

ORIGINAL ARTICLES

The state of public hospital governance and management in a South African hospital: A case study

Adam Fusheini*^{1,2}, John Eyes^{1,3}, Jane Goudge¹

¹Centre for Health Policy/MRC Health Policy Research Group, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa

²Department of Health Policy, Planning and Management, School of Public Health, University of Health and Allied Sciences, Ho, Ghana

³School of Geography and Earth Sciences, McMaster University, Hamilton, Ontario, Canada

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ABSTRACT

Purpose: The purpose of this paper is to examine the operations and management of a public hospital in South Africa in the light of recent organizational reforms. Management of public hospitals in South Africa is often seen as fragmented, impacting on their operations. Management processes are dominated by hierarchy and poor communication and interaction. They are also poorly linked to patients' needs and experiences. In this paper, we examine the operations and management of a district hospital in North West Province to ascertain the extent to which the nature of hierarchy, communication, and interaction in the management process (meetings, establishing guidelines and others) impact on the efficient and effective governance of the hospital, especially in the light of recent organizational reforms.

Methods: A qualitative case study approach involving 15 in-depth interviews were conducted at three management levels. All interviews were conducted in English, and were digitally audio-recorded and professionally transcribed. Management and organization of data were done with NVivo 10 software, while analyses were based on pattern-building and emerging themes.

Results: By and large the hospital was constrained by hierarchical control and rule-following. While hierarchy and dysfunction still shape communication and interaction, there is some optimism with regards to strategic planning. Key features of hospital governance and its functionality, involving financial management or stewardship, strategic planning, performance management and appraisal, and clinical governance are emphasized.

Conclusions: For effective public hospital governance in South Africa, management must be guided in practice by the key principles set out in the national policy on management of public hospitals.

Key Words: Public hospital, Governance, Hierarchies, Communication and interaction, South Africa, Dominance

1. INTRODUCTION

South Africa's public hospital system is undergoing important reforms but the attention on national health insurance

(NHI) (universal health coverage), with its emphasis on primary health care (PHC), may well lead to their being under-emphasized. Although the importance of hospitals and their

*Correspondence: Adam Fusheini; Email: adam.fusheini@gmail.com; Address: Centre for Health Policy, School of Public Health, University of the Witwatersrand, Private Bag X3, Wits 2050, Johannesburg, South Africa.

coordinated management and provision of services has been recognized in South Africa since the White Paper of 1997,^[1] many studies have noted the skills gaps and managerial competencies among hospital managers,^[2-4] the interface between clinical and administrative leadership^[5] and their overall dysfunctional, inefficient and effective status.^[6] The significance of the White Paper for the transformation of the health sector in South Africa is underscored by the fact that it sought among others to decentralize management of health services, with emphasis on the district health system increasing access to services by making primary health care available to all citizens as well as ensuring the availability of safe, good quality essential drugs in health facilities; and rationalizing health financing through budget reprioritisation. Hospitals roles were to be redefined in these reforms to include the introduction of decentralized hospital management to promote efficiency and cost-effectiveness; as well as the establishment of hospital boards to increase local accountability and power.^[1] The White Paper's rationalization was that most public hospitals have been severely undermanaged, mainly due to: limited responsibility and authority accorded to hospital managers; ineffective and inappropriate structures and systems of management; limitations in the number and skills of managers; insufficient operational authority or incentives for managers to manage budgets efficiently; and the existing organisational culture within hospitals.^[1] Beyond the 1997 White Paper, recent documents including the National Health Act of 2003,^[7] the medium-term strategic framework, commonly referred to as the ten (10) Point Plan for the period 2009 to 2014, in which point number four (4) emphasizes "overhauling the health care system and improving its management";^[8] and the Policy on the Management of Public Hospitals promulgated in March 2012^[9] among others point to the fact that the South African public hospital sector is still locked into the past in terms of management.

Harrison has further noted the problems of authority and delegation in public hospitals, with their being as poorly organized to deal with financial, strategic, internal performance, clinical and stakeholder governance issues.^[10] The government has recognized these challenges and has begun to formulate new plans for leadership, with the most senior managers- Chief Executive Officers (CEOs) being re-certified and re-appointed.^[11] Governance in public hospitals must in future comply with national quality standards.^[12] Consequently, the present study contributes to exploring public hospital governance in South Africa through a case study where a CEO has been recently appointed under these reform guidelines. It emphasizes the features of governance required for the effective operation of a public hospital and the extent to which the nature of hierarchy, communication, and in-

teraction in the management processes affect the successful management of the hospital.

The paper will, therefore, examine hierarchy and communication and interaction (meetings, establishing guidelines and others) and their impact on efficient and effective governance, derived from Anderson & Brown's^[13] examination of the positive and negative impacts of hierarchy. Many modern organizations suffer from isolated departments, poor coordination, and limited lateral communication^[14] due to steep hierarchies, weak processes and poor communication and interaction. Hierarchy can impact team performance;^[15] so an organization with significant leadership change is worth investigating. Furthermore, South Africa presents a very specific context with its post-apartheid state, struggling to replace its race and class-based bureaucracy through new employment guidelines and policy coordination and institutional efficiency.^[16] Hierarchy may, of course, allow for functional rationality,^[13, 17, 18] yet it does not always guarantee that organizations will function effectively. So what happens to management practices in a new organizational environment in the case study? How then do the direction and frequency of work and information flows link the differentiated roles within and between departments of complex organizations^[19, 20] such as a hospital? In addition, the questions remain regarding goal setting, communications channels adopted by organizational actors, the approach to problem-solving and decision-making, and ultimately how leaders lead.^[20, 21]

South African public hospitals remain under-researched. Some studies elsewhere have attributed the performance problems of public hospitals to the rigidity of hierarchical bureaucracies, managers lacking the ability to oversee the day-to-day operations of their facilities, and the absence of performance-based incentives.^[22] To what extent is this true in the South African public hospital sector as many public hospitals have been described as highly hierarchical, institutionally ineffective and dysfunctional.^[23, 24] Management failures in public hospitals are further explained by lack of management capacity. For instance, management departments often face constraints in the effective performance of routine or strategic tasks.^[23, 24] A clear example is the case of the Human Resource (HR) function in public hospitals, which is essentially a personnel function for administering payroll, leave, and recruitment. Functionally, managers are often unable to manage human resource development and labor relations, improve the disciplinary regime, or draw up skills development or employment equity plans. The result of these issues is far-reaching, affecting morale, discipline and labor relations.^[23, 24] It is thus timely to examine hierarchy, communication and interaction and dysfunction on

performance.

2. METHODOLOGY

2.1 Study design

In this study, we adopted an exploratory qualitative case study design based on analytical methods originating from both public health and social science research^[25] to understand the extent to which the dominance of hierarchy, communication and interaction and dysfunction impact on the management of the case hospital in North West Province. Our choice of the strategy was informed by the fact that case studies are in-depth investigations of a single instance of a phenomenon in its real-life context.^[26] The study was conducted in March 2015 using semi-structured in-depth interviews as the primary instrument for data collection. From individual responses, the paper examines how hierarchy, communication and interaction manifest themselves given the context of hospital reform and the legacies of the past.

2.2 Study setting and sample

The study setting was chosen because of the claim that while hospitals in North West Province are somewhat better resourced than in other provinces, they are, nonetheless, highly stressed institutions.^[23,24,27] “Highly stressed” implies weak institutional functioning, with governance breakdowns not being addressed, improper management and lack of effective operational systems; overworked staff, with their own health under stress; high levels of conflict and poor labor relations. Consequently, there are poor public health outcomes (inadequate patient care, poor and inconsistent clinical outcomes, increased costs of poorly managed illnesses). But the recruitment of a new Chief Executive Officer (CEO) under the re-certified model of the policy on management of public hospitals presents an opportunity to examine how hierarchies and the communication and interaction of management are shaped to meet institutional goals of effective delivery of high-quality care.

The study hospital is a medium size level one facility according to the criteria set out in the policy for the management of public hospitals.^[28] With a capacity of two hundred and sixteen (216) beds, the package of services the hospital provides includes trauma and emergency care and crisis center, in-patient care, out-patient visits and pediatric and obstetric care. Other services include surgical and medical wards; neonatal high care, kangaroo mother care, X-ray, step-down facility (Step-down refers to an intermediate level of nursing care for patients with requirements in-between the general ward and the intensive care unit); maternity, theatre, mortuary and laboratory services. The hospital receives between eighty and three hundred patients a day-both in-patient and

outpatients combined. The services are provided by family physicians and or general practitioners, and clinical nurse practitioners. The hospital only employs specialists in family physicians, pediatricians, obstetrician/gynecologists, and general surgery.

In all, fifteen participants were recruited from three levels of the hospital’s management-executive, middle and operational. The selection of interview subjects was purposefully done. One criterion used for the selection was a review of public hospital organizational charts and later the specific organizational chart of the selected hospital to articulate its functioning. The highest management level was the executive, which consisted of participants including the CEO, the clinical manager, the deputy director of corporate services and the deputy director of nursing services. This executive managers together with the board constitute what is described as the axis of “hospital governance”.^[29,30] The next category of interview participants from the management structure of the hospital was recruited from the middle management level. They are next to the executive managers. Participants included the assistant director responsible for finance and supply chain management (ADFSCM), the acting human resources manager, the human resources development manager (HRDM), the assistant director of technical and support services (ADTSS), and the pharmacy manager. Others were the acting assistant director of quality assurance; also having responsibility for occupational health and safety, and the senior information services manager. The rest of the interviewees were those responsible for the day-to-day routine management activities of the hospital as they supervise the frontline workers. Managers responsible for outpatients department (OPD), theatre, complaints and step-down, and the medical ward constituted the operational level interviewees recruited to participate in the study.

To ensure convenience for the interviewees, schedules were agreed with them in advance and all interviews took place in their offices during working hours of the hospital. A semi-structured interview guide with a protocol of questions, specifically, adapted for each category of hospital managers was used as a guide. Broadly, the interview guide consisted of questions with probes around the nature of the prevailing governance systems and structures, within which communication and interaction in the hospital occur in relation to the day-to-day management, and the hospital managers’ roles and responsibilities with regard to these governance arrangements. In order to capture the interviews environment and mood as well as to give “richer meaning to the words spoken”,^[31] additional notes were taken when necessary. All but four of the interviews lasted between thirty and sixty minutes. All the interviews were held in English in March 2015 by the

interviewer (first author).

The audio files were professionally transcribed. The interviewer then listened to the audio, checked against the text, and edited for grammatical errors without changes to the content. Together, all the authors developed a coding scheme based on the emerging themes. Data were then coded using NVivo 10 software. These data and a summary of the themes were shared with the research team. Major agreed themes included: issues surrounding existing governance structures; roles and responsibilities of the different categories of managers; policies, rules and regulations governing the management of units and departments; and comments on interactions between units or departments. Hospital managers' perspectives are presented in the results section in light of management's function to identify the roles of hierarchy and communication and interaction with the themes emerging from data analysis and presented as sub-section headings.

Before the commencement of the study, ethics approval was granted by the University of the Witwatersrand Research Ethics (Medical) Committee and the North West Department of Health's Research and Development Unit. Reporting of data and findings (including the actual hospital itself) has been made anonymous.

3. RESULTS

In this section, we present the major themes identified as explaining how the dominance of hierarchy, communication, interaction, and dysfunction affect the management and impact on the performance of the hospital. The themes include:

- (1) Fiscal Performance and Financial Stewardship
- (2) Strategic Planning
- (3) Performance Appraisals
- (4) Clinical Governance
- (5) Accountability to various stakeholder groups

3.1 Fiscal performance and financial stewardship

Fiscal performance or stewardship has been identified as a key function of hospital governance.^[32] In the hospital, executive and middle-level managers see financial stewardship consisting mainly of ensuring efficient and prudent use of budgetary allocations from the national level through the province:

My primary responsibility is to ensure effective and efficient management of State resources, especially in finance. Remember at the beginning of the financial year, we have got an allocation of budget, my responsibility is to ensure that whatever is procured or whatever you are using

the budget for has been planned before (ADF-SCM).

There is a limited delegation from the province in relation to funds provided, further demonstrating the hierarchically shaped ways of doing things (even deciding what can be done).

Unfortunately, delegations have not been evolved that much. Most of the delegations are still arrested in the district office. Like, for instance, we cannot employ anybody, even if it's a cleaner who needs to be employed, we would then do the recruitment process and then it will be approved in the district (CEO).

For example, in terms of supply chain management delegations, the hospital can only procure up to R300,000 (about \$19,000) without provincial permission.

Preparing the budget for submission to the province has become a rote exercise; the hospital is allocated what the province deems appropriate, so budget construction becomes a rather futile endeavor. This position was confirmed by the CEO: in the 2014 financial year, a request of 297 million Rand (\$19 million) was made but an allocation of 123 million Rand (\$8 million) was received. Budget over-centralization causes frustrations and tensions in running the hospital:

The budget is somewhere in Mafikeng, sitting with the district and by the time it gets to the hospital, we don't actually have a budget. As a result, you can't monitor your training plan because you don't have a budget, it's centralized with someone else and whoever has got the budget must make the decision wherever he or she is. So it is frustrating this thing of the budget (HRDM).

The overall effect of the financial stewardship on the governance of the hospital was summed up by the Assistant Director for finance and supply chain management:

I must make sure that we spend in line with Public Finance Management Act (PFMA) and Treasury regulations. I must make sure that we don't overspend or underspend but we are overspending, because they gave us R31 million for corporate services and we are at R39 million expenditure as we speak, which is R8 million extra (ADFSCM).

Thus good financial governance in the hospital means following the public services processes, determined by others at province and district level. The hospital possesses little financial autonomy. Financial hierarchy is rigorously enforced.

3.2 Strategic planning

At the executive management level, strategic planning entails providing direction for the hospital for the next three years based on “nine indicators that we have to report to the National Department of Health” (CEO). This is carried out through a *Lekgotla* (a Tswana word for meeting and discussing issues adapted from the traditional way of doing business by traditional chiefs in South Africa). It involves inviting different stakeholders of the hospital, including those from outside the district but with knowledge of health care and other ideas, to help shape the plans and future direction of the hospital. This approach to planning is described as a formal articulation through relationship-building open to all, including unions, as they occupy a prominent place in the hospital’s governance structure, especially around performance appraisal and discipline. The involvement and participation of all stakeholders in this important exercise are to forestall what was described as “being messed up” by the unions in the running of the hospital. Much depends on the leadership style of the hospital executive management, especially that of CEO:

We have monthly reviews where we look at the nine indicators that we have that we report to the National Department of Health and then there will be quarterly reviews (CEO).

Middle-level managers also alluded to how strategic planning is carried out but noted the process remains hierarchical:

Financially, I have already explained that we start from the Strategic Plan, which we have formulated from the Department Plan, and the Annual Performance Plan. Then we go to the Operational Plan. From the Operational Plan, we develop our Demand Plan. Then we do have a prioritization ... a session whereby you will then have a Prioritized Plan, based on the needs and allocated budget (ADFSCM).

Normally at the beginning of each financial year, which is April, around about December/January, we compile a maintenance plan, which includes all the services that need to be done through the year, the description of the item, when it must be serviced per month, because we can’t do it immediately, we have to plan for that (ADTSS).

Putting all these plans in place demonstrates a commitment to team-building, but the implementation is often difficult due to budgetary constraints and unpredictability in the hospital environment. Besides, strategic planning is seen as time-consuming and the process does not always operate smoothly, especially as the daily demands of care take precedence:

I think the most important thing to do is your planning but Government work makes planning very difficult because we would get a notice from head office saying that this and this course is happening in two days (Pharmacy manager).

There’s crisis management that is caused by the top. You come in the morning; you then get to be told there’s a meeting in such and such a place, then you run. There’s training, why haven’t you sent people... where is the email? No, we sent an email two weeks’ ago, you check the email; the email is not there... (CEO)

What I have also seen is if you would remove crisis management, the middle managers don’t even know what to manage because they are used to crisis managing. They are not used to pre-operatively looking at planning, implementing and evaluating (CEO).

While theoretically there is a planned process, the command and control hierarchy, with practical demands often dominating, may lead to dysfunction. Furthermore, at the operational level, strategic planning appears to be non-existent. Planning is more of a routine process of weekly duties, of rule-following in carrying out those activities:

I’ve done a weekly planning for the unit. So the planning process is like every morning we gather and we pray before the start of duties. Then after that, I delegate them. I delegate each and everyone by telling them, “today you are going to do this; this one will do that”. Then, after completing what is assigned to you; you have to sign that, ‘yes I have completed my work’ at the end of the day (Operations manager, surgical Theatre/Operations Room).

Thus hierarchy trumps principled interaction and guidance leading to the perceived dysfunctionality in management in the hospital.

Formulating future strategy also includes priority setting in relation to district health programs and aligning them with the vision and mission of the hospital. Thus, the hospital’s strategic plan and the “priority programs are borne out of

mandates that the provincial department receives from the National Department of Health” (Clinical manager). This again brings to the fore the issue of hierarchy and potential dominance by those who fund and regulate:

So when you look at all those things, the National Department will form priorities, and say okay maybe for this year (or for the next three or four years), these are the things we want to achieve and these are the outcomes. When that has been done at the strategic level and all the broad objectives have been mapped out, then we as line managers will then fashion out our own strategies in line with those of the Department (Clinical manager).

3.3 Performance appraisal

All participants mentioned the existence and institutionalization of accountability mechanisms, designed at the national level:

The performance management (PM) that is in place is designed at the national level, and then down to the province; the district and down to us (hospital) and that is why we have to report to them. It goes up to the highest level from us (Complaints manager).

At the hospital, it applies to all the employees including the managers:

It is an agreement between me (employee) and my Supervisor - the supervisor representing the employer. We call it the Performance Management Development System. I get the job description and the work plan and performance will be evaluated on a quarterly basis, and the review will be done by those two people (supervisor and employee).

But the evaluation mechanism emphasizes processes rather than impact or outcome in the hospital. Participants explained that, procedurally, at the beginning of the year, key performance areas are agreed upon by executive managers with the CEO; middle-level managers with their respective executive managers; operational managers with middle-level managers and sometimes with executive managers. The CEO is supposed to be accountable to the board, the political Member of Executive Council (MEC) of the province responsible for health, and the Head of Department (HoD) for health.

Overall, the Performance Management system is seen as a good measure for fostering responsibility and accountability.

However, respondents maintained that evaluation is largely procedural and, practically, it is “business as usual”. Employees make sure they satisfy the requirements of the appraisal but the extent to which this translates into effective and efficient service delivery and management of the hospital was questioned. This has often resulted in expression of dissatisfaction with the evaluation procedures, as some respondents argue that it breeds favoritism, nepotism, and ineptitude in the governance and management of the hospital.

There were instances where the management used to approach things in an unethical manner. Now I am faced with a case of people that paid themselves bonuses in doing what was always theirs. . . The foundation of what you know to be management is no longer that, there is another different foundation (CEO).

The process of scoring, a key element of the performance appraisal, was claimed to depend on personal relationships rather than performance. This is a common criticism of Performance Management in different contexts. The appointment of the new CEO has not changed the perception of most employees regarding the evaluation procedure in the hospital. Furthermore, budgetary constraints limit the ability of the hospital to reward high performers financially, increasing levels of frustration:

It is a requirement of the departmental policy that when you start to work, you need to have a performance agreement or a work plan. It has targets and the performance is informed by the strategic plan of the institution and for the institution, it is informed by the district (Deputy Director, Corporate Services).

Performance appraisal, a formal way to ensure fair treatment in a hierarchical system, does work but appears in part compromised by the informality of the process – who can interact with whom on what basis, the role of unions, and the inability to reward.

3.4 Clinical governance

The American College of Healthcare Executives^[32,33] identified clinical efficiency and quality as another important function of hospital governance. In the hospital, this is a major priority. Patients or clients were said to be the core business of the hospital. The clinical manager described good practice as being found in guidelines and protocols, which must be strictly followed in rendering clinical services. These include auditing of records; mortality; morbidity, and maternal death reviews; continuous professional development to keep

abreast with national and international standards; certifications; debriefing; safety; employee welfare; a well-stocked and functioning pharmacy; and access, among others.

Auditing of records, a vital element in the maintenance of any hierarchical system, is not only about processes and procedures that are followed in making diagnoses and prescribing treatment for patients, but also about ensuring that physicians take responsibility for their actions:

We make sure that doctors take ownership for their actions. It is like a peer review, where we all sit together. This is what A has done on patient C. Has s/he done those things to the best of his/her ability or do you think he could have done things differently? (Clinical Manager).

The Quality Assurance, Occupational Health and Safety (QAOH&S) unit within the hospital continuously evaluates clinicians based on the National Core Standards.

In relation to record auditing, there are mortality, morbidity and maternal death reviews, all strengthening clinical efficiency and good clinical governance.

There are so many reviews we do in the hospital, and we bring up those cases (negative incidents like death). All the doctors will be there. It is usually multi-disciplinary (Clinical Manager).

Participants indicated that good clinical governance in the hospital requires unity of direction, coordination, and collaboration, especially between doctors and nurses working together as a team. Clinical governance is aided by a process of shared leadership and responsibility by the various actors, each taking responsibility for the total functioning of the hospital, in this case through adherence to the formal qualifications of medical practitioners, aided by regular and continuous professional development (CPD) courses. However, there may be a gap between clinical services and administration. The CEO noted that *“senior doctors supervise the junior doctors but our doctors were not trained to be managers”*. Good clinical governance requires more than medical training. Part of the process means ensuring that all competencies are present to fulfill functions, but this requires training and adequate functionality.

3.5 Accountability to various stakeholder groups

In terms of the hospital's accountability to its various stakeholders, there appears to be a poor relationship, particularly with the community and, until recently, the unions:

The biggest challenge is how to change community perceptions. It has not been good as

an institution for the staff, even for the community. Unfortunately, it is the staff that is getting strained when the community comes and they are negative (CEO).

This has led to a weak engagement in terms of educating and promoting the health of the community and the population as it is the responsibility of the hospital to oversee the clinics in its catchment area. This vital social responsibility of the hospital to the host community is lost in the process.

Again, to foster a good and cordial relationship with the community, the hospital board has a role to play as a link between the two. However, over the years the role of the board has rather exacerbated the poor relations. Members of the board tried to interfere in the management of day-to-day running of the hospital rather than providing strategic direction and vision for the hospital to perform its core mandate of quality health delivery. It was reported that board members tried to interfere in the recruitment of staff by submitting a list of candidates, who neither have the requisite qualification or experience for advertised positions for consideration. This resulted in resistance by management leading to “inciting” of the community against management. In other words, governance actors were pursuing their own interests. Hospital leadership reforms have led to the CEO putting mechanisms in place in an attempt to improve the hospital's accountability and stakeholder relationships. An engagement strategy has been developed aimed at having community and church meetings and campaigns:

We also are planning to have church meetings. We are going to go to the community and go to their churches and I want to morally blackmail them to say as a church, you are the moral fiber and the moral fiber of the hospital (CEO).

According to the CEO, hospital management has also embarked on a new strategy of using outreach programs via radio stations, posters and newspapers to improve community governance and accountability. The process is expanding to include more views of how to administer the hospital.

4. DISCUSSION

This study reveals the views and opinions of executive, middle and operational level managers in a district hospital in relation to how its governance is shaped in line with the changes effected by the South African government.

From the study, it is clear that public hospital managers in South Africa face competing pressures in maintaining a balance between performing key functions of governance at the institutional level and responding to the hierarchical

control and supervision exercised by the provincial administration through its budgetary influence. A consequence of this is the evolution of a norm of management characterized by rule-following, which, anecdotally, appears to have become the norm and standard in managing public hospitals in South Africa.^[23,24] Management is more about following the processes and outcome appears secondary. If communication and interaction styles – the articulation of hospital functions and the relations necessary to ensure the successful implementation of these functions – are set at province level through budget, criteria, and meetings to plan operations, it is likely that good governance will be achieved slowly even if the CEO is motivated to improve functionality and reduce dysfunction.

It has also emerged that while financial stewardship is critical to efficient hospital governance,^[32,33] in South Africa, there appears to be a disconnect between budgets and budgeting and the practical requirements for the efficient delivery of health services by the hospitals due to the hierarchical relations between province and hospital.^[24] While hospital managers are invited to budget discussions, these are often mere formalities, as decisions are usually imposed from the center. We thus agree with Von Holdt that managers of functional domains within hospitals are constrained by this gap between their planning and provincial budget allocation.^[23] Thus, the approach of decentralized centralization where higher levels of authority still exercise control over decision space and management of hospital managers renders the latter incapacitated with regards to financial spending including procurement, staff establishments, and/or information systems. This finding is consistent with an earlier study by Pillay that established how hospital managers are paralyzed over human resources and finance due to tighter controls over decision making and delegation issues. Decisions to appoint or procure equipment remains at the higher levels.^[2]

Our findings are also consistent with studies on governance in a number of African countries, where it has been reported that there is a high degree of “centralization” in decision-making, which reflects the desire to exercise close monitoring in organizations.^[34] While supervision is crucial in governance, it often leads to what Vengroff et al. described as adherence to textbook (rules and regulations) approach to managerial decision-making.^[35] We also argue that it creates inertia and kills innovation and strategic thinking. Indeed, policy documents lay out the need for greater managerial competencies,^[36] yet the environment often does not permit their incorporation, especially to change practice.

The findings on strategic planning again highlight the importance of hierarchy and the need for team development

and buy-in. But with strategic planning that we can be more optimistic than other studies. Strong and shared leadership is present and collegiality with respect to purpose is being built. All the same, managers’ responses to provincial demands at short notices leave them fire-fighting and crisis managing for much of the time. This suggests that stress and tensions may appear, resulting in the routinization and formalization of strategic planning and a difficult commitment to team-building.

Structures for accountability and performance evaluation remain crucial conflict areas which may impact efficient and smooth functioning hospital governance. These were identified as thorny issues, with many feeling that the performance appraisal mechanisms designed at the national level were formalistic and that scoring depends on employee-boss relationships. Nevertheless, there is optimism in senior management views of governance as a process of shared leadership and responsibility. Thus, in keeping with Anderson and Brown’s study on the functions and dysfunctions of hierarchy, highlighting the types of tasks performed by organizational members, the focus should be on mechanisms, structures and appropriate systems for selecting the right leaders. How the system responds to internal and external environmental factors in nurturing the right leaders for healthcare delivery is crucial. Again, the extent to which hierarchy steepness bears a relation to member motivation in the group, and above all the implications of the hierarchy steepness on intra-group coordination are critical if effective public hospital management is to emerge.^[13,28] All these factors critically interact in the case hospital so progress towards good governance is present in some activities (strategic planning) but not others (finance).

Limitations

The nature of hierarchies and communication and interactions have implications for policy reforms in relation to how public hospitals are efficiently managed in South Africa. However, in interpreting the findings, we acknowledge limitations. Case studies generally cannot be generalized beyond the particular case and our study only focused on one medium-size district public hospital with a dissolved board. This implies the findings should be interpreted in relation to the particular hospital due to the unique demographic characteristics of the district and local contextual factors.

5. CONCLUSION AND IMPLICATIONS

For effective decision authority with strong accountability mechanisms as prescribed by Bogue et al.; and Preker & Harding;^[22,33] for efficient hospital governance,^[37] and robust oversight practices^[22,38–40] to happen in hospital man-

agement in South Africa, emphasis should be on improving governance structures by devolving these to those who effect service delivery.

Thus with some central oversight, the budgetary allocation should be guided by the principles that underpin the health care environment and health system of South Africa as contained in the national policy on public hospital management.^[28] At the same time, the inputs of capable hospital managers must be incorporated in budgets and governance more generally so that the dominance of hierarchies and the formal process can be reduced. This is easy to say but quite difficult to do even with a determined CEO. There is a positive change, but some established ways of carrying out tasks remain: the board remains largely political and the local com-

munity often overlooked. However, change cannot always be dramatic and often requires many iterations to reach all targets. But the change in leadership has had some positive consequences.

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CONFLICTS OF INTEREST DISCLOSURE

The authors declare that they have no conflict of interests.

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