularity in contemporary literature. However, this is a watered-down, over-simplified model. It lacks the rigor and complexity of Lewin's representation of a 'life space' depicted in Figure 9 (Burnes & Cooke, 2013). Figure 10 only focuses on a few elements categorised into two opposing forces, driving and restraining forces (Kippenberger, 1998). Other important elements including the context, important relationships and interdependences of these elements are ignored (Burnes & Cooke, 2013). Burke & Cooke (2013, p. 417) further argue that, "at best, just focusing on a few obvious driving and restraining forces, and ignoring the 'complex psychological conditions' that make up the entire life space, will only provide a very partial understanding of the situation, if not a misleading one. The consequences, or unintended consequences, of change initiatives based on such poor foundations are unlikely to be what the change initiators expected."

Figure 10: The Force Field Analysis, (Burnes & Cooke, 2013)



2.4.2.2 Group Dynamics

In developing the group dynamics concept, Lewin's primary preoccupation was to understand the importance of a group in shaping an individual's behaviour (Kippenberger, 1998). Although coining the term "group dynamics" is largely attributed to him, he was by no means the founding father of the movement. Other earlier scholars had made similar observations. One such scholar is Wertheimer. Quoted in Westheimer (1999, p. 6), he argued as early as 1924 that, "there are entities where the behaviour of the whole cannot be derived from its individual elements nor from the way these elements fit together; rather the opposite is true: the properties of any of the parts are determined by the intrinsic structural laws of the whole."

The group dynamics theory therefore, sought to address questions such as, what is it about the nature and characteristics of a particular group that causes it to respond the way it does to the forces which impinge on it? How can these forces be changed in order to elicit a particular form of behaviour? (Burnes, 2004). Consequently, Lewin's work has helped to lay a framework of our understanding of groups. For instance, his definition of a group, which generally remains accepted today, looked at a group not as an entity based on the similarity or dissimilarity of individuals that constitutes it, but "interdependence of fate" of its members (Burnes, 2004) Also, in an even more elaborate argument, he proposed that the focus of a change initiative should not be on individuals, but the groups they belong to because individuals in isolation are constrained by group pressures to conform (Burnes, 2004).

2.4.2.3 *The 3-Step Model*

This is probably by far the most recognised of Lewin's contributions to change literature. It can also be argued that most contemporary models used in organisational change, such as Kotter's 8-step model, have their roots steeped in this model (Schein, 1999). "However, it needs to be recognized that when he developed his 3-step model Lewin was not thinking only of organizational issues. Nor did he intend it to be seen separately (from the other elements) which comprise his planned approach to change.... Rather Lewin saw (the concepts) as forming an integrated approach to analysing, understanding and bringing about change at the group, organizational and societal levels," (Burnes, 2004, p. 985).

Lewin argued that lasting change involved three steps. First, he postulated that the stability of human behaviour was based on 'quasi-stationary equilibrium' that is supported by a large force field (Schein, 1999). For change to occur, he argued, this force field had to be destabilised under complex conditions (*unfreezing*) before old behaviours can be discarded (unlearned) and new behaviour successfully adopted (Burnes, 2004). Lewin called the second step, which is the behavioural shift after unfreezing, *moving*. Schein (1999, p. 62) further added to this concept of *moving*, expanding on Lewin's ideas, *unfreezing* is not the end in itself, instead, "it creates the motivation to learn, but not necessarily control or predict the direction." This makes planned change to be difficult because of the complexity of several forces concerned (Burnes, 2004). In the final step of his model, *refreezing*, a new quasi-stationary equilibrium that is congruent to the new field forces.

2.4.2.4 *Action Research*

In action research, Lewin acknowledged the complexity of trying to map all relevant forces in a field and their interconnectedness. Some are overt while some occult. This led to the development of what came to be known as action research. As Schein explained, it was Lewin's view that one cannot understand an organisation without trying to change it (Schein, 1999). Action research is therefore a spiral iterative process of acting, reflecting, then diagnosing, planning and act again (Burnes, 2004). To this end, action research builds on the field theory to identify forces in the field in which change is occurring. It also draws on group dynamics to understand why group members behave the way they do when subjected to forces that impinge on them (Burnes, 2004).

2.4.2.5 Summary of Kurt Lewin and Change

The work of Lewin has appeared quite prominently in change literature since the 1940s. Most of his work has formed basis on which a lot of models for planned change and organisational design were built (Cummings & Worley, 2009). However, it is important to appreciate that Lewin, in developing his concepts, was primarily interested in solving social conflict through behavioural change, be it organisational or societal (Burnes, 2004). To achieve this, he developed the field theory and group dynamics in order to comprehend the behaviour of social groupings and what maintained them. To change the behaviour of these groupings, he proposed the 3-step model and action research.

2.5 Summary of the Literature Review

This literature review discussed important theoretical frameworks under three themes. First, it reviewed relevant frameworks to help contextualise the organisations-environment in which policy change occurs. Second, it reviewed theoretical models of how ideas turn into policy and how policy translates into reality. However, these theories on policy change tacitly assume a policy designer's perspective – effective strategies for formulating policy as well as frameworks for analysing how the policy change unfolds in order to devise strategic interventions to manage the process. There is little more than a passing notice of the recipients' comprehension of a change process. But in social science literature there are important theoretical models to help analyse normative behaviour of a collective during a change process, particularly contributions by Kurt Lewin. This was the aim of the third and final theme, reviewing Lewin's change models.

The first theme analysed two models - the descriptive influence of the stakeholder approach and the dynamism of the organisational ecology perspective. The stakeholder approach emphasises cognisance of the broader boundaries of an organisation's relations with its external environment, how such an environment can influence its internal structures. The ecology perspective highlighted the dynamism of forces that shape and maintain the communities of organisations over long periods of time. Two sub-schools of thought in the ecology perspective were also discussed. The first one, the adaptation perspective, asserts that in order to remain relevant, leaders in organisations constantly scan the environment for opportunities and threats then formulate strategies and adjust their organisations' structure to suit the changing

environment. The second view, structural inertia challenged the extent of organisations' flexibility to adapt and suggested that organisations inherently harbour a structural inertial component that limit their flexibility to adapt.

This analysis was relevant in this study for two key reasons. First it helped to answer the question – who really matters when analysing a business environment? It clearly highlighted the importance of the interdependence of various units of analysis that can be looked at - leaders of organisations, individual organisations themselves and the entirety of the population of organisations. It also highlighted important elements of a force field that shapes and maintains this community of organisations.

The second theme analysed theoretical frameworks in policy change processes. The main concern was to discuss theories in political science literature that help to make sense of how ideas get translated into policy and policy into reality. Two approaches in policy literature have dominated policy debates for a while, the top-down approach and the bottom-up approach. They both seek to identify generalisable variables that can be manipulated at a central level to drive policy implementation towards a desired outcome. As the names say, top-downers place a lot of emphasis on fidelity to the designer's plans while bottom-uppers emphasise the role of "street-level bureaucrats". Contemporary thinking now acknowledges the validity of both approaches and suggests choice of approach is context driven (Hupe, 2014). One particular approach to emerge from this thinking was Matland's conflict ambiguity matrix, which is discussed at length in Section 2.3.1.3.

The second theme also analysed theories on how policy change unfolds. Three models relevant to this study were discussed. Historical institutionalism uses social science methods to analyse political behaviour over time. The advocacy coalition framework proposes that change occurs through interactions between external shocks to a political system and success of ideas within coalitions of with shared beliefs. The punctuated equilibrium model suggested that there are usually many ideas competing for attention. At a particular time, something generates attention on one of the ideas and expands rapidly to a point that it becomes difficult to reverse its impact.

These models helped to shape a framework for identifying and analysing factors that help bridge the gap between ideas, policy formulation and implementation. However, these models were developed from the perspective of a policy designer with very limited appreciation of the recipients' view of the change process. This is where the third theme came in.

The third theme sought to provide a framework through which recipients' responses to the change process would be analysed. The literature review analysed social science literature on the behaviour of collectives in response to a change process, in particular, Lewin's pioneering work on this subject. Lewin's work was primarily committed to solving social conflict in order to improve human condition. His theories have however found relevance within the broader sociological aspect of planned change.

Section 2.4.2 reviewed Lewin's four models, the field theory, group dynamics, the 3-step model, and action research. The field theory was the basis on which all his other theories were built. The theory proposed that to understand or to predict behaviour, the person or group and their environment have to be considered as one constellation of interdependent factors. In group dynamic theory, he analysed individual decision making behaviour. He proposed that intrinsic structural laws in groups shape the behaviour of its members. He also further proposed that the behaviour of a group as a whole cannot be derived from individual elements or from the way these elements fit together. Instead, the intrinsic structural laws that govern the collective determine behaviour of that group. The 3-step model proposed that a social system is maintained in a quasi-stationary equilibrium whose stability is supported by a large force field (a "frozen" state). In order to change, the force field needs to be destabilised ("unfreeze") before old behaviours can be discarded and new behaviours successfully adopted ("moving"). This is however not the end of the change process. A new quasi-stationary equilibrium congruent to the new forces has to be established ("refreezing"). Last, Lewin acknowledged the complexity of trying to map the entire force field in which change is to occur. He suggested that one could not understand this force field without attempting to change it. He then developed the action research, an iterative process of acting, reflecting, diagnosing, plan a set of actions and act again.

3 RESEARCH QUESTIONS

3.1 Logic of the Inquiry

This chapter specifies the questions this study set to answer. At the heart of this inquiry is an investigation into recipient's perspectives of a change process. Rather than simply describing what policy change looks like, how it unfolds or how to better manage it, this study turned its perspective to how a change process is perceived by the recipients. The focus here was to comprehend the experience of a change process from the recipients' perspective and, which is more, make sense of transcendental factors that influence recipients' response to change.

To do this, insights gained from the literature review in Chapter 2 were used to frame a set of five research questions that this study sought to answer. These research questions sought to not only identify with the recipients' perspectives of a change process, but also investigate the potency and orientation of factors influencing their responses to change as well as analyse how such responses potentially impact the policy reform process.

3.2 Research Questions

The five research questions formulated to guide this investigation are as follows:

3.2.1 *Research Question 1*

What is the context of South Africa's private healthcare environment and the challenges in the healthcare system?

This first question not only sought to identify the relevant stakeholders in this ecosystem, but also the historical context of how they came to be, how their relationships with each other have evolved and to understand their relevance in the current environment.

3.2.2 *Research Question 2*

Do the relevant stakeholders who are recipients of the proposed policy reform feel that there is a felt need for change?

This question sought to understand the prevailing climate for change from the interviewees' perspective. The government formulated the policy reform proposal on a premise that South Africa's healthcare system is inefficient, unsustainable and needs change. Did the interviewees share the same need for change?

3.2.3 *Research Question 3*

What do the relevant stakeholders understand to be the challenges in the healthcare system that need change and what created them?

This question sought to comprehend the challenges in the healthcare system from the perspective of the interviewees themselves and the underlying reasons that led to these challenges. The discussion helped to unpack the interviewees' ideas of the goals of the policy reform and their perception of means to achieve that goal.

3.2.4 *Research Question 4*

What are the stakeholders' opinions of the changes proposed in the reform proposal?

This question framed the interviewees' perspectives of the impending reforms relative to their conceptualisation of the challenges that need to be changed. This interview question indirectly investigated congruency of goals and means with that of the government, as well as the level of policy ambiguity among the recipients.

3.2.5 *Research Question 5*

How have the relevant stakeholders responded to the proposed reforms?

This question sought to understand the rationale behind the behaviour of the interviewees and their organisations in response to the proposed change. Furthermore, each response was analysed in the context of their environment - how each interviewee's actions (or inaction), as well as that of the organisations they represent, created additional forces that impinged on other organisations within the organisations-environment.

4 RESEARCH METHODOLOGY

4.1 Introduction

This chapter outlines the investigative methods employed in this study. Chapter 1 outlined the background to the research problem, while Chapter 2 provided a theory lens through which the research problem was interrogated. Chapter 3 synthesised the field of inquiry into a targeted set of research questions to be explored in detail. This chapter's primary objective is to clearly outline the study design used in the research, justify the choice of design, frame the sources of raw data and define methods used for data collection.

4.2 Research Design

This is the research design employed in this study.

4.2.1 *Exploratory Design*

This study followed an in-depth exploratory design investigating structural forces that impinge on individuals and organisations as they interact with each other in the face of a looming radical policy reform. Ultimately the study sought to contribute to broader empirical understanding and applicability of the Field Theory in managing major policy reform. The study used South Africa's impending healthcare reforms as the context.

Many publications, books and academic articles have been written on the subject of change, mostly on strategic processes of how to manage or lead the change process within an organisation. Many insights gained from this wealth of literature has helped individuals and executives in organisations and governments to better understand the complexity of leading and managing change. In an effort to contribute to this discourse, this study departed from some of the tacit assumptions made in most familiar change literature to try and illuminate possible insights previously overlooked.

The most significant departure is that a lot of change literature investigates the subject from a perspective of a monolithic organisation being the unit of analysis dealing with its internal structures facing the environment out there. Whereas, in policy reform, a more appropriate approach would be a population ecology perspective, where the unit of analysis is the organisations-environment. Very few studies or publications have

explored how change occurs at this level. Moreover, of the few studies that committed to studying change at this level, most of them focused on strategies for formulating policy reform and strategies for managing the implementation of change process and analysing recipients' behaviour during the process. However, there is limited literature, if any, on the deterministic value of external factors that impinge on recipient organisations, how these factors drive the way they act and ultimately impact the progress and direction of a policy reform process.

Therefore, while this study sought to examine an age-old phenomenon – how a change process unfolds – it investigated the subject from a different angle in an attempt to uncover possible insights previously overlooked. Accordingly, as Saunders and Lewis (2012) suggest in a study seeking to investigate an old subject in new light or ask new questions in a field where what is going on is not clearly defined, an exploratory design would be the most appropriate approach.

4.2.2 *Qualitative Approach*

A qualitative approach was used because the study was not only concerned with characterisation of recipients' responses, but which is more, the rationale underpinning those responses. Using a qualitative approach allows the researcher to explore elaborate interpretations of the phenomena under investigation and allows the researcher to work inductively from what is there in the research setting (Zikmund, Babin, Carr, & Griffin, 2013). This was critical because the way people behave, feel or think can best be understood if one gets to know their world and what they are trying to achieve in it (Gillham, 2000).

4.2.3 *Research Philosophy*

The study employed principles of critical realism. The central idea in critical realism, applicable to this study, is that reality possesses a deep dimension that is not directly observable and is independent of our concepts and our knowledge of it. This reality has causal mechanisms to effect what we observe (Danermark, 2002). Therefore social phenomena can best be understood if people first understand the structures that generate this deep dimension that is not directly observable. This research therefore sought to “investigate and identify relationships and non-relationships, respectively, between what we experience, what actually happens, and underlying mechanisms that produce the events that we observe” (Danermark, 2002, p. 21).

4.2.4 *Scope of Study*

The context of this study was based on South Africa's healthcare reform. The study however only covered a limited period, which was primarily a period of impending reforms. The policy proposal had been released for public commentary, enough to shed light into the thinking behind the proposed change, looming reforms and an overview of a desired end state. The scope of this study was therefore limited to transcendental events and the behaviour of organisations during this period of impending reforms. The study also explored historical events that have contributed to shaping the context of study.

4.2.5 *Unit of Analysis*

A study's unit of analysis dictates who and what is being studied and at what level of aggregation (Zikmund et al., 2013). This study's unit of analysis was organisations in the private healthcare industry in South Africa. Although the proposed healthcare reforms aimed at changing the entire healthcare industry in South Africa, this study focused specifically on the private healthcare industry due to the nature of the proposed reforms. On one hand the proposal recommended wide ranging process improvement plans in the public healthcare sector, which in all measures are incremental changes on existing systems in order to improve their efficiencies rather than radical changes. However, in the private sector, the proposal recommended a radical reform process that would significantly change the way business will be conducted in the future. For this reason, the unit of analysis in this study was restricted to the private healthcare industry to ensure homogeneity of the subject of investigation.

At a more granular level, the unit of analysis also dictates who provides raw data (Zikmund et al., 2013). To unpack this, two themes drawn from Kurt Lewin's work in his group dynamics theory and field theory helped to frame the approach in this study.

- 1) In his field theory, Lewin argued that, "the group to which an individual belongs is the ground for his perceptions, his feelings and his actions." (Allport, 1948, p. vii) Therefore, to fully understand group behaviour one must try to map out the totality and complexity of the field in which the behaviour takes place. (Burnes, 2004)
- 2) In his group dynamics theory he argued that individual behaviour could not be analysed or altered in isolation because individual behaviour is constrained by

group pressures to conform. From this premise, he then proposed that in instigating change, the behaviour of a group rather than individual should be the focus of attention.

From this perspective, there are clearly two levels to this study's unit of analysis, a primary and a secondary level. The primary level was an analysis of forces in the organisations-environment in general, or "the field" as Lewin termed it. This included tacit information such as the roles, the norms, attitudes, interactions and relations between organisations and industry associations within the private healthcare industry. The secondary level was an analysis of perceptions, attitudes and behaviour of top executives in key organisations that command the most influence in the industry. This secondary level provided more in-depth granular insight into psychosocial dynamics influencing the observed behaviour and attitudes of the organisations they lead.

4.2.6 *Sampling*

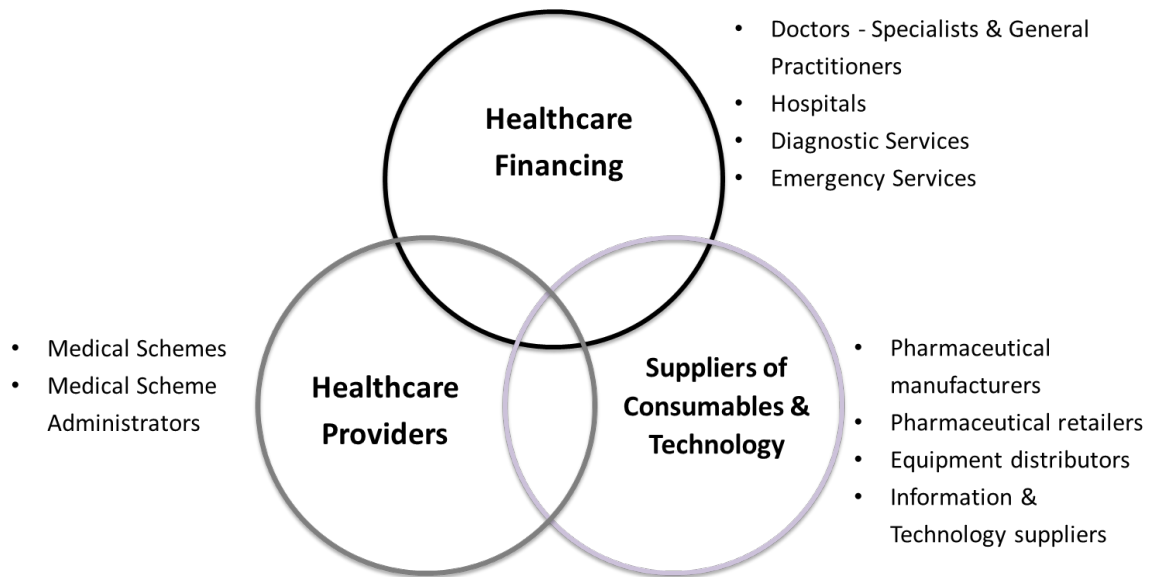
It would not have been practical to collect data from all organisations and industry associations in the private healthcare sector due to limitations of time and resources. The research was therefore conducted on a selected sample representative of the relevant population (Saunders & Lewis, 2012). It is imperative to ensure that the sample selected is representative of the population under investigation if findings from investigating the research sample are to be generalised to the entire population. To do this, the relevant population was defined first then a combination of sampling techniques employed to define the most appropriate data sources representative of the population under investigation.

4.2.6.1 *Broad Focus on the Relevant Population*

As discussed in Section 4.2.5 above, the proposed policy reforms sought to implement incremental process improvement changes in the public sector, but the private healthcare sector appeared to be the primary target of radical reforms to change the way business would be conducted in the future. This study specifically sought to investigate factors impinging on recipients' attitudes and behaviours in anticipation of radical change that has potential to drastically affect their modus operandi or even their survival. The relevant population of this study was therefore primarily organisations in the private healthcare industry in South Africa.

South Africa’s private healthcare sector is made up of a variety of organisations operating at various levels. These fall broadly into three categories; the healthcare providers, healthcare funders and suppliers of consumables and technology as depicted in Figure 11 below.

Figure 11: Subsectors in the Healthcare System in South Africa



Tables 1 to 3 below provide other relevant considerations of each of these subsectors.

4.2.6.1.1 Healthcare Providers

Healthcare providers encompass doctors, hospitals, clinics, emergency services and allied healthcare providers such as physiotherapists, optometrists and psychologists. Table 1 below provides an overview of considerations relevant to each of the stakeholder groups in this study.

Table 1: Relevant considerations for the healthcare providers subsector

Sector	Subsector	Relevant Considerations
Healthcare Providers	Hospitals	<p>Important sector, accounts for over 36% of total private healthcare expenditure</p> <p>Concentrated to 3 hospital groups that account for 80% of the total hospital market share - Netcare, Mediclinic and Life Healthcare</p> <p>Private Hospitals are not allowed to employ Doctors</p> <p>Hospitals compete by attracting the best specialists through investing in high-end technologies and facilities. Consequently this draws patients who follow specific specialists and well-equipped facilities</p> <p>Hospitals make their revenues primarily through hospital occupancy and operating theatre usage</p> <p>The Hospital Association of South Africa (HASA) is the industry association</p>
	Doctors	<p>Key driver of healthcare consumption</p> <p>Composed of General practitioners (who account for 10% of total private healthcare expenditure) and specialists (who account for over 20% of total private healthcare expenditure)</p> <p>Operate independent of each other except for few group practices</p> <p>South Africa Medical Association (SAMA) is the primary overall industry association</p> <p>Each of the specialties also have their own industry association</p> <p>Regulated by the Health Professions Council of South Africa (HPCSA)</p> <p>Cannot be employed by a corporate entity in the delivery of healthcare services</p>
	Supplementary Practitioners	<p>Collectively account for about 8% of total private healthcare expenditure but composed of a variety of smaller segments of supplementary practitioners - physio, occupational health, optometrists, podiatrists, dieticians etc</p> <p>Limited to a few regional independent practitioners and group practices</p> <p>Play a very limited role in influencing healthcare policy</p>
	Emergency Services	<p>Very small, account for less than 1% of total private healthcare expenditure</p> <p>Limited to a few regional independent practitioners and group practices</p> <p>Play a limited role in influencing healthcare policy</p>

4.2.6.1.2 Healthcare Funders

Table 2 below summarises some of the key considerations pertaining to healthcare funders.

Table 2: Relevant considerations for the healthcare funders subsector

Sector	Subsector	Relevant Considerations
Healthcare Funders	Medical Schemes	<p>Over 80 medical schemes in South Africa but the biggest 6 schemes account for over 80% coverage of the insured population</p> <p>2 classes of schemes - closed schemes which are confined to employer groups and open schemes that are open to anyone who wishes to enroll</p> <p>By law all medical schemes are non-profit insurance schemes run by an elected board of trustees</p> <p>Collectively command a R174billion (2013)</p> <p>The Board of Healthcare Funders (BHF) is the industry association</p> <p>Governed by the Council for Medical Schemes</p>
	Administrators	<p>Medical schemes outsource the administration of funds to Administrators</p> <p>Administrators charge the scheme administration fees for such services</p> <p>Administration fees accounted for about 9% of total private healthcare expenditure (2013)</p> <p>Concentrated to 3 biggest administrators - Medscheme, Discovery and Metropolitan Health Risk Managers</p> <p>The Board of Healthcare Funders (BHF) is the industry association</p> <p>Regulated by the Council for Medical Schemes</p>

4.2.6.1.3 Suppliers of Technology, Equipment and Consumables

The suppliers of consumables, technology and equipment sector is dominated by the pharmaceutical industry followed by suppliers of medical equipment. Table 3 provides an overview of this sector.

Table 3: Relevant considerations for the suppliers subsector

Sector	Subsector	Relevant Considerations
Suppliers of Consumables and Technology	Pharmaceuticals	<p>Highly regulated sector through price regulations, generic substitutions, importing of generic equivalence, patent laws</p> <p>Several manufactures in the country, including international players</p> <p>Industry associations for manufacturers include the Innovative Pharmaceuticals Association of South Africa (IPASA) for innovators/originators and National Association of Pharmaceutical Manufacturers (NAPM) for generic manufacturers</p> <p>Generic manufacturers primarily supplying the public sector and Innovators/Originators supplying the private sector</p> <p>Retailers include 2 big companies - Clicks and Dischem, and a variety of smaller companies and community pharmacies</p> <p>Industry association for retailers is the SA Retail Chemists and Druggists Association (SARCDCA)</p> <p>Manufacturers regulated by the Medicines Controls Council (MCC) retailers by the HPCSA</p>
	Equipment	<p>Most suppliers in South Africa are distributors for major off-show manufacturers</p> <p>Supply to both the public and the private sector</p> <p>Unconcentrated market</p> <p>Play very limited role in influencing policy</p>
	Technology	<p>Small emerging industry</p> <p>Many independent small players</p> <p>Very fragmented, no standards, no industry board, no regulator</p> <p>Virtually no influence on healthcare policy currently</p>

4.2.6.1.4 *Academics, Activists and Journalists*

An additional group of stakeholders considered in this study was clustered into “industry experts”. This included academics within the healthcare policy environment, activists representing various civil organisations involved in healthcare as well as journalist well focusing on healthcare journalism in South Africa. This additional group of stakeholder provided perspectives of informed ‘observers’ and to some extent influential lobbyists to changes occurring in the industry.

4.2.6.2 *Sampling Methods Used*

A combination of three sampling technics was be used.

First, quota sampling was used, a non-probability sampling technique to make sure the selected sample was representative of the of the entire population under investigation (Saunders & Lewis, 2012, p. 137).

Second, non-probability purposive sampling was used. This is a sampling method where “the researcher’s judgement is used to select sample members based on a range of possible reasons and premises” (Saunders & Lewis, 2012, p. 138). Given the limited time and resources available to conduct this study, it was imperative to focus on organisations that had the greatest impact on the attitudes and behaviour of the industry. To identify these organisations, a selection criteria based on three modalities was used:

- a) Organisations that consumed the largest share of healthcare funding,
- b) Organisations or group of individuals that were the most organised either as a monolithic organisation or at the level of an industry association
- c) Organisations that were an influential voice in their category.

The third method used was snowball sampling method, in which subsequent members were identified and proposed by earlier sample members (Saunders & Lewis, 2012). This method was mainly used for in depth interviews where snowballing was used to identify the most appropriate executives in selected organisations and industry associations. The full details of the sample selected are given in Tables 4 to 6 in Chapter 5.

4.2.7 *Data Collection Methods*

Two data collecting methods were employed in this study. The first method used systematic review to help frame the context of South Africa's healthcare system. The second method used in-depth face-to-face interviews with targeted top executives to provide more granular insights on the subject of inquiry.

4.2.7.1 *Systematic Review*

Systematic review involves a form of literature review where an exploration of existing literature on a particular subject is conducted in order to select, appraise and synthesise relevant evidence gathered in other studies for use to answer a current question (Petticrew & Roberts, 2006). A systematic review is therefore somewhat a synthesis of extensive summaries of available literature relevant to the current research question.

This study used this method to the extent that it helped to frame the context of South Africa's healthcare environment. The analysis involved an extensive search for relevant archival studies, documentaries, country reports and government publications that reviewed South Africa's healthcare environment, particularly the historical logic that contributed to shaping the current healthcare ecosystem.

4.2.7.2 *In-depth Interviews*

The second method involved in-depth interviews with targeted top executives of key organisations and industry associations within the private healthcare industry. The in-depth interviews helped to provide more granular data to help make sense of the behaviour and attitudes of organisations in response to the proposed reforms. In-depth interviews were also held with industry experts and journalists as informed observers to the change environment.

4.2.7.2.1 *Interview Techniques*

The interviews were semi structured to allow the interviewee an opportunity to share their interpretation of events unfolding in the healthcare industry in their own way. A semi-structured interview is where the "interviewer (interrogates) a set of themes using some predetermined questions (as a guideline)" (Saunders & Lewis, 2012, p. 151). The predetermined questions helped to guide the interview while allowing the participant to

explain, in their own view, the events unfolding in the industry as a result of the impending reforms and their role in it. The study also went on to investigate how industry experts, as third party observers, were interpreting these recipients' responses using semi-structured in-depth interviews. These interviews also followed similar approaches to interviews with executives discussed above. The drafting of the interview guideline is discussed in more detail in section 4.2.8 below.

The semi-structured interview technique was also mixed with episodic interviewing. Episodic interviewing is a technique used to specifically orient participants to particular topical domains. The technique combines invitations for the interviewee to recount relevant events using general questions aiming at more general answers. It mentions concrete situations in which the interviewee is assumed to have experienced and kept open enough to allow the interviewee to recount the events in their own way (Flick, 1997). This method was used to probe interviewees to recall their experience of particular events considered relevant to the subject of inquiry, to help illuminate transcendental processes leading to such specific events. This also helped to probe interviewees to elucidate more on some specific observations uncovered in fieldwork analysis.

The interviews were conducted at the convenience of the interviewee, most of them face to face at their place of work. However, due to executives' busy schedules some of the interviews were squeezed in over lunch or over coffee at restaurants. Face to face interviews allowed the interviewer capture more tacit information from the interviewee's facial expressions, body language and tone, information that would not have otherwise been captured by other interview methods. As a result, the interviewer made effort to conduct most of these interviews face to face, this meant travelling across the country to another city just for the interviews. Three of the interviews were however held over the telephone because the executives were travelling out of the country.

Each interview lasted about an hour and all interviews, except the three held over the phone, were audio recorded for analysis. Before each interview, the researcher sought consent to conduct the interview and record the findings. A standard consent letter presented to all the interviewees is shown in Appendix 3. The researcher also captured detailed field notes during the interview process in order to ensure tacit observations were not overlooked.

This research was conducted at the same time with a highly sensitive Competition Commission inquiry into the cost of private healthcare. Because of this, some executives were very reluctant to interview. Furthermore, the study also touched on some company-specific confidential information, particularly strategic plans on the organisation's response to the impending changes. Therefore, in interviewing those that agreed to the interview, the researcher had to develop rapport to allow the interviewees to gain trusts and be comfortable to share information.

4.2.8 *Interview Guideline*

Presented in Appendix 1 and 2 are two interview guidelines used for data collection. The first guideline, in Appendix 1 helped guide interviews with executives from target organisations and industry associations. The study also investigated the views of industry experts and journalists as informed observers to change process occurring in the industry. Experts' interview guideline is presented in Appendix 2. Both interview guidelines were formulated based on the research questions presented in Chapter 3.

4.2.9 *Data Reliability and Validity*

Saunders and Lewis (2012, p. 127) describe data validity as “the extent to which data collection methods measure what they were intended to measure and that the research findings are really what they profess to be about.” This study first sought to understand the private healthcare industry in its totality – its current state, the challenges in the system and its historical context. To do this, the study first aggregated of archival data from previous studies to help build this context. Semi-structured in-depth interviews were then used to explore the change process from the recipient themselves.

Data reliability is “the extent to which data collection methods and analysis procedures provide consistency” (Saunders & Lewis, 2012, p. 128). To maintain consistency in data collection, an interview guideline was used to orient interviewees to topical issues to be covered in each interview. Also, mainly open-ended question were used and the interviewee allowed unpacking the subject in their own way in order to limit the effects that the phrasing of the question itself may have on the responses the interviewee gave.

4.2.9.1 *Triangulation*

To counter biases in data collection, the study triangulated findings from the interviews with executives with the archival content analysis and interviews with industry experts. This approach where different methodological standpoints – various data sources, different data collection methods and different perspectives in analysing findings – not only helps to check convergence of findings (Gillham, 2000, p. 13), but it also helps to ensure that the finds are not just superficial accounts but robust, well-developed and rich insights (Patton, 2015).

4.2.10 *Data Interpretation*

Data analysis in a qualitative study requires summarising interview material, condensation of meanings, categorisation of meanings and structuring of meanings into a sensible narrative (Saunders & Lewis, 2012). Qualitative data was collected through interviews. All the interviews except three were recorded into audio files. The three unrecorded interviews were due to technical difficulties of recording a telephonic interview. The data collected was then unitised. Saunders and Lewis (2012) referred to unitisation as a process of identifying units of data that can be knitted into recognisable relationships that are appropriate for analysis.

To do this, the research first used in vivo coding. This is a practice of assigning a label to a section of data using a word or short phrase taken from that section of data (Lewis-Beck, Bryman, & Liao, 2004). This practice was used to ensure that data collected and concepts drawn stayed as close as possible to the participant's interpretation of the concept under consideration, expressed in their own words.

Content analysis was then used to group the data into logical categories. The content analysis was conducted by capturing categories and common themes on a *Microsoft Excel* spreadsheet then exploring the frequencies and patterns of these themes. Analytic induction procedures were then employed to aggregate and categorise this data to corresponding research questions. Analytical induction, or inductive reasoning is a logical process whereby a multiple premises are used to provide evidence for a probable argument (Zikmund et al., 2013).

Each interview took on average of three hours to analyse. The process involved revisiting each interview one by one and drawing relevant meaningful narratives and patterns of themes one interview at a time. To further enhance this analysis, each

interview was analysed concurrent with a review of corresponding interim summaries of each interview that the researcher had captured immediately after each interview. Additional to the interim summaries, the researcher also kept a self-memoire through the data collection process and also diarised field notes that captured any other relevant insights gained during the data collection process.

4.2.11 *Limitations of Study*

No study is without limitations. Listed below are a number of limitations and compromises made in the study. Some of these limitations are inherent to a qualitative study of this nature, while some were particular to this study.

- Exploring an idea from a different perspective may help uncover new insights previously over looked. Findings of such a study are often built from extrapolating generalisable findings into meaningful narratives. However, follow up research is necessary to build up epistemic certainty of its conclusions
- Sampling bias – the study population in this research was clearly defined and defended. However, selection of the sample required the researcher to employ a judgement call on who the most appreciate sources of data would be. Although a lot of effort was invested in carefully mapping who could provide data and at what degree of aggregation, there is still risk that other important sources were overlooked

Furthermore, not all identified data sources were available or willing to interview. The study protocol started off with a list of 22 executives and 6 ‘industry experts’, targeted specifically because they represented fully the relevant subsectors. However, only 13 of the executives and 4 ‘industry experts’ were available for interviews during the limited data collection period available. While the 17 provided ample information to map a generalisable conclusion, there is risk of overlooked data from the under-represented sample groups

- Interviewee bias – one inherent risk in conducting semi-structured interview is the interviewer introducing cognitive bias into the study. This is where the interviewer’s body language, facial expressions or follow up questions can unconsciously influence the response given by the interviewee (Zikmund et al., 2013)

- Experimentor-expectancy effect – Also related to cognitive bias is the unintended influence of experimentors' previously held hypotheses or expectations on the results of their research (Lewis-Beck et al., 2004).
- Sensitive data – This study was conducted during the time when the Competition Commission of South Africa was running an inquiry on pricing and anticompetitive behaviour in South Africa's private healthcare system, commissioned by the minister of health (South Africa, The Competition Commission, 2015). As a result, some targeted interviewees were reluctant to interview. And those that agreed to interview, they were reluctant to discuss sensitive information with potential to jeopardise their standing in the inquiry.

4.3 Conclusion

The research design and methodology were intended to meet the requirements and the objectives of this research report, as stipulated in Chapter 1. The research serves to investigate a policy reform process, but looking at it from the perspective of the change recipients in an attempt to uncover potential insights previously overlooked or provide empirical support to previously held beliefs.

5 RESULTS

5.1 Introduction

This chapter presents results of the study and these correspond with the research questions as stipulated in Chapter 3. Data was collected primarily through a combination of two methods, systematic review and in-depth interviews.

Systematic review was used only to the extent that it provided relevant information to help contextualise South Africa's healthcare ecosystem. Using systematic review, this study explored multiple studies previously conducted in some way to unpack the complexities of South Africa's healthcare environment. This helped to answer the first research question, which sought to contextualise South Africa's healthcare environment.

In-depth interviews were then used to contextualise the change process from the perspective of the change recipients. Interviews were conducted with interviewees across two broad sample groups. The first research sample group consisted of change recipients - 13 highly influential executives representing organisations and industry associations in each of the three subsectors in the private healthcare system, namely; providers, funders and suppliers of consumables and technology. Additional data was also collected from the second research sample group of 'experts'. Expert interviews were conducted with two prominent healthcare industry experts and two healthcare journalists. These four interviewees, although they are not necessarily representing recipient groups, their insights helped provide broader context of the subject of study from the perspective of informed 'observers'. Also, these experts and journalists are also influential drivers of opinions of other stakeholders in the industry. Their views, therefore helped to both triangulate findings from interviews with executives as well as provide additional insight on their views as potential influencers to recipients opinions and attitudes. Tables 4 to 7 below give an overview of these data sources. The interviewees are presented by their industry sector and company each interviewee represented at the time of the study. However, given the relevance of historical context in this study, a brief historical overview of each individual's experience within the healthcare industry is also discussed.

Table 4: Overview of Funders Interviewed

#	Interviewee Name	Interviewee's Organisation(s) and Designation(s)	Research Sample
1	Dr H. Zokufa	Board of Healthcare Funders (BHF), Managing Director Pharmacist by profession, previously worked in the Medicines Control Council (MCC) as the Registrar and the National Department of Health as the Chief Director of Pharmaceutical Planning and Policy	Funders
2	Dr. C. Mini	Board of Healthcare Funders (BHF) Chairman Government Employees Medical Scheme (GEMS), Trustee Active member in the governing party, the ANC and has served on several of its national committees Previously practiced medicine as a general practitioner before taking up administrative roles in government and various healthcare organisations	Funders
3	Dr. L. Walters	Medscheme, Executive Manager Medical doctor and clinical pharmacologist by training. Previously professor of clinical pharmacology at University of Pretoria and University of Cape Town. Also previously worked in the National Department of Health heading several portfolios in planning and primary care services	Funders
4	Mr B. Khan	MMI International (Health Division), CEO Background training as a chartered accountant, Mr Khan has had extensive experience in the private healthcare financing industry at executive levels since 1996. Started off as a general manager at Bankmed before joining Metropolitan Health Group, initially as a Director. Later became CEO of Metropolitan Health Group before Metropolitan's major with Momentum to form MMI Holdings. Mr Khan also previously served on the BHF board	Funders
5	Dr A. Ntsaluba	Discovery Holdings Limited; Executive Director, Member of Executive Committee and Member of Social & Ethics Committee Medical Research Council, Board Member Medical doctor, gynaecologist by training. Dr Ntsaluba previously served as the Director General of the Department of International Relations and Co-operation (formerly Foreign Affairs) and also served as Director General of the Department of Health. Dr. Ntsaluba has extensive systems, technical and public policy expertise in the healthcare sector	Funders

Table 5: Overview of Healthcare Providers Interviewed

#	Interviewee Name	Interviewee's Organisation(s) and Designation(s)	Research Sample
6	Dr N. Matlala	<p>South African Surgical Association (SASA), Board Member Hospitals Association of South Africa (HASA), Board Member (previously Chairman) Mediclinic Group, Executive Director of Government and Industry Affairs Phodiso Holdings, Chairman and Co-founder</p> <p>Dr Matlala is also a board member of several healthcare companies such as, Clicks, Wits Donald Gordon Hospital and Curamed Holdings. Previously Dr Matlala served in academia as a senior specialist surgeon at the Medical University of Southern Africa. He has also served on the boards of the National Medical and Dental Association (NAMDA) and South African Medical Association (SAMA)'s private practice committee</p>	Providers (Doctors & Hospitals)
7	Dr. S. Godinho	<p>Radiological Society of South Africa (RSSA), President Drs Van Rensberg and Partners (One of Africa's largest radiology practices), Director Practicing Radiologist</p>	Providers (Doctors)
8	Dr. A. Laubscher	<p>Netcare, Medical Director</p> <p>Dr Laubscher is a qualified medical doctor. She previously worked as an emergency practitioner before joining Netcare 911 (South Africa's largest emergency services) as the Medical Director and later moved to Netcare the holding company as Medical Director</p>	Providers (Doctors & Hospitals)
9	Dr. B. Ruff	<p>PPO Serve, CEO and cofounder</p> <p>Dr. Ruff is a medical doctor by training and previously worked as the head of Clinical Risk Management at Discovery Health</p>	Providers (Primary care)

Table 6: Overview of Suppliers of Technology, Equipment & Consumables Interviewed

#	Interviewee Name	Interviewee's Organisation(s) and Designation(s)	Research Sample
10	Dr. K. Sebati	<p>Innovative Pharmaceuticals Association of South Africa (IPASA), CEO.</p> <p>Dr Sebati, a medical doctor by training previously worked as a Medical Director for Pfizer Pharmaceuticals. Dr Sebati also previously worked for the government of South Africa as an ambassador to Switzerland and France before joining the World Intellectual Property Organisation (WIPO) as a Director</p>	Suppliers (Pharmaceuticals)
11	Mr. M. Magwaza	<p>BGM Pharmaceuticals, Managing Director and cofounder</p> <p>Mr Magwaza previously worked in various senior roles at AstraZeneca, a large biopharmaceutical company in South Africa before setting up his own pharmaceutical distribution company, BMG</p>	Suppliers (Pharmaceuticals)
12	Mr. K Dand	<p>Siemens Healthcare, South Africa, CEO Impilo Consortium, Director</p> <p>Mr Dand has held several senior positions within Siemens in different countries before moving to head Siemens South Africa</p>	Suppliers (Equipment)
13	Dr. S. Dube	<p>Phillips Healthcare, Business Development Manager</p> <p>Dr Dube is a medical doctor by training.</p>	Suppliers (Equipment)

Table 7: Overview of Experts & Journalists Interviewed

#	Interviwee Name	Interviewee's Organisation(s) and Designation(s)	Research Sample
1	Dr. A. Van den Heever	<i>Social Security Systems Administration and Management Studies (University of Witwatersrad), Chairman</i> <i>Wits School of Governance, Adjunct Professor</i> Dr Van den Heever holds Masters in economics from UCT and has worked in the areas of health economics and finance, public finance and social security in various capacities for over 23 years. He also previously served on the Melamet Commission of Inquiry into medical schemes, the Taylor Committee of Inquiry into Comprehensive Social Security, and the Ministerial Task team on Social Health Insurance. He also previously worked as an advisor to the Council for Medical Schemes (CMS) on social security processes	Expert (academic)
2	Mr. P. Boere	<i>International Finance Corporation (IFC) Health Sector Investment Officer (Private Public Partnerships)</i> Mr Boere previously headed a healthcare management consulting firm, HBS consulting for over 10 years before joining the IFC. He consulted to the government, the World Bank and various local healthcare companies primarily on healthcare infrastructure investments	Expert (Business Consultant)
3	Ms. Tamar Kahn	<i>Business Day, Science and Health Editor</i> Ms. Kahn writes on the health industry, research and health policy. She has won numerous awards, including the 2012 Discovery Health award for health economics journalism, ther 2008 award for investigative journalism, a Rosalynn Carter Mental Health Journalism fellowship and a Clive Menell media fellowship to Duke University	Journalist
4	Ms. L. Still	<i>Healthcare In South Africa (Book), Author</i> <i>Collingwood Consulting, Founder and Director</i> Ms. Still researches and writes about the healthcare industry in South Africa. For 10years now she has published annual edition of her book, Healthcare in South Africa, an in-depth account of South Africa's healthcare landscape	Journalist, Author

5.2 Results for Research Question 1:

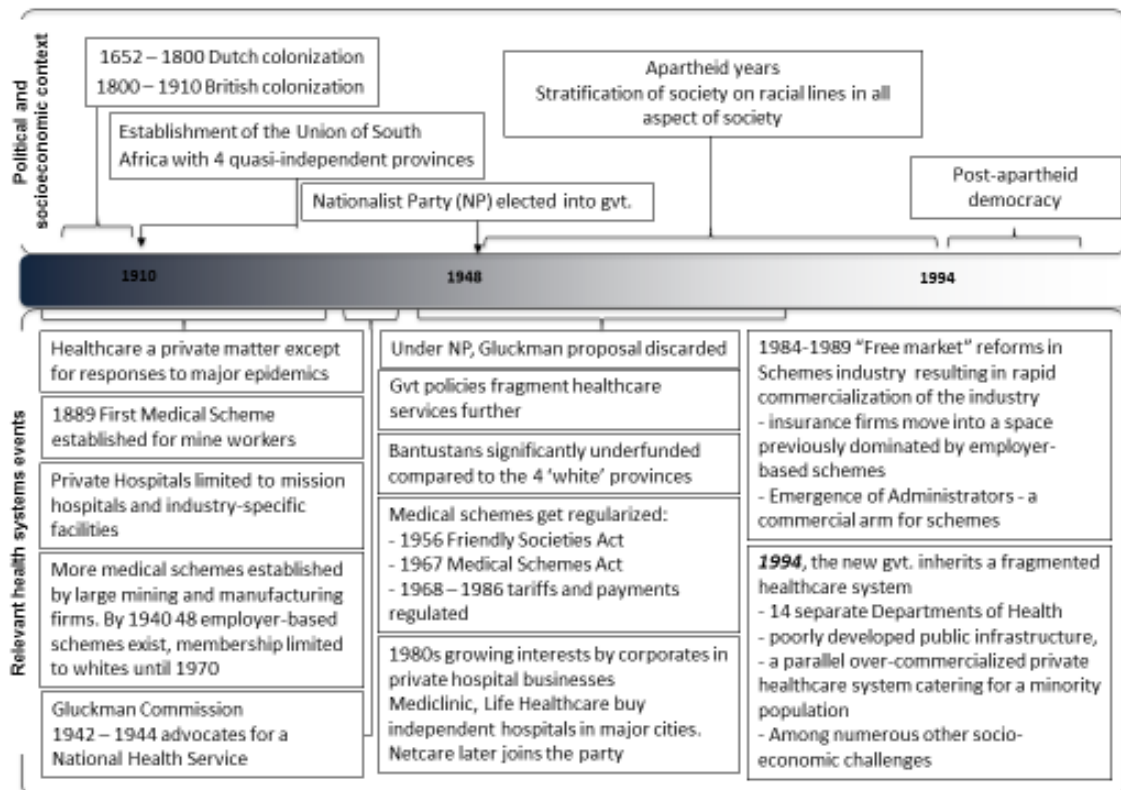
Mapping the context of South Africa's private healthcare environment

The NHI policy paper paints a picture of a fragmented healthcare system riddled with structural inefficiencies, poor outcomes relative to the endowment of healthcare resources in the country and inequities that favour the affluent. This is what necessitated the proposed reforms. But, how did the system become this way? What are the 'factors' helping to sustain this status quo and what makes it so difficult to change?

This section presents results from a systematic review of various archival literature and government reports to provide a historical logic of South Africa's healthcare ecosystem. It is, in most parts, a collation of literature gathered from several papers, particularly; work by van den Heever (2012), work by Taylor Committee of Inquiry (2002), the book *Health and Democracy* by the advocacy group Section 27 (Hassim et al., 2007), *The*

Lancet report on the state of healthcare in South Africa (Coovadia et al., 2009), the EQUINET discussion paper on healthcare financing by McIntyre (2010), the NHI policy paper (Department of Health, 2011) and the book *Health Care in South Africa 2015/16* by Still (2015). Further information was also collated from company websites of companies referred to in this section.

Figure 12: Timeline of relevant historical events



5.2.1 The Bureaucracies and Fragmentation in the Healthcare System

The roots of South Africa's bureaucratic and dysfunctional public healthcare system are found in policies from periods of the country's colonial history. In the early years of orthodox medical services, hospital-based services and preventative healthcare were managed separately. Hospital-based services were regarded a private responsibility and were funded by the user. The state only responded to major epidemics and infectious diseases which were regarded to have major externalities (Coovadia et al., 2009). The formation of the Union of South Africa in 1910 led to further fragmentation of health services among the four provinces in the Union (Coovadia et al., 2009). Each province ran its own independent health department, with its own budget. Furthermore, each health department was segmented on racial lines through the establishment of a

completely separate health service system for blacks, co-governed by the Department of Health and the Department of Native Affairs (Harrison, 1993)

There were attempts in the mid-20th century to consolidate health services. This started with the Health Act of 1919 that established a Union-wide Public Health Department then the Gluckman Commission of 1942-1944, which advocated for a unitary National Health Service (NHS) to govern and finance all healthcare services in the Union (Harrison, 1993). Most of these advances were however later derailed by the change of government when the Nationalist Party assumed power in 1948, rejecting all of the Commissions' recommendations before implementation (Kautzky & Tollman, 2008).

The apartheid regime further entrenched the fragmentation of health services by implementing Bantustans, each with its quasi-independent government. Each Bantustan managed its own health department, funded from the state. However, these were significantly underfunded. For example in 1986/87 public sector spending per capita on healthcare ranged from about R23 in Lebowa and R91 in Ciskei - both of which were Bantustans, and to about R150 in Transvaal and R200 in Natal and Cape Province (Coovadia et al., 2009). This led to serious underdevelopment of healthcare systems in some provinces, which were predominantly made up of Bantustans such as Limpopo and Eastern Cape. By the end of the apartheid, South Africa had 14 separate health departments with fragmented services, some better developed than others (Department of Health, 2011).

5.2.2 The Historical Logic of the Private Healthcare Funding System

As already discussed, healthcare in the early years of the formation of the Union of South Africa was regarded a private responsibility apart from responses to major epidemics and serious communicable diseases. Individuals privately funded their healthcare needs through out-of-pocket payments in public health facilities. What later became legislated as medical schemes emerged organically to fill this gap. Initially large firms established social security-type schemes for the welfare of their employees. Over time, these evolved into an important parallel healthcare funding vehicle for income earners, particularly those employed by large firms (van den Heever, 2012).. In later years, insurance firms saw an opportunity in smaller firms that did not have capacity to set up their own schemes. This created an avenue for non-employer-based

'open schemes', which enrolled employees from these smaller firms and grouped them into a single larger insurance risk pool.

As a consequence of their original mandate, Medical Schemes remained as not-for-profit organisations and later became legislated as such. However, a commercial arm to this system later evolved in the 1980s. Medical Schemes started outsourcing their administration services to a commercial arm, an Administrator for an administration fee. Smaller schemes and schemes without a major sponsor in the form of a large firm (open schemes) found it even more attractive to outsource their risk management and administrative services to an Administrator. This, together with 'free market' reforms in legislation discussed in more detail below, promoted the proliferation of smaller schemes not affiliated to a particular employer to the extent that by 1990, South Africa had over 240 registered medical schemes (McIntyre, 2010), almost all of them outsourcing the administration of their funds to independent Administrators.

5.2.2.1 The Emergence of Giant Medical Schemes and Administrators

Between 1984 and 1994, the government made some policy decisions pertaining to medical schemes that resulted in lasting legacies. The policy decisions were a result of lobbying by multi-employer 'open schemes' to loosen several restrictions on schemes. Key among these was loosening limitations on Schemes to risk-rate or price differentiate client contributions on the basis of risk. Schemes were allowed to differentiate premiums on the basis of group health risk and could even retrospectively adjust contributions on the basis of actual claims. Mandatory benefits for medical schemes were also removed (van den Heever, 2012).

This led to a protracted period, post 1994, of unregulated commercialisation of healthcare funding until most of these 'free market' regulations were reversed after 2000. Traditional insurance companies quickly pounced on the opportunity to move into this medical insurance space. Using brokers to taunt for clients, these new open schemes drew many new clients as well as clients from company-linked 'closed schemes'. The industry started to consolidate. This ultimately led to establishment of few large open schemes; most of them formed out of insurance firms, alongside large with administrator firms. The challenge however, is that this over commercialism came at the detriment of healthcare delivery. By 1999 no open scheme enrolled individuals over the age of 55 (Hassim et al., 2007). There was a growing exclusion of the sick, the elderly, the poor, women and people with chronic conditions either directly or through

exorbitant premiums or limitation of benefits. Between 1992 and 1998, there was a 243.5% real increase in medical scheme expenditure on non-health related costs - payments brokers and administrators, compared to only a 6.5% increase in medical beneficiaries (Hassim et al., 2007). Although most of these reforms were later reversed post 2000, the large firms established during this period still command significant influence in the private healthcare funding industry today.

5.2.3 The Development of the Private Hospital System

Prior to the 1980s, healthcare in South Africa was mainly provided by the state and a few industry-linked hospitals mainly in mining. There were also very few private healthcare facilities in urban areas but these were very few and far in between.

In the early 1980s, South Africa went through tumultuous macroeconomic conditions, placing major constraints on the government's social spending. The healthcare budget was one of the hardest hit, resulting in significant declines in investments in public hospitals. This began to threaten career opportunities for many physicians working in the public sector. As a result some of them moved into independent private practice and some established small private hospitals to which they referred patients for hospital care. Although this practice dates way before the 1980s, it was in this decade that it became prolific (Taylor Committee of Inquiry, 2002).

The growing trend of private hospital business later began to attract corporates. Starting with Afrox, then a leading supplier of oxygen, nitrous oxide and other gases used in the healthcare facilities, they established a subsidiary to explore this avenue by purchasing interests in four hospitals from the Ammed group in 1983. Over a short period of time, Afrox had grown its footprint in the hospital industry through acquisition of independent healthcare facilities as well as developing their own. Afrox Healthcare later changed its name to Life Healthcare. Around the same time Afrox started venturing into hospital business in 1983, the Rembrandt Group, then a business conglomerate with interests in tobacco, mining, industrial and financial services also started exploring investing in hospitals by purchasing several independent established medical facilities around Johannesburg and Cape Town and expand their capacities into larger hospitals. The third of the three large hospital groups in South Africa, Netcare Holdings, was listed on the JSE in 1996 with only six owned hospitals, also purchased from independent practitioners in Johannesburg. The three then expanded

their portfolio of hospitals through acquisition of small independent facilities mainly in major cities and later building their own.

Between 1976 and 1989, the number of private hospitals grew from 25 to 101 and later to 162 by 1998 – an increase of over 6 times in just two decades. Acute private hospital beds increased almost 10-fold from 2 346 to 20 908 over the same period (van den Heever, 2012). Several compounding factors helped to cement the establishment of this parallel healthcare system – the growing demand for better quality of care at the back of a deteriorating public system, the corporatisation of the private hospital industry, the existence of a parallel funding model through medical schemes and absence of clear policy from the government to regulate this industry.

As more private hospitals were established, the situation in the public hospitals continued to deteriorate. This resulted in a massive exodus of healthcare personnel from the public sector towards this financially more lucrative system, further deepening the crisis in the public hospitals. More and more people who had medical aid cover or who could afford to pay for hospital services also started to turn away from the public hospitals towards the private system. In 1989, 27% of medical scheme expenditure was spent in the public healthcare system. By 2012 this figure had dropped to only 0.3% (Econex, 2013). Consequently, the public sector turned into a healthcare system for the indigent population who could not afford private healthcare.

Access to medical schemes has been a privilege realisable predominantly by the employed, and growth of private hospitals also mirrored the geographic distribution of industrial or business cities. Today, more than 80% of private hospital beds in South Africa are concentrated in Gauteng followed by the Western Cape and Kwa-Zulu Natal provinces (Health Systems Trust, 2013).

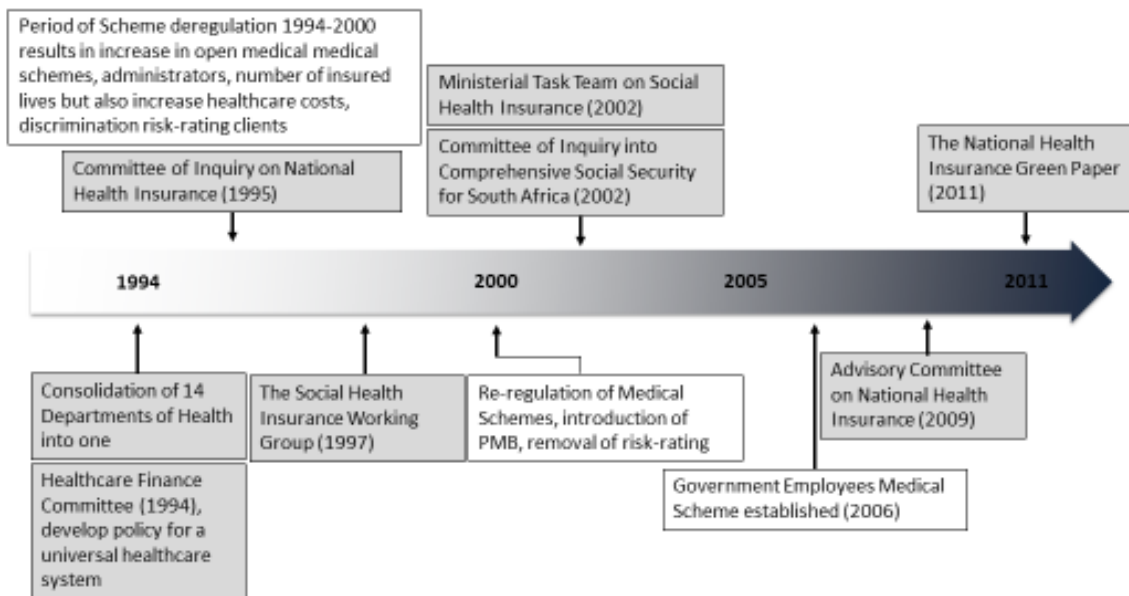
5.2.4 Efforts to Reform the Healthcare System

In 1994 South Africa had its first democratic elections and the African National Congress (ANC) assumed power from the National Party. Along with it came in several reforms to try and address the ills of its apartheid past. One of these, pertaining to health, was a deliberate effort to address the fragmented healthcare care system. This started with the consolidation of the 14 departments of health into one National Department of Health under the Minister of Health. This however did not solve the question of access to healthcare, particularly for the poor majority and it has turned out

to be a protracted problem for policy makers. The distribution of healthcare resources in South Africa remained skewed, favouring the affluent on geographic spread of both public and private facilities as well as affordability of private facilities.

To deal with this challenge, there have been several specific proposals presented by various committees as part of official policy processes to develop a universal healthcare system. Figure 13: below shows a high-level overview of these proposals.

Figure 13: History of proposals on healthcare reforms since 1994



5.2.5 The Prevailing Healthcare System

Table 8 below summarises several considerations helping to shape the context of the organisations-environment in the private healthcare sector examined in its current state.

Table 8: Overview of Contextual Considerations for the Current Healthcare System

Funders	Overview
	Made up of more than 80 medical schemes (mostly open schemes) and few administrators. The open medical scheme industry is dominated by very few large schemes most of which were formed out of commercial insurance firms - Discovery Health, Bonitas, Metropolitan, Momentum, Liberty Medical schemes are non-profit entities. They outsource administration of their funds to administrators, a commercial arm to the industry
	External Constraints
	Medical schemes legislated by the Medical Schemes Act, operate only as non-profit entities, governed by the Council for Medical Schemes. The population target for schemes is a finite number of middle to upper income population. Growth in this population of income earners has been poor for more than a decade. As a result, the population with medical scheme coverage has remained stagnant Few administrator firms, also legislated by the Medical Schemes Act and governed by the Council for Medical Schemes. Allowed to operate as for-profit entities Schemes have limited control over cost of healthcare as the demand for healthcare services is under the control of the supplier - healthcare providers. All of the over 80 medical schemes independently negotiate tariffs with providers, collective bargaining is prohibited.
Providers	Overview
	Made up of hospitals, doctors and allied healthcare providers. Doctors and hospitals consume the largest portion of healthcare expenditure on providers. Private hospital industry is very consolidated with the 3 largest hospital groups, Netcare, Mediclinic and Life Healthcare controlling over 80% of the market share. Hospital services considered to be exorbitantly expensive Geographic distribution of hospitals mirrors areas of affluence Private doctors operate independent of each other
	External Constraints
	The private hospital industry is poorly regulated outside of legislation that governs designing of hospital structures and the licensing of hospitals based on need. Private hospitals not allowed to employ doctors Doctors legislated through the Health Act and governed by the Health Professions Council
Suppliers	Overview
	Made up of pharmaceutical suppliers, suppliers of other consumables, suppliers of equipment and suppliers of technology Predominantly made up of large foreign firms with local distribution offices except for pharmaceutical manufacturers who have established local manufacturing capacity
	External Constraints
	The pharmaceutical industry is heavily regulated, legislated through the Pharmacy Act and governed by the Medicines Controls Council. Specialised medical equipment also governed by the Medicines Controls Council The other suppliers of consumables, equipment and technology are largely unregulated outside of the general standards compliance laws Very fragmented industry with over 40 pharmaceutical manufacturers and multiple suppliers of consumables and technology

5.2.6 Conclusion

South Africa in general has poor healthcare outcomes relative to its endowment of healthcare resources compared to other countries of same level of development. The healthcare system has two sectors that exist in parallel. On one hand is an embattled public sector struggling with under-resourcing, poor infrastructure and human resource shortages, catering for almost 85% of South Africans. On the other hand is an expensive private sector that caters for the affluent few in the country. The private sector emerged organically and has remained poorly regulated. The private sector sources its human resources from the public sector and is subsidised by the government through tax exemptions on medical aid contributions. Few large hospital

groups, Medical Schemes and Medical Scheme Administrators dominate this private sector

This section reviewed some of the relevant policies in South Africa's history that contributed to these structural challenges; particularly how a formidable private healthcare sector emerged out of a policy vacuum. The section also helps to contextualise the positioning of relevant stakeholders in the private healthcare sector – where they come from and what they are trying to achieve in the environment they are part of.

5.3 Results for Research Question 2:

Establish the felt-need for change

The first interview question was designed as an open-ended question:

What is your opinion of South Africa's healthcare system?

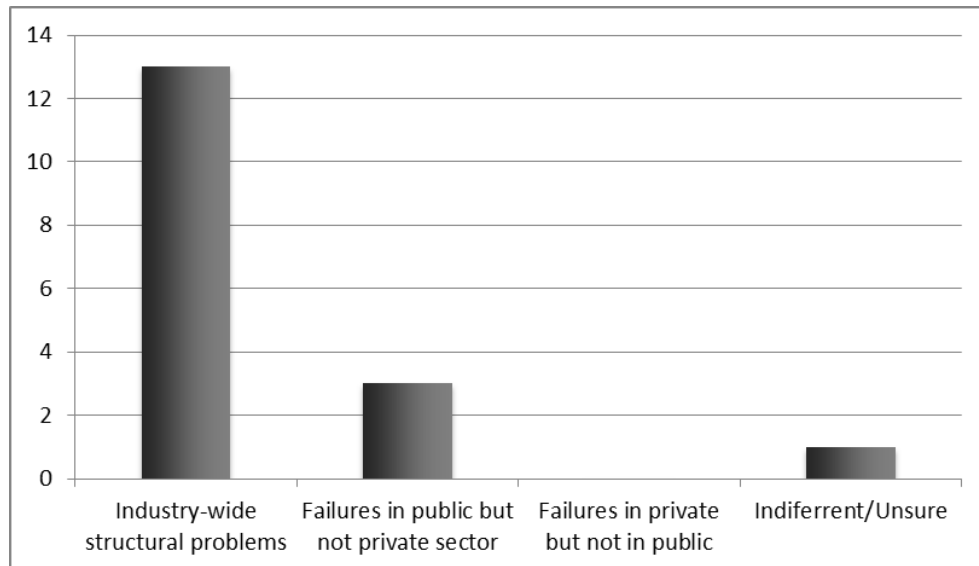
This allowed the interviewee an unfiltered opportunity to express their opinion of the healthcare system in their own words. An analysis of their narratives helped to establish the interviewees' level of satisfaction with the status quo. To do this analysis, each interviewee's narrative was analysed first into whether the interviewee thought there was a problem in the healthcare system in South Africa at all. Because this study is concerned with reforms pertaining to the private sector, the analysis went further differentiate whether the interviewees who thought there were problems in the healthcare system, saw the problems in the system as a whole, in the private sector only or in the public sector only. Table 9 below presents these results

Table 9: Results for Research Question 2: Challenges in South Africa's Healthcare System

	Industry-wide structural problems	Failures in public but not private sector	Failures in private but not in public	Indifferent/Unsure
Funders	5	0	0	0
Providers	2	2	0	0
Suppliers	2	1	0	1
Experts&Journalists	4	0	0	0
Total	13	3	0	1

The histogram in Figure 14 below presents overall responses from all the 17 respondents.

Figure 14: Results for Research Question 2: Problems in South Africa’s healthcare system



5.3.1 Discussion

13 of the interviewees believed that the problems in the healthcare industry were an industry-wide systems failure. They used phrases like “a *terrible mess*”, “*fragmented and broken*”, “*systemic failure*” or “*not in a good place*” to describe the entire industry. The public system was described as a “*dysfunctional*”, “*system in a crisis*” with poor management” and “*poor quality of care*”. Those who also identified problems in the private sector as well described a system that is “*fragmented*”, “*very expensive*”, “*opaque in every way*” and “*not accountable to anyone*”. Those arguing that the system is fragmented pointed out how providers operate in “*silos*” and players in the entire private healthcare system “*don’t talk to each other*”. By lack of accountability, they went on to explain lack of data on outcomes to justify expenditure in the sector.

One interviewee gave an anecdotal incident that summed their views of the two systems:

“... (our domestic helper who has worked for us) since 1990... was (involved) in a taxi accident... she hurt her leg and her chest. She went to Groote Schuur hospital (public hospital) and she waited for a few hours (to be attended to). They

too her chest x-rays and sent us a bill of R2 600. They gave her some Panado and discharged her. They missed a haematoma on the leg (blood clot under the skin), quite a large one. So my children sent her to the Day Hospital (a form of private hospital that offers minor surgical procedures with no overnight accommodation like a normal hospital). They aspirated it, but it re-accumulated (indicating there is an underlying bleed that needed attention). So she went back and they just put her on a bandage and more Panados. But now it's quite big. So my wife took her to our private GP (General Practitioner) who then referred her to a surgeon. (The surgeon then instructed us) she needed a surgical procedure. We first need(ed) to do a Doppler scan to check if it is not a false aneurysm (injury to a blood vessel that results in ballooning of the vessel wall causing excessive bleeding). Then she will need proper surgical drainage of the haematoma and so on... for these conditions ... it will cost about R12 000 – R14 000... (However) there was a financial issue here (she did not have medical insurance)... (and she) had a small income”

The interviewer went on to explain, however, that they have known this surgical practice for years now and they knew the surgeons involved very well. After discussions with the surgeon, she ended up having the procedure done for R1600.

In essence, in this anecdote, the interviewee gave the tale of two systems. They described a public healthcare system, which is not necessarily free or cheap and also riddled with a problem of long waiting times. The quality of care is also poor. On the other hand, in private sector, one could pay private healthcare fees but also not guaranteed of good outcomes, and there is no accountability on the part of the service provider. You also could get world-class quality of care in the private system but, this will not come cheap and is not accessible to low income earners.

The private sector was also accused of behaving like a parasite on the public system. In explaining this sentiment, those who purported so argued that the private healthcare system benefits massively from public system support. It draws a massive number of skilled healthcare providers trained in the public system at the public expense. The government subsidised Medical Scheme contributions through tax benefits. However, the system only “cherry-picks” a small affluent section of the population to which it provides services. This, consequently also results in an overcrowded understaffed public system.

However, there were three interviewees who firmly believed that the private healthcare system was doing well and should not necessarily be interfered with. They described the private healthcare system as “*outstanding*”, “*world class*” with “*good standards of care*”. If there is any change necessary, these interviewees felt it should be finding means to extend the service to the greater majority of the population rather than restructure the industry. They appreciated the need for a solution to extend healthcare coverage to the entire population, which they expressed as a “*concept entrenched in the constitution.*” What they had a problem with, however, was, “*the government’s propensity of taking something which is working and reduce it to something which is broken and then claim solution*”. In this, they claimed that the private system was great, but the public system dysfunctional. Their proposed solution was, therefore, the government fixing the public sector than temper with a well-functioning private system and reduce it to a public sector level.

5.3.2 Summary of Responses to Research Question 2

The majority of the interviewees expressed felt-need for reforming the industry. They acknowledged the structural challenges the system was faced both in the private and public sector. Three of the interviewees, largely providers representing large established organisations or associations, believed the private healthcare system was great. They, however, suggested need for incremental policy changes in order to expand their coverage to the greater majority of the population rather than radical structural changes to the system.

5.4 Results for Research Question 3:

Stakeholders’ perspectives of the problem

Results to this Research Question were drawn from follow up questions to the initial open ended question – what do you think of South Africa’s healthcare system. Follow up questions such as: “*Why do you think that?*” or “*why do you think caused that?*” were used to help unpack the interviewee’s perspectives of the problems in the system.

This helped to explore the interviewee’s understanding of the problems that require change and the underlying reasons behind their interpretation of these problems. Most interviewees generally cited a litany problems in the healthcare system as a whole and gave several reasons why the system is the way it is. These responses were then

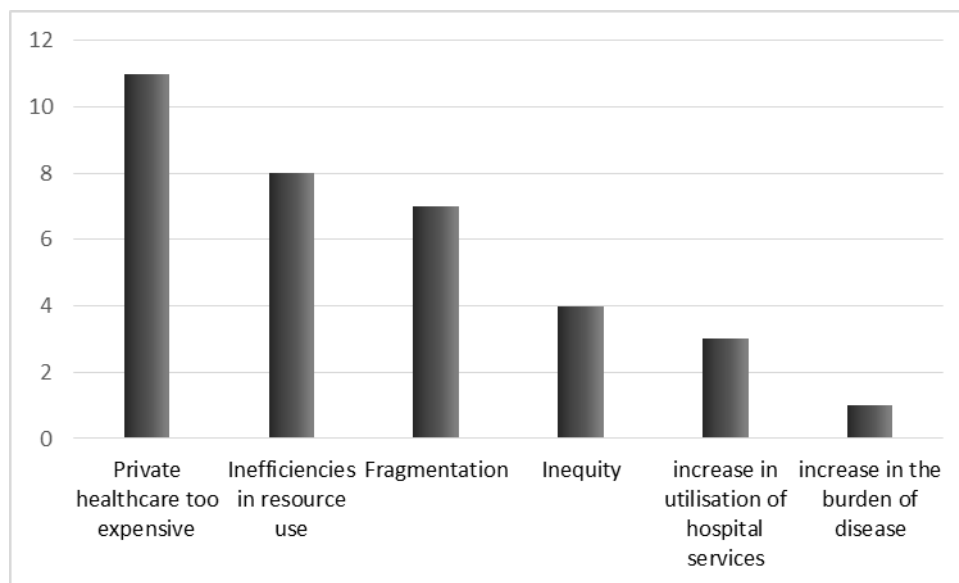
coded into meaningful units and interpretive short phases then summarised into frequency charts.

5.4.1 *Problems in the Private Healthcare Sector*

Although some of the interviewees initially suggested that they felt there saw no problems in the private sector, they all had an opinion to share on the state of national healthcare, particularly on problems in the system as a whole causing significant impact on the private sector.

Figure 15 below presents the commonly cited problems with the healthcare system from the perspective of the interviewees. Because this study is concerned primarily with the private healthcare industry, challenges unique to the public healthcare system, with no direct or indirect influence to the private system were not included.

Figure 15: Frequency of Problems with the Private Healthcare System



The commonest problem cited was that the private healthcare system was too expensive with 11 of the 17 interviewees citing this. Related to this was the problem that there is poor accountability in the system and gross inefficiencies in resource use, eight of the interviewees cited this problem. To explain this, one interviewee argued that South Africa has very poor outcomes relative to its rich healthcare resources. Part of the problem is that most of these resources are concentrated in the private sector, servicing a minority and has very little accountability for this resource splurge. Another frequently cited problem was that the private healthcare system was too fragmented with individual stakeholders in the system operating in “*silos*”. The private sector was

also seen as alienating a large majority of the population largely as a result of its sometimes unjustifiably high costs. The other two, less frequently raised problems were increasing utilisation of hospital services and increase in the burden of disease which also directly contributed to an increase in the cost of healthcare.

The distribution of these responses across the different subsectors is presented in

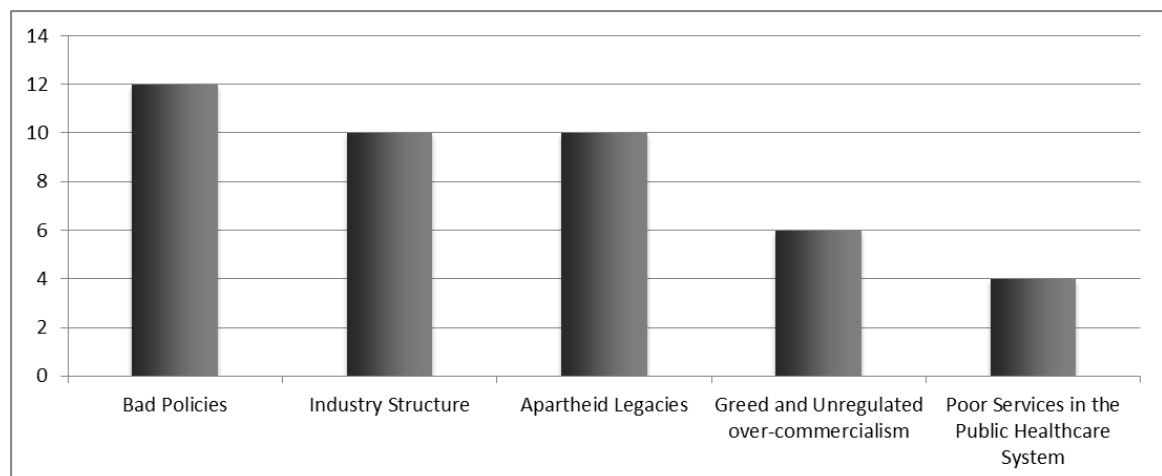
Table 10: Problems in the Private Healthcare Sector Across Subsectors

	Private healthcare too expensive	Inefficiencies in resource use	Fragmentation	Inequity	increase in utilisation of hospital services	increase in the burden of disease
Funders	5	3	3	3	2	0
Providers	2	1	1	1	0	1
Suppliers	1	0	1	0	0	0
Experts&Journalists	3	4	2	0	1	0

5.4.2 Underlying Reasons for the Challenges

The histogram in Figure 16 below is a list of these reasons given these problems

Figure 16: Results for Research Question 3: Reasons behind health systems failures



5.4.3 Discussion

Below is a discussion of these findings

5.4.3.1 Poor Policies

‘Poor policies’ was overtly brought up as a major reason for the current healthcare system in eleven of the interviews. Several explanations were given for the poor

policies, but one common thread was that South Africa's private healthcare sector evolved largely in the absence of policy direction. Legislation that latter came into existence, particularly the Medical Schemes Act then followed this *de novo* evolution to formalise and regularise the environment in order to provide protection for consumers. The challenge with such a system, as most interviewees pointed out, is that there is often no coherence in the legislative environment or there are "*legislative gaps*" that are "*vulnerable to capture*". As one interviewee aptly explained:

"In the early stages this (the Medical Schemes Act of 1967) was framed around the occupational medical schemes. Later on, the system changed (to accommodate) the commercial environment, which begins to emerge in the 1980s. (Around this) time ... the model of the private system starts to change. So what do they (the players in the private sector) do, they go to (lobby) the government to change the legislation." Legislation would then be modified to deal with this changing market. These changes were therefore made "*without a real design in mind, (the system) was just lobbied into a particular configuration.*"

In seven of these interviews, largely with funders and some industry experts, they further argued that the Medical Schemes Act, first introduced in 1968 to regularise the funding industry, provided some significant regulatory scope for medical schemes. This legislative framework has over the years been amended and consolidated, but it still remains today the key regulatory system controlling the functions of medical schemes. However, the supply side remains largely unregulated. The only form of regulation applicable to private hospitals is the Regulation 158 dictating standards on the design of hospitals and the Certificate of Need to justify the licensing of hospitals. For medical doctors, they simply need registration with the HPCSA that they are qualified to practice a particular discipline of medicine that is all. There is however no legislative framework that enforces accountability. Providers are "*self-regulated and accountable to themselves*". This has become a serious bone of contention between funders and providers.

5.4.3.2 Industry Structure

At least eight interviewees brought up the different aspects of the industry structure as problematic. The commonly fingered structural problem was the fragmented nature of the private healthcare industry. The HPCSA prevents private hospitals from employing

doctors; as a consequence providers operate in silos. On the funders' side, medical schemes as a collective have enough bargaining power to counter, and provide oversight on healthcare providers. However, providers lobbied the Competition Commission into introducing a regulation that prevented collective bargaining by funders. As a consequence, each of the 80 plus medical schemes in South Africa negotiates rates and provides oversight for its own clients independent of each other.

Because of this fragmentation, the system becomes so complex and inefficient. As one expert explained:

“...there are problems (imbedded) in the fact that you don't know what you're buying and in most instances the doctor (also) doesn't know the consequences of where they are referring you to... they don't know the mortality rates of that hospital, they don't know the outcomes of (that particular facility), they don't know (the expertise of the specialist they are referring you to). The system is opaque at every level... even for people internal to the system... The system as a whole doesn't provide the information which is useful, they complex the problem... They are not organised in such a way that they will produce information that's useful, and they have very little incentive to do so... (This prevents consumers from) making a value based choice...”

Adding to this structural complexity is the fact, aptly pointed out by two interviewees, that *“the nature of the healthcare sector is an abnormal market”* in that it is *“very vulnerable to market failures”*. They argued that healthcare providers have *“control over two variables ... they can manipulate supply ... and influence demand”*. They manipulate supply through acquiring new equipment, new facilities, additional theatres, additional beds etc. This does not necessarily imply new technologies that improve service delivery; it is not necessarily new innovation. It is simply adding to the available basket of services. At the same time these providers are also at liberty to *“manipulate demand”* for these services. If providers install a new MRI scan, new theatres or additional beds, they will create the need for them in order to get a return on this investment. People buying the service, medical schemes and patients, have very little influence over demand *“because of information asymmetry”*.

5.4.3.3 *Apartheid Legacies*

Seven of the interviewees highlighted the role of the apartheid policies in creating the healthcare challenges in the country. However, there was strong inclination towards its role in public healthcare system failures, largely the inadequate development of infrastructure in formerly ‘black communities’ and rural areas. The only reference to the role of apartheid in the private sector was on a more general socio-economic level, to explain structural inequalities in access to healthcare services.

5.4.3.4 *Greed and Unregulated Over-commercialism*

Five of the interviewees, largely funders, moaned about greed amongst some of the largest players in the market, particularly providers and suppliers of medicines. They accused them of over-commercialising a social good. They acknowledged the need for a corporate entity to make a profit, but they argued, the lack of regulation on the supply side allowed greed to prevail and some firms were making “*super profits*” at the detriment of providing broader healthcare.

For instance, one interviewee felt that the private sector had acted “*in an insular way*” for a while now. They argued that the sector designed a system that is structured around maximising their commercial interests, “*with no long-term view of significantly contributing to national agenda*”. Three other interviewees who suggested that some players in the private industry had become too “*greedy*” and abused policy loopholes to maximise shareholder value at the expense of the consumers echoed such views. However, they noted that this was not necessarily an industry-wide phenomenon

It is worth noting, however, that two of the interviewees who suggested there was excessive commercialism on the supply side also argued that it is in the nature of business. They went on to add that it is the role of the government to provide regulation against excessive profiteering and it is not in business interests to be concerned about national agenda. One interviewee further suggested that part of the reasons for excessive profiteering was a result of what they termed “*short-termism*”. “*If one believes the future is bleak*”, they argued, the plan is to “*...make as much as you can while you can and go elsewhere*”.

5.4.4 *Poor Services in the Public Sector*

The deterioration of services in the public sector was also cited as a particular problem indirectly affecting the private sector. Some argued that in most economies, a private system exist to provide luxury services to those who can afford and this should not necessarily be a problem. In South Africa, however, this is becoming a problem because of failures in the public system that is driving demand for private healthcare services. Another interviewee also argued that poor management in the public system, deteriorating infrastructure, inadequate resources and over-crowding was driving many doctors out of the public system to the public sector. The problem with this, the interviewee further explained, was that in healthcare demand for services is largely driven by providers, not the consumer like any other market. If a provider requests numerous investigations of simple problem like a sprain, the consumer has no information to compare whether he/she is getting value for money. As a result, the increase in supply of doctors in the private sector inevitably to some extent results in an unjustifiable increase in demand for healthcare services.

5.4.5 *Summary of Responses to Research Question 3*

Various reasons were cited to be problematic in the private healthcare system and these problems are interrelated. The most commonly cited was that private healthcare is too expensive. The other reasons include systems inefficiencies, fragmentation, unjustifiable increase in hospital utilisation and increase in the burden of disease, all of which contribute to increasing the cost of healthcare. Ultimately, the high cost of private healthcare alienates the poor.

This research question also investigated the underlying reasons behind the identified problems. Most of the interviewees cited lack of policy direction in the industry as an important reason behind some of these problems. There was palpable interest in contributing to national agenda amongst most interviewees but the majority felt that the government was not showing clear policy direction. As a result, strategic decision making has become too individualistic, with each organisation or individual making decisions based on what best suits them. There was also a deep sense of acknowledging structural reasons affecting the private healthcare industry as a whole. These included fragmentation, lack of accountability, information asymmetry and provider induced demand. However, most interviewees blamed much of these structural challenges on poorly coordinated regulations. Most funders also levelled

accusations at providers for taking advantage of their under-regulated industry to make massive profits at the expense of advancing national health.

5.5 Results for Research Question 4:

Stakeholders' opinions of the NHI proposal?

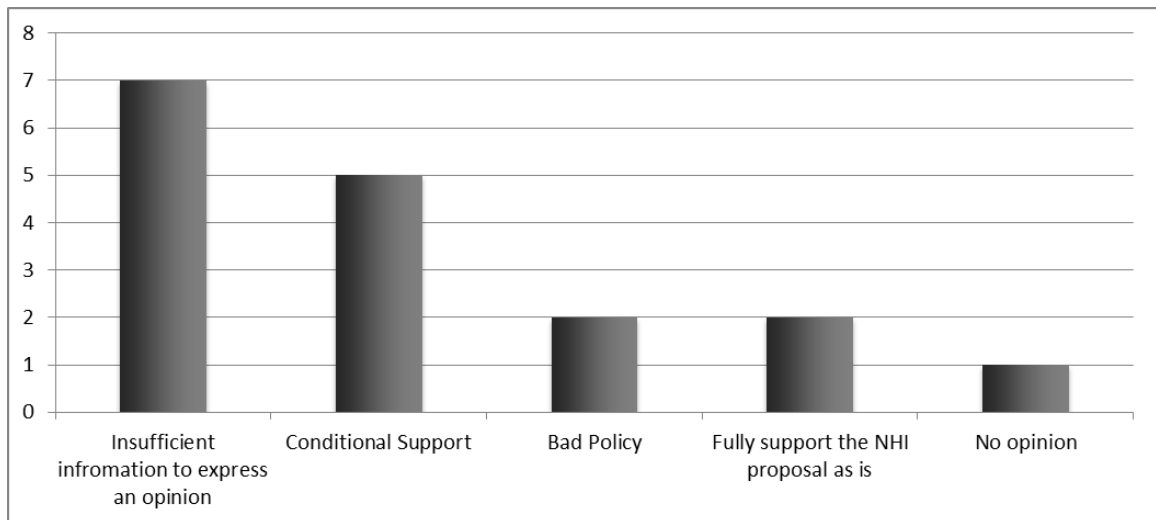
Interview Question 2 helped provide answers to Research Question 4. It investigated the interviewee's opinion of the proposed reforms. Follow up questions also sought to explore whether these opinions and attitudes evolved over time as well as possible factors (forces) that influenced such changes.

Responses to this question were very mixed. This was partly because the question on its own could refer to two perspectives - the ideology of a universal healthcare system or the means to achieve that goal. An attempt was made to unpack both perspectives during the interviews. Shown below are two histograms showing responses to these two views, first their views on the idea of a universal healthcare system and second, interviewees' views on the proposed plan to achieve it.

All respondents were not opposed to the idea of a universal healthcare system. Instead, the view was unanimous that a universal healthcare system is not only a good idea, but also mandatory.

However, the NHI policy proposal as presented in the Green Paper received less-favourable views. Almost all the interviewees had vociferous opinions on the proposed plan except for one who reserved their opinion because they were not well acquainted with the details of the proposal. These opinions were classified into five groups; fully support the policy document, as is, conditional support, insufficient information in the document to make a decision, bad policy document and no opinion.

Figure 17: Responses to Research Question 4: Views on the proposed NHI policy as presented in the Green Paper



5.5.1 Discussion

5.5.1.1 Views on the Idea of a Universal Healthcare System

All the interviewees from the different sectors of the private healthcare industry were in support of the idea of a universal healthcare program. They agreed that health was a fundamental human right that should be afforded to all citizens, regardless of their financial circumstances. They also agreed that it was the duty of the government to ensure that universal health access is actualised.

However, most interviewees did not agree with the government's proposed plan as demonstrated in Figure 17. Their views are discussed in more detail in the section below.

5.5.1.2 Views on the Proposed NHI Green Paper

The majority of interviewees were unsure of how the government was proposing to go about it. They argued that the proposed policy document was lacking in a lot of crucial detail, particularly regarding the role of private healthcare system. However, despite the concession that the policy document lacked detail, most of these interviewees were still able to formulate an opinion on the government plan. This was a crucial observation. Their opinions were not only formulated on the policy document but multiple other factors like their opinion of the government, previous experiences with the government and observing other parallel events at play in the business environment. For instance,

some interviewees pointed out the incompetence in other government entities such as the Road Accident Fund to discount the healthcare reform proposal without reference to particular weaknesses of the policy proposal. Other interviewees referred to the government's adversarial attitude towards the private sector to suspect that the policy reform, although the proposal lacking in detail, would seek to annihilate the private sector.

There were five other interviewees who conditionally supported some aspects of the program. They had segments of the proposal that they resonated with and openly supported, but could not fully endorse the proposal because either they strongly opposed other aspects of it or had other suspicions of the government's intentions. As one interviewee put it, "*if (the NHI) is purely a funding mechanism, then I am fully supportive.*" However, the same interviewee did not fully support the proposal because of suspicion that the government's ultimate aim was to bring heavy-handed controls on the private system. Another interviewee also supported the primary healthcare component of the proposal but did not agree with the centrally controlled funding model.

There were two interviewees who supported the current policy proposal as it is but later expressed conditions to their opinions by adding that the proposal was good as starting point for public commentary and initiate discourse. They however, also felt that the proposal lacked much content to be considered a complete policy document but the intent was in the right direction. They did not feel threatened by the proposal because they felt the government had no capacity to carry this forward without the private sector. Their job was to ensure their organisations remain relevant under an NHI environment.

Two interviewees felt the proposal was a just a poorly thought out document and a bad policy. They called it "*a farce*", "*a disaster*", "*a fantasy*", "*not a policy ... but a wish list*". They argued that while they were not opposed to the idea of universal healthcare, the government was going about it the wrong way. They argued that the whole document missed important areas for reform and was founded on speculative and untested hypotheses that were given undue weight. In their view, the government needed to consider developing a new Green Paper with a valid and distinct business case that holistically responded to clearly identified institutional challenges in the healthcare system.

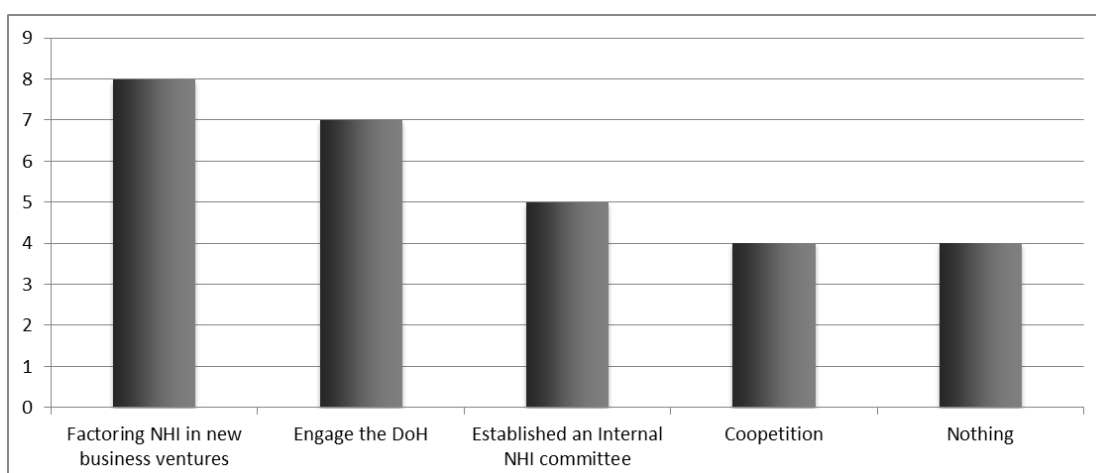
The significance of diagnostic accuracy and congruence of diagnosis is worth additional emphasis here. All the interviewees who shared an opinion on the NHI proposal referred to a ‘diagnosis of the problem’ in one way or the other to justify their opinion. Six of the interviewees from the funding and providers subsector felt that the NHI proposal was diagnostically sound. They argued that although they held differences of opinion on the goals and means of the proposal, it accurately identified several root problems that required attention. Only two interviewees felt the proposal was based on many diagnostic inaccuracies. The other nine interviewees were not bothered much about diagnostic accuracy of the policy proposal, or lack thereof. They concerned themselves more with their view of what they felt problem was, and consequently their suggested solutions to those problems.

5.6 Results for Research Question 5:

Stakeholders’ responses to the proposed reforms.

Interview question 3 illuminated answers for Research Question 5, which sought to marry the interviewee’s attitudes and opinions to the actual actions. These responses are presented in the histogram in Figure 18 below. Industry experts and journalists were not asked this question although an alternative question was asked to gather their views of how the industry is responding to the proposed reforms.

Figure 18: Responses to Research Question 5: Responses to the proposed reforms



5.6.1 *Discussion*

The commonest responses were considering the NHI in their new business development as well as engaging the government to voice their opinions. Engaging the government was either through formal submissions of their comments on the Green Paper or meeting with the relevant parties within the DoH. The majority of the interviewees representing an organisation or industry association had submitted a report to the DoH on the NHI. Either the interviewee themselves drafted the report on behalf of the organisations they represent, or contributed to and supported the report drafted by their industry association. Those who hadn't presented any commentary or report on the NHI to the government were either new in their positions or indicated that they were part of a bigger industry association that presented a unanimous opinion on behalf of the industry. However there was a common sense of shared helplessness among the interviewees. They felt the government disregarded their views anyway.

Each organisation or industry association also had an internal strategy on dealing with the looming policy reform. Each of these strategies was geared towards carving their own relevance under an NHI to safeguard their survival. This included factoring in a business environment under the NHI in organisational strategy and in developing new business ventures. For instance, three of the interviewees mentioned that they were developing data management systems using their wealth of experiences and resources geared towards an NHI environment, which they all believed the government would need some day. There was also a sense of sincerity among the interviewees to actively contribute towards a better healthcare system. Two providers described interventions in which they were employing their own resources to help alleviate pressure in state hospitals. One interviewee also explained how their organisation was helping in training of personnel through supplying no-obligation scholarships to doctors and had also established nursing colleges across the country.

Also, four industry associations, the Board of Healthcare Funders (BHF), the Hospital Association of South Africa (HASA), South Africa Medical Association (SAMA) and Independent Pharmaceutical Association of South Africa (IPASA), seem to be consolidating themselves into vociferous advocates for their industries on the policy. Interviewees who represented or belonged to these industry associations expressed how concerted effort was being made in each of these associations to reach a unanimous view on the policy and present a singular voice for the collective to the private healthcare industry as a whole and to the government.

Four interviewees from different subsectors also spoke of how they had initiated conversations with one another, including interactions with competitors, in the hope of developing a mutually beneficial road map to present to the DoH. This act is commonly referred to as *coopetition*, a neologism used to describe a cooperative competition (Investopedia, 2015). However, the interviewees also expressed concerns over restrictions around the extent they are allowed to engage with each other, as this could potentially be considered anti-competitive behaviour by the regulators.

Most of the suppliers of consumables and equipment expressed that their strategy was basically “*wait and see*”. They were neither contributing to the discourse nor factoring in the NHI in their near-term strategies. At the end of the day their primary concern was who their ultimate customer will be in the future. The only concern shared amongst them was the bargaining power the government had should all the purchasing processes be centralised within in the government.

5.7 Conclusion

This chapter presented results from both the systems review as well as interviews with 13 executives, two industry experts and two journalists. The systems review helped frame the historical context of South Africa’s healthcare system and place in context the relevant stakeholders within the private healthcare industry. The interviews with the executives, experts and journalists served to help comprehend the change process from the recipients’ perspectives. These results are analysed comprehensively in Chapter 6.

6 INTERPRETATION OF RESULTS

This chapter uses the theoretical lenses discussed in the literature review in Chapter 2 to provide insight into research findings presented in Chapter 5. Analysing a change process is not necessarily an abstract concept in literature. Instead, the subject has been investigated over several decades, primarily from the perspective of the instigators of the change process to better understand how to effectively turn ideas into policy and policy into actionable mandates as well as how the implementation process unfolds in order to better manage it. As a result, several models and theories emerged to provide strategic insight into how to better manage the reform process. This study, however, took a different perspective. It is not an attempt to appraise or develop another prescriptive model or theory on how to better manage change. Instead, it is primarily concerned with understanding recipients' conceptualisation of the change process in an attempt to explore or highlight insights previously overlooked. This section discusses the results of this investigation in the context of existing literature.

The results presented in Chapter 5 were obtained through two parallel methods. First, the results obtained from a systematic review of various research papers, publications and opinion pieces were presented to help to provide the historical context of the study, answering the first research question. The second method was through in-depth interviews with 17 executives in organisations in the private healthcare industry, two healthcare industry experts and two healthcare journalists. These interviews helped to unpack what the policy reform process looks and feels like from their perspectives, their responses to the reforms and their understanding of the reasons behind the poor progress in implementing the reforms. This section will follow the same format. First, an analysis of the historical context of study through the lens of relevant literature will be presented followed by an analysis of the interview results.

6.1 Discussion of Results for Research Question 1

Mapping the context of South Africa's private healthcare industry

Research Question 1 sought to frame the context in which the change process is unfolding. It sought to answer questions such as

- How did South Africa's healthcare find itself in this state?
- As a result of this, what is the structural configuration of this industry?

- Who are the most prominent or influential stakeholders, how did they come about?
- What are the possible political, economic and market considerations helping to shape this industry's structural configuration?

As Lewin (1943) observed in his field theory, one cannot understand individual behaviour without mapping the totality and complexity of the environment in which the behaviour takes place. He then further argued in his group dynamics theory that the behaviour of a group cannot be derived from its individual elements or simply how the individual elements fit together, but rather it is determined by the intrinsic structural laws governing the whole, or 'force field' maintaining the status quo (Burnes, 2004). This perspective reinforces the importance of understanding the totality of the environment in which change occurs before attempting to understand the behaviour of the recipients of the change process.

Lewin's work provided foundational theories on understanding group and individual behaviour in a social setting, be it organisational or societal. However, pertaining to an organisations-environment, a similar approach is applied in organisational ecology, which is discussed in more detail in Section 2.2.2. This perspective also places emphasis on the role of the macro-environment in which organisations coexist and form part of in shaping their behaviour. It argues that in response to a changing environment, organisation leaders scan the environment for opportunities and threats and adapt their organisations to the changing environment in order to survive (Hannan & Freeman, 1977). However, each organisation's ability to adapt is constrained by both internal and external forces that create inertial pressures to organisational structure (Hannan & Freeman, 1977).

Another important premise to consider in mapping the context of study is the role of historical events and decisions made in the past in shaping the current 'force field'. Historical institutionalism theories help to make sense and explain of the organisations-environment we have today. This perspective claims that political processes can best be understood if studied over a period of time rather than isolating a particular point in time (Pierson, 2004). One of the historical institutionalism theories, the path dependence theory argues that under a set of initial conditions conducive for self-reinforcing sequences, a number of relatively small events occurring in a particular sequence can set into motion event chains that produce large outcomes with enduring consequences (Pierson, 2000). Mahoney (2000) then added that earlier parts of the

sequence matter more than the later parts. Critical junctures theory, an additional perspective in historical institutionalism, places emphasis on critical points in history where decisions made placed institutional arrangements on a particular path dependent trajectory that is difficult to alter.

Using these theoretical lenses, the context of South Africa's private healthcare system, which is the subject of this research, is discussed below.

6.1.1 *Path Dependence*

Section 5.2 presented results of a systematic review into the history of South Africa's healthcare system, focusing particularly on events relevant to the subject of this study, the private healthcare system. This study argues that South Africa's private healthcare system and its related challenges faced today can best be understood as consequential to several relatively minor event chains in the past. The discussion below looks at path dependent process on a sector by sector.

6.1.1.1 *Funders*

The private healthcare system emerged out of a policy vacuum. Healthcare in the early foundations of the Union of South Africa was regarded a private matter except for major epidemics regarded to have serious negative externalities. This lack of a clear healthcare policy allowed for experimentation with different ways of providing and funding healthcare. This experimentation also coincided with the industrialisation of South Africa's economy following the discovery of diamonds in Kimberly and later gold in the Witwatersrand. Big mining firms and parallel industries supporting this burgeoning industry emerged. These big firms formed non-profit schemes to provide welfare for their workers creating over time a lucrative parallel healthcare funding model. Because medical schemes were established as employer-based, non-profit, social welfare programs, the legislation that followed between 1958 and 1967 (starting with the Friendly Societies Act of 1956 then the Medical Schemes Act of 1967) aimed to formalise and regularise a system that had already developed organically. As a result of this, medical schemes today still function as non-profit organisations.

The legislation that formalised medical schemes also triggered another important chain of events. Because medical schemes were established as non-profit organisations, a commercial arm to the system emerged to help administer the scheme's funds. This gave birth to administrator firms. Initially these administrator firms were small managing

specific schemes. However, in later years, the administration industry began to attract commercial insurance firms with broader actuarial capacity to help manage the funds. These independent administrators subsequently stimulated the emergence of smaller independent non-employer based schemes. Many of these 'open' schemes would focus on employees of smaller firms that did not provide medical scheme benefits. They would then outsource administrative functions to an administrator who would pool funds from various Schemes.

In the late 1980, the government implemented deregulated the medical scheme industry. This allowed 'open' schemes to risk rate clients, taut for healthier clients from closed schemes or who were previously uninsured and use various mechanisms to exclude the elderly and the sick. As a result, open schemes expanded rapidly, alongside their counterparts, administrator firms.

The private healthcare funding system that South Africa has today is a consequence of what historical institutionalism terms relatively small temporally sequenced events chains, occurring in an environment conducive for self-reinforcing sequences. The funding system today is made up of many 'open' (non employer-based) schemes dominated by a handful of former subsidiaries of commercial insurance firms, a few relatively large 'closed' (employer-based) schemes and administrators. The medical schemes are still required by law to operate as non-profit organisations and all of them outsource the fund administration functions to a commercial arm with maybe a sister company or an independent administrator.

6.1.1.2 Providers

As discussed in Section 4.2.6.1.1, healthcare providers in South Africa's private healthcare system are made up of independent healthcare practitioners, hospitals and emergency care services. (As mentioned in the same section, the emergency care services industry is very small and relatively inconsequential to this inquiry and will therefore not be discussed in this section)

Since early years of the establishment of the Union of South Africa, the profession of orthodox healthcare practice was always regulated and these legislations have remained unchanged. Only the state can train medical practitioners in academic hospitals that are attached to state universities. Only the state is allowed to employ doctors for the practice of medicine in state hospitals and clinics. Corporate entities are not allowed to employ medical practitioners for the purposes of practicing medicine.

Healthcare providers are allowed to form private practices. Practitioners are allowed to form partnerships with each other but only with other practitioners in the same discipline. These regulations have been stable for many decades. As a result, today's private healthcare practitioners are largely fragmented service providers operating independent of each other. They however generally belong to an industry association, a practice that also dates back to early 19th century.

Private hospitals, on the other hand, like the private insurance industry also emerged out of a policy vacuum as a path dependent process. Initially, almost all hospital services were provided by the state or mission hospitals. However there were few private doctors who owned small private facilities. The emergence of a parallel funding system, coupled by the deterioration of the public healthcare system and an exodus of healthcare practitioners from the state hospitals towards a financially more lucrative private system helped the private hospital business to swell. This attracted corporate entities with substantial capital to start buying small hospital properties from independent practitioners and expand them into larger, better-equipped facilities, consequently consolidating the industry. This helped fuel the problem of 'hospicentrism' discussed in Section 1.2.2.

Because corporate entities were not allowed to employ doctors, this allowed for the development of mutually beneficial consociation between doctors and hospitals where hospitals developed and equipped the infrastructure and doctors ran private practices within these facilities. Also because private hospital care was largely funded through medical schemes, the growth of private hospitals also mirrored the geographic distribution of affluent areas. This also contributed to the problem of inaccessibility of private hospitals due to geographic spread,

6.1.1.3 Suppliers of Consumables and Equipment

Healthcare industry suppliers are largely the pharmaceutical industry, suppliers of equipment and suppliers of technology. As would be expected of a supply industry, its emergence, growth and evolution is largely dependent on the demand side. It is therefore no surprise that the evolution of the demand side, the healthcare providers, influenced the evolution of the suppliers.

This subsector generally supplies both the private sector and the public sector. However, given the bargaining power of the government and the deterioration of infrastructure in the public sector, growth among suppliers has largely been driven by

the private industry. The emergence of the private healthcare system in the 1970s and its growth in the subsequent years resulted in many foreign owned firms, largely well-established firms from developed countries, establishing local distribution offices in South Africa. However, in the pharmaceutical industry, some of the firms developed local manufacturing capacity.

6.1.2 *Relevant Critical Junctures in the Past*

As discussed in the literature review, there are also specific periods in history of distinct changes, or critical junctures that placed institutional arrangement on specific path dependent trajectories, which are then difficult to alter (Capoccia & Kelemen, 2007). Some of these critical junctures are briefly discussed below.

- The Gluckman commission of 1942-1944 sought to establish a universal healthcare policy. However, all of the Gluckman's reforms were reversed following the assumption of power by the Nationalist Party as discussed in Section 5.2.1.
- The Nationalist Party also formalised and consolidated racial discrimination through the implementation apartheid system. This resulted in several social legacies that the NHI policy seeks to address as discussed in the NHI policy proposal such as the fragmentation of services, the quadruple burden of disease and a racially skewed inequitable distribution of healthcare resources.
- The Medical Schemes Act of 1967 legislated schemes to operate as non-profit organisations. This was a critical juncture that led to the establishment of the medical scheme administrators as discussed in more detail in Section 5.2.2.1, an additional layer to an already fragmented system.
- Many countries, in an effort to pressure the Nationalist Party government to end apartheid, imposed sanctions on South Africa in the 1970s and 1980s. This caused significant macro-economic upheaval that altered the trajectory of South Africa's healthcare system. The government, in an attempt to manage its budget deficits, significantly cut its social spending and healthcare was one of the most significantly affected. This contributed to the deterioration of public health infrastructure, the exodus of doctors towards the private sector and increase in healthcare expenditure in the private sector than the public sector.

- The 'free-market' reforms in the medical schemes industry between 1984 and 1994 discussed in Section 5.2.2.1 helped fuel commercialisation of the healthcare funding industry and the establishment of large 'open' medical schemes and administrators
- In 1994 South Africa gained independence from the apartheid government, which ushered in a new democratically elected government. This led to several reforms that, to a large extent, have altered the trajectory of the country's healthcare system as discussed in Section 5.2.4.
- The NHI policy reform could potentially be another critical juncture.

6.1.3 *Conclusion*

The interpretation of results for Research Question 1 was done using the organisations ecology theory and the historical institutionalism theory as the frame of reference. The interpretation helped to answer questions such as: who are the relevant stakeholders involved in the private healthcare industry, how did they come about and what is the historical logic of the current healthcare system, which the policy seeks to transform. This appreciation provided context to this study, which helped to illuminate deeper insights into findings obtained from the interviews.

The results emphasised the relevance of historical institutionalism in political sciences. They demonstrated that South Africa's current healthcare system, with its challenges, emerged as a consequence of several temporally sequenced, seemingly minor decisions (and indecisions) made in the past. These decisions, viewed in isolation may not paint a complete picture of the complexity of the challenges in the current healthcare environment. But viewed from cadence of events and decisions made in the past, it begins to explain some of the reasons why these challenges are so difficult to alter. This perspective also begins to demonstrate the powerful constraint that an environment places on the autonomy of organisations and highlights the importance of comprehending the collective aspects of interorganisational life when analysing a community of organisations.

6.2 Discussion of Results for Research Question 2

Establish the felt-need for change

This Research Question sought to explore any level of discomfort amongst the change recipients with the status quo. Responses to this question were derived from interviews with the recipients themselves and these responses are discussed in Section 5.3. Ultimately, the purpose of this Research Question was to unpack whether there are any forces impinging on the current ‘quasi-stationary’ equilibrium, viewed from the perspective of the recipients, regardless of the orientation or valence of these forces.

6.2.1 *Need for Change*

Data from the interviews suggested that there is generally a wide acknowledgement that the healthcare system in South Africa has serious challenges that require policy reforms. Results displayed in Table 9 show that of the 13 of the 14 executives interviewed felt that the “*system was in a crisis*”. Although four of these interviewees thought the root of the challenges was unique to the public system, the general consensus was still an acknowledgement that there was a need for reforms to create a mechanism for universal healthcare access for all South Africans.

In the context of existing literature, Burnes (2004) in his appraisal of Lewin change theories, argued that people’s readiness for change and willingness to act is dependent on ‘felt need’ for change. He further defined ‘felt need’ as “an individual’s inner realisation that change is necessary,” (Burnes, 2004, p. 984). Introducing change is generally problematic if the ‘felt need’ for change is low. Drawing from Lewin’s field theory, in this state of low ‘felt need’ for change, people regard the prevailing status to be in a relatively comfortable ‘quasi-stationary equilibrium’. However, if the ‘felt-need’ is high, this points to existing forces in the individual or group’s ‘life space’ threatening the prevailing equilibrium.

Establishing ‘felt need’ for change however says very little, if any, on the orientation or valence of the individual or group’s desired change. It only serves to inform one that the prevailing ‘quasi-stationary equilibrium’ is unstable. However, it cannot be assumed that in an environment with organisations sharing a ‘felt need’ for change, their desired change goals are similar.

The analysis of the environment in which the change process is taking place, discussed in Section 6.1 can help illuminate this force field. It places into context the

relevant stakeholders in this field, their positioning relative to each other and their orientation towards change.

Stemming from this perspective, a revisit to Table 9 shows some useful additional insights. As discussed in Section 5.2, the medical schemes industry is heavily regulated and has limited bargaining power over the healthcare providers. It is therefore no surprise that all the five interviewees in the funding industry felt that the private healthcare system had serious systemic challenges.

The provider side, on the other hand, particularly hospital groups are enjoying limited regulation. The industry is consolidated and has strong bargaining power. And as would be expected, their perception of the challenges in the private healthcare system were not as vehement as the funders. In fact, two of the four interviewees from the providers felt that the private healthcare system was “*world class*” with “*good standards of care*” and should not necessarily be interfered with. However, growth in the private industry has, for over a decade now, stagnated due to stagnation in enrolment into medical schemes. And hence, the providers who felt the private healthcare had challenges, their view of the challenge was a question of how to extending access to private healthcare for the broader population.

The pattern of responses from suppliers of equipment, consumables and pharmaceuticals were mixed. This mirrors the nature of this subsector. The suppliers of equipment and consumables are unregulated and their businesses are demand driven from the providers. Their views of the challenges in the healthcare system were either neutral or more ideological. However, interviewees from the heavily regulated pharmaceuticals industry had more virulent opinions on the challenges to the entire healthcare system.

6.2.2 *Conclusive Findings for Research Question 2*

The results indicated that all the interviewees generally felt that the healthcare system had some serious challenges that needed to be addressed at a policy level. However, a deeper analysis of the responses illuminated additional insights. Although there was a felt need for change, different groups of interviewees had different views of what the problem was. To make sense of these differences, the context of this environment, discussed in Sections 5.2 and 6.1 was briefly revisited.

The market dynamics in the private healthcare sector are skewed favouring healthcare providers. As a consequence of their history, funders are very fragmented and are

regulated on structure, funding and pricing. Hospitals on the other hand, also as a consequence of their historical narrative, are consolidated with the three biggest hospital groups owning up to 80% of the market share and largely unregulated. Thus, the felt need for change was vehement among funders, but tame among providers and suppliers (except for pharmaceutical groups who were also heavily regulated). Also, the orientation of the desired change was somewhat different.

Lewin (1939) proposed that people's readiness for change and willingness to act is dependent on 'felt need' for change. This assertion is now generally accepted most contemporary change scholarship, particularly organisational design models (Burnes, 2004; Cummings & Worley, 2009; Kotter, 1996). However, from the interpretation of results of this Research Question, it is clear that creating 'felt need' for change says very little about the recipients' orientation of their assumed change pathway or valence of forces propelling the need for change. From this perspective, there are two questions that become apparent and are unanswered in contemporary literature – *is resistance to change also potentially a function of incongruous orientation of the change pathway?*, and *if so, how can this orientation be manipulated to foster a more congruous orientation?*

6.3 Discussion of Results for Research Question 3

Stakeholders' perspectives of the problems in the private healthcare industry

Results for Research Questions 1 and 2 framed the context of the change environment. Results for Research Question 1 helped to frame the status quo and provided a historical logic of this status quo. Research Question 2 tested the stability of the current 'quasi-stationary' equilibrium and established that there is a palpable need for change. However, this felt need for change says very little about the recipients' orientation of their assumed pathways to address the challenges. In order to understand the orientation of recipients' change pathways, this study proposes that one needs to first conceptualise their understanding of the challenges that created this need for change. This is the conundrum Research Question 3 sought to unpack.

6.3.1 Interviewees' Conceptualisation of the Challenges in the System

Again, building on Lewin' change theories, an individual or organisation is maintained in a specific state by forces in a quasi-stationary equilibrium (Burnes & Cooke, 2013). However, the dynamism of forces impinging on the individual or group can shift and

destabilise this quasi-stationary equilibrium, creating a 'felt need' for change. It creates the compulsion for the individual or group to release their previously held attachments, move and search for a new quasi-stationary equilibrium (Kippenberger, 1998). The direction of this move towards a new quasi-stationary equilibrium is similar to the concept that Matland described as policy orientation. He described policy orientation as the individual or organisation's disposition to advance towards a specific policy agenda (Matland, 1995).

Kurt Lewin's work was devoted to understanding factors that influence this move, its orientation and how it can be manipulated. Much of this inquiry is encapsulated in his field model, group dynamics theory and action research. In his field theory, Lewin argued that the orientation of this move is influenced by a force field within the individual or group's force field, or as he called it, 'life space' (Burnes, 2004). But, as discussed in results for Research Question 2, even though the balance of the forces impinging on the organisations-environment is creating a 'felt need' for change, it cannot be assumed that the policy maker's change orientation is congruous to that of anyone else experiencing this felt need for change. It also cannot be assumed that the valence of forces impinging on each the organisations in this change environment is the same. Therefore, to fully understand this force field, it is not sufficient to identify only one or two of the forces impinging on the individual or group, let alone identify them in isolation. Instead it is essential to account for all the forces in their 'totality', and their interrelatedness to one another (Burnes & Cooke, 2013).

This section attempts to explore this totality of forces impinging on the stakeholders in the private healthcare industry by analysing their interpretation of the challenges in the healthcare system that created the felt need for change.

6.3.2 *Goal Orientation and Valence of Change Drive*

Figure 15 demonstrated that the majority of interviewees felt that private healthcare services were too expensive. Several other problems highlighted such as fragmentation, inefficiencies and unjustifiable increase in the utilisation of hospitals all contribute to increasing costs of healthcare. The problems were reportedly stemming from poor policies, as demonstrated in Figure 16. However, a deeper look at these results across each of the three sectors, presented in Table 10, paints an important picture.

Only two of the five healthcare providers felt there was a problem with the cost of healthcare. In fact, a deeper analysis of the responses of those providers who felt there

was a problem with the cost of private healthcare, they had justification for such costs. From this alone, it can be assumed that this subsector has no drive to advocate for legislation that seeks to address factors driving the cost of healthcare. Also, an analysis of Table 10 shows that healthcare providers and suppliers of consumables and equipment had the least contributions to the conversation on problems in the healthcare system. Of a total of 34 codes on the problems in the healthcare sector from the 17 interviewees, only six came from providers and four from suppliers of consumables and equipment. The other 26 codes came from funders and experts. This possibly implies a very strong drive for change emanating from the funders and experts but, indifference or little drive from suppliers and healthcare providers.

6.3.3 *Conclusive Findings for Research Question 3*

Lewin's field model, demonstrated in Figure 9 useful in visually demonstrating the force field impinging on an organisation. He proposed that carefully mapping these forces, their orientation and valences could help to plot each individual or group's change goal orientation as well as the valence of forces driving their desire to change (Burnes & Cooke, 2013; Burnes, 2004). To illuminate such micro-sociological dynamics, this study proposed that a deep exploration of both current and historical context of the environment in which change is taking place.

However, there is an additional question that this study failed to fully answer and calls for further empirical inquiry: *what is the appropriate unit of micro-level analysis for examining these force fields? Is it an industry, an industry subsector, an organisation or right down to leaders of particular organisations?* This study used organisational ecology theory (Hannan, Polos, & Carroll, 2002) and the field model (Burnes & Cooke, 2013) to argue that there is powerful constraint that an environment places on the autonomy of organisations in strategic decision making. Therefore, it is possible that the unit of analysis can be a group of organisations within a sector that shares an interdependent fate or share common paths.

6.4 Discussion of Results for Research Question 4

Stakeholders' opinions of the NHI proposal?

This Research Question sought to explore two phenomena argued by Matland (1995) to be fundamental in policy formulation and policy implementation - policy ambiguity and policy congruence. To do this, the study investigated the stakeholders'

understanding of both the goals and means proposed in the NHI Green Paper. This helped to shed light into several aspects of this policy. First it exposed the level of congruence between the stakeholders' idealised goal for the healthcare system and that proposed by the government. Second, it tested the level of policy ambiguity through analysing the stakeholder's understanding of what is proposed in the NHI Green Paper – both the goals and means. Finally, it also tested congruence between the various stakeholders' suggested means with those proposed in the NHI Green Paper.

6.4.1 *Policy Goal*

The fundamental goal of South Africa's NHI policy proposal is that the government plans to ensure that everyone in the country has access to quality, appropriate and efficient healthcare regardless of their financial status (Department of Health, 2011). The first part of this research question sought to test stakeholders' opinion of this policy goal.

All the interviewees from different sectors within the private healthcare industry support the idea of a universal healthcare program. If looked at from this face value, it appears there is goal congruity between various stakeholders in the private healthcare industry and the government. However, while there was a unanimous agreement on achieving the overall goal of a universal healthcare program, a deeper look into the responses exposed a slightly different picture. There was no congruity on some of the sub-goals also suggested in the policy document and these raise more vociferous opinions among stakeholders than the main goal. For instance, the policy document proposes abolishing the 'two-tiered' system into one tier under the NHI which will procure healthcare services on behalf of all citizens. Although this 'sub-goal' may potentially contribute to the ultimate goal of a universal healthcare system which the stakeholders are agreeable to, it generated extreme contention that overshadowed congruity to the main goal.

This consideration was also observed by one interviewee who aptly argued that a policy of this magnitude cannot rely on one policy document. They suggested that it "*requires several policy documents feeding into one...*" In other words, it is unlikely that this policy would have one goal, but many sub-goals feeding into one ultimate goal. These sub-goals have potential to attract different levels of conflict from different stakeholders. Accordingly, there would be serious potential risk in synthesising these

sub-goals into one policy document which could elicit many complex layers of conflict which could have been better managed in isolation than as one.

This is an important consideration that available literature does not explicitly address. It calls attention to investigating adequate levels of goal synthesis or goal disintegration necessary in order to better manage policy conflict. This gap was also identified by Hupe (2014, p. 1) who also pointed out that “*the multi-layer problem* (in policy implementation studies) *appears to have remained relatively unresolved* (in policy studies).” More research is needed on this subject.

As it currently stands, the NHI policy remains a highly contentious subject. Even though the ultimate goal of achieving universal healthcare access for all South Africans is well received across all the relevant stakeholders interviewed, there are ardent conflicts on several sub-goals proposed in the document. These conflicts overshadowed the primary goal of the proposed policy. This was evidenced by the intensity of responses among some interviewees who used words like “*a farce*”, “*a total disaster*”, “*a fantasy*” referring to the entire proposal, yet they initially agreed with the primary goal of universal healthcare access. This was also the reason behind some interviewees expressing conditional support of the proposal

6.4.2 *Policy Ambiguity*

As discussed in literature review, policy ambiguity deals with the question of clarity of goals and clarity of means to achieve those goals (Matland, 1995). All the interviewees agreed that the policy proposal was ambiguous on both levels. Some of these argued that the detail was so scant that it could not be regarded a policy but “*a wish list*”, while some felt it provided detail enough for public discourse but not enough to be a comprehensive policy document. Moreover, all the interviewees felt that there was lack of clarity on the future role of the private sector in the proposed plan. Several interviewees felt this was an intentional tactic by the government to conceal its intentions until it's late for anyone to mount reasonable action against it. Some interviewees even speculated that the government's attitude was very adversarial to the private sector and it was driving towards abolishing the private sector. However, there were also four interviewees who argued that it was not just an intentional tactic to conceal their plans, but a pure act of incompetence on the part of the government to formulate policy. Whichever way this can be looked at, all the interviewees agreed that the NHI policy proposal is very ambiguous.

6.4.3 *Conflict Ambiguity Matrix*

The NHI proposal, based on the results discussed above, would therefore fall in the high conflict high ambiguity quadrant. The results clearly demonstrated that the policy document was vague and ambiguous on specific goals as well as means to achieve the ultimate goal of universal healthcare access. As would be expected, consistent with Matland's assertion, this has resulted in a lot of uncertainties and evoked anxiety in the industry.

There is also failure to agree on a set of policy goals among the stakeholders and between the stakeholders and the government. According to Matland (1995) when there is lack of congruence on a set of goals for the policy, conflict ensues. However in this case, the NHI policy itself has vague and ambiguous goals. So how then can there be goal conflict when the proposed goals themselves are abstract? Matland (1995) further argued that a policy with vague goals, which he referred to as "*referential goals*", can evoke salient symbols that breed differing perspectives on those abstract goals. These perspectives can evoke strong opinions among stakeholders who see their futures directly tied to what they perceive the policy intends to achieve. And if this perception is not congruous to their goals, the response from stakeholders is likely to be conflictual.

6.4.4 *Diagnostic Accuracy and Diagnostic Congruence*

Another important consideration that most implementation theorists have not thoroughly investigated is the question of diagnostic accuracy versus diagnostic congruence. John Tuley, a 20th century American statistician is frequently quoted in several colloquial writings as having once said, "*better an approximate answer to the right question, which is often vague, than an exact answer to the wrong question, which can always be made precise*". What does this mean for political sciences?

The results discussed in Section 5.5.1.2 suggests that coming up with the right answer, or the most accurate policy program that every stakeholder is agreeable to is very difficult. Everyone has their opinion of what the right answer should be. This fact is also demonstrated in the discussion of goal orientation and valence of change drive in Section 6.3.2. Different stakeholders could potentially harbour conflicting opinions of what the policy goal should be. Moreover, the intensity of their change drive may also vary. But, commencing policy discussions at the goal setting stage misses an important

stage. Building on Tuley's quote mentioned above, the policy goal is the proposed 'answer'. But what is the question?

This study proposes that 'the question' is a frequently overlooked important point of departure on the policy process. This 'question' is merely a set of facts, a diagnosis of the status quo. Often, if a well-researched, diagnostically indisputable statement of facts is presented, it is unlikely to evoke as much conflict because it is the state of verifiable facts. As John Adams, the first vice president of the United States of America once said, "facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passions, they cannot alter the state of facts and evidence." Because one cannot easily alter the state of facts and evidence, it is easier to build congruence over a diagnosis across various stakeholders. So, although answers are often vague, the diagnosis does not necessarily need to be so. The proposed goals and means to this diagnosis may be vague or an approximation but, as Tuley argues, it is far better to have such an answer with the right question, than a precise policy document to the wrong question. However, this proposition requires further empirical inquiry.

This study however, proposes that one way to build the diagnosis is accurate context mapping as discussed in Section 6.1. This is a two-pronged process – comprehending the prevailing conditions as well as full appreciation of events that led to such conditions. The force field analysis and organisations ecology perspective helps map the prevailing ecosystem. Historical institutionalism helps to illuminate how past decisions and events shaped the ecology of relevant stakeholders in the organisations environment as well as the nature of the problem that requires change.

6.4.5 *Conclusive findings for Research Question 4*

This research question examined various stakeholders' understanding of the NHI policy. The primary purpose was to assess two aspects of a policy proposed by Matland (1995), the level of policy conflict and policy ambiguity.

On the surface, the results of this research question suggested that the stakeholders are agreeable to the NHI policy's primary goal. However, a deeper analysis of the interviewees' responses exposed a different paradigm. Although the stakeholders were agreeable to the primary goal of the policy – achieving universal healthcare access for all, they ferociously contested various sub-goals inferred in the policy proposal. These sub-goals were not necessarily clearly stipulated, but several salient symbols in the policy document were significant enough to evoke strong conflictual opinions from the

stakeholders. These opinions were so strong that they overshadowed the stakeholders' support of the primary goal.

The policy document did not only stir conflict, but it also evoked anxiety and uncertainty among stakeholders because it was very ambiguous on its numerous sub-goals and means to achieve those goals. This supported Matland's assertion of the impact of policy ambiguity on the stakeholders.

The question of conflictual referential goals bring attention to another interesting premise. The results demonstrated that while on the surface all stakeholders were agreeable to the NHI's goal of achieving universal healthcare access, the policy proposal also had numerous 'referential goals' that evoked opinions among stakeholders so intense that they overshadowed initial agreement to the primary goal of the policy. The implication of this finding might suggest, if assessed at face value, that policy makers should pay equal, if not more, careful attention to a policy's referential goals as its primary goal. However, the researcher argues that such focus on policy goals and its sub-goals would be a band-aid approach. Instead, the researcher proposes that to better handle conflict, the first step of a policy reform process should be seeking diagnostic congruence with relevant stakeholders. It further proposed that an accurate, fact-based diagnosis is less likely to evoke conflict. This conjectural assertion is based on the premise that facts are "stubborn things", not malleable to one's passions, inclinations or affiliations. Lastly, it was proposed that an approach to such a diagnosis would require an analysis of the prevailing change environment and its historical logic. These propositions were, however, inferred with very little evidence to support them and would therefore require further empirical inquiry.

6.5 Discussion of Results for Research Question 5

Stakeholders' responses to the proposed reforms.

This research question investigated specific actions variously taken by the interviewees and their organisations in response to the impending change. The primary motive for this research question was to comprehend responses to change from the recipients' perspective as well as attempt to comprehend transcendental processes influencing this behaviour. It is not concerned with developing a prescriptive model of how to better manage recipient responses, but an attempt to explore recipient behaviour from a

different perspective in an effort to uncover previously overlooked insights in a policy reform process.

McDermott *et al.* (2013) argued that in policy reform, first order change recipients become second order change agents as they embellish and modify both their organisations and the change mandate to suit their environment. This perspective raises the profile of recipients' involvement in a change process beyond the traditional perspective that viewed recipients through a passive 'acceptance-resistance' dimension. It calls attention to both scholars and policy instigators to better understand the change process from the perspective of the recipients. However, even if it is not consequential for the change's success, this perspective is still very important. Among other things, the various organisations that are recipients of the policy reform employ people; they support many livelihoods and are contributors to the economy of the country. For this reason alone, it is important to understand what the change process looks like from their perspective. And, if this understanding could contribute towards more successful implementation of a policy reform, all the better.

6.5.1 *Stakeholder Responses*

The results of the various stakeholder responses are presented in Section 0. These responses were analysed in the context of the change environment as well as the stakeholders' views of the proposed reforms.

Research Question 1 argued that the private healthcare sector emerged out of a policy vacuum. Through a series of path dependent process, the sector matured into its current fragmented and inefficient structure that has skewed regulations, which seem to favour providers. The private sector is expensive and caters mainly for the small population with medical insurance. Research Question 2 showed that the majority of stakeholders felt there was need for change in the current healthcare environment particularly to ensure universal healthcare access for all citizens. However, Research Question 3 and 4 showed that the proposed NHI policy was conflictual and very vague on the important sub-goals and means to achieve those goals.

The results for this Research Question support the argument by Matland (1995) and Bryant (2015) that under conditions of high policy conflict and high policy ambiguity, relevant stakeholders start forming coalitions. These coalitions are being formed largely within industry associations. Although there was a growing interest in reaching out across industry associations, particularly between the two most powerful stakeholder groups, the healthcare funders and hospital groups, the current regulatory environment

prevented this cooperation. It regards any form of cooperation between the funders and providers as anticompetitive and therefore illegal.

Matland (1995) also argued that under these conditions of high policy conflict and high ambiguity, the course of the policy reform process will ultimately be determined by the strength of the coalitions being formed. It is yet to be seen if the course of this reform process will follow that pattern. However, events occurring in the industry speak of a setup for active bargaining. Several recipients believed that the government's implementation of a Commission of Inquiry on the private healthcare sector has little to do with investigating healthcare pricing as it is presented, but a strategic move to clamp the bargaining position of the powerful hospital groups using authority. In response, the hospital groups have attempted to haggle over this Commission of Inquiry and it remains to be seen if similar tactics will be used against the White Paper on the NHI when it finally gets released.

Despite this power play, the various stakeholders are also making internal strategic decisions to accommodate a future NHI environment. This is a very important observation. Seven out of the 17 interviewees reported that their organisations had submitted articles to the government expressing their support of the overall goal of the NHI program but with other propositions on refining the policy. Also eight of the 13 executives were already incorporating a future NHI environment in their business strategies or established a committee to investigate how best to respond the impending NHI environment or both. Of course this can be considered a strategic move to protect their down side in event the NHI is thrust upon them. But there was a sense of sincerity among the interviewees in developing an internal NHI strategy.

This observation supports the view that the totality of recipient responses cannot just be interpreted as direct acts of 'resistance' or 'acceptance'. Instead, it appears in this instance that the primary aim of the change recipients is to achieve goal congruity on the numerous 'referential' sub-goals in this reform. It can also safely be argued from these findings that the intensity of commitment to haggle over these sub-goals can be ferocious to the extent that it can overshadow the tacit acceptance of the primary goal of achieving universal healthcare access for all.

6.5.2 *Conclusive Findings for Research Question 5*

This section analysed recipient response to change from the perspective of the policy recipients themselves. The analysis looked at the responses of the 13 executives interviewed, particularly their direct actions towards the NHI and those of the

organisations they represent. These actions were analysed within the context of their environment, their opinion of the challenges in the healthcare system and their opinion of the NHI policy proposal already discussed in Research Questions 1 to 4.

The findings supported the view in literature that a policy that is highly conflictual and with high ambiguity leads to high anxiety. There have also been multiple interpretations of the policy and debate over the appropriate pathway to follow. Theory also suggests that under such circumstances, policy course evolves in the direction determined by the strength of coalitions at the level of stakeholders who control the available resources. In this study, there is evidence that coalitions are forming. There is also evidence that there is some progression towards bargaining and haggling between powerful coalitions - the hospital groups, the funders and the government. But, in addition to these power dynamics at play, there are concerted efforts among the different stakeholders to factor in an NHI environment in their future strategic plans. The implications of this observation support the view that responses to change cannot simply be classified as either 'resistance' or 'acceptance'. Recipients may tacitly accept the ultimate goal of the change process but intensely haggle to achieve congruity on 'referential' sub-goals of the policy.

6.6 Conclusion

This chapter provided an interpretation of results discussed in Chapter 5. The aim of the chapter was to use empirical approaches discussed in Chapter 2 to help interpret the findings of the study. However, as already stated, there is a gap in academia on literature that is explicitly committed to examining recipients' conceptualisation of a change process. To bridge this gap, this study drew a few theoretical conjectures from social sciences and organisation studies. In particular, the study integrated the descriptive value of stakeholder theory, the micro-sociological insights of the organisational ecology approach and the epistemological perspectives of historical institutionalism theories. This chapter also used several theoretical approaches in political science literature to contextualise policy change events occurring in the healthcare sector.

The insights uncovered out of this exercise are discussed in Chapter 7, together with an integration of the rest of this report.

7 CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This concluding chapter revisits the main research problem and research objectives outlined in Chapter 1 in an attempt to integrate the initial purpose of this research and its findings. This chapter also presents contributions and recommendations for scholars, business leaders and policy makers, together with suggestions for future research.

7.2 Answering the Research Problem

The research problem outlined in Chapter 1 is revisited here in light of the research findings presented in Chapter 6. There were two primary objectives of this study. First, it was to comprehend a policy change process from the perspective of stakeholders who are primary recipients of the change agenda. Second, it was to investigate factors influencing these stakeholders' behaviours in response to change, viewed also from their perspectives of the change agenda and their context of the business environment that surrounds them. The study explored the healthcare reform process in South Africa, the NHI, examining the private healthcare industry as the primary recipient of the change agenda.

The literature reviewed in Chapter 2 helped provide the theoretical lens through which this subject was interrogated. Two approaches were used in this literature review. First, because the subjects of policy change and policy implementation have undergone numerous transitions over more than three decades, the literature review took a 'long-view' approach exploring how the ideas have evolved over time, rather than looking into perspectives on the subjects at a particular point in time. Second, because of the paucity of literature that is explicitly committed to investigating the policy change process from recipients' perspectives, the study also drew theoretical conjectures combining relevant insights from social sciences and organisational studies. This second approach was particularly concerned with theories on the microsociology of groups or organisations and how they behave in response to a change process.

The primary themes to emerge from this literature review include the following. The environment in which an organisation exists in, and forms part of, matters. It not only exerts pressure on organisations to change and adapt, but it also exerts inertial

pressures that constrain the flexibility of that organisation to adapt. This environment can be viewed as a force field comprising of a balance of forces in a 'quasi-stationary equilibrium'. When this balance of forces shifts, it destabilises the 'quasi-stationary equilibrium' and creates a 'felt need' for change. Without this 'felt need' for change it is difficult to drive change. Literature also emphasised the deterministic role of historical events and decisions made in the past on the structure of the current environment and its change orientation. The literature review also reflected on political science literature to help to frame the prevailing political policy context in the healthcare industry in South Africa.

Five research questions were formulated out of the stated research objectives. The research used two research methods to answer the research questions. The first method was a systemic review of available literature, reports and publications on the history of South Africa's healthcare system. This helped frame both the historical and prevailing context of the healthcare system. The study then employed a qualitative, exploratory methodology to investigate stakeholder perspectives of the change process and their responses to the proposed policy changes. The findings of the study are summarised below.

7.3 Summary of Research Findings

Research Question 1 investigated the historical context of South Africa's private healthcare environment and the context of the proposed changes in the NHI policy. The results of this study assert the critical importance of historical scrutiny in analysing an organisations-environment. Such an analysis helps to fully contextualise who the relevant stakeholders are, what their role in the industry is and what they are trying to achieve in it. This also illuminates some of the critical forces impinging on each stakeholder in the organisations-environment. Furthermore, the results to this question also demonstrated the powerful constraint that an environment places on the autonomy of organisations and highlights the importance of comprehending the collective aspects of interorganisational life when analysing a community of organisations.

Research Question 2 investigated the interviewed stakeholders' felt need for change. The results indicated that although on the surface all the interviewees generally felt that the healthcare system had some serious challenges that needed to be addressed at a policy level, a deeper analysis showed that different groups of interviewees had different views and different intensities of what they felt the problem was. This difference was partly a consequence of historical events and decisions that shaped

market dynamics. This finding opened an important area for further empirical inquiry. Contemporary literature (a concept drawn from Lewin (1943) but now largely employed in organisational design) asserts that people's readiness for change and willingness to act is a function of 'felt need' for change (Cummings & Worley, 2009). However, from the interpretation of results of this Research Question, it is clear that creating 'felt need' for change says very little about the recipients' orientation of their assumed change pathway or valence of forces propelling the need for change.

Research Question 3 interrogated stakeholder understanding of the challenges in the healthcare system that require change. This Research Question sought to examine each of the interviewees' change orientation. To help illuminate such micro-sociological dynamics, this study proposed a deep interrogation of both current and historical context of the environment in which change is taking place. But this also brought up an additional question in political studies that this research could not fully answer and calls for further empirical inquiry. That is: *what is the appropriate unit of micro-level analysis for examining an organisations-environment?, Is it an industry, an industry subsector, an organisation or right down to leaders of particular organisations?* This study used the structural inertia view (Hannan et al., 2002) which argues that there is powerful constraint that an environment places on the autonomy of organisations in strategic decision making. Therefore, it is possible that the unit of analysis can be a group of organisations within a sector that shares an interdependent fate or share common paths.

Research Question 4 examined stakeholder opinion of the NHI policy proposal as presented in the Green Paper. The results helped to map the NHI policy on Matland's (1995) conflict ambiguity matrix. The outcome of this inquiry demonstrated that the NHI policy had very vague goals and as a result was creating a lot of uncertainty and anxiety in the industry, confirming Matland's (1995) assertions. The analysis of goal conflict emphasised the role of a frequently overlooked aspect in change and policy studies. While on the surface all stakeholders were agreeable to the NHI's goal of achieving universal healthcare access, the policy proposal also had numerous 'referential goals' that evoked opinions among stakeholders so intense that they overshadowed initial agreement to the primary goal of the policy. The implication of this finding might suggest, if assessed at face value, that policy makers should pay equal, if not more, careful attention to a policy's referential goals as its primary goal. However, the researcher argued that focus on policy goals and its sub-goals would be a band-aid approach. Instead, the researcher proposes a concerted focus on diagnostic accuracy and diagnostic congruity. This proposal is based on conjectural assertion that an

accurate diagnosis, built on indisputable facts, cannot be altered by one's passions, inclinations or wishes and is therefore less likely to be conflictual. The formulation of policy goals to solve for this diagnosis can then be debated, but emanating from congruous, accurate diagnosis limits variance of opinions.

Research Question 5 then examined stakeholders' responses to the NHI policy proposal. These actions were analysed within the context of their environment, their opinion of the challenges in the healthcare system and their opinion of the NHI policy proposal already examined in Research Questions 1 to 4. The findings supported the view in literature that a policy that has highly ambiguous goals causes anxiety and uncertainty. To deal with this uncertainty, the stakeholders come up with multiple interpretations of the policy, formulated from inferences and salient 'referential goals' alluded in the policy proposal. Their attitudes and actions were conceived out of these assumptions. These actions included formation of stronger coalitions and progression towards bargaining and haggling between powerful and the government. But, in addition to these power dynamics, the stakeholders were also making efforts to factor in an NHI environment in their future strategic plans. The implications of this observation supports the view that responses to change cannot simply be classified as either 'resistance' or 'acceptance'. Recipients may tacitly accept the ultimate goal of the change process but intensely haggle to achieve congruity on 'referential' sub-goals of the policy.

7.4 Implications for Academia

7.4.1 *Methodological Contributions*

Due to the gap in literature on study explicitly committed to examining the change process from recipients' perspectives as noted in the literature review, it was deemed necessary to build a theory base by drawing theoretical insights from social sciences and organisation theories. This approach is applicable in the development of theoretical knowledge. It did not force fit theories from other fields of study. Instead, it examined the evolution of ideas in closely related fields in order to draw valuable insights necessary to help build an ideal theoretical base relevant to this study. Using this theoretical overture allowed for the emergence of themes such as the powerful constraint that an environment places on the autonomy of organisations, field force analysis of group behaviour, structural inertia and collective rationalism which were otherwise not apparent, or at least clearly defined in political science literature. These

themes were then used in formulation of research questions and interpreting research data.

7.4.2 *Empirical Contributions to Literature*

The purpose of the research was to re-examine a previously well-researched subject, but approaching it in different light in an attempt to illuminate possible insights previously overlooked. It interrogated a policy reform process, South Africa's NHI program, from the perspective of specific change recipients, stakeholders in the private healthcare industry. An important requirement in this study was to first fully understand the environment in which change is taking place, the challenges it is facing and how they came about. This was achieved through systematic review of archival data, publications and reports on the healthcare system in South Africa. This was followed by qualitative, semi-structured interviews used to gather data on recipients' perspectives of the healthcare reform program. Interpretation of the data collected through the theoretical lens framed in the Literature Review resulted in a deep, detailed appreciation of the stakeholders' perspectives of the change process. This process unearthed several insights that could potentially add to the body of knowledge.

From an exploration of an industry (or as referred to in this study, organisations-environment) perspective, the study helped emphasise the critical importance of historical institutionalism. This is not simply a reflection of the how the past has shaped the present healthcare environment. Such a watered down perspective of historical institutionalism undermines its rigor. Historical institutionalism implores one to fully comprehend the inter-relatedness of relatively minor events and decisions of the past, their temporal sequencing and how they have set into motion institutional patterns that created the prevailing structures. In this study, it was found that a historical incursion into these depths helped to contextualise the prevailing healthcare system, the challenges it faces, why the industry is structured the way it is and why certain organisations in private sector 'behave' the way they do. From this perspective, it also helped to make sense of relevant stakeholders' likely orientation in response to change and the intensity of their opinions.

The study also promulgated the empirical rigor of the organisational ecology approach in studying the microsociology of organisations. In this study in particular, this approach helped to contextualise constraints that the healthcare industry places on the autonomy of organisations in making strategic decisions and highlighted the importance of the collective decisions of organisations with an interdependent fate.

From a policy implementation perspective, it was found that stakeholders in the private healthcare sector are not opposing the policy reform simply because they are uncomfortable with the change process or prefer the status quo. In fact, the stakeholders also identified several challenges in the system that need to be addressed at a policy level. They are not opposed to the primary goal of the NHI proposal. But, the proposal insinuated several ambiguous sub-goals which created anxiety and uncertainty amongst stakeholders. In concert with Matland's (1995) assertion, this exposed the NHI policy document to multiple interpretations and assumed implications of the implied sub-goals. The conflict on the NHI policy was found to be on these implied sub-goals and was so intense that it overshadowed congruity to the stakeholders' congruity to the primary goal of the policy.

7.4.3 *Theoretical Contributions*

The study established that contention against the NHI policy primarily emanated from lack of congruity to the policy's implied sub-goals (or 'referential goals') rather than its primary goal. To address this challenge, top-downers advocated for eliminating ambiguity by clarifying the policy goals and means as discussed in the literature review (Matland, 1995). But this research argues that clarifying all the policy goals is not necessarily the solution. This is because clarifying those goals only serves to confirm conflictual inferences already drawn by the stakeholders. Instead, the study argued that the focus should not be centred on policy goals and its sub-goals. That would be a band-aid approach – dealing with the superficial problem. Instead, the research proposed a shift of focus towards diagnostics of the underlying problem that the policy seeks to address. The research theorises that the primary role of policy makers should be to accurately diagnose the problem to be solved for through policy change, built on indisputable facts, and define a desired end state. The formulation of policy goals and means to solve for this diagnosis can then be debated or negotiated. But, if the policy process is approached from a congruous, accurate diagnosis (or diagnoses), this can potentially constrain variance of opinions.

This proposal is built on presumption that facts are clear and lead to a singular diagnosis, or congruous diagnoses. However, this may not apply in cases where incongruous diagnoses are reached, both built on indisputable facts. Also, this proposal assumes an accurate singular diagnosis (or congruous diagnoses), built on indisputable facts, cannot be altered by one's passions, inclinations or wishes and is therefore less likely to be conflictual. Such a diagnosis (or diagnoses) may be uncomfortable, but more likely to be indisputable, hence lower levels of contention.

7.5 Implications for Policy and Practice

The empirical and theoretical contributions of this study have a few practical implications for both business leaders and policy makers. These implications are not limited to healthcare policy environment or to South African context only.

Implementing policy reform is notoriously difficult, particularly when relevant stakeholders have intense, incongruous opinions about what the goal for the policy reform should be. In theory, there may still be debates on whether the policy makers should fully communicate the planned policy, or strategically conceal the details in order to manage conflict. The latter strategy is also sometimes referred to as constructive ambiguity. This research, however, demonstrated that even when policy goals are ambiguous, recipients can make their own inferences from salient elements of the policy document ('referential goals') and these become grounds for their opinions. The study also demonstrated that these referential goals can evoke more vociferous reactions that can overshadow any potential agreements with other elements of the policy proposal.

To deal with this conflict, particularly around referential goals, this research proposes a departure from aiming to reach congruity of goals. Instead, policy makers should focus on two issues. That is, accurately diagnosing the fundamental challenges that could be solved through policy change and frame the ultimate desired future. Accurately diagnosing the underlying problems, based on undeniable facts, limits the level of conflicts on the issues to be solved for. This in turn could constrain the variance of alternatives to be debated when formulating the numerous policy goals that will eventually feed into the ultimate desired future. Also, this approach helps to disaggregate the policy into its smaller goals. Managing goal at this level provides better scope for handling conflict.

To formulate this diagnosis, the research further proposes an incursion in to the organisations-environment(s) likely to be impacted by the policy reforms. This incursion involves comprehending the factors sustaining the status quo, their historical roots and the historical roots of the entire organisations-environment. This helps, not only to frame path dependent processes that have created the challenge to be solved by the policy change, but fully comprehend who the key stakeholders are, what their environment is and what they are trying to achieve in it as well as their felt need for change and change orientation.

7.6 Limitations

Listed below are a number of limitations and compromises made in the study. Some of these limitations are inherent to a qualitative study of this nature, while some were particular to this study.

- Exploring an idea from a different perspective may help uncover new insights previously overlooked. Findings of such a study are often built from extrapolating generalisable findings into meaningful narratives. However, follow up research is necessary to build up epistemic certainty of these conclusions
- Sampling bias – the study population in this research was clearly defined and defended. However, selection of the sample required the researcher to employ a judgement call on who the most appropriate sources of data would be. Although a lot of effort was invested in carefully mapping who could provide data and at what degree of aggregation, there is still risk that other important sources were overlooked

Furthermore, not all identified data sources were available or willing to interview. The study protocol started off with a list of 22 executives and 6 'industry experts', targeted specifically because they represented fully the relevant subsectors. However, only 13 of the executives and 4 'industry experts' were available for interviews during the limited data collection period available. While the 17 provided ample information to map a generalisable conclusion, there is risk of overlooked data from the under-represented sample groups,

- Interviewee bias – one inherent risk in conducting semi-structured interview is the interviewer introducing cognitive bias into the study. This is where the interviewer's body language, facial expressions or follow up questions can unconsciously influence the response given by the interviewee (Zikmund et al., 2013)
- Experimenter-expectancy effect – Also related to cognitive bias is the unintended influence of experimenters' previously held hypotheses or expectations on the results of their research (Lewis-Beck et al., 2004).
- Sensitive data – This study was conducted during the time when the Competition Commission of South Africa was running an inquiry on pricing and

anticompetitive behaviour in South Africa's private healthcare system, commissioned by the minister of health (South Africa, The Competition Commission, 2015). As a result, some targeted interviewees were reluctant to interview. And those that agreed to interview, they were reluctant to discuss sensitive information with potential to jeopardise their standing in the inquiry.

7.7 Recommendations for Future Research

This study proposed an untested theory that would require further empirical interrogation. It proposed a shift of the point of departure for policy implementation, away from goal setting and policy formulation to diagnostics, particularly when there is high risk of conflict on what the policy goals should be. This research argues that when the diagnosis of the problem is based on accurate, indisputable facts, this constrains the variation of alternative opinions, consequently limiting the scope of conflicts around policy goals. More focused research in different contexts would allow a greater depth of understanding to the proposed concepts.

It is also recommended that further research be conducted on South Africa's NHI reform program, accommodating a broader audience and also accommodating views from the public healthcare sector and the DoH in order to get a more comprehensive view of the reform process.

Care needs to be taken, however, when selecting the appropriate unit of analysis. As stated earlier, organisational theory suggests that organisations-environments place powerful constraints on the autonomy of organisations and highlights the importance of collective rationality in strategic decision making (Hannan & Freeman, 1977). Lewin also argued that the behaviour of an individual in a group, or a group in a broader social setting is constrained by the statutes of the environment they belong to and form part of (Burnes, 2004). This raises an important question that is yet to be fully explored in academia, of what is the most appropriate unit of analysis when examining an organisations-environment (such as the healthcare industry). Is it organisation leaders, individual organisations or industry associations?

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APPENDIX 1: Interview Guideline for Recipients

a. Introduction and Background Information

- Welcome
- Discuss confidentiality of information
- Explain the purpose of interview and purpose of research
- Request to audio-record the interview

b. Theoretical Discussion

- Explain in very simple terms the theoretical concepts under investigation, particularly:
 - Historical perspectives and critical conjectures
 - Policy Reform
 - Policy implementation
 - Recipients' responses

c. Objectives

The primary objective of this interview is to get an overall view of events occurring in the industry from the perspective of industry experts.

An initial background discussion on the state of healthcare to break the ice

Interview question 1: What is your opinion of South Africa's healthcare industry?

Themes to be explored:

- State of nations' health
- Personal role in the industry/country
- Government's role in the industry/country
- Personal views about the private healthcare sector
- Challenges in the industry and underlying causes

Interview question 2: What is your opinion of the NHI policy proposal?

Themes to be explored

- Policy goals

- Policy means

Interview question 3: What have you or your organisation done about it? Why?

Themes to be explored

- Allow interviewee to take me through the journey
- Explore specific nodal events

Interview question 4: The DoH has so far not made much progress in implementing the reforms, in your opinion what has caused this delay?

Themes to be explored

- Allow interviewee to take me through their view

Interview question 5: What do you think is the way forward?

Themes to be explored

- Allow interviewee to take me through their view

Interview question 6: Is there anything else you wish to add that you think would be useful for this study?

Themes to be explored

- Allow interviewee to take me through their view

Thank interviewee and request permission to call them should there be anything else I need further clarity on.

APPENDIX 2: Interview Guideline for Experts and Journalists

d. Introduction and Background Information

- Welcome
- Discuss confidentiality of information
- Explain the purpose of interview and purpose of research
- Request to audio-record the interview

e. Theoretical Discussion

- Explain in very simple terms the theoretical concepts under investigation, particularly:
 - Historical perspectives and critical conjectures
 - Policy Reform
 - Policy implementation
 - Recipients' responses

f. Objectives

The primary objective of this interview is to get an overall view of events occurring in the industry from the perspective of industry experts.

An initial background discussion on the state of healthcare to break the ice

Interview question 1: Share with me your views of South Africa's healthcare industry?

Themes to be explored:

- State of nations' health
- Personal role in the industry/country
- Government's role in the industry/country
- Personal views about the private healthcare sector
- Challenges in the industry and underlying causes

Interview question 2: What is your opinion of the NHI policy proposal?

Themes to be explored

- Policy goals
- Policy means

Interview question 3: How has the industry responded to it? Why?

Themes to be explored

- Allow interviewee to take me through the journey
- Explore specific nodal events

Interview question 4: The DoH has so far not made much progress in implementing the reforms, in your opinion what has caused this delay?

Themes to be explored

- Allow interviewee to take me through their view

Interview question 5: What do you think is the way forward?

Themes to be explored

- Allow interviewee to take me through their view

Interview question 6: Is there anything else you wish to add that you think would be useful for this study?

Themes to be explored

- Allow interviewee to take me through their view

Thank interviewee and request permission to call them should there be anything else I need further clarity on.

APPENDIX 3: Informed Consent Letter

Dear Participant,

I am conducting research to investigate policy change processes from the perspective of recipients of a major change initiative – those whom the change initiative is meant to influence. The research is focused on the proposed NHI policy. I will be interested in exploring your views on the proposed reform as well how you and your organisation have responded and in part contributed to the changing healthcare landscape in South Africa. Ultimately, the research is intended to contribute towards a broader empirical understanding of transcendental processes that help shape outcomes of a major change process.

Our interview is expected to last about an hour. Your participation is voluntary and you may withdraw at any time without penalty. All data will be kept confidential; no comment will be linked to an individual. I however would like to ask your permission to audio record this interview for the purposes of backing up the data collected for future reference. Should you have any concerns regarding audio recording the interview, I can turn to note-taking by hand.

If you have any concerns, please contact either me or my supervisor. Our details are provided below.

Researcher

Adolf Tapelo Makgatho

atmakgatho@gmail.com

078 102 2887

Supervisor

Signature of participant: _____

Date: _____

Signature of researcher: _____

Date: _____

APPENDIX 4: GIBS Ethical Clearance

**Gordon Institute
of Business Science**
University of Pretoria

Dear Dr Adolf Makgatho

Protocol Number: **Temp2015-00883**

Title: **Rethinking resistance to change: A historical institutionalism perspective**

Please be advised that your application for Ethical Clearance has been APPROVED.

You are therefore allowed to continue collecting your data.

We wish you everything of the best for the rest of the project.

Kind Regards,

GIBS Ethics Administrator

APPENDIX 5: Medical Ethical Clearance



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee
12-Jun-2015

Dear Dr Adolf Makgatho

Regarding your submission

Protocol Number	Temp2015-00883
Protocol Title	Rethinking resistance to change: A historical institutionalism perspective
Principal Investigator	Dr Adolf Makgatho Tel: Email: Dept: Gordon Institute of Business Science
Sub Investigators	Makgatho, Adolf AT~
Study Coordinator	
Supervisor (only with students)	
Study Degree	Not for Degree Purposes
Sponsor/Company	None
Contact Details of Sponsor	Contact Person: None Email: None Tel: None Cell: None
Postal Address of Sponsor	None
Meeting Date	24-Jun-2015
Duration of Study	Start Date: Not Entered End Date: Not Entered Duration: Not Entered
Documents submitted electronically	25-May-2015
All Documents	HEALTH SCI APPROVAL FOR OTHER FACULTY RESE~

The **New Application / Study Proposal** was reviewed by the members by the Faculty of Health Sciences Research Ethics Committee and the following recommendations have been made for the purposes of consideration at the *next* Main Committee meeting.

<p>Recommendations</p> <p>Recommendations of Prelim meeting 11 June 2015</p> <ul style="list-style-type: none"> We recommend that the following comments be addressed: <ol style="list-style-type: none"> Please expand in the PICD on details regarding the interviews, i.e. individual, duration, contents. Ask permission from participants to audio-record the interview Please submit a cover letter indicating all revisions made (point by point), together with the revised documents. The researcher need not attend the meeting. <p>Date of Main meeting: 24 June 2015 Revisions need to be uploaded on the RIMS site and a hard copy delivered to Mrs D Behari, H W Snyman South Building, Rm 2.33 before 12:00 on 17 June 2015.</p>
--

Kindly adhere to the following when submitting your revised documents:

- Submit a cover letter indicating all revisions made (point-by-point for each of recommendations)
 - e.g. **Query 1:** "How will confidentiality be maintained?"
Response: Questionnaires will be completed anonymously.
- Revised documents:
 - Kindly upload your revised documents on <https://up.rims.ac.za> (**as Response to Deferral**).
 - Please deliver to our office before, 1 hard copy format (please make sure that the changes are clearly marked, e.g., Italic and underline... /or Track changes...) *How to do Track-changes: (Ctrl+Shift+E) (Open the document that need the corrections/ Go to the Toolbar/ Click on Review/ Click on Track Changes / then work on the document and save it: "...with track changes".)*

With regards

Dr R Sommers;

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

Tel : 012:354 1677

Fax : 086 651 6047

E-Mail : depeka.behari@up.ac.za

Web : <http://www.up.ac.za/healthethics> 31 Bophela Road, H W Snyman South Building, Level 2.33, Gezina, Pretoria Private Bag x 323, Arcadia, Pta, S.A., 0007

APPENDIX 6: Turnitin Report

 Turnitin Originality Report

Making sense of stakeholder responses to impending major policy reform in the private healthcare sector by Adolf Makgatho

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