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The Implementation of BEE in Gauteng-based private hospital groups

By

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ABSTRACT

The South African government is committed to breaking the cycle of underdevelopment and marginalisation of black people and is utilising Broad-Based Black Economic Empowerment as a key strategy to achieve its objectives of creating a fair and just society. The South African private hospital industry is highly competitive and regulated and the jury is still out on whether and how this industry is transforming. This research sought to assess the implementation of BBBEE and its importance to corporate strategy in selected private hospital groups based in Gauteng. The results of the research will add to the body of knowledge and practice regarding the implementation of BEE in South Africa. The literature suggested that there was little progress being made on BBBEE and qualitative research methods were utilised to find out if this was the case.

The key findings were that participants felt that their hospital groups were doing in meeting the DTI BBBEE targets, the hospital groups found it difficult to meet targets on preferential procurement, ownership, management control and employment equity. Corporate strategy approaches were utilised by the previously white-owned groups. Strategies employed were successful and BBBEE was of strategic importance to the hospital groups. Black-owned companies were not making any concerted efforts to implement BBBEE.

Recommendations are made to government, private hospital groups and for future research.

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DECLARATION

I declare that this research project is my own work. It is submitted to the Gordon Institute of business Science, University of Pretoria, in partial fulfilment of the requirements for the degree of Master of Business Administration. It has not been submitted before for any degree or examination in any other University.

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1.1 Background to research problem

"Apartheid systematically and purposefully restricted the majority of South Africans from meaningful participation in the economy." South Africa's Economic Transformation: A Strategy for Broad-Based Black Economic Empowerment (DTI, 2004).

1.1.1 BBBEE

South Africa has a history of systematic disempowerment and exclusion of the majority of its population, black people. Through various pieces of legislation such as the Native Land Act of 1913, the pass laws, and exclusion from property ownership, black people were excluded from the mainstream economy of the country (Innes, 2007). The result was massive inequalities between black (African, Coloured, Indians) and White people. In 1995, for example, 3.3 per cent of Whites, 9.6 per cent of Indians, 14.2 per cent of Coloureds and 19.6 per cent of Blacks were unemployed (DBSA, 2005).

With this history, redress was a moral and economic imperative for the new government and broad-based black economic empowerment (BBBEE), was viewed as a crucial growth strategy that could complement the political transformation of South Africa by getting black people to participate in the mainstream economy (DTI, 2004).

The South African Government has illustrated its commitment to the implementation of BBBEE by introducing the Broad-Based Black Economic Empowerment (BBBEE) Act 2003 and the BBBEE Codes of Good Practice with its BBBEE Scorecards which set very specific targets on black ownership, management control, employment equity, skills development, preferential procurement, enterprise development and socio-economic development.

1.1.2 The private hospital sector and BBBEE

South Africa has a large private health care sector that is characterised by fierce competition for scarce patients (Maqhina and Mapham, 2006), threats of regulation of prices (Department of Health, 2008), curbs on joint shareholding in hospitals by practising doctors and high barriers to entry.

In 2005, the Health Charter described the sector as largely untransformed, with a paucity of black representation at senior management level in the private sector, with little evidence of significant progress in addressing skills development as well as very little BBBEE in the sector (Department of Health, 2005a).

1.2 Nature of problem

The Black Economic Empowerment (BEE) Codes of Good Practice and its Generic Scorecard are the “single all-embracing regulatory regime for BEE in South Africa”, but do not apply to the private sector, unless it is doing business with an organ of state or a public entity (Lester, 2007). This means that private sector entities are not required to comply with the legislation but are encouraged to do so in their

interaction with each other (DTI, 2007a). In practice however, BBBEE is a strategic imperative if businesses are to remain competitive, retain their market share, and leverage off new business opportunities (Baldshaw and Goldberg, 2004).

Implementation of BBBEE has been a challenge for a number of companies. The 2008 KPMG BEE study revealed “a regression in progress on the BEE Scorecard”. A DTI study in 2007 revealed that 38.9 per cent of companies described themselves as having no plan or making no progress on BBBEE, while 19.7 per cent had fully implemented BBBEE (DTI, 2007b).

Few studies disaggregate for the implementation of BBBEE in the health care sector to show how the sector is performing, what challenges it has in the implementation of BEE and whether BBBEE is viewed as being of strategic importance. Where data is available it is difficult to compare as different criteria are utilised for categorising companies.

The private hospital industry in South Africa accounts for a significant share (25.6per cent) of service providers in the private health care sector (McIntyre and Thiede, 2007) and can thus contribute significantly to BBBEE and transformation of the sector. Although two JSE-listed private hospital groups, Medi-Clinic and Netcare, have published their BBBEE compliance status, there is no information on how other hospital groups are implementing BBBEE.

There is also limited information on the challenges hospital groups face in the implementation of BBBEE, how they are overcoming these challenges, and whether BBBEE is of strategic importance to them.

Noting the importance of BBBEE to the South African government's transformation agenda, the stated lack of transformation in the health sector, and the contribution the private hospital sector can make in the transformation of the sector, this study will explore how BEE is implemented in the private hospital sector, the challenges encountered, the strategies that are being taken to overcome these challenges, and to ascertain whether BBBEE is of strategic importance to the sector.

1.3 Research aim and purpose

The aim of the research is to assess the implementation of BBBEE and its importance to corporate strategy in Gauteng-based private hospital groups. The specific objectives are as follows:

(a) To ascertain if selected private hospital groups are meeting the targets set in the DTI's BBBEE Codes of Good Practice scorecard.

(b) To determine which targets the selected private hospital groups find hard to meet and why this is the case.

(c) To establish what strategies the selected private hospital groups have employed in meeting BBBEE targets.

(d) To establish which strategies have been successful in the implementation of BBBEE.

(e) To determine how important BBBEE is to the private hospital groups' corporate strategy.

The research will add to the body of knowledge on the implementation of BEE in South Africa, particularly BEE in the private hospital industry. The results will be used by private hospitals as advice on how to achieve BEE compliance in the future.

1.4 Research scope

The research will be limited to Gauteng-based private hospital groups and in-depth interviews will be utilised to collect data from officials working for the private hospital groups.

1.5 Relevance of the research

The research is relevant to South Africa as it will provide information on how BBBEE is being implemented in private hospital groups in the healthcare sector. There is currently limited research or information available on the extent to which the BBBEE targets in the health sector are being met, and how companies deal with problems in meeting the targets.

The results of the study will be of interest to the Department of Trade and Industry (DTI) and Industry which is the custodian of BBBEE and is charged with promoting and achieving its objectives. It is currently not clear to what extent hospital groups are implementing BBBEE, the challenges they face and how they deal with these

and it will be of interest to the DTI to know the situation pertaining to the health sector.

The results will be of interest to the National Department of Health as they will show how the private hospital groups based in Gauteng are complying with BBBEE and thus transforming.

The private sector will benefit from the results as they will learn about what measures and coping mechanisms other companies have adopted in the implementation of BBBEE.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

This literature review provides the theory base for black economic empowerment, starting with empowerment and then focussing specifically on black economic empowerment. Black economic empowerment is then reviewed in the context of South Africa moving from BEE through its transition to BBBEE, the rationale and the implementation of the policies and the challenges for BBBEE. As BBBEE is a strategy for transformation, a literature review of strategy, leadership, organisational change and transformation, and their importance to the survival of companies, is also provided.

A review of the South African private health care sector and its responses to BBBEE is also conducted, and at the end, there is a conclusion on the literature review.

2.2 Broad Based Black Economic Empowerment

2.2.1 Theory base for BEE and BBBEE

The theory base for BEE and BBBEE is empowerment and empowerment has different meanings to different people and in different socio-cultural and political contexts (Khosa, 2001; World Bank, 2002).

Mohanty (2001:22) provides a simple and inclusive definition of empowerment, which is “giving power to certain unprivileged sectors of society.” The World Bank defines empowerment in the context of poverty reduction as “The expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives.” (World Bank, 2002:xviii).

Friedmann (1992), in Khosa (2001:3) defines alternative development as “a process of social and political empowerment whose long term objective is to re-balance the structure of power on society by making state action more accountable…. and making corporate business more socially responsive”. Friedmann goes further to distinguish between social, political and psychological empowerment. Friedmann (1992) in Khosa (2001) saw social empowerment as access to bases of household reproduction such as knowledge and skills, social networks and financial resources. Political empowerment was about access by individuals and households to processes by which decisions that affect their lives. Psychological empowerment was about the person’s sense of potency which is gained through successful actions in the social and political spheres (Khosa, 2001).

Terms used to equate empowerment are control, self-reliance, life of dignity according to one’s values, self-strength, independence, being free, own decision making and capability, depending on one’s values and beliefs. In the case of South

Africa, there is economic empowerment, black empowerment and a combination of the two former forms of empowerment.

The central principle in BEE is empowerment in economic terms, with black people being the beneficiaries. Experiences with other populations, local and international are thus relevant to understand the underpinnings of strategies utilised to achieve economic empowerment for those populations. The empowerment of the Afrikaner in South Africa and the Bumiputeras in Malaysia will be explored.

2.2.2 Afrikaner and Bumiputera economic empowerment

BEE is not seen as a new strategy for empowerment, as there is local and international experience in economic empowerment.

Locally, Afrikaner economic empowerment evolved as part of addressing the "poor white problem". From 1934, the Broederbond addressed empowerment of Afrikaners at several levels; language, culture, economics and politics (Innes, 2007). Innes (2007) further states that, through the Ekonomiese Volkskongres cooperation between Sanlam, Santam and the Broederbond the slogan "*reddingsdaad*" (act of rescue) was adopted and it mobilised Afrikaners around three powers: savings-power, labour-power and buying-power. This led to an expansion of Afrikaner investment companies and most of these organisations utilised "informal" affirmative action policies to promote Afrikaners (Innes, 2007).

In 1948, the National Party won the elections and Afrikaners had thus wrested political power from the English. Afrikaner empowerment was then formally and legislatively driven by the government (Luhabe, 200); Innes, 2007); Southall, 2007). The State directed its business to Afrikaner banks, and through direct employment and procurement, Afrikaners were given business by the State in posts, communications, electricity and transport (Ponte, Roberts and van Sittert, 2007).

Internationally, the New Economic Policy (NEP) in Malaysia can be viewed as an economic empowerment policy. In this case, a programme, the NEP, was introduced in 1970 and provided affirmative action for the Bumiputeras (indigenous Malays) to narrow the gap between them and the Chinese Malaysians in education and participation in the economy (Jomo, 1990).

For both the Afrikaner and the Bumiputera populations, the evidence is that empowerment was successful for the targeted groups. Between 1939 and 1948 the number of Afrikaner-controlled businesses had increased almost fourfold and their turnover had risen by over fivefold (Innes, 2007:55) In 1948, Afrikaners controlled 6 per cent of private industry and this rose to 21 per cent in 1975 (Southall, 2007). In Malaysia, Bumiputera control of the economy grew because of the NEP, as their share capital in limited companies grew from 2.4 per cent in 1970 to 20.6 per cent in 1995 (Choi, 2003).

2.2.3 Arguments against preferential empowerment

Experience with preferences and quotas in places such as India, Malaysia and the United States show that these benefit mainly those that are already better off, rather than the poorest. In a study done in the United States, minority beneficiaries of government contracts set aside in the Small Business Administration were largely to individuals with a high net worth, including wealthy sportsmen such as O.J. Simpson (Sowell, 2004).

Sowell (2004) asserts that the poverty rate among blacks in the United States was cut by half before affirmative action was instituted and that rate has not changed since affirmative action was introduced. He further states that evidence around the world shows that preferential treatment leads to conflict within the identified groups with the most advantaged in the group accessing the new resources at the expense of others within the disadvantaged group. He cites India and Sri Lanka as examples where preferential treatment to increase the number of Maharashtrian business executives did not lead to losses among the dominant Gujaratis but among less represented South Indians.

Some of the consequences of preferential treatment are the withdrawal of the non-preferred group from society, for example the emigration of non-Bumiputera professionals in Malaysia, White South Africans in South Africa, Fiji, Soviet Central Asia and East Africa. (Sowell, 2004).

2.2.4 Evolution of BEE

The origin of the term “black economic empowerment” is not totally clear. Gqubule (2006) asserts that the consensus view is that the term was first popularly used in the 1980s in the context of the United Democratic Front and black entrepreneurs mobilising around economic issues. He accredits the use of the first use of the term to Joas Mogale, a founding member of the Foundation for African Business and Consumer Services (FABCOS), an organisation representing a number of these entrepreneurs.

Macozoma (2003) is of the view that the BEE concept emerged for the first time at the second conference of the FABCOS in May 1991, although he states that Sam Motsuenyane laid the basis for BEE in 1986 when Motsuenyane, indicated that the National African Chamber of Commerce (NAFCOC) and the African national Congress (ANC) “had agreed that future policies might have to include positive discrimination or affirmative action to be sanctioned in the short term to enable blacks to bridge the economic backlogs, which centuries of discriminatory policies have given rise to” (Macozoma (2003:23).

Two phases of BEE are recognised by Ponte *et al* (2007) and Jack (2007) identifies three waves of BEE. The first of the two waves was from 1994-2000 and was mainly characterised by ownership deals (Ponte *et al* 2007). Other legislation related to BEE that was passed around this period was the Employment Equity Act of 1998 and the Skills Development Act of 1998. The second phase from 2000 was

the characterised by Broad-based BEE and the first industry charters were produced, and the BBBEE Act and Strategy were also promulgated.

Jack (2007) asserts that the first of the three waves of BEE started in 1993, with a few prominent participants such as Dr Nthato Motlana in New Africa Investments Limited (NAIL), Mzi Khumalo with Simane and Wendy Luhabe with Women Investment Portfolio Holdings. This first wave was focused on buying stakes in existing companies.

The second wave of BEE saw the establishment of a BEE commission in 1997, the BEE Commission releasing its report in 2001 and legislation on BBBEE being passed in 2003 (Jack, 2007).

The third wave, Jack (2007), linked to the Preferential Procurement Policy Framework Act of 1997 which made BEE a business imperative. The Act has a trickle down effect on the whole economy as companies at all levels need to ensure that their suppliers are BEE compliant if they are to get maximum points on procurement in the BEE scorecard.

Although there are slight differences in describing the evolution of BEE, what is clear is that there was a distinct shift when BBBEE was introduced as this was meant to be more inclusive of the general poor population.

2.2.5 Transition to Broad Based Black Economic Empowerment

In response to criticism that BEE was creating a black elite where a few benefitted, the report of the BEE Commission was released in 2001 and it defined BEE as:

"Aimed at redressing the imbalances of the past by seeking to substantially and equitably transfer and confer the ownership, management and control of South Africa's financial and economic resources to the majority of its citizens". (BEE Commission, 2001)

The broad definition espoused by the Commission departed from the fact that black people remained excluded from financial and economic resources. It therefore sought that BEE should increase black people's access to productive assets, while ensuring that these assets remained productive. It also sought to promote new opportunities and to increase participation of black people in ownership, management and control of economic activities.

2.2.6 Legislative and regulatory framework for Based Black Economic Empowerment

Following the recommendations of the BEE Commission, in 2003 Department of Trade and Industry (DTI) produced the BBBEE Strategy which was followed by the BBBEE Act under which the Minister of Trade and Industry could issue guidelines for codes of good practice and publish transformation charters. The strategy also provides for "balanced score cards" that gauge success on BEE. The BBBEE Act should be read together with the BBBEE Strategy as the details of implementation are found in the Strategy.

The BEE Strategy defined broad-based BEE and the transformation imperative. It is perceived as providing a comprehensive and focussed strategy that is essential to address the "systematic exclusion of the majority of South Africans from full participation in the economy" (DTI, 2004). It is hoped that, through meaningful participation by black people in the economy, prosperity will be achieved (South African Government, 2004).

The BBBEE Strategy outlines the policy instruments required to achieve BBBEE. These are legislation, regulation, preferential procurement, partnerships and charters and financial and other incentive schemes (DTI, 2004).

2.2.6.1 BBBEE Act

The official government definition of BBBEE is found in the BBBEE Act and can be paraphrased as being "the economic empowerment of all black people (African, Coloured, Asian) including women, workers, youth, people with disabilities and people living in rural areas" (South African Government, 2004). In 2008 the Pretoria High Court ruled that South Africans of Chinese descent qualified for the full benefits of employment equity and black economic empowerment (BEE) laws (News24, 2008). Beneficiaries must be able to claim (or their parents must be able to claim) South African citizenship as at April 1994.

A "Black-owned company" is defined in Section 9 of the Act as an enterprise that is 50.1 per cent economically owned by black people, while a "black-empowered company must be 25.1 per cent owned by black interests.

2.2.6.2 Codes of Good Practice and the balanced score card

The Codes of Good Practice (the Codes) and Score Card were first released under the BBBEE Act in 2005 and were amended in 2007. In 2005 the conceptual framework and the measures for the seven elements wee launched. The latest amendments to the Codes were made in 2007. Gazetted in 2007, the Codes are effective for a period of 10 years over which time required entities should have fully complied (DTI, 2007a).

The Codes provide a standard framework for the measurement of broad-based black economic empowerment across all sectors of the economy and as stated in the BBBEE Strategy, government uses the balanced scorecard to measure progress made in achieving BEE by enterprises and sectors. The Score Card allows government, state-owned enterprises and other public agencies to align their procurement practices, especially in, *inter alia*, granting of licenses, granting concessions to a private enterprise to operate state assets, selling assets or state owned enterprises (SOE), and in entering into public-private partnerships (DTI, 2007a).

The private sector is not obliged to follow the Codes but is encouraged to do so as they need to comply with the Codes should they wish to transact with government. Special provisions are made for multinationals in the Codes and they are offered alternative means of contributing towards the ownership element (DTI, 2007a).

The scorecard measures three components as follows (DTI, 2007a):

- Direct empowerment through ownership and control of enterprises and assets;
- Human resource development and employment equity, and
- Indirect empowerment through preferential procurement and enterprise development.

The three components are further divided into seven elements; equity ownership, management control, employment equity, skills development, preferential procurement, enterprise development and socio-economic development. The full scorecard with weights is in Table 1 below.

Table 1: The DTI BBBEE Scorecard for 2005 and amended in 2007

Element	Points	
	2005	2007
Ownership	20	20
Management control	10	10
Employment equity	10	15
Skills development	20	15
Preferential procurement	20	20
Enterprise development	10	15
Socio-economic development	10	5
TOTAL	100 Points	100 Points

BBBEE compliance is measured using an overall score of 100 on the seven elements of the scorecard as points are given for each of the seven elements. In 2007 the Score Card gave more weight to employment equity and enterprise development and reduced the weight for skills development and socio-economic development (DTI, 2007a).

The Interpretive Guide on the BBBEE Act provides a summary of key issues to be noted regarding scoring in the Scorecard, based on the Codes of Good Practice, as outlined below (DTI, 2007c):

(a) Ownership

Recognises voting rights in the hands of black people and black women, economic interest of black people and black women in the enterprise and the interest of black natural people as represented in employee ownership schemes, broad-based ownership schemes and black people in cooperatives.

(b) Management control

Recognises the following areas:

- Representation of black people at board level.
- Involvement of black people in daily operations and strategic decision-making at the most senior level.
- Black people represented in positions that are key to the functioning of companies.

- The inclusion of black women in daily operations and strategic decision-making at the most senior level.

(c) Employment equity

Recognises the following:

- Representation of black employees with disabilities
- Representation of black employees at junior, middle and senior management levels only.
- The inclusion of black women managerial positions.

This area is also aligned to the Employment Equity Act which is applicable to all organisations that employ more that 50 people (Janisch, 2008). Janisch (2008) sees the employment equity part of the BEE Score Card as having potential to drive the application of the Employment Equity Act as verification for BEE is on site, rather than through reporting as is the case in the Employment Equity Act.

(d) Skills development

This recognises the following:

- Skills development spend for expenditure in any area of training, without the implementation of programmes focussing on Priority Skills (these are SETA-defined core, critical and scarce skills)
- Skills development spend not restricted to SETA-accredited training only
- Skills development spend for informal, in-house training and associated costs.

This also recognises monetary spend on black employees and the number of black employees who are enrolled in learner ships.

(e) Preferential procurement

"Preferential procurement is used to drive transformation throughout the economy by encouraging procurement only from suppliers that are compliant with the BBBEE scorecard" (DTI, 2007c:70). It is designed such that more points are gained by an enterprise that procures from suppliers that are more compliant. The ripple effect being that everyone will want to procure from only those with high BBBEE compliance scores.

(f) Enterprise development

This is meant to address the challenges faced by small enterprises and, points are allocated for providing assistance to them in the form of loans, guarantees, seed capital, access to finance, early payment for goods, infrastructure support and investment and support to enterprises operating in rural communities.

(g) Socio-economic development

"The principle is that socio-economic development initiatives should strive to facilitate access to the mainstream economy for black people" (DTI, 2007b:88). The most critical aspects of the support provided to beneficiaries is that the support should not create dependence, but should result in sustainable economic participation.

All entities required to comply with by the Code of Good Practice should keep a scorecard prepared and verified by an accredited verification agency (Lester, 2007). The overall performance of the entity is evaluated against a BEE compliance scoring matrix. The matrix has eight contribution levels ranging from 0% (level eight contributor) to 135% (level one contributor) (Lester, 2007), see Figure 1 below. Businesses in which more than 50% is owned by black people are automatically elevated to the compliance level immediately above their actual compliance level (Lester, 2007).

Figure 1: BEE compliance scoring matrix

BEE Status	Qualification	BEE procurement recognition level
Level One Contributor	≥100 points on the Generic Scorecard	135%
Level Two Contributor	≥85 but <100 points on the Generic Scorecard	125%
Level Three Contributor	≥75 but <85 on the Generic Scorecard	110%
Level Four Contributor	≥65 but <75 on the Generic Scorecard	100%
Level Five Contributor	≥55 but <65 on the Generic Scorecard	80%
Level Six Contributor	≥45 but <55 on the Generic Scorecard	60%
Level Seven Contributor	≥40 but <45 on the Generic Scorecard	50%
Level Eight Contributor	≥30 but <40 on the Generic Scorecard	10%
Non Compliant Contributor	<30 on the Generic Scorecard	0%

Contributors who score 65% and more on the Generic Scorecard which is out of 100 (from Level 4 and above) are viewed as good contributors to BBBEE, those scoring between 40 -64.9% are satisfactory contributors while those scoring less than 40% are called limited contributors to BBBEE (DTI, 2004).

In conclusion, the Codes of Good Practice and scorecard are binding on government and any SOE, but private sector enterprises need only consider them and are usually negotiated as Charters between the public and private sectors (Baldshaw and Goldberg, 2005). Besides the moral imperative to comply with the BBBEE targets, private sector entities need to comply with BBBEE requirements should they want to transact with government for licensing, procurement or for purposes of entering into public-private partnerships.

2.2.6.3 Arguments for and against BBBEE

BBBEE has been one of the most controversial policies for the new ANC government. Those arguing for BEE do so on the grounds that it is part of the normalisation South Africa, the de-racialisation of the economy (Shubane, 2007; Macozoma, 2007) is an essential part of the evolution of ANC policies and a political necessity (Southall, 2006). Those arguing against it assert that it scares foreign investors, is a perpetuation of racial identity and is enriching a few high profile, well-connected individuals (Iheduru, 2008; Tangri and Southall, 2008).

At the centre of most arguments are people's views of the role of the state, and whether BEE is advancing South Africa as a developmental state**.** This is complicated by the different expectations of the tri-partite alliance regarding the economic policies of the ANC. Also entangled in arguments about BEE are expectations on what the role of black capital is and whether again BEE is advancing black capital and entrepreneurship.

Macozoma (2003) asserts that the ANC had not applied itself to how it would de-racialise the economy as it believed that the Freedom Charter would take care of this. With the transition in 1990-1994 it however found itself in an international context that favoured capital and where a lot of the socialist states had imploded (Macozoma, 2003, Southall, undated). Socialism was no longer a reality and the ANC was described in 1996 as “betraying the revolution” when it replaced the Reconstruction and Development Programme (RDP) for the Growth, Employment and Redistribution (GEAR) programme (Iheduru, 2008).

It is thus within this context of differing views and expectations around South Africa’s political and economic trajectory that BEE gets criticised.

A strong proponent of BEE is Saki Macozoma who is very comfortable as a capitalist and goes as far as saying “Where have you ever seen a capitalist system producing socialist results?” (Macozoma, 2007:177). Macozoma (2007) views BEE as part of the de-racialisation of the economy, although he admits that it does have unintended consequences. He strongly asserts that apartheid denuded black people of basic capacities needed to take full advantage of BEE and advocates that more energy is expended in helping people take advantage of opportunities in BEE.

Macozoma’s views are supported by Shubane (2007) who asserts that the country must harness as many of its people as possible if it is to grow economically.

Shubane (2007) is a capitalist and believes in class formation and laments the fact that apartheid distorted natural class formation in South Africa.

For different reasons, very vocal opponents of BEE have been Moeletsi Mbeki (SABC News, 2008) and Blade Nzimande (Nzimande, 2007). Moeletsi Mbeki is opposed to BEE on the basis that it is wealth distribution and not wealth creation. He goes as far as saying BEE is a failure and should be abolished as it is not a solution to poverty, that is benefits the people in power and is more of a problem that a solution (SABC News, 2008).

Blade Nzimande, the Secretary General of the SACP, sees BEE as an essential part of changing the current reality of the marginalisation of the black, particularly, African, working class (Nzimande, 2007). At the core of his argument is “whether building people’s power in the economy and BEE mean the same thing” (Nzimande, 2007:181). What Nzimande proposes therefore is that BEE must be about addressing the needs of the majority of black people, black workers and the poor. He is looking for basic economic empowerment, in a broad sense, which can be achieved through access to jobs, the provision of affordable electricity, housing, transport, etc.

Nzimande’s arguments are informed by socialist ideology and are not shared by those of capitalist leaning who see no conflict between BEE and capital accumulation by the black middle class, and having government programmes that address the rest of the needs of the poor, e.g. electricity, and housing.

In conclusion, BEE will always generate argument and these arguments are mainly informed by people's world views and expectations on the country's development trajectory. In a number of cases, it is clear that it is not so much that BEE is wrong, but how far people think it should be extending, or how it should be implemented.

2.2.7 Implementation of BBBEE

Under the BBBEE legislation, charters have been developed and besides the mining and liquid fuels charters which were legislated and had concrete sanctions, most other charters were concluded on a voluntary basis with no sanctions for con-compliance (Ponte *et* al, 2007) compliance. Again, as stated before, the Codes of Good Practice need only be considered and are not binding to the private sector, and government is thus only in a strong position in sectors that require licensing and procurement from government.

The emerging consensus on the pace of implementation of BEE is that the process has been slow. Ponte *et al* (2007) believe that the pace of change due to BEE has been sluggish. Others state that not much has changed in the corporate world as, fourteen years after democracy, whites still control 80% of the economy (Iheduru, 2008). Tangri and Southall (2008) state that the deracialisation of the economy, in terms of ownership, management, and procurement has been slow. Tangri and Southall (2008) further state that, in 2006, even the Presidential Black Business Working Group expressed concern about the slow pace of empowerment, especially in the automotive, manufacturing, retail and property sectors.

Several organisations have been monitoring whether and how companies are meeting the targets set in various BEE Scorecards and their reports are discussed below.

The Empowerdex survey, conducted in 2006 on JSE-listed companies found an overall average BEE score of 49,3%, the highest score being in health and pharmaceutical sector at 59.6%. The health and pharmaceuticals sector scored best (one of top three sectors) in ownership, management, employment equity and social development. The sector was in the top five sectors in preferential procurement and enterprise development and scored below the JSE average on skills development (Empowerdex, 2006).

Research by the DTI shows that a large number of companies are not meeting BEE Scorecard targets set in the Codes of Good Practice (DTI, 2007a). The DTI report states that companies performed best in meeting employment equity and ownership targets, while they performed worst on preferential procurement, enterprise development, skills development, socio-economic development and management control. The report concluded that companies seemed to comply with elements of the Scorecard where there were legislative requirements, e.g., the Employment Equity Act.

Two KPMG studies on BEE compliance have been released, in 2007 and 2008. Both studies on BEE compliance used the Standard Industrial Classification to divide companies into sectors and Healthcare companies fell under the

Community, Social and Personal Services. The companies were further categorised into JSE-listed, multinational, parastatals and SMMEs companies (KPMG, 2007; KPMG, 2008).

The 2007 study revealed that companies generally scored worst in employment equity and enterprise development, while positive progress was being made in ownership, preferential procurement and skills development (KPMG, 2007). The Community, Social and Personal Services (including healthcare sector) did not meet any of the BEE targets and performed below average for ownership, preferential procurement and employment equity. The sector performed above average in skills development and enterprise development, management control and socio-economic development. The 2008 KPMG Study also found that the Community, Social and Personal Services (including Healthcare) Sector experienced most difficulty in implementing the preferential procurement and ownership elements of the score card (KPMG, 2008).

Of concern in results of the 2008 KPMG BEE Survey was the revelation of an overall industry-wide regression regarding progress on the BEE scorecard (KPMG, 2008). The report attributed the regression to the impact of the adjusted gender recognition principle in the latest Score card and the broader BEE targets in the ownership element. The adjustment for gender penalised organisations that had not addressed gender in management control, employment equity and skills development (KPMG, 2008).

Another factor identified was the poor performance in the preferential procurement element due to the requirement by most companies that suppliers have independently verified BEE certificates, rather than the self-assessment that had been allowed initially (KPMG, 2008).

The KPMG report went further to suggest that independently verified BEE scorecards could be a real competitive advantage in the market and be a major factor in the growth an survival of organisations. Non-BEE compliance could thus make it difficult for organisations to operate in South Africa (KPMG, 2008b).

On employment equity, due to the overlap with the Employment equity Act, reports from the Commission on Employment Equity (the Commission) were reviewed to show progress on inclusion of blacks, women, and people with disabilities. According to the Commission, “More than 10 years into our democracy, institutional racism continues to reign supreme… A resultant feature of this is the continued gross under-representation of Africans, Coloureds and People with Disabilities within the designated groups in key areas of the labour market” (Department of Labour, 2008:iv).

2.2.8 Obstacles to achieving BBBEE

Even where there is a will to implement BBBEE there are in some cases still valid reasons why companies find it difficult to meet BBBEE targets. A challenge cited by all types of companies in both the 2007 and 2008 KPMG Studies was the lack of experienced and skilled black people (KPMG, 2007; KPMG 2008). This however

is challenged by the Commission on Employment Equity which indicates that its studies have shown there is little merit to assertions that there is a shortage of black and black female candidates (Department of Labour, 2008).

Another problem identified in both 2007 and 2008 KPMG studies was the ownership of JSE-listed companies as these were publicly traded companies. The types of challenges they had as listed companies ranged from having no control over who became a shareholder to being subject to investor mix (KPMG, 2008).

A commonly reported reason for the difficulty in employing black people was job hopping by black people, and the Commission on Employment Equity commissioned a study on this subject. The study was conducted by TNS Research Studies and it failed to prove this assertion. The research concluded that "while a proportion of black professionals have changed jobs since they started their careers; 'White' professionals are significantly more likely to have changed jobs, thus proving that job-hopping in South Africa is not unique to Black professionals" (Department of Labour, 2008:3)

Janisch (2008) identifies the lack of accreditation of verification agencies by the Department of trade and Industry (DTI) as a challenge to BEE implementation and sees this as dependent on government getting its house in order. A full year after the gazetting of the BEE Codes on 9 February 2007, the DTI had still not accredited verification agencies, meaning that there were inconsistencies in the way BEE was being rated (Janisch, 2008). This problem is also highlighted by the Business Report as late as in September 2008 (Business Report, 2008a).

Other obstacles that have been identified in the implementation of BEE are access to finance, the independence of BEE parties from the sponsoring private party and effective participation in the operations and management of the companies (Bidvest, 2006; Mbabane, 2003). These obstacles limit the meeting of targets for ownership and management control.

Kgomoeswana (2008) provides more insight into obstacles to BEE at a psychological level when he highlights resistance to change on the part of whites and black pessimism as slowing down implementation of BEE. He states that some whites see BEE as “apartheid in reverse while black people do little to advance each other and this he encapsulates as their “lack of cohesive optimism”. Kgomoeswana (2008) also suggests that black suppliers or managers get left out on the basis of keeping high standards, and that this suggests that “black is equal to the lowering of standards”.

2.2.9 Strategy and leadership

In this section, a literature review of strategy, competitive strategy and leadership is provided.

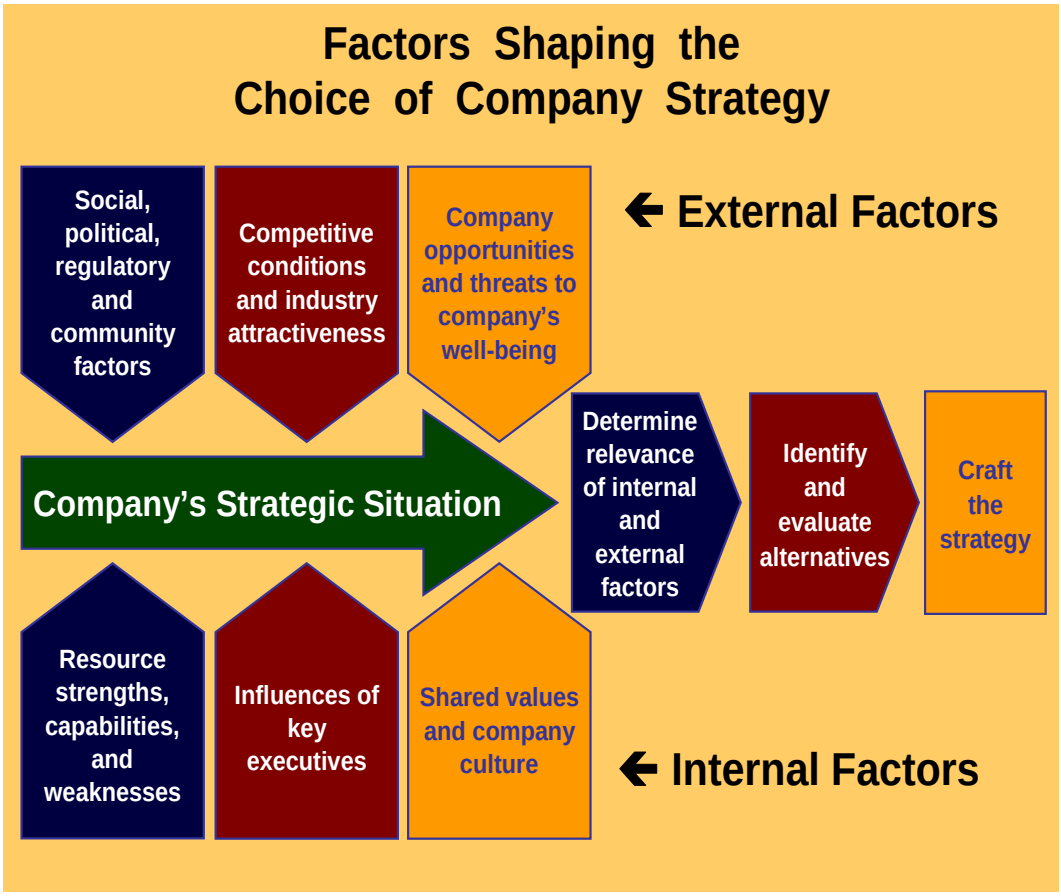
Strategy is defined in many ways and the definition provided by Thompson, Strickland and Gamble (2008:3) is “Management’s action plan for running the business and conducting operations.” This definition encompasses management’s commitment to pursue actions that will grow the business, attract customers, and improve the company’s financial and market performance (Thompson, Strickland

and Gamble (2008). Strategy is also defined as “the creation of a unique and valuable position, involving a different set of activities” (Porter, 1996:68).

Strategy is both proactive (intended) and reactive (adaptive) (Thompson and Strickland, 1999), and has several dimension; strategy process concerned with the *how, who* and *when* of the strategy, strategy content concerned with the *what* of strategy and strategy context which is the set of circumstances that determine both strategy process and context (De Wit and Meyer, 2004).

There are several ways of viewing strategy context. De Wit and Meyer (2004) divide strategy context into three contexts, organisational, industry and international, while Thompson and Strickland (1999) define two types of strategy-shaping factors; external and internal to the company. These are illustrated in Figure 2.

Figure 2: Strategy-shaping Factors to the Company



Source: Adapted from Thompson and Strickland, 1999

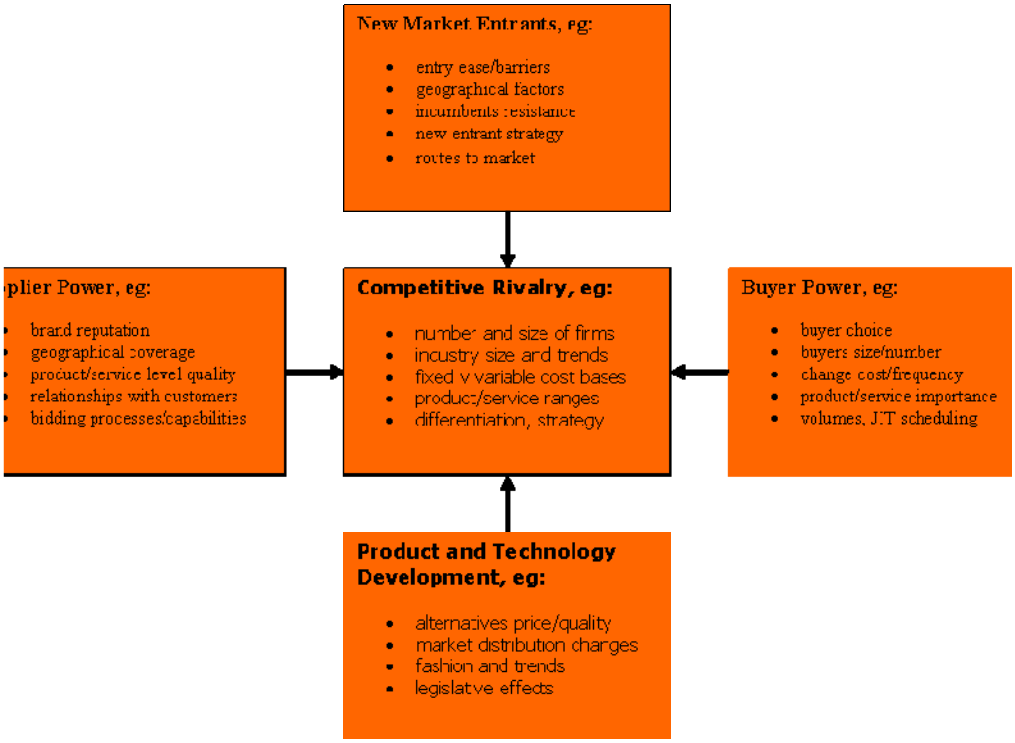
The societal, political, regulatory and citizenship considerations in Figure 1 include the following:

- Societal concerns over, among others, health and nutrition, alcohol and drug abuse.
- Demonstrating willingness to take action ahead of regulatory confrontation.
- Being a good citizen in the community
- Corporate social responsibility.

Strategy is about competition. The competitive conditions and overall industry structure are big strategy-determining factors (Thompson and Strickland, 1999). In the market place, a firm needs to decide how it will position itself to compete in its chosen business to attract, win and retain customers (Fahey and Randall, 2001).

Porter (1998), in De Wit and Meyer (2004:258) states that “competition is the core of the success or failure of firms.” He further goes on to state that competition determines the activities such as innovation, a cohesive culture or good implementation that contribute to a firm’s performance. In analysing industries Porter (1998), in De Wit and Meyer (2004:258) states that the “first determinant of a firm’s profitability is industry attractiveness” and goes on to identify five competitive forces; the degree of rivalry, the threat of substitutes, buyer power, the threat of entry and supplier power, these are illustrated in Figure 3.

Figure 3: Elements of industry structure



Source: Adapted from De Wit and Meyer, 2004

In summary, these five elements deal with the following, among others:

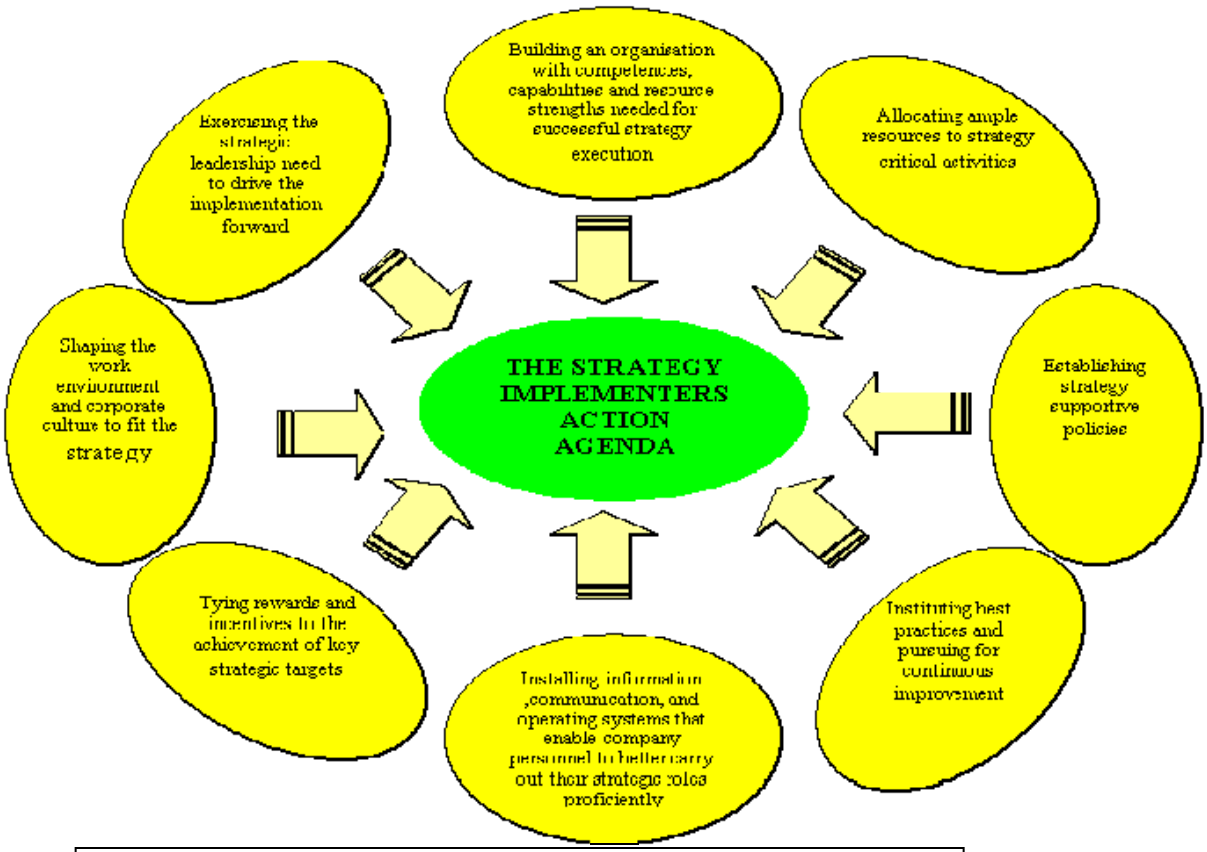
- Degree of rivalry: concentration and balance in industry
- Threat of substitutes: switching costs and buyer propensity to substitute.
- Buyer power: buyer concentration versus firm concentration, buyer information, buyer switching costs relative to firm switching costs.
- Threat of entry (barriers to entry): Government policy, economies of scale, capital requirements, proprietary product differences, brand identify, expected retaliation.

- Supplier power: supplier concentration, switching costs of suppliers and firms in industry.

Strategy is as good as it is executed or implemented. For the execution of strategy, Hrebiniak (2005) proposes a model with five elements; corporate strategy, corporate structure, business strategy and short-term operating objectives, business structure integration and incentives and controls.

Thompson and Strickland (1999) define Eight Big Managerial Components of Implementing Strategy and these are illustrated in Figure 4 below.

Figure 4: Eight Big Managerial Components of Implementing Strategy



Source: Adapted from Thompson and Strickland, 1999

In brief they can be defined as follows:

(a) Building a capable organisation – selecting able people for key positions, ensuring that the organisation has the correct structure, skills, core competencies, managerial talent, and organising business processes and decision making for successful strategy execution.

(b) Allocating resources – shifting of resources an allocating enough budgets to support the implementation of the strategy.

(c) Strategy-supporting policies – prescribing policies and procedures that aid the tasks of implementing strategy.

(d) Best practices – commitment to searching out and adopting best practices and emphasizing continuous improvement.

(e) Information, communication and operating systems – Innovative, support systems that can track key performance indicators for the monitoring of progress.

(f) Tying rewards to achievement of targets – Both monetary and non-monetary rewards are designed for the sustained energetic commitment from staff.

(g) Corporate culture – a culture grounded in values, practices and behaviours that match the strategy and energises people in what they have to do.

(h) Strategic leadership – major change efforts need to be led from the top and led by a clear vision.

To execute their strategy, companies require a strategy hierarchy and Thompson, Strickland and Gamble (2008) define four levels of strategy;

- Corporate strategy which is initiatives the company uses to establish its position in different industries.

- Business strategy which is actions and approaches that are designed to produce performance in specific lines of business in the organisation.
- Functional-area strategies which are actions and approaches by a head of a particular function within a business.
- Operating strategies which are narrow strategic initiatives for managing key operating units.

Corporate strategies are used to establish business positions in different industries and are reviewed by the company's board of directors (Thompson, Strickland and Gamble (2008).

Collis and Montgomery (2005) define corporate strategy as "the way a company creates value through the configuration and coordination of its multimarket activists". They propose a framework for corporate strategy that has three elements in the form of a triangle, with all three contributing to corporate advantage. A firm's corporate performance is affected by the competitive strategy it pursues in each industry (Collis and Montgomery, 2005).

Another factor that is critical for strategy execution is leadership and Blanchard (2006) proposes a model with six essential elements for high performing organisations, as follows:

- Shared power and high involvement – Power and decision making are shared and distributed throughout the organisation and participation, collaboration and teamwork are valued.

- Shared information and open communication – information for making decisions is available to employees.
- Energising systems and structures – systems, structures, processes and practices are aligned to support the organisation's strategic direction.
- Compelling vision – the organisational vision is clearly understood and supported.
- Relentless focus on results – the organisation is focussed on results.
- Ongoing learning – there is constant improvement of capabilities.

Leadership is also critical for driving change or transformation in organisations. There are commonalities in the factors that have been identified by several authors as essential for successful change in organisations. These common features, as identified by Covin and Kilmann (1990), Kotter (1996), and Cummings and Worley (2001) are:

- Creating readiness for change, and having a strong business-related need for change
- Developing a shared vision
- Visible management support and commitment.
- Encouraging employee participation/management structures
- Reward systems that support change
- Communication

To summarise this section on the theory of strategy, leadership and change, successful strategy implementation is dependent on the execution of a set of principles that ensure that all elements essential for strategy implementation are in place. Leadership is critical for any strategy implementation and the leading of change or transformation. These theoretical constructs will make an understanding of BBBEE implementation easier as it is itself a strategy.

2.2.10 BBBEE as a strategic imperative for business

> "*The wider and critical struggle of our era, to secure an acceptance and actualisation of the proposition that while capital might be owned privately, there must be an institutionalized system of social accountability for the owners of capital. In this context, it may well be that the success of out strategy for BEE will address not only the objective of the creation of a non-racial South Africa. It might also be relevant to the creation of a system according to which the owners of capital would, willingly, understand and accept the idea that business success can no longer be measured solely by reference to profit."*
>
> Nelson Mandela, in BEECom 2001:7

The quotation above, shows that, even as early as 2001, there was an expectation that business would change the way it works, in line with government's vision on redressing the economic inequalities of the past through BEE legislation.

BBBEE legislation changed the macro environment for business in South Africa, and the private sector can no longer ignore BBBEE, especially relating to procurement (Jack, 2007). The bargaining power of suppliers was affected as "suppliers that do not contribute to BEE and also do not buy from BEE companies present a threat to their clients, who will not be able to score any preferential procurement points by buying from them" (Jack, 2007:110). BBBEE has become a business imperative if firms are to compete in South Africa (Jack, 2007; Arya, Bassi and Phiyega, 2008) It is also a moral imperative for redressing the imbalances of the past, as well as an economic imperative as it will create jobs and grow the economy (Arya *et al,* 2008) .

Competitive firms change their strategies depending on the environment they face. This is a known phenomenon as firms respond to changes in their environment by restructuring their set of businesses as a means to improve their chances of achieving synergies and increasing their performance (Hoskisson, Cannella, Tihanyi, and Faraci, 2004).

In South Africa the response of business to BEE has been varied. Some companies, for example, Old Mutual, SAB, Liberty Life, DeBeers and Anglo American responded by relocating their headquarters outside South Africa, thus keeping the bulk of their assets away from the state (Ponte *et al,* 2007). Others saw it as a necessary evil and started working with and around it (Southall, undated). Iheduru (2008) has an explanation for why capital, which had an "exit option" ended up complying with BEE and not opposing it. His explanation is that

capital adopted “strategic compliance” as they were too heavily invested in South Africa and faced globalization pressures in other markets” (Iheduru, 2008:340).

2.2.11 Strategies employed by business for achieving BBBEE compliance

A number of companies, such as Telkom, Phumelela and The Don Group, have managed to do very well in achieving targets for BEE (Financial Mail, 2005a). Some of the strategies adopted by Telkom in maintaining a top position on BEE empowerment in 2005 were, the development of policies on empowerment long before this was a requirement, selling discounted Khulisa shares to the Black public, and ensuring that all its suppliers are BEE compliant (Financial Mail, 2005a). Having a procurement policy in place, and training programmes also assisted Phumelela in being a top company in terms of BEE status (Financial Mail, 2005b).

In the case of the ABSA Group, they found that top management support, good communication within the organisation on BBBEE and linking transformation indicators with management incentive systems were instrumental in the successful implementation of BBBEE (Arya *et al,* 2008). There thus seem to be similarities in what successful companies do.

For achieving ownership targets, trusts are seen as an appropriate vehicle for truly broad based participation in companies as they are used to earmark selected assets fro certain beneficiaries (Bowman Gilfillan, 2008). They are thus seen as a

way of addressing the narrow-base empowerment where few individuals benefited from ownership deals.

The Standard Bank identified a number of mistakes that businesses make in the implementation of BBBEE. The first is thinking that ownership equals empowerment. This is a problem with black-owned companies thinking that they are already empowered and they caution as follows, “While black-owned and managed companies have a head start, they have to perform in other areas as well…. before they are acceptably empowered” (Standard Bank, 2008:4). The second mistake is not making BBBEE part of the company’s business strategy. In this case, BBBEE is a standalone function and not integrated into the rest of the business. For effectiveness, they suggest integration into the business plans. The last mistake highlighted here is making BBBEE “one person’s job”. In this case, they recommend that BBBEE should involve everyone (Standard Bank, 2008).

2.3. The private health care sector in South Africa

In 2005, South Africa had a R100 billion health care industry, with 40% and 60% of expenditure going through public sector and private sector intermediaries respectively (McIntyre & Thiede, 2007). Hospital groups are the largest health care providers in the private sector, and have always been a powerful player which has been very skilful in countering government’s attempts at controlling it (Van Rensburg, 2004).

From 2000 there were a significant number of mergers leading to a few hospital groups surviving (Van Rensburg, 2004). The current private hospital environment is described as an oligopoly between Netcare, Life Health Care and Medi-Clininc (Board of Healthcare Funders, 2008). There is fierce competition for scarce patients (Maqhina and Mapham, 2006) as the number of medical aid patients has not grown significantly since the 1990s (McIntyre & Thiede, 2007), and government attempts to regulate prices hospitals can charge (Department of Health, 2008). The Health Professions Council also put a cap of 10% on joint shareholding in hospitals by practising doctors, although it is now considering a review of the policy (Business Report, 2008b). This restriction has a direct impact on ownership of hospitals by doctors as they cannot acquire as many shares in private hospitals as they would like.

Barriers to entry into the private hospital industry are high. Some of these are due to the high costs of building hospital infrastructure. The Financial Mail quotes Gerhard Swiegers, the Chief Financial Officer of Medi-Clinic saying "It costs between R1.5m and R2m per bed to establish a new hospital and with existing tariffs the development of new hospitals is already under pressure" (Financial Mail, 2008).

A report by CITI Group quoted in the Business Day also stated that the moratorium by government on private hospital licenses raised barriers to entry to the market. They also saw the legislation prohibiting doctors from having shareholding in

hospitals as leading to the three private hospital groups increasing their stakes and thus further limiting competition (Business Report, 2007).

The public and private health care sectors are interdependent as factors such as human resources circulate between the two sectors and challenges in one tend to affect the other. The development of human resources for management in the health sector has not been optimal. There is a general shortage of skilled managers in the public sector as a whole (Public Service Commission, 2005), and the lack of management capacity was cited as a problem in the latest strategic document on human resources of the Department of Health (DOH, 2005b).

The ANC government has aspirations for a more unitary health system in which private hospitals would be part of a national health system, hence its proposals for a National Health Insurance (ANC, 2007). The National Department of Health embarked on several measures to regulate the private health care industry. The department introduced amendments to the National Health Act to ensure transparency and fairness in the negotiation of hospital tariffs and to try and bring down prices in the sector (Department of Health, 2008).

As part of the transformation of the health sector, the Department of Health published the Health Charter in 2005. The Charter recognised the paucity of black representation at senior management level in the private sector, little evidence to suggest that the health sector had made significant progress in addressing skills development as well as very little BBBEE in the health care sector, leaving it

largely untransformed (Department of Health, 2005a). The Health Charter set targets for the transformation of the sector that were slightly different from those of the DTI Scorecard but as the Health Charter has still not been adopted the sector continues to follow DTI BBBEE Codes of Good Practice.

2.3.1 BBBEE in the private hospital industry

The three major hospital groups acquired BEE partners in 2005 and although they have shown commitment to transformation, procurement from BEE entities still remains a challenge (Matsebula & Willie, 2007).

The implementation of BEE in the private hospital industry may have particular challenges for the sector. These range from ownership, where discounting of shares to health professionals may be in breach of regulations set by the Health Professional council, and a number of products such as medical and surgical devices are manufactured by multinational companies (Financial Mail, 2005c).

Information available from two listed companies, Medi-Clinic and Netcare, reveals that both companies perceive BEE to be of strategic importance and report annually on BEE implementation (Medi-Clinic, 2007; Netcare, 2007). Medi-Clinic is has employment equity committees at national, regional and hospital level and proactively uses the BBBEE status of suppliers for awarding contracts (Medi-Clinic, 2007). Netcare has a Board Committee on BEE and Transformation, has set a 25% black representation target for the management level, and engaged a consultant to advice them on improving preferential procurement (Netcare, 2007).

2.4 Conclusion

There is widespread agreement on the need for BBBEE to address the legacies and inequalities that resulted from apartheid. Legislation and regulations in the form of the BBBEE Act of 2003, and the Code of Good Practice and score care are in place to guide and monitor the implementation of BBBEE.

The literature review suggests that the implementation of BBBEE is progressing slowly in most of the corporate sector, and ownership, management control, preferential procurement and employment equity have been identified as difficult to meet. The literature also shows that no review has been conducted on the private hospital sector and this is the gap in the literature that will be addressed.

The need for BBBEE to be part of the strategic processes of organisations is emphasised by the literature and BBBEE as a strategic imperative emerges strongly if companies are to be competitive. The literature review has also shown that the private hospital industry has unique challenges such as stiff competition, threats of regulation of prices, caps on joint shareholding by doctors in hospitals. All these have a potential to impact on how the sector addresses the implementation of BBBEE.

In Chapter 3, research questions, based on this literature review are formulated to fill gaps in the literature regarding the implementation of BBBEE in the private hospital industry.

CHAPTER 3: RESEARCH QUESTIONS

3.1 Introduction

The general purpose of the research was to explore various facets regarding the implementation of BBBEE in the private hospital industry. The research objectives were to ascertain if the private hospital groups were meeting the targets set in the DTI's BBBEE Codes of Good Practice scorecard, to determine which targets they found hard to meet and why that was the case, to establish what strategies they employed in meeting BBBEE targets, to establish which strategies had been successful, and to determine how important BBBEE was to their corporate strategy.

3.2 Statement of research questions

The research questions were developed in line with the literature review which showed that implementation of BBBEE is proceeding at a slow pace. The questions were specifically designed to investigate how selected private hospital groups in Gauteng were implementing BBBEE. The research questions were as follows:

Research question 1:

Do selected private hospital groups meet the targets set in the DTI's BBBEE Codes of Good Practice scorecard?

Research question 2:

Which targets in the DTI's BBBEE Codes of Good Practice scorecard do the selected private hospital groups find hard to meet and why this is the case?

Research question 3:

What strategies do the selected private hospital groups employ in meeting BBBEE targets.

Research question 4:

Which of the strategies adopted by the selected hospital groups in meeting BBBEE are successful and why?

Research question 5:

Is BBBEE a major strategic consideration for the private hospital groups?

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Rationale for research design

The study was cross-sectional and qualitative (exploratory) and was conducted through in-depth interviews using a semi-structured interview guide.

The study was cross-sectional as it was once-off, during a specified period were all data was collected. Zikmund (2003) defines a cross-sectional study as one where data is collected at a single point in time, that is, a defined period.

The choice of research methodology utilised is very dependent on the understanding of the philosophical foundations for the research, and deciding whether there is a good fit between the type of research and the researcher's personality, attributes and skills (Merriam, 1998). In contrast to quantitative research which examines parts of a phenomenon, Merriam (1998:6) states that qualitative research "can reveal how all the parts work together to form a whole".

In this case qualitative research designs were utilised and Merriam (1998:7) defines five characteristics of qualitative research, as follows:

- Understanding phenomena from the perspective of the participants in the study, rather than the researcher.

- "The researcher is the primary instrument of data collection and analysis". There is thus a human instrument, as opposed to an inanimate questionnaire or inventory.
- It usually involves field work as the researcher has to physically go to the people or sites.
- It is inductive research as it builds abstractions, concepts and hypothesis, rather than testing existing hypotheses or theories.
- The product of qualitative research is richly descriptive as it focuses on process, meaning and understanding.

Zikmund (2003: 54) asserts that qualitative research which is a form of exploratory research leads to a better understanding of various facets of a problem. He goes on to explain that this type of research provides information for analysing a problem, but will not provide conclusive evidence that can be used for action.

For the purposes of this study, qualitative research methods were suitable as there were a lot of unknowns in what would be investigated. It was not clear how private hospital groups in the health sector were dealing with some of the requirements of the DTI's BBBEE Codes of Good Practice scorecard and how important BBBEE was to their strategies as organisations.

There are various types of qualitative research and the typology differs among authors. Merriam (1998) states that Tesch (1990) lists forty-five approaches, while

Patton (1990) identifies ten perspectives. Merriam (1998) defines five types; basic or generic, ethnography, phenomenology, grounded theory and case study.

This study drew from the basic or generic type of qualitative research method. Merriam (1998:11) describes basic or generic qualitative research as the most common and that it "seeks to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved".

4.2 Research process

The research process was in the form of in-depth interviews with officials at various levels (strategic, business unit, operational, and persons responsible for human resources, procurement and corporate social responsibility) in the selected private hospital groups.

4.3 Population

The population in a study is the "complete group or entities sharing some common set of characteristics" (Zikmund, 2003:369). In this case the population was the private hospital groups based in Gauteng.

4.3.1 Inclusion and exclusion criteria

The study was on private hospital groups, not individual hospitals. The working definition of hospital groups was that this was a company with more than one hospital in its portfolio. The hospital group needed to have one corporate strategy for the group and had a head office with its own management structure. This meant

that hospitals in associations did not qualify as they did not share one corporate strategy or management structure.

Proposed criteria for inclusion were as follows:

- Private hospital groups with their head office based in Gauteng.

Exclusion criteria were:

- Private hospital groups based in provinces other than Gauteng.
- Hospital groups with no single corporate strategy.
- Individual hospitals

On the basis of the criteria above, the final population for study was determined and consisted of four hospital groups, Netcare, Life Health Care Group, Clinix and Lenmed and their short descriptions are provided below.

Netcare

Netcare is a JSE-listed company which was previously white-owned company, and now has 10% equity with broad-based black groups (Netcare, 2008). It has a network of 42 hospitals in South Africa and interests overseas and over 7 000 hospital beds (Matsebula and Willie, 2007).

Life Health Care Group

Life Health Care Group is a black-owned, previously owned by AFROX (white owned), unlisted private company. The black owners are Mvelaphanda Group and

Brimstone Investment Limited. It has network of 54 hospitals in South Africa and over 7 000 hospital beds (Matsebula and Willie, 2007).

Clinix

Clinix, a black-owned hospital group, was founded in 1992 by Dr Peter Matseke and has four hospitals in Gauteng and over 500 hospital beds.

Lenmed Health

Lenmed Health has its origins in 1984 and is black-owned and has four hospitals in South Africa.

4.4 Sampling and size

4.4.1 Sampling

"Qualitative inquiry typically focuses in depth on relatively small samples, even single cases (N=1), selected *purposefully*" (Patton, 2003:230). In purposive sampling, also known as non-probability sampling, the sample is not chosen randomly, but purposely (Riley, Wood, Clark, Wilkie & Svivas, 2000). This study initially selected hospital groups purposefully according to a number characteristics such as the size (number of beds), whether they were listed on the JSE or not and whether they were black-owned or not. Following enquiries with the hospital groups, it became clear there were very few hospital groups based in Gauteng, and thus all four Gauteng-based hospital groups were included in the study.

Identification of specific officials to be interviewed utilised a mixture of purposive sampling according to people's expected involvement in BBBEE, e.g. at a strategic level the CEO or other official at a senior management level would be familiar with the hospital group's approach to BBBEE. Most organisations had a specific official responsible for human resource development, procurement and corporate social responsibility and these officials were able to provide detailed information on specific aspects of the BBBEE scorecard. The CEO or other official at a senior management identified participants at the business unit and operational levels.

The unit of analysis is the level at which the investigation focuses for data collection (Zikmund, 2003), and in this case the unit of analysis is the BBBEE implementation.

4.4.2 Sample size

It must be taken into account that in qualitative research sample sizes are not a major issue as the results are not for generalisation to a larger population. Patton (2002:244) states this very well when he says "there are no rules for sample size in qualitative enquiry".

A total of four (4) hospital groups were to be chosen from each of the following categories:

- A big (more than 5 000 beds) JSE-listed hospital group
- A big non-listed hospital group
- A black-owned hospital group

- An independent hospital group.

As stated above, all private hospital groups based in Gauteng were included in the final sample.

For each unit of analysis (private hospital group), six officials were to be interviewed according to their level in the organisation and their involvement with BBBEE. The officials were as follows:

- At strategic level – the CEO or other senior official at a strategic level in the organisation.
- At business unit level - one official
- At operational level – one official
- At levels related to the BBBEE scorecard:
    - Human resources manager
    - Procurement manager
    - CSI manager

This gave a total of six (6) participants from each hospital group and an anticipated grand total of twenty-four (24) interviews to be conducted.

4.5 Data collection

4.5.1 Research tool

The research tool was a semi-structured interview guide, see Appendix 1. A semi-structured interview guide is halfway between a structured one with pre-set and

pre-ordered questions like an oral form of a written survey, and an unstructured interview guide which is like a conversation. In the semi-structured interview guide, there is “a mix of more and less structured questions” as specific information is elicited from all the respondents but the interview is only guided by a list of questions and the exact wording and order of the questions is not determined ahead (Merriam, 1998:74). Merriam (1998) asserts that this approach allows for the researcher to respond to the situation as it unfolds and to the emerging worldview of the interviewee. The interview guide thus serves as a guide and is not to be followed slavishly.

4.5.2 Data collection method

The data collection method was personal interviews. Interviews are commonly used for qualitative research and a personal interview is a person-to-person encounter where the researcher elicits information from the other party and tries to find out what is in their mind (Merriam, 1998). Personal interviews have many advantages, including opportunity for feedback, probing on complex questions and high participation rate. Their disadvantage is cost and problems in eliciting information around sensitive questions (Zikmund, 2003).

The interviewer introduced herself and indicated the purpose of the study. The interviewer also stated the following:

- That the interview was confidential and no details of companies would be revealed without the permission of the specific company.
- Explanation that the interviewee was not forced to answer all question.

- Explanation that the conversation would be recorded for ease of analysis and accuracy.

All interviews were scheduled beforehand, were recorded and transcribed into text by a professional.

4.5.3 Validity

To improve the validity of the study several steps were followed. Interviews were recorded to ensure accuracy and make transcription and analysis possible. Experts on qualitative research were consulted in the development of the interview guides.

The interview guide was piloted and tested for accuracy, non-ambiguity of questions, the order of questions, and the length of interviews. The piloting was on individuals working for a hospital group that did not participate in the study.

4.6 Data analysis

Data analysis for qualitative research is complex due to the volume of data and the structuring required after data collection. Data analysis utilised qualitative methods such as content thematic analysis. Content analysis measures the extent of emphasis or the omission of emphasis through noting the frequency and use of certain words (Zikmund, 2003). Patton (2002) sees content analysis as a way of reducing qualitative data and making sense out of a volume of material, identifying consistencies and meanings. This is done through searching text for recurring words and themes and the core meanings are grouped into patterns or themes.

Miles and Huberman (1994) suggest many methods of simplifying analysis and some of those utilised in this study are marginal remarks, coding, memoing and categorisation into themes and subthemes.

4.7 Limitations of the study

The limitations of the study were as follows:

(a) There was thus no verification of information provided through interviews. Answers given did not have documentary proof and were solely based on what interviewees said. This subjects the research to interviewee bias and respondents could give false information.

(b) The CEO or official at strategic level chose all other respondents within the company. This could lead have led to selection bias and the views of the respondents would thus not represent the whole company but those close to the CEO or senior official.

(c) The research questions were too numerous, leading to volumes of data that could not be fully analysed in all respects. This made it impossible to perform in-depth analysis on e.g. hospital groups and features characteristic to them.

4.8 Ethical clearance

Ethical clearance was sought and received.

CHAPTER 5: PRESENTATION OF RESULTS

5.1 Introduction

In this section a short description of the participating hospital groups is provided and this is followed by presentation of the demographic data for the respondents. The results are presented according to the four research questions, and generally, information obtained from questioning under the specific section will be presented. Where information from other sections is utilised this will be pointed out. In the concluding section, and in Chapter 6, all information obtained will be utilised to support arguments.

Data is presented collectively across the hospital groups and quantified as far as possible. Data from specific hospital groups or individuals is mentioned where there are peculiarities that pertain to the hospital group or individual.

A summary of the findings is provided at the end.

5.2 Results obtained from data collection process

The four participating hospitals were:

- Netcare, a large white-owned group with 10% equity empowerment. Referred to as previously white-owned.
- Life Health Care Group, a black-owned large group that was previously white-owned. Referred to as previously white-owned.
- Clinix, a black-owned company referred to as black-owned.
- Lenmed, a black-owned company, referred to as black-owned.

It was planned that a total of twenty-four (24) interviews would be conducted, six (6) from each hospital group. Some hospital groups were however not large and responsibilities were shared resulting in less individuals being interviewed. At the end however, a total of eighteen (18) interviews were conducted, of which one was a spoiled recording and thus the results of seventeen (17) interviews are presented.

5.2.1 Overview of demographic data

The list of interviewees, designations and demographic details is in Appendix 2.

The demographic details of respondents are in Tables 2, 3 and 4 below.

Table 2: Gender of respondents

Gender	Number	Percentage
Male	12	70.6%
Female	5	29.4%

Table 3: Race of respondents

Race	Number	Percentage
African	3	17.5%
Coloured	1	5.9%
Indian	3	17.9%
White	8	47.1%

Table 4: Level of respondents in organisation

Level in organisation	Number	Percentage
Strategic	7	41.2%
Business unit	2	11.8%
Operational	4	23.5%
Related to BBBEE scorecard	4	23.5%

Of the 17 respondents, the majority were male (70.6%), white (47.1%), and the largest number was at a strategic level (41.2%). The business unit level had the least number of people (11.8%).

5.2.2 Meeting of DTI targets

Research question 1: Do selected private hospital groups meet the targets set in the DTI's BBBEE Codes of Good Practice scorecard?

This research question sought to elicit how private hospital groups are implementing BBBEE. The responses in this section were mainly to question 2.2.4 and 2.2.5 in the questionnaire. Question 2.2.4 was phrased as follows, "Specifically, how well do you think your hospital group is performing in meeting the following targets of the scorecard, and why?" A listing of the 7 DTI BBBEE targets was then provided. Question 2.2.5 was as follows, "In your assessment, overall how well do you think your hospital group is performing in terms of meeting the targets set in the DTI's BBBEE Codes of Good Practice scorecard, and why?"

In both questions, participants were expected to provide an explicit answer on how well they thought their hospital group was performing on the targets and to provide evidence for their opinion. Most participants gave an opinion on how well they thought their hospital group was doing, but in a few instances, no direct response was given, hence total responses differ for the various targets. Where participants did not use the phrase "well", coding was performed to fit the data into the three categories of "not well", "well" and "very well" (Miles and Huberman, 1994).

Seventeen (17) respondents gave an answer to this question and a summary table of responses is provided in Table 5.

Table 5: Responses to how well hospital groups perform against the DTI BBBEE targets (Number and percentage)

Element/target	Total participants that answered	Not well		Well		Very well	
		No.	%	No.	%	No	%
Overall	14	0		10	71.4	4	
Ownership	14	2	14.3	7		5	
Management Control	16	Mixed		12 Mixed		Mixed	
Employment equity	17	0		6	35.3	11	64.7
Skills development	16	0		9		7	
Preferential	15	1	6.6	5		9	60.0

Element/target	Total participants that answered	Not well		Well		Very well	
		No.	%	No.	%	No	%
procurement							
Enterprise development	15	7	46.6	5		3	
Socio-economic development	17	0		5		12	70.6

Overall, all participants felt that their hospital groups were doing well or very well on meeting the DTI BBBEE targets.

On ownership, 14.3% of participants believed that they were not doing well, however, 35.7% thought they were doing very well on this same target.

The target where participants were most dissatisfied with meeting of targets was enterprise development where 47% of participants said their hospital group was not doing well.

Participants were most satisfied with their hospital group's performance on socio-economic development, with 70.6% stating that they were doing very well. Programmes being supported included free medical tests, free surgery, especially cataract operations, anti-drug campaigns and supporting deserving charities.

Employment equity and preferential procurement were areas where most (64.7% and 60% respectively) participants indicated that their hospital group was doing well.

In employment equity however, there was recognition that the nature of the industry learnt itself to being easy to achieve black female employee targets as most employees were female and were usually black. This was mentioned by eight (47%) participants and is encapsulated by the quote below.

"*overall we end up beating the system because there is lots of nurses at the bottom that are most of them black"* Company B, Individual 5.

The lack of disabled people was mentioned by at least one participant in all the hospital groups. In both previously black hospital groups, they (3 participants) mentioned the need for more white people, as there were very few of them.
"*The whites are 1% or non-existent. So, in fact what we are doing is BEE in reverse."* Company 1, Individual 2.

Management control elicited mixed responses as the response was dependent on the level of staff in question. The historically white companies mentioned the good progress at lower management levels, and poor progress in senior management. This problem was mentioned by two participants in Company B, and three in Company C, see extract below:

"We don't do well. The top 200 managers are largely white men. It is an old company, it has been around a long time, it is well established, it is not easy to transform... on our medium to lower categories, nursing, supervisory type of categories, we're doing extremely well." Company C, Individual 2.

"Middle management I think we increasing now from 25% - 30% … I think we're there…. the top level I think we're too slow …. so why in the top level slow? I think it's the pipeline that is not coming through into the top management." Company B, Individual 4.

In summary, most participants thought their companies were doing well or very well on meeting the DTI BBBEE targets. One hospital group expected an upgrading of their rating in 2008. The hospital groups were generally very satisfied with performance on socio-economic development, employment equity, and preferential procurement. They were most dissatisfied with meeting the targets for enterprise development, while management control had a mixed response with good progress at lower management levels, and poor progress in senior management.

In response to question 2.2.6, which was "Has your company been rated by another agency on BBBEE compliance and what was the outcome of the rating?" two of the hospital groups had been rated, and respondents indicated that they were rated at Level 5. Both hospital groups that were rated were the previously white-owned companies. Two respondents in one hospital group stated that their

rating would be upgraded in 2008 and one is quoted, *"I think from a Level 5 we will definitely move up to a Level 4 this year."* Company B, Individual 2.

One black-owned hospital group was exploring being rated, while the other had no plans for being rated.

5.2.3Difficulty in meeting DTI BBBEE targets

Research question 2: Which targets in the DTI's BBBEE Codes of Good Practice scorecard do the selected private hospital groups find hard to meet and why this is the case?

These were responses to question 2.3 in the questionnaire which was phrased as follows, "In your assessment, which of the targets set in the DTI's BBBEE Codes of Good Practice scorecard are/were difficult to meet and why?"

Due to overlaps in responses provided, data from other sections, particularly from questions 2.2.3 and 2.2.4 of the questionnaire dealing with implementation of BBBEE in companies and self-assessed performance on the BBBEE targets, are also presented.

Seventeen (17) respondents gave an answer and the full list of themes and subthemes generated by this question is in Table 6. Out of seven DTI targets, four came through as posing difficulty in meeting. Six respondents (35.3%) mentioned preferential procurement, five each (29.4%) mentioned ownership and

management control, and four (23.5%) mentioned employment equity. A few other themes were also mentioned.

Table 6: Responses to question on difficulty in meeting DTI BBBEE targets (number of participants that mentioned problem in brackets)

Theme	Sub theme	Examples
Preferential procurement (6)	Lack of accreditation (3)	"*Preferential procurement most challenging as suppliers were not accredited and were waiting for DTI verification agencies an no one was ding anything.* Company B, Individual 6.
	Health standards (2)	"*it is quite difficult in an environment like healthcare where you are very sensitive to the quality of delivery for patient care. It's not an easy decision to try something that you don't know ….. because if cleaning in a hospital isn't done right it can cause infection control problems."* Company C, Individual 3.
	Multinationals (1)	"*Most and biggest spend areas for us is pharmaceutical so those are typically multi-nationals that don't have black ownership or black women ownership*
Ownership (5)	Structuring of companies (3)	"*ownership …when it is a public listed company…it is hard to actually track where black shares are when they are publically traded, etc. I think that would probably be one of the hardest ones."* Company B, Individual 2. *" You can't make shareholders sell. … We always said that we wanted to be minimum 26% BEE owned. If your shareholders decide to sell there is not much that the company or you can do. It is not your decision".* Company C, Individual 1.
	Funding/expense (2)	*"…challenge is ownership. … to acquire a stake in huge corporate is expensive. 10% of X equals R200m, therefore not easy, esp. with interest rates up.* Company B, Individual 6. *"as an entrepreneur in the beginning funding is a problem"* Company A, Individual 4.

Theme	Sub theme	Examples
Management control (5)	Lack of skills or experience (5)	*" there are few people with management expertise. I don't think we have enough people exposed to hospital management, specifically black people."* Company A, Individual 4.
	Retention, high turnover (2)	*"Executive management, there was a person who left. But retention is a problem in South Africa. New environment and people see opportunities elsewhere.'* Company B, Individual 5.
	Low turnover of white people (2)	*" the top managers sort of remain, … more the white men, which is a legacy from our past. …Where there are new positions coming open, they are filling them with black candidates … It is a slow process. People are not resigning quickly at the moment or move on.* Company C, Individual 2.
Employment equity (4)	Disability (3)	*Disability awareness is also an issue. The line management is not fully aware how and what to do,"* Company B, Individual 4.
	Experience (1)	*"employment equity in senior management…need to take a leap in faith…will not get experienced people"* Company B, Individual 6.
	Turnover (1)	*"not a small group o people which you can just do a quick turnover"*
Other (2)	Change in DTI rating methodology (2)	*"the one way we got downgraded significantly was on the measure that applied to the board. The previous one, …was used on the board composition, and then they changed it to your executive board members only."* Company C, Individual 1.

5.2.3.1 Preferential procurement

Preferential procurement was a problem across three of the four hospital groups, and was mainly attributed to the lack of approved accreditation agencies for suppliers (50%), the fear over lowering of the quality standards (33.3%) and the largest spend being on pharmaceuticals which were produced by multinationals (16.7%).

5.2.3.2 Ownership

The challenges regarding ownership were due to the structuring of companies, that is shareholder prerogatives and publicly traded companies in 60% of cases. Shareholders were seen as free to dispose of their shares as they wished, and this sometimes affected black empowerment targets. It was also difficult to monitor black ownership with publicly traded shares that were available to everyone. The balance (40%) was attributed to problems with funding, e.g. the high costs of purchasing a stake in the industry and lack of funding for entrepreneurs.

5.2.3.3 Management control

The cited challenges fell mainly into three main categories; lack of skills, poor retention and high turnover among blacks and a low turnover of whites, making transformation slow.

Lack of skills was the most cited reason for difficulties in meeting management control targets, with 5 respondents mentioning is as a reason. One respondent saw skills as a problem generally in the country, *There's a shortage of skills in this country, not only in nursing."* Another saw it as a problem of lack of skills in management generally, and in hospital management in particular. A respondent in a black owned company cited difficulties in getting black directors, *"we also find ourselves that we're having difficulty in executive directors"*.

Two respondents cited a high turnover among blacks as a problem, while tow other respondents cited the lack of turnover of whites as a problem, with one going as far

as saying that there were not many opportunities in the health sector and therefore turnover was low.

5.2.3.4 Employment equity

In employment equity, inability to meet targets in the disabled category of employees was mentioned by three of the four hospital groups. One respondent mentioned that disabled people were difficult to get, while another felt that managers were not sensitised to looking for disabled people.

Other reasons mentioned were lack of experience, and the process taking time as there were large groups of people involved and there could not be a “quick turnover”.

5.2.3.5 Other findings

The change in DTI BBBEE rating methodology was also mentioned as a difficulty as it changed goalposts for the hospital groups. This was a particular case in point for Company C, where two of the four respondents felt that their rating had gone down due to the changes in rating methodology.

In summary, preferential procurement, ownership, management control and employment equity were the targets that were most difficult to meet. Another difficulty that was noted was the change in DTI rating systems.

5.2.4 Strategies adopted to meet BBBEE

Research question 3: What strategies do the selected private hospital groups employ in meeting BBBEE targets.

These were responses to question 2.4 in the questionnaire which was phrased as follows, “What strategies/measures has your organisation adopted/taken to meet the targets set in the DTI’s BBBEE Codes of Good Practice scorecard?”

All 17 respondents answered the question and the full list of themes and subthemes generated by this question is in Table 7. Interventions were categorised using the definitions by Thompson, Strickland and Gamble (2008) for corporate and business strategy. They state that corporate strategy involves initiatives the company uses to establish its position in different industries and includes review by the board of directors, while business level initiatives are actions that are designed to produce performance in specific lines of business in the organisation.

Table 7: Strategies adopted to address BBBEE (number of participants that mentioned problem in brackets)

Theme	Subtheme	Example
Corporate strategic level interventions (10)	Governance structures (4)	*“The transformation council on a monthly bases has this meeting and then it evaluating not only the stats ….council is the watch dog ultimately, whether we on track and if objectives have been met.”* Company B, Individual 4.
	Policy and target setting (4)	*“It is a policy. Halfway through 2007, we required all our suppliers to come and present their credentials to us.”* Company A, Individual 1.

Theme	Subtheme	Example
		"The strategies is through the targets that we set." Company B, Individual 2.
	Monitoring (2)	*"our target, our strategy is ongoing improvements and measurements and keeping track of whatever is happening"* Company B, Individual 2.
	Metrics (1)	*"Driven from top, bonuses also linked to transformation"* Company B, Individual 6.
Business strategic level interventions (11)	Training and internal promotions (4)	*"what we have now is a hospital designated programme. It looks essentially at black potential hospital managers."* Company B, Individual 1.
	Headhunting (2)	*"when we try to recruit we try to headhunt"* Company D, Individual 1.
	Trusts (2)	"*we have a staff trust so which means every person in the organization other than executive has a stake in the business …then they actually further extended it to the doctors and … we made a conscious effort of actually making sure that our black doctors were offered first."* Company C, Individual 3.
	Accreditation and other (4)	*"it is one of our accreditations/requirements on our big suppliers are you BEE compliant or what is your rating or do you intend to become accredited….. So if you actually have suppliers where one has a rating and one doesn't, we'll start moving to somebody that does."* Company C, Individual 2. *""'Top spend, 80:20. With preferential procurement can achieve a lot on BEE due to cascading effect, most successful."* Company B, Individual 6. *" Buying stake in pharmaceutical company that is BBBEE."* Company

Theme	Subtheme	Example
		D, Individual 3.

Out of the 10 responses mentioning corporate strategic interventions, (40%) mentioned establishment of governance structures for BBBEE implementation (Board Committees and organisational structures), (40%) policy and target setting, 20% monitoring and 10% reward systems.

The business strategic interventions were dependant on the specific BBBEE element being addressed. Out of 11 responses at a business strategic level, (54%) were regarding skills development, (36%) were on preferential procurement, and (18%) were addressing ownership. All hospital groups mentioned strategies to address skills development and to improve on preferential procurement and the most common business strategy level interventions were in these two areas. Three hospital groups had training programmes for developing managers, and the two big hospital groups trained health professionals such as nurses.

In preferential procurement, accreditation of suppliers was pursued by all, with one group deciding to acquire a stake in a BBBEE company as part of its strategy to procure from BBBEE companies. In one company, the approach used was called the 80:20 principle where about 20% of companies accounted for 80% of their procurement costs, and they concentrated on getting this lot of suppliers accredited.

On ownership, the two previously white-owned hospital groups had established trusts as strategies to meet ownership targets.

The historically black hospital groups tended to have business strategy level interventions. One group had no interventions at the corporate strategy level, while the other only had target setting as a corporate strategic intervention.

> *"Now I am going to say no we haven't made anything specific [strategies]….If I am saying we meet 80, 90%, then obviously our efforts should be very little too, or am I missing the point?* Company D, Individual 2.

Both historically white hospital groups had full governance structures for BBBEE, i.e. Board Committees, individuals responsible for transformation, regular meetings and reporting, and in one, reward systems that included transformation targets.

In summary, the historically white hospital groups had interventions at both the corporate and business strategy levels. The historically black hospital groups tended not to have interventions at the corporate strategy level and had business strategy level interventions, or in one case, believed they did not need to have any strategy in place.

5.2.5 Success of strategies

Research question 4: Which of the strategies adopted by the selected hospital groups in meeting BBBEE are successful and why?

Responses in Table 8 were to question 2.5 in the questionnaire which was phrased as follows, “Which strategies/measures were successful and in your assessment why were these strategies/measures successful?”

This question was intended to elicit whether the strategies implemented by the hospital groups were successful and some of the reasons they believed made them successful.

5.2.5.1 Successful or not

Sixteen (16) respondents answered the question and almost all responses indicated success or the expectation that the strategies would be successful. Thirteen (81.2%) respondents felt that the strategies adopted were successful. Two felt that the strategies being implemented would be successful. Only one strategy was cited as not having been successful and it was to secure a black catering company.

5.2.5.2 Reasons for success

Fourteen (14) respondents gave reasons for the success of the strategies employed and a summary of the themes and subthemes derived from responses is in Table 8 below. Most examples of success related to the business strategic level interventions that had been instituted. Highest scoring for the success of business strategy intervention were preferential procurement and skills development where 5 each (45%) out of the 11 responses stated that these interventions had been a success.

At a corporate strategy level, leadership in the organisation came through as one of the reasons for success in one company, with all 3 respondents attributing leadership as a reason for success.

In summary, business strategy interventions that had been employed were most commonly mentioned as the reason for success of the strategies employed to address BBBEE. Leadership was also a factor in the success of the strategies.

Table 8: Reasons for success of strategies (number of participants that mentioned problem in brackets)

Theme	Subtheme	Example
Business strategic interventions (11)	Measures to overcome procurement challenges (5)	*" using the consultancy in preferential procurement paid off…had like a leap forward effect.* Company B, Individual 2.
	Measures to overcome skills shortage (5)	*" Yes, I would say, moderately successful …it takes 4 years to train a nurse….we are training 1000 - 1200 at a time.* Company C, Individual 4.
	Measures to overcome problems with ownership (1)	"*They have worked because you have 2 major players that owned, initially ….together owned 50 some odd percent. They had to relinquish on both sides a certain amount to accommodate a staff trust."* Company C, Individual 3.
Corporate strategic intervention (Leadership) (3)	Cohesive leadership (3)	*" the way the executive is cohesive, because sometimes it becomes a person's job. And because X is black and it's his job, well, oh well he will think like that because he is black. But if Y (who is white) says "no" , "absolutely no, you've got to find a black person", well maybe X and Y are on the same page and I think that makes a big difference."*

5.2.6 Strategic importance of BBBEE to company

Research question 5: Is BBBEE a major strategic consideration for the private hospital groups?

These were responses to question 2.6 in the questionnaire which was phrased as follows, "Can you describe how and why BBBEE is important to your company?"

The responses presented are only drawn from the responses to this question and they fall into two broad themes; business sense (41.2%) and all respondents mentioned the moral reasons for BBBEE. Seventeen (17) respondents answered the question and the responses are presented in Table 9.

Table 9: Strategic importance of BBBEE to hospital groups (number of participants that mentioned problem in brackets)

Theme	Sub theme	Examples
Makes business sense (7)	Maintaining competitiveness (6)	*"If you look at the international markets, if you look at national markets and what our competitors are doing and in terms of politics, it is critical, its no question, it is a no brainer.* Company B, Individual 1. *"We are looking at doing business with government. If you're not compliant, I don't think you can expect to do business with government."* Company A, individual 1.
	Change in customer profile (1)	"*we are servicing the full spectrum of the people out there …and that has changed dramatically in the last 5 to 10 years. ……The demographics inside that*

Theme	Sub theme	Examples
		have changed enormously. So that is the customer, the people using our services. Ultimately if we don't get involved into the broader spectrum we're not going to survive" Company C, Individual 1.
Moral reasons (17)	Corporate social responsibility (2)	*"X are a socially responsible company."* Company A, Individual 1.
	Supporting government (2)	*"it is part of our strategic decision that we want to support transformation then it is important that we support."* Company C, Individual 2.
	Supporting development (2)	*"I would think it is for development. To get everybody educated."* Company D, Individual 1.
	Empowerment (2)	*"let the country, the peoples of the country be empowered like you say, what is political freedom without economic freedom."* Company D, Individual 2.
	Restore demographics (4)	*"we need to do it for the right reasons. And the right reasons is that we need to rectify the mistakes of the past… and that's why we need to do it that's the right reasons and to get diversity into a company."* Company C, Individual 4.

Of the seven (7) responses highlighting that BBBEE was of strategic importance because it made business sense, six (85.9%) thought it was important for remaining competitive, while one saw its importance as being linked to the change in demographics of customers (more black customers).

In three hospital groups, BBBEE was mentioned as important for doing business, particularly doing business with government. There was also a recognition that if one was not BBBEE compliant others would be chosen over one, see quote below.

' *Again it is important that you have the right BEE rating or else they will select somebody else.* Company C, Individual 2.

Beyond the expected business sense reasons, an overwhelming response (17) was for the moral reasons for BBBEE. These ranged from the need to restore the right demographics (23.5%), and 11.8% each for corporate social responsibility, supporting government, supporting development and empowerment.

In summary, BBBEE was seen as being of strategic importance for business reasons by 41.2% of respondents and for moral reasons by all respondents. The need to remain competitive was the main business reason (85.7%) and it was also seen as important for doing business with government. There was an overwhelming response for implementing BBBEE for moral reasons.

5.2.7 Other findings

To gain a broader understanding of how BBBEE is viewed and implemented in the private hospital industry, the following questions were also asked:

"2.2.1 What is your understanding of BBBEE?"

"2.2.2 Are you aware of the targets set in the DTI's BBBEE Codes of Good Practice Score Card, and what they are?"

"2.2.3 How would you describe the implementation of BBBEE in your company?"

5.2.7.1 Understanding of BBBEE

In response to question 2.2.1 above, almost all 17 respondents mentioned words such as empowerment, participation of previously disadvantaged, equal opportunity, development, redress, shifting to a broader base and transformation. Most commonly used words were empowerment (51.9%) and redress (17.6%).

One respondent, from a historically black hospital group saw BBBEE as bringing high-tech medical services to township areas and this understanding was consistent throughout his interview.

5.2.7.2 Awareness of DTI targets

Responses to question 2.2.2 varied according to hospital groups. In the historically white hospital groups all respondents mentioned that they knew about the DTI targets and could mention a few of them and gave a few examples such as management and procurement.

In the historically black hospital groups there were respondents that did not know much about the DTI targets. In one hospital group only one out of four respondents could give a correct description, while in the other, one of the three respondents was not fully aware of the targets. In both hospital groups the lack of full awareness extended to respondents at a strategic level.

These were some of the responses from the respondents in the historically black hospital groups:

"I don't, because of the situation that we work in [black owned] and the percentage in terms of ownership and employee profile, I don't think we pay a lot of attention to that" Company A, Individual 1.

"Ja. Is it law now or not?" Company A, Individual 2

"Not specifically. I just understand that the government wishes to bring out the services that were highlighted previously to respective zones/ areas/regions around the country." Company A, Individual 3.

'there is a score card, yes. I am not fully aware I'll have to refer to it" Company D, Individual 2.

5.2.7.3 Implementation of BBBEE in hospital groups

In response to question 2.2.3 above, most respondents in historically white hospital groups mentioned the structures in place for monitoring implementation of BBBEE. In one of these hospital groups, everyone interviewed had a good understanding of how the company was implementing BBBEE, encapsulated by this quote:

"We have a good sense of what is going on and in terms of what our targets are and what our actuals are. Company B, Individual 2.

In the same company, their transformation committee had representation at various levels (strategic and operational) and this was seen as positive, as illustrated by this quote:

"We have 1 or 2 line managers … so that they're part of the whole process and also because it is a good insight and a good indication to have that sort of mixed involvement, that it becomes a corporate initiative and that those guys are also comfortable that the executive is doing the right thing and is in touch with the operations." Company B, Individual 3.

In the historically black hospital groups, there was no concerted effort around implementation of BBBEE as they saw themselves as already compliant. Some quotes are below:

"I have not sat back and thought about these things, because it is just normal businesses to us." Company A, Individual 1.

"X being predominantly a black company I mean we are already there. It is 100% implementation. Company A, Individual 2.

"No [initiatives on BEE] 100% of hospital is BEE." Company D, Individual 3.

In summary, there were marked differences in general understanding of BBBEE and its implementation between the historically white and historically black hospital groups. The historically white hospital groups had structures in place and BBBEE was well understood, while respondents in the historically black hospital groups displayed less knowledge of the DTI targets and the groups were not consciously trying to implement BBBEE as they believed that they were already compliant.

CHAPTER 6: DISCUSSION OF RESULTS

6.1 Introduction

This chapter provides an in-depth discussion of the results obtained in Chapter 5. In Chapter 2, the literature review offered the relevant theory for the subject and this was utilised in the formulation of the research questions in Chapter 3. In this chapter, the writer will weave all three chapters together. The format of the chapter will be that results obtained under each research question will be presented succinctly with appropriate insights, these will then be compared with the literature review and the findings will subsequently be summarised for each research question. Conclusions will be drawn in the next chapter.

6.2 Discussion of demographic data

The total number of interviews done (17) was a very good sample, although sample size is not a major consideration in qualitative research (Patton, 2002). The results should thus be able to provide a good picture on the research questions being asked.

As shown in Tables 2, 3 and 4, of the 17 respondents, the majority were male (70.6%), white (47.1%), and the largest number was at a strategic level (41.2%). The business unit level had the least number of people (11.8%). The high number of white males in the study is not unexpected, in light of assertions that the private health care sector is still largely untransformed (Department of Health, 2005a).

The large number of people at a strategic level is good for getting information on corporate strategy, but has potential to limit information on actual implementation at an operational level.

6.2 Research Question 1:

Do selected private hospital groups meet the targets set in the DTI's BBBEE Codes of Good Practice scorecard?

6.2.1 Restatement of findings

Overall, all respondents felt that their hospital group was doing well or very well in meeting the DTI targets.

On meeting of targets on the specific elements of the BBBEE scorecard, there was a mixed response. In Table 5 it is shown that on ownership, 14.3% of respondents did not think they did well, whereas 35.7% thought they did very well. The respondents were generally very satisfied with performance on socio-economic development, employment equity, and preferential procurement. They were most dissatisfied with meeting the targets for enterprise development, while management control had a mixed response with good progress at lower management levels, and poor progress in senior management.

On whether hospital groups had been rated, two hospital groups indicated that they had been rated as Level 5 contributors by an accredited verification agency, and both were the historically white-owned groups. One of the groups expected its

rating to be upgraded to a Level 4 contributor by the end of 2008. The other two black-owned hospital groups had not been rated. One was planning to be rated, while the other had no plans for being rated.

6.2.2 Evidence from literature

The findings obtained in the study were dependent on the subjective opinions of the respondents as this was a qualitative study with no verification of records. Using the literature to analyse this critically and objectively, the DTI defines good contributors to BBBEE as those that score 65% and more on the Generic Scorecard which is out of 100 (from Level 4 and above) (DTI, 2004). None of the hospital groups had been verified to be at that level, although in Table 3 it is mentioned that one hospital group's rating had been downgraded due to changes in the DTI rating methodology. This means the group could have been on Level 4. According to the literature however, Medi-Clinic was the best performing company in the health sector according to the Financial Mail/Empowerdex Survey, achieving the rating of a Level 5 contributor (Medi-Clinic, 2007).

The Codes of Good Practice give entities 10 years within which to comply (DTI, 2007). Level 5, is one step below "good" (Level 4) compliance and is a good position currently for the hospital groups that have been rated. There is also evidence of improvement as one hospital group expected its rating to be upgraded by the end of 2008.

The literature showed a mixed bag of achievements in relation to meeting of targets for BBBEE. As mentioned before, no study had been done exclusively on hospital groups, but a number of studies on the private sector in general had not shown marked progress on implementation of BBBEE. Ponte *et al* (2007) described the pace of change due to BBBEE as sluggish and they had further stated that even the Presidential Black Business Working Group expressed concern about the slow pace of empowerment. Iheduru (2008) also stated that not much had changed in the corporate world and showed evidence of this in the ownership element. This view had been confirmed by the 2008 KPMG which showed a regression in progress on implementation of BBBEE (KPMG, 2008).

Due to overlaps in the discussion section below, discussion of findings on the specific areas of ownership, preferential procurement and employment equity will be dealt with in the next section.

The poor performance on enterprise development is supported by the 2007 KPMG BEE study which showed that companies were performing worst in meeting the targets for employment equity and enterprise development.

The good performance in socio-economic development is not unexpected in the sector due to its context as a hospital sector with opportunities for providing social services such as medical tests and surgery, and drug programme for free. Thompson and Strickland (1999) identify societal concerns such as health and

nutrition as part of the societal, political, regulatory and citizenship considerations that from part of firm's strategy context.

Of note, regarding being rated by accredited verification agencies, was the lack of motivation on the part of black-owned groups to get accredited for BBBEE. Although black-owned and managed companies have a head start with regard to BBBEE, they must still perform on all the other elements of the score card for them to be acceptably empowered (Standard Bank, 2008).

6.2.3 Conclusion

The findings in this study do not support the slow progress that has been documented in the literature on the performance of private sector companies in general. In their self-assessment, and taking into account the time required to comply with the Codes, the Gauteng-based hospital groups are making good progress on meeting the DTI BBBEE targets. There is also progress being made with an expected improvement in BBBEE rating for one of the hospital groups.

On meeting of targets on the specific elements of the BBBEE scorecard, the findings support other studies showing a mixed response on meeting the specific targets of the BBBEE score card. In this study, some respondents thought their hospital groups did not do well on ownership, while a larger number thought they did very well. The respondents were generally very satisfied with performance on socio-economic development, employment equity, and preferential procurement. They were most dissatisfied with meeting the targets for enterprise development,

while management control had a mixed response with good progress at lower management levels, and poor progress in senior management.

The low satisfaction with meeting enterprise development targets confirms findings in other studies, while the very good performance on socio-economic targets is not unexpected due to the context of the sector in the social sphere.

The Level 5 BBBEE rating of two hospital groups indicates that the hospitals are keen to be BBBEE verified. Black-owned companies had however not yet been rated on BBBEE and one had no plans for getting rated.

6.3. Research question 2:

Which targets in the DTI's BBBEE Codes of Good Practice scorecard do the selected private hospital groups find hard to meet and why this is the case?

6.3.1 Overview

As shown in Table 6, 35.3% of respondents indicated that preferential procurement was the BBBEE target that was most difficult to meet. It was followed by ownership and management control which were each mentioned by 29.4% of respondents, and employment equity, mentioned by 23.5% of respondents.

This finding is evaluated against previous studies but the limitation again is that no study has ever been done exclusively on hospitals. The 2008 KPMG BEE study revealed poor progress in four elements of the scorecard, ownership, preferential

procurement, skills development and employment equity (KPMG, 2008). The same study also found that the Community, Social and Personal Services (including Healthcare) sector found preferential procurement and ownership to be the most difficult BBBEE targets to implement. The findings of the 2008 KPMG study are not an exact match with the 2007 KPMG study that showed companies generally doing worst in employment equity and enterprise development (KPMG, 2007). The DTI study also showed that companies across various sectors performed worst in meeting preferential procurement, enterprise development, skills development, socio-economic development and management control (DTI, 2007b).

Although there is no exact match with any of the previous studies, some elements of the study do come through as posing a challenge to meet. Preferential procurement was found to be hard to meet in this study, as well as in the 2008 KPMG and DTI studies. Ownership was a challenge in this study and the 2008 KPMG study, while employment equity was a problem in both the 2008 and 2007 KPMG studies.

To conclude this section, the findings of the study are that, similar to other studies, Gauteng-based private hospital groups find it most difficult to meet the BBBEE targets on preferential procurement, ownership, management control and employment equity.

The reasons for difficulty in meeting the individual targets are explored further below.

6.3.2 Difficulty meeting preferential procurement target

The three main reasons mentioned in Table 6 for the difficulty in meeting preferential procurement targets were the lack of accreditation of suppliers (50%) of respondents, the need to maintain health standards (33.3%) and presence of multinationals in the sector (16.7%).

The finding on lack of accreditation of verification agencies is supported by the literature where the 2007 KPMG study, the Business Report (2008) and Janisch (2008) highlighted the lack of accreditation of verification agencies as a challenge for the implementation of BEE (KPMG, 2007). In this study, suppliers to the hospital groups were using the lack of accreditation of their own suppliers downstream as the reason for not being BEE compliant. Shortcomings on the part of government were thus leading to delays in the implementation of its own policies.

The need to maintain health standards such as infection control was mentioned by two respondents, and as much as this is peculiar to the health sector, it is within the general realm of maintenance of standards. The fear here is that giving a chance to unknown black companies to provide a service might lead to a lowering of standards and thus expose patient care to risks. This thinking is supported in the literature when Kgomoeswana (2008) talks about the notion that “black is equal to the lowering of standards”. According to Kgomoeswana (2008), the fear of lowering standards is sometime used by even black people to keep BBBEE candidates out, this hampering implementation of BBBEE.

One respondent mentioned the difficulty of procuring from multinationals that are exempt from BEE legislation. The respondent pointed out that their biggest spend was with multinationals and since multinationals did not have BEE status, this had a major impact on their scorecard. The literature also supports the view that multinationals have an impact on procurement in the health sector as they manufacture a number of products such as medical and surgical devices (Financial Mail, 2005c). Multinationals, however, also have a special dispensation for qualifying under the Codes of Good Practice (DTI, 2007) and should be able to qualify as BBBEE compliant entities.

In summary, challenges in meeting preferential procurement targets in the private hospital industry are both generic and specific to the sector and are recognised in the literature. The delay in accreditation of verification agencies is a generic problem, while fears around infection control are specific risks to the industry but are generic when viewed in the context of lowering of standards. Procurement from multinationals is also a generic problem but is of specific significance to the sector due to the volume of goods procured from these companies.

6.3.3 Difficulty in meeting ownership targets

As stated in Table 6, the reasons proffered for difficulty in meeting the target on ownership were related to how companies are structured, i.e. publicly traded companies and shareholder decision and problems with funding.

The problem of publicly traded companies and shareholder decision is not unique to the study. Both the 2007 and 2008 KPMG studies did find this mentioned as a challenge to ownership in JSE-listed companies. One respondent was quoted as saying, “being a listed entity limits the amount of ownership within the BEE framework” (KPMG, 2008:54).

Problems with funding were mentioned by two respondents, in the context of the high cost of buying a stake in the industry, as well as the difficulty soliciting funding as an entrepreneur. This is a recognised problem in the literature as access to finance has been raised as a problem in the implementation of BEE (Bidvest, 2006; Mbabane, 2003). A particular problem to the health sector is the high costs associated with the hospital industry as it costs around R1.5m to R2m per bed to establish a new hospital (Financial Mail, 2008).

In summary, the reasons for difficulties in meeting BEE ownership targets found in this study are supported by the literature.

6.3.4 Difficulties in meeting management control and employment equity targets

These two targets are handled together as there is marked overlap in the reasons for not meeting targets. Some of the findings deferred from discussion under section 6.2 on employment equity, and management control will now be discussed in this section.

As seen in Table 6, the study found that in meeting management control targets, lack of skills and experience was the most cited reason (5 mentions), followed by lack of retention or turnover (2 mentions) and low turnover of white people (2 mentions). For employment equity, lack of disabled people was the main reason (3 mentions), while lack of experience and lack of turnover were mentioned by one respondent each.

Lack of skills generally in South Africa, and hospital management and director skills in black people were the reasons mentioned. This finding is supported by the literature as both the 2007 and 2008 KPMG studies indicated that lack of skilled black people was one of the reasons mentioned by companies for not meeting BEE targets (KPMG, 2007; KPMG 2008). The 2008 KPMG study cited one respondent as follows, “There aren’t enough high calibre ‘black’ people available on the market to fill the management and executive levels” (KPMG, 2008:54). This majority view is however not supported by the Commission on Employment Equity which asserts that its studies have not shown merit to the argument that there is a shortage of black people and black females (Department of Labour, 2008).

Again, the lack of managers in the public health sector is well recognised (Health Systems Trust, 1996; DOH, 2005b). Due to the interdependence between the public and private sectors a shortage of managers in the public sector would also affect the private sector.

The lack of skills led to what a respondent in Table 6 said was required, which was "the need to take a leap in faith as one would not get experienced people".

The high turnover in black people was mentioned by 2 respondents, this is commonly, mentioned as evidenced by the 2008 KPMG Stud, but is disputed by the Commission for Employment Equity which states that its studies have failed to prove this assertion (Department of Labour, 2008).

The specific problem of difficulty in finding people with disabilities, which was cited by 3 respondents, is confirmed by numerous studies over the years by the Commission for Employment Equity which has expressed concerns about inadequate recruitment of people with disabilities at all levels (Commission for Employment Equity, 2004).

In summary, the study found that key difficulties with meeting employment equity targets were lack of skills and experience, high turnover of black people and difficulty in finding people with disabilities and the literature generally confirms these findings, although there are dissenting views on the shortage of black skilled individuals and the high turnover in black people.

6.3.5 Other reasons for difficulty in meeting targets

The change in DTI rating methodology was mentioned by two respondents (Table 6) as making it difficult to meet BBBEE targets and had led to the downgrading of the BBBEE compliance level.

This is a real concern and is recognised by the 2008 KPMG study that noted that the regression in BBBEE compliance in 2007 was related to the impact of the adjusted gender recognition principle and thus organisations that had not addressed gender in management control, employment equity and skills development had been prejudiced (KPMG, 2008).

6.3.4 Conclusion

The study confirms that the Gauteng-based private hospital groups find it difficult to meet targets on preferential procurement, ownership, management control and employment equity. Lack of accreditation of verification agencies, fears for lowering of health standards, structuring of companies, the lack of skills, high turnover of black people, lack of people with disabilities and, changes in the DTI rating methodology were all mentioned as reasons for difficulty in meeting the targets.

6.4 Research Question 3

What strategies do the selected private hospital groups employ in meeting BBBEE targets.

6.4.1 Overview

As shown in Table 7, strategies adopted by hospital groups to respond to BBBEE fell broadly almost equally into two categories, responses at a corporate strategy level (10) and responses at a business strategy level (11).

6.4.2 Corporate strategy level interventions

Out of the 10 responses mentioning corporate strategic interventions, 40% were on establishment of governance structures for BBBEE implementation (Board Committees and organisational structures), 40% policy and target setting, 20% on monitoring and 10% on reward systems.

Both historically white hospital groups set up governance structures, with board committees that monitored progress on BBBEE, had policies in place and one mentioned rewarding based on transformation.

The historically black hospital groups had very few responses at corporate strategy level, with only one having policy setting. This is not unexpected as both groups expressed the view that they were already compliant, *"X being predominantly a black company I mean we are already there. It is 100% implementation.* Company A, Individual 2 and *"No (initiatives on BEE) 100% of hospital is BEE."* Company D, Individual 3.

The corporate strategic activities undertaken by these companies (governance structures, policy setting, monitoring and metrics) are supported by the literature with regard to strategy and strategy implementation. Strickland and Thompson (1999) proposed Eight Big Managerial Components of Implementing Strategy which include building a capable organisation, allocating resources, strategy-supporting policies, best practices, information, communication and operating

systems, tying rewards to achievement of targets, corporate culture and strategic leadership.

In this study four of these eight steps are covered in this research question. Governance structures are part of building a capable organisation, policy and target setting is strategy-supporting policies, monitoring is part of information, communication and operating systems for monitoring, and reward (metrics) are tying rewards to achievement of targets.

In terms of levels of strategy, the activities described, such as establishment of board committees in the two previously white hospital groups, show that these activities are at a corporate level. Thompson, Strickland and Gamble (2008) define corporate strategic initiatives as those the company uses to establish its position and state that corporate strategy is reviewed by the board.

Literature on strategies for BBBEE implementation reveals that Telkom used strategies such as development of policies on empowerment to maintain its top position on empowerment (Financial Mail, 2005a).

6.4.3 Operational strategy level interventions

Table 7 showed that out of 11 responses at a business strategic level, 54% were regarding skills development, 36% were on preferential procurement, and 18% were addressing ownership. All hospital groups mentioned strategies to address skills development and to improve on preferential procurement. Three hospital

groups had training programmes for developing managers, and the two big hospital groups trained health professionals such as nurses.

In preferential procurement, accreditation of suppliers was pursued by all. On ownership the establishment of trusts was used by the two previously white-owned hospital groups to address problems with meeting this target.

Once again, the literature supports the strategies adopted. One of the strategies adopted by Telkom was ensuring that suppliers were BEE compliant (Financial Mail, 2005a). Having a procurement policy in place and training programmes also assisted Phumelela in being a top company in BEE status (Financial Mail, 2005b), while the ABSA Group linked transformation indicators and management incentive systems to implementation of BBBEE (Arya, Bassi and Phiyega, 2008). Trusts are also seen as a good vehicle for ensuring truly broad-based ownership (Bowman Gilfillan, 2008).

Regarding procurement, an additional principle used, which has its foundations in the literature, is competitive strategy. One of Porter's five forces for competition is buyer power (Porter, 1998), and in this case the hospital groups utilised their power as buyers to pressure the suppliers to conform to BBBEE accreditation. The threat of substitutes was also a driving force for the suppliers as evidenced by this quote, "*So if you actually have suppliers where one has a rating and one doesn't, we'll start moving to somebody that does."* Company C, Individual 2.

6.4.4 Conclusion

In summary, the study found that the two previously white-owned hospital groups were utilising both corporate and business strategic approaches to address BBBEE, while there was a limited corporate strategic approach in the black-owned hospital groups. All hospital groups employed business level strategies such as skills development, accreditation of suppliers and establishment of trusts for ownership to achieve BBBEE. Corporate level strategic approaches adopted included use of buyer power by the hospital groups and both business and corporate level strategic approaches were supported by the literature.

6.5 Research Question 4: Which of the strategies adopted by the hospital groups in meeting BBBEE are successful and why?

6.5.1 Restatement of results

Table 8 showed that thirteen (86.7%) out of 15 respondents that answered this question felt that the strategies adopted were successful. Two felt that they would be successful as the strategies were still being implemented. Only one strategy was cited as not having been successful and it was to secure a black catering company.

6.5.2 Reasons for success

Table 8 presented the reasons for success of the strategies adopted. Most examples of success related to the business strategic level interventions that. Highest scoring for the success of business strategy intervention was preferential

procurement and skills development where 5 each (45%) out of the 11 responses stated that these interventions had been a success.

The literature on the use and success of these strategies has already been presented in the section above.

Corporate strategy, in the form of leadership in the organisation came through as one of the reasons for success in one company, with all 3 respondents attributing leadership as a reason for success. This finding is supported by the generic literature on strategy and leadership. Blanchard (2006), Covin and Kilmann (1990), Kotter (1996) and Cummings and Worley (2001) have all stated the importance of leadership in strategy implementation and in leading change in particular. BBBEE is a form of transformation of organisations and the principles of change apply to it. In the case of ABSA, top management support was found to be instrumental in the successful implementation of BBBEE (Arya, Bassi and Phiyega, 2008).

6.5.3 Conclusion

In summary, the strategies adopted by the hospital groups on preferential procurement and socio-economic development were successful and the reasons for their success are supported by the literature on strategy implementation and success of BBBEE. Leadership also emerged as a factor in the success of the strategies.

6.6 Research question 5: Is BBBEE a major strategic consideration for the company?

This research question was meant to elicit responses on how much BBBEE was seen to be a consideration for strategic positioning in individual hospital groups.

6.6.1 Restatement of results

Table 9 showed that out of 17 respondents, 7 (41.2%) thought BBBEE was of strategic importance due to it making business sense, and all respondents mentioned its importance from a moral perspective. Of the seven (7) responses highlighting that BBBEE was of strategic importance because it made business sense, six (85.7%) thought it was important for remaining competitive, while one saw its importance as being linked to the change in demographics of customers (more black customers).

In three (75%) of hospital groups, BBBEE was mentioned as important for doing business, particularly doing business with government. There was also a recognition that if one was not BBBEE compliant others would be chosen over one, see quote below.

> *" Again it is important that you have the right BEE rating or else they will select somebody else."* Company C, Individual 2.

The moral reasons for BBBEE being of strategic importance ranged from, corporate social responsibility, supporting government and development, empowering and restoring demographic.

6.6.2 Evidence from literature

The generic literature supports the importance attached by respondents to BBBEE as being of strategic importance and its crucial role in enabling companies to compete. A number of authors have stated that the private sector can no longer ignore BBBEE and it is now a business imperative (Jack, 2007; Arya *et al*, 2008). Companies also need to tailor their strategies to their strategic context (Thompson and Strickland, 1999), which in this case includes legislation that affects the industry. The 2008 KPMG Study states that “we have entered a period where non-BEE compliance could signal the end of organisations seeking to operate in South Africa” (KPMG, 2008:62).

Competitive strategy determines how companies position themselves and Porter (1998) identified five competitive forces, including threat of substitutes and supplier power. Competitive strategy was evident in the procurement sphere in hospital groups as they wanted to be able to do business with government. Competition in the private hospital pace is fierce (Maqhina and Mapham, 2006) and government is trying to reduce tariffs and profits in the industry (DOH, 2008) This trend is also supported by the literature as the DTI Codes of Good Practice and Scorecard were designed to drive transformation throughout the economy (DTI, 2007c) and Jack (2007:110) warned that businesses would not be able to ignore BBBEE, especially

relating to procurement as the bargaining power of suppliers would be affected as "suppliers that do not contribute to BEE and also do not buy from BEE companies present a threat to their clients, who will not be able to score any preferential procurement points by buying from them". The threat of substitution with other suppliers was thus a concern for the hospital groups.

The moral imperative for BBBEE is well supported in the literature. The BEE Commission mentioned the need for redress and opportunity and participation for those that had been previously disadvantaged. The views of Mohanty (2001), "giving power to certain unprivileged sectors of society" and the World Bank (2002) also resonate with the findings.

6.6.3 Conclusion

BBBEE is seen as being of strategic importance by a significant segment of respondents in the Gauteng-based private hospital groups. It is seen as important for maintaining competitiveness as the "threat of substitution" is real.

6.7 Other findings

Other findings that were of relevance to this topic are discussed and will be integrated into the general findings as they provide a more complete picture on the implementation of BBBEE in the private hospital industry.

6.7.1 Understanding of BBBEE

Almost all 17 respondents mentioned words such as empowerment, participation of previously disadvantaged, equal opportunity, development, redress, shifting to a broader base and transformation. Most commonly used words were empowerment (51.9%) and redress (17.6%). These are all definitions contained in the BBBEE Act and BBBEE Strategy.

Of note was one person from a black-owned group did not have a good understanding and equated it to providing high-tech services in black areas.

In conclusion, there was an excellent understanding of BBBEE in the hospital groups.

6.7.2 Awareness of DTI targets

Awareness of DTI targets varied according to hospital groups. In the historically white hospital groups all respondents mentioned that they knew about the DTI targets and could mention a few of them and gave a few examples such as management and procurement.

In the historically black hospital groups there were respondents that did not know much about the DTI targets. In one hospital group only one out of four respondents could give a correct description, while in the other one of the three respondents was not fully aware of the targets. In both hospital groups the lack of full awareness extended to respondents at a strategic level.

The awareness on DTI targets could be linked to perceived relevance of the legislation for the particular hospital group and since black-owned groups already felt they comply fully with BEE, although they were not rated, this could be the reason for not paying any particular attention to BBBEE. Some respondents even gave this as a reason, *"I don't think we pay a lot of attention to that (BBBEE)"*.

In conclusion, awareness of DTI targets is not a priority within the black-owned groups, while staff in the previously white-owned groups is fully aware of the targets.

6.7.3 Implementation of BBBEE in hospital groups

The study found that most respondents in historically white hospital groups mentioned the structures in place for monitoring implementation of BBBEE and in one of the hospital groups, everyone interviewed had a good understanding of how the company was implementing BBBEE. In the historically black hospital groups, there was no concerted effort around implementation of BBBEE as they saw themselves as already compliant, "No (initiatives on BBBEE) 100% of company is BEE".

From the literature, the impact of black ownership on BBBEE scoring elevates the company to the next compliance level (Lester, 2007). This means that if a company is more than 50% black-owned and scores at Level 5, it is promoted to Level 4. Although black-owned companies could have scored well under the old narrow-

based BEE Scorecard that had a focus on ownership and management, they could find themselves not doing well with the new scorecard that has seven elements.

Since the Codes and Scorecard apply to all those entering into decisions with the state on procurement, licensing and concession, PPPs or the sale of state-owned entities, they are required to be accredited as BBBEE entities as of August 2008 (DTI, 2007c).

In conclusion, implementation of BBBEE in previously white companies is well integrated into their structures and there is good understanding on what needs to be done. Black companies, however are not making any concerted efforts to be implement BBBEE and run the risk of not being formally accredited, which would impact on their ability to do business with government, and other private entities.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1. Introduction

Through BBBEE, the South African government aims to break the cycle of underdevelopment and marginalisation of black people from the mainstream economy (BEE Commission, 2001). Government has further put in place legislation and regulation to ensure the monitoring of BBBEE implementation. Through broad-based BBBEE elements such as preferential procurement, BBBEE has become a strategic imperative for businesses in South Africa (Jack, 2007) and businesses risk losing out if they do not comply.

The private hospital industry in South Africa is highly competitive and regulated. In 2005, the Health Charter described the sector as largely untransformed, with a paucity of black representation at senior management level in the private sector, with little evidence of significant progress in addressing skills development as well as very little BBBEE in the sector (Department of Health, 2005a). Although information on implementation of BBBEE was available for JSE-listed private hospital groups, no information was available for the other private hospital groups.

This research sought to assess the implementation of BBBEE and its importance to corporate strategy in selected private hospital groups based in Gauteng.

7.2. Summary of findings

The key findings of the research were as follows:

- The Gauteng-based hospital groups are making good progress on meeting the DTI BBBEE targets. There are indications that progress is being made with two hospital groups rated at BBBEE compliance Level 5, and one hospital group expecting to be upgraded to Level 4.

- There was a mixed response on meeting targets for the specific elements of the BBBEE scorecard. Respondents were generally very satisfied with performance on socio-economic development, employment equity, and preferential procurement. They were most dissatisfied with meeting the targets for enterprise development, while management control showed good progress at lower management levels, and poor progress in senior management.

- The private hospital groups find it difficult to meet targets on preferential procurement, ownership, management control and employment equity. Key challenges are related to lack of accreditation of verification agencies, fears for lowering of health standards, structuring of companies public owned and shareholder prerogatives), the lack of skills, high turnover of black people and lack of people with disabilities.

- The two previously white-owned hospital groups were utilising both corporate and business strategic approaches to address BBBEE, while there was a limited corporate strategic approach in the black-owned hospital groups.

- Strategies adopted by the hospital groups were generally successful and leadership emerged as a factor in the success of the strategies.

- BBBEE is seen as being of strategic importance by the Gauteng-based private hospital groups and is perceived as important for maintaining competitiveness.

- Implementation of BBBEE in previously white companies was well integrated into their corporate structures. Black companies, however were not making any concerted efforts to be implement BBBEE

7.3. Recommendations

Flowing from the findings above and taking into account government's objectives for BBBEE, the following recommendations are made:

7.3.1 For private hospital groups

- The hospital groups need more concerted efforts in developing skills for senior management and finding ways of recruiting and accommodating people with disabilities.

- Previously black-owned hospital groups should adopt a strategic approach to the implementation of BBBEE as this will lead to a systematic approach and better awareness of BBBEE and its implementation.

- Previously black-owned hospital groups need to undergo verification of their BBBEE status as this will provide them with objective evidence of meeting BBBEE scorecard requirements and ensure that they do not get disadvantaged in an environment where verified scorecard will become more essential.

7.3.2 For government

- The Department of Trade and Industry needs to:
    - Ensure that it does not present constraints to the implementation of BBBEE, e.g. lack of accreditation of verification agencies.
    - Limit changes to rating systems as this leads to “shifting of goal posts”.

- The Department of Health needs to:
    - Support skills development at a senior management level by providing more training for hospital management.

7.3.3 For future research

Drawing from the limitations of this study, and the findings a number of recommendations for future research are made as follows:

- Case studies of BBBEE implementation in specific hospital groups. This research was too wide to go into details on individual hospital groups and there are indications that the hospital groups possess certain idiosyncrasies in how they approach implementation of BBBEE.
- The perceived high turnover of black people. Due to the contradictory findings from the Commission on Employment Equity, this is an area that would be worth exploring, especially as staff turnover was said to be high.

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APPENDIX 1: INTERVIEW GUIDE

1. INTRODUCTION

The interviewer introduces herself. “Good day, my name is Thuthula Balfour-Kaipa. I am currently doing conducting research on “The implementation of BEE in Gauteng-based private hospital groups”. The aim of the research is to assess the implementation of BEE in selected private hospital groups in Gauteng and to determine how important BEE is to the group’s corporate strategy.

Our interview is expected to last about an hour, and will help us better understand how BEE is being implemented in this sector.

Your participation is voluntary and you can withdraw at any time without penalty. Although I will take details on your name and the group, all data will be kept confidential, including your name and your views.

2. QUESTIONS

2.1 DEMOGRAPHIC QUESTIONS

2.1.1 Name of

company:_____

2.1.2. Name of

interviewee:_____

2.2.3. Interviewee's position in

company:_____

2.2.4 Sex of interviewee;

2.2.5 Race of interviewee

2.2 COMPLIANCE WITH THE BEE SCORECARD

2.2.1 What is your understanding of BBBEE?

2.2.2 Are you aware of the targets set in the DTI's BBBEE Codes of Good Practice scorecard, and what they are?

2.2.3 How would you describe the implementation of BBBEE in your company?

2.2.4 Specifically, how well do you think you hospital group is performing in meeting the following targets of the scorecard, and why?

2.2.4.1Ownership

2.2.4.2 Management control

2.2.4.3 Employment equity

2.2.2.4 Skills development

2.2.4.5 Preferential procurement

2.2.4.6 Enterprise development

2.2.4.7 Socio-economic development

2.2.5 In your assessment, overall how well do you think your hospital group is performing in terms of meeting the targets set in the DTI's BBBEE Codes of Good Practice scorecard, and why?

2.2.6 Has your company been rated by another agency on BBBEE compliance and what was the outcome of the rating?

2.3 DIFFICULTY IN MEETING TARGETS

In your assessment, which of the targets set in the DTI's BBBEE Codes of Good Practice scorecard are/were difficult to meet and why?

2.4 STRATEGIES FOR MEETING TARGETS

What strategies/measures has your organisation adopted/taken to meet the targets set in the DTI's BBBEE Codes of Good Practice scorecard?

2.5 SUCCESS OF STRATEGIES

Which strategies/measures were successful and in your assessment why were these strategies/measures successful?

2.6 STRATEGIC IMPORTANCE OF BBBEE

2.6.1 Can you describe how and why BBBEE is important to your company?

CONCLUSION

Do you have any final thoughts/recommendations on BEE in the private hospital industry.

Thank you

APPENDIX 2: List of participants in the study

HOLDING	NAME	DESIGNATION	GENDER	RACE	LEVEL IN COMPANY
Life health Care Group	Rachel Wrigglesworth	Procurement Manager	Female	White	Related to scorecard
	Roger Hogworth	Financial manager	Male	White	Strategic level
	Ansuyiah Padayachee	Manager Community & External affairs	Female	Indian	Related to scorecard
	Sagran Sukhesson	Hospital manager	Male	Indian	Operational level
	Denis Scheuble	Regional manager	Male	White	Business unit
Clinix	Moses Mokgapa	Hospital manager	Male	White	Operational level
	William Osburn	Hospital Manager	Male	White	Operational level
	Fanus van Huysteek	Financial Director	Male	White	Strategic level
	Dr Peter Matseke	Chief Executive Officer	Male	African	Strategic level
Netcare	Peter Warrener	Group Human resources Director	Male	White	Strategic level

	Corinne Kennedy	Group procurement Manager	Female	White	Related to scorecard
	Sandi Mbatsha	Government relations and CSI Manager	Male	African	Related to scorecard
	Barry Bedford	Regional Director	Male	White	Business unit
	Esme Abrahams	Hospital Manager	Female	Coloured	Operational
	Dr Victor Lithlakanyane	Executive Director	Male	African	Strategic
Lenmed	Martha Kirsten	Nursing Service manager	Female	Indian	Operational
	Dr Ahmed kaka	Chief Executive Officer	Male	Indian	Strategic
	Ahmed Nana	Financial Director	Male	Indian	Strategic