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Understanding Health System Reform: A South African Private Cancer Care Perspective

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Declaration:

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Acknowledgements and dedication

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I am extremely appreciative towards my supervisors; without their direction, guidance and support I would not be in the position to submit my thesis.

To the “Adams family”- you are my reason for being my purpose. Because of you, I strive to be a better version of myself and a better human being.

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Abstract

The major goal of the health system reform taking place in South Africa (SA) is to offer universal healthcare coverage (UHC) for all South African citizens through the establishment of National Health Insurance (NHI) incorporating an NHI Fund. To achieve this, SA underwent a major healthcare reform, with the SA healthcare system facing significant changes, including effecting the NHI Fund as the mandatory mechanism for the procurement of healthcare services.

In response, the private cancer healthcare organisation (HCO) in SA is maintaining the status quo by means of inertia. This is an ineffective response, as the organisation will not qualify to participate as a cancer care provider to the NHI Fund in future.

Applying an interpretivist philosophy, this qualitative based action-orientated study investigated the sources of inertia which are creating barriers to reform adaption. It applied a multi-level framework incorporating the micro-meso-macro levels and used multiple research data collection methods—including a series of semi-structured interviews, a research group, documentary and artefact examination, and a market analysis—to generate actionable and practical knowledge from all three levels.

Based on the premise of learning from practice, the outcomes, and learnings from research Cycle (1) informed broadening the research study to include Cycle (2), the meso-level, and Cycle (3), the macro-level of the private cancer care system in SA. Its ultimate aim was to investigate if the status quo is valid across all three levels, and if the sources of inertia at the meso and macro levels shape the response to reform.

Outcomes from Cycle (1), the micro-level inquiry, identified organisational rigidity as a source of the inertia, characterised by routine rigidity and resource rigidity, and underpinned by psychological inertia, insight inertia, action inertia. Outcomes from research Cycle (2), the meso-level inquiry, identified the challenges of the wider private cancer care system are sources of inertia including fragmentation, intransigence of business models and indecipherable structures and systems underpinned by threat perception. Lastly, outcomes from research Cycle (3), the macro-level inquiry, identified the complexity of healthcare and healthcare reform as sources of inertia, here characterised by dysfunction, polarisation, and socioeconomic factors.

By harnessing these valuable study findings, recommendations for action are presented. These include improving organisational learning and flexibility, creating value for private cancer care services, and a collective leadership approach to enable adaption to reform.

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List of acronyms

AR	Action Research
ARM	Alternative Reimbursement Model
BHF	Board of Healthcare Funders
CAS	Complex Adaptive System
CEO	Chief Executive Officer
CFIR	Consolidated Framework for Implementation Research
DBA	Doctor of Business Administration
DPME	The Department of Planning, Monitoring & Evaluation
DOH	Department of Health
DR.	Doctor
FFS	Fee for Services
GDP	Gross Domestic Product
HCO	Healthcare Organisation
HealthCo Exec	Healthcare Company Executive
HR	Human Resource/s
MD	Managing Director
MSA	Medical Schemes Act
MSE	Multi-Stakeholder Engagements
NHA	National Health Act
NHI	National Health Insurance
NPO	Non-Profit Organisation
OCF	Organisational Change Framework
RQ	Research Question
SA	South Africa
SAOC	South African Oncology Consortium
SEF	Social Ecological Framework
UHC	Universal Healthcare



VBHC

Value Based Health Care

SEP

Single Exit Price

CFO

Chief Financial Officer

1 Introduction

1.1 Introduction


Drawing on the researcher's experience and leadership role within the private cancer care and healthcare landscape in SA, this research study takes place within the wider context whereby private cancer care is facing healthcare policy reform in SA. As an action-research-orientated project taking place in the researcher's practice, the study focused on constructing knowledge and learning which is useful to practice—and specifically to the problem identified—whilst also focusing on the learning taking place for the practitioner-researcher (Ramsey, 2014).

The cancer incidence in SA continues to grow, with over 100,000 new cases per year, according to the Globocan Report (Bray et al., 2018). Cancer care treatment takes place within the two-tiered healthcare system in SA, with treatment for cancer provided in the public sector for 82% of the population (funded by the state's resources) and in the private sector for 18% of the population, mostly funded by medical insurance. The reforms to healthcare policy have changed the cancer care landscape significantly, in particular with the establishment of the NHI. The NHI Fund has a mandatory purchasing function, encompassing strategic purchasing by contracting out services to qualifying healthcare providers.¹ Medical insurance will therefore not be the payer for private cancer care services according to the NHI Bill (2019). In addition, the policy reform has designated high-priority areas, of which cancer care is one.

Faced with this reform of healthcare policy, the private cancer HCO, which has a network of oncology centres offering radiotherapy treatment and chemotherapy across SA, is responding by maintaining the status quo by means of inertia. This is an ineffective response: the consequence of inertia is the threat of organisational failure—in this case, as they may not then be eligible to qualify as a health care service provider to the NHI Fund. By including the views and experience of the agents across the cancer care system, the aspiration of the practitioner-researcher and as manager was to bridge the gap between theory and practice. We sought to identify the sources of inertia and, with this knowledge construction and learning, limit the sources of inertia as existential threats for organisational failure.

The research initially commenced as a micro-level inquiry with the insider researcher immersed and engaged in generating knowledge, seeking to understand why the private

¹ "Health care service provider" is defined in the NHI Bill (2019) and National Health Act (NHA) as a "natural or juristic person in the public or private sector providing health services in terms of law".



cancer HCO is maintaining the status quo by means of inertia despite this threat of organisational failure. Informed by the micro-level learnings, the research study then evolved into a multi-level inquiry employing a framework and constructing knowledge at the micro, meso and macro levels of private cancer care in SA.

By first engaging with participants in Cycle (1) with a genuine and authentic approach to learn, rather than espouse the researcher's ideas, solutions and strategies based on past experiences and assumptions and using positional power as an executive manager, the researcher instead followed a Mode 2 learning approach (Argyris et al., 1985). Based on the outcomes of research Cycle (1), the researcher instead questioned the underlying assumptions and behaviours underpinning organisational inertia by employing two more research cycles: iterative sequences of gathering knowledge, and then using that knowledge to inform learning at the organisational level. Then, based on this dialogue and shared meaning, the researcher then sought to develop recommendations for solutions, in order to limit inertia and identify enablers for adoption.


By employing reflexivity as an attribute of Action Research (AR), the learning was not only limited to the practice environment. The researcher also had “moments of learning” on a personal and professional level, having initially been motivated to take up this role through a higher-level oversight of the wider private cancer care system.

The researcher contributed to practice-learning and the development of organisational knowledge by utilising first-person research, practising reflexivity and using pre-understanding, and also then by employing second-person research—engaging with others in practice to create actionable knowledge (Ramsey, 2014; Coghlan, 2003). The aim of the research was not to generate generalised outcomes, but by engaging in the third person, the researcher extrapolated understanding from the knowledge and theory generated from this practice-centred study and thus also contributed to scholarly knowledge (Coghlan, 2003), more specifically relating to organisational inertia as a means to maintaining the status quo when organisations face change.

1.2 The research context

1.2.1 Healthcare reform and reform of healthcare policy in SA

At its most basic level, healthcare reform involves several key variables, including but not limited to the country's political framework, socioeconomic circumstances, cultural shifts,



power mobilisation, and resource allocations and reallocations (Rethmeier, 2010). The literature indicates that healthcare reform measures are multi-faceted and multi-variate, encompassing drivers of change to enable transformation of the healthcare system, including through new systems, processes, and measures.

Despite it having been 24 years since democracy was introduced, the SA healthcare system is characterised by a fragmented, dual-healthcare system inherited from the previous apartheid era. Approximately half of the 8.6% of healthcare gross domestic product (GDP) is private sector expenditure (4.2%), for 18% of the population (StatsSA, 2017), while the remaining expenditure (4.4%) is spent in the public sector for 82% of the population (DPME, 2017). Thus, the reform of the healthcare policy in SA is driven by moral and political imperatives to address inequities, irregularities and widening inequality to access affordable and quality healthcare.

As mentioned in the introduction, the NHI Fund will purchase services from both public and private healthcare providers, and by virtue of its size it aims to take advantage of its bargaining power to improve efficiencies and value for money, as well as ensuring geographical and socioeconomic equity in access to healthcare services (White Paper, 2015). At its core, the NHI is a financing system designed to provide access to affordable universal healthcare for all citizens of SA irrespective of their socioeconomic status by contracting with healthcare providers as the mandatory procurer of healthcare services in SA.

The criteria to qualify as a healthcare provider to the NHI include implementing alternative models for the reimbursement of health services and models of care, aligning with the NHI pricing, and demonstrating adherence to the NHI quality protocols, guidelines, and output measures. These reform measures are in stark contrast to the finance mechanisms and reimbursement models established in the mid-1980s, which were characterised by closed funding models based on FFS and paid for by the medical insurer; these were embroiled with issues around lack of transparency and poor innovation.

1.2.2 The NHI implementation phases

Using a linear approach, the SA government and policy makers are implementing reform in three phases (see Figure 1).

- **Phase (1) 2009-2017:** The implementation of several NHI pilot projects, with specific focus on primary care and prevention, and screening specifically for children and

females and cancer care. It includes preparation of the public sector institutions for NHI rollout (improving quality of institutions, and quantity to address access), and establishing an integrated provision platform where the NHI Fund contracts directly with accredited healthcare providers in both the public and private sectors. The NHI has a mandatory purchasing function for strategic purchasing and designated priorities, including contracting with healthcare providers to address backlogs in cancer care (and other high-priority areas);

- **Phase (2) 2018-2022:** Focused on creating enablers for NHI including enabling regulation—for example Amendments to Health Act, Amendments to Medical Schemes Act (MSA)—as well as enlisting NHI participants with a focus on treating vulnerable groups (e.g., women and children, cancer patients focusing on female cancers of breast and cervix) by outsourcing services for these groups of patients to qualifying private and public healthcare providers; and
- **Phase (3) 2023-2026:** Implementation of mandatory NHI tax for all employees and outsourcing and appointing healthcare providers through mandatory contracting of accredited service providers.


Phase 1: Preparation (Year 1 to Year 5)	Phase 2 (Year 6-11)	Phase 3 Implementation
<ul style="list-style-type: none"> • Implement NHI pilots focus on primary care • Prepare public sector facilities for NHI rollout 	<ul style="list-style-type: none"> • Enabling Regulations and policies • Enlisting /outsourcing services to private sector using qualifying criteria and ARM's for payment 	<ul style="list-style-type: none"> • Setting up NHI financing mechanisms such as tax credits abolished . • Contracting for all healthcare services at public and private facilities • Combing dual health system into one system (private sector to serve entire population)

Figure 1: Phases of SA NHI implementation (adapted from NHI, 2019)

1.3 Introduction to the research topic

1.3.1 Healthcare reform as discontinuous change

It is not in the scope of this research study to examine change theory and change models in detail; however, a brief examination of the literature illustrates that change is classified as either continuous or first-order change (characterised by long periods of stability and brief periods of change in which equilibrium is maintained or in contrast discontinuous), or second-order change, which may be considered transformational.




Reform of healthcare policy is an intentional and disruptive process and adaptation aimed at improving access to affordable, quality healthcare involving political and socio-economic frameworks focused on structure, policy, and behaviour change. It often involves implementing new processes and systems. Healthcare reform can be considered as a disruptive innovation according to Christensen (2006) and, as such, reforms in this study are said to be discontinuous change. Gilbert (2005, p.742) defines discontinuous change as “*external change that requires internal adaption*”. The research premise is therefore that healthcare reform can be explained as second-order discontinuous change. The literature review will focus on discontinuous change in the context of healthcare reform.

1.3.2 Organisational inertia

The researcher acknowledges there is a diverse literature and many different perspectives on understanding organisational change, for example: the study of precipitating factors, the interpretive processes involved in change, change implementation and issues relating to change, constraints, and restraints and second- and first-order change. Rather than frame the problem identified within the theories of change management, the researcher used the research opportunity both for addressing the problem identified and for learning: a combination of mechanistic and organistic AR approaches. As such, this research study was framed from the premise of understanding organisational inertia as a threat for organisational failure, a critical factor for resistance to change and a barrier to adaptation when facing change (Tsai et al., 2008; Godkin and Allcorn, 2008).

In the introduction, the researcher refers to organisational inertia as a means for maintaining the status quo when faced by change. In the 17th century, Newton defined “inertia as everything stays the same”; similarly in social sciences Starbuck et al. (1978) considered organisational inertia as a stagnant organisation, reflecting stability and certainty in production, products, processes, and policies. Using organisational ecology theory, Singh and Lumsden (1990) introduced the concept of organisational inertia as the organisation, its surrounding environment and phenomena not easily adjusting in the face of environmental change. In this description, the researcher notes that the authors refer to a multi-level construct when discussing organisations facing change.

The researcher concluded from the initial scanning of the literature that organisational inertia occurs due to engrained habits and behaviours developed over time from past experiences



and biases limiting actions when faced with external change; this thus creates stability and certainty, in other words selective organisational inertia offers benefits to the organisation, however in contrast inertia can also be suppressive by limiting action and creating inflexibility and thus a threat for organisational failure for some organisations which may need to adapt to external change (Boyer and Robert, 2006).

Chapter 3.3 explores the sources of inertia found in the studies and the literature. In summary, according to Gilbert (2005), there are two types of organisational inertia: resource rigidity, characterised by inflexibility of resource strategies; and routine rigidity, characterised by inflexibility of organisational routines, processes and structure when faced with external change. Other types of inertia impacting the response to change and thus relevant to the study include threat perception, with characteristics described in psychological inertia of fear and uncertainty leading to the tendency of those impacted by the reform to revert to the status quo. We must also recognise there are numerous interwoven factors influencing behaviour and thus organisational inertia such as leadership, culture, mental models, and organisational learning (Godkin and Allcorn, 2008).

1.3.3 Multi-level inquiry framework

Learning from the outcomes of research Cycle (1), the researcher recognised meanings are generated from multi-loci across the cancer care system; there are linkages, interconnectedness, and interdependencies which influence the response to healthcare reform faced by the private cancer care system. The study applied a multi-level framework to the private cancer care system in SA, adapted from several multi-level frameworks found in the existing literature and research (as discussed in Chapter 3.1). The framework enhanced sensemaking and understanding of the underlying mechanisms in the cancer care system to uncover the properties and characteristics of the private cancer system, exploring the relationships and interdependencies among agents and elements of the cancer system. It then went on to identify the drivers and behaviours influencing the response to healthcare reform, the sources of organisational inertia, as well as barriers and enablers of reform adaption.

The proposed multi-level framework includes three levels of the cancer care construct. At the micro-level is the cancer care provision including the patient and private cancer HCO; the meso-level includes the institutional infrastructure and resources of the wider cancer care network in SA; and lastly the environmental level—the macro-level—including the regulatory, policy framework and payors.

1.4 The research problem

As mentioned above, the regulatory changes in SA healthcare are a catalyst for structural, process and other changes to the cancer care system in SA. In the face of this discontinuous change faced by the cancer HCO, the organisation is continuing on the same trajectory, maintaining the status quo by means of inertia, in spite of the threat of failure. As a practitioner, senior manager, and insider researcher it was thus an imperative to identify the sources of inertia, understand how these are creating barriers to adaption and use the knowledge generated. This would help inform actions and interventions required as enablers of reform adaption, ultimately to avoid organisational failure whilst simultaneously improving learning.

The research initially considered the research problem in the construct of the cancer HCO facing reform, however a combination of the pre-phase problem framing together with the outcomes of research Cycle (1) and review of the literature helped the researcher to identify two very important elements which shaped the research study, namely: 1) micro-level research is used in reductionist and mechanistic healthcare research studies (Martin and Félix-Bortolotti, 2014) ; Sturmberg et al., 2014); and 2) the problem is taking place within a multi-level construct of the cancer care system, with the interconnectedness and interactions between the levels and agents influencing each other.

As such, the study moved beyond the boundaries of the cancer HCO and evolved to a multi-level inquiry involving the micro, meso and macro levels of the private cancer care system to understand the properties of the whole system and reveal why there is a bias towards the status quo by means of inertia despite the threat to organisational survival. The study therefore examined the relationships, interactions, interdependency, and interconnectedness among these multiple levels, to identify sources of inertia and generate knowledge for learning, and from these learnings to generate recommendations and enablers of adaption and change.

Research Problem: The private cancer care system in SA is maintaining the status quo by means of inertia despite the threats this causes. This is an ineffective response as they will not be eligible to qualify as a health care service provider to the NHI, and as such risk organisational failure.

Research Question: Why, despite the threat of organisational failure, is private cancer care in SA maintaining the status quo by means of inertia?

1.5 Research objectives

- **Micro-level:**

RQ 1: What are the sources of inertia at the organisational level, and how are these influencing the response to healthcare reform and reform adaption by the cancer HCO?

- **Meso-level:**

RQ 2: Does the status quo hold valid across the wider cancer care system, and what are the sources of inertia which shape the response to healthcare reform?

- **Macro-level:**

RQ 3: Does the complex nature of healthcare reform and the associated complexity influence the response to and adaption in light of healthcare reform?

- **Learning in practice**


From the knowledge generated, what recommendations can be made to address the barriers to reform adaption and identify enablers for adaption?

1.6 The researcher

1.6.1 The role of the researcher

The present researcher has extensive experience of the private cancer care and healthcare system in SA (as noted in the introduction) at a senior level. By employing an AR orientation, the research study draws on this experience with the intention of improving organisational learning, and of generating knowledge useful to the organisation and its context (the multi-level cancer care construct) faced with discontinuous changes triggered by healthcare reform. The intention included development of the practitioner-researcher (discussed in more detail in the reflections of Chapter 6).

The study commenced at the micro-level of the private cancer HCO. As an insider researcher with access to a wide community within and outside the organisation, the researcher was able to generate useful knowledge about how the organisation, its agents and surrounding environment experience the current healthcare reform and its measures. The research focused on understanding the behaviour, assumptions, norms, beliefs, values, and other factors influencing the selective inertia as a response to reform by the organisation.




The outcome of this AR-orientated study also led to development of the researcher. Undertaking AR in the researcher's own practice was done with the intention of remaining within the practice context (Adler and Adler, 1987, cited by Coghlan and Brannick, 2005) and as the study expanded to include the wider cancer care construct, so the researcher evolved and thus moved into a new role within the wider cancer practice environment. Moving to this new role, the researcher was able to leverage the current study and continue to add value as an insider researcher, generating knowledge and contributing to learning across the levels of the cancer care system.

As seen above, the researcher was therefore deeply immersed in the research study, even more so because of the multi-level construct used to frame the study and for analysis of the study findings. At a micro-level, the researcher's experience and extensive knowledge led to an understanding of the "way things work," both at the cancer HCO and at its main shareholder, the HealthCo, as well as understanding the business model, routines, structures, and processes. As an insider researcher the researcher has knowledge of the components, elements and agents and organisations within the wider cancer care market and held well-established and long-standing relationships with the agents at the organisation, in the wider cancer care network, at the HealthCo, and at the macro-level. At both the micro-level and meso-level, the researcher had awareness of the organisational structure, politics, and power.

The researcher was able to gain access to participant interviewees, as well as approval and access to organisational and market artefacts and documents. In conducting the market analysis, the researcher's knowledge and experience was helpful in selecting what to include relevant to the study. The above also demonstrates not only how deeply the researcher was immersed at two levels of the cancer care multi-level construct, but also the thorough preunderstanding of the micro- and meso-levels. This pre-understanding has various advantages, some mentioned above, including access to peers in the system, already having a level of trust due to a well-established reputation and history within the industry, as well as access to documents and artefacts to name a few.

To address role duality—a disadvantage of pre-understanding—the researcher had to be very clear about the research role during participant interviews and use reflexivity to address bias which may skew the research findings (Coghlan and Brannick, 2014, and Coghlan et al., 2014). Chapter 6 discusses the researcher's reflexivity journey in more detail.

1.7 Study approach



Having clarified the research problem and thus constructed the research questions (RQ), and developed the aims and objectives of the study, the researcher applied the “research onion” metaphor developed by Saunders et al. (2009) as a framework for designing the research study. This is discussed in chapter 2 in depth.

1.7.1 Philosophical stance

In considering the layers of the research design which inform the data collection and interpretation, and considering the researcher’s own belief system, an interpretivist stance grounded in constructivism was identified by the researcher as the most appropriate philosophical stance for the study. An interpretivist paradigm considers the study of phenomena in their natural environment and constructivism is socially constructed: as such it supports the emergence of stories from data collection and, in this case, created practical knowledge across the multi-level private cancer care system (Creswell, 2013).


1.7.2 Qualitative methodology

Healthcare research, research of HCOs and research of healthcare systems commonly apply a traditional research approach based on Newtonian understandings of organisations, with many empirical studies viewing healthcare and reform as mechanistic systems, and therefore applying a reductionist, single-discipline, micro-level research (Sturmberg et al., 2014).

When the researcher evaluated the most appropriate methodology for examining the experiences and behaviours of agents, a non-reductionist approach was identified as the preferred approach. A non-reductionist qualitative study approach focuses the study on exploring and capturing the complexities and revealing the interactions in the cancer care system and their consequences to the system facing reform and influencing the researched organisations’ response to reform (Leykum et al., 2014; Sturmberg et al., 2014).

1.7.3 Action research

Considering the study takes place in the researcher’s practice with the aim of learning in practice, the philosophical stance—the non-reductionist research approach—of this research study was best suited to using a qualitative methodology based on an action research orientation incorporating AR cycles to enable feedback that will generate knowledge,



contribute to a learning organisation, and create recommendations for action at the researched organisation.

Collection of data involved gathering data from the private cancer HCO and the ecosystem it operates in, as well as the agents and organisations across the wider cancer care ecosystem by using semi-structured interviews together with documentary examination and analysis of the SA cancer care market. The AR study involved three AR cycles, with: Cycle (1) at the micro-level generating learning and knowledge from the private HCO and its agents; Cycle (2), the meso-level inquiry, involving the wider cancer care institutional level; and Cycle (3) a macro-level inquiry to understand the complexity of the environmental level including the regulatory and policy framework. The outcomes from the three cycles of inquiry generated knowledge iteratively, learning and informing recommendations for actions and interventions, while also developing the researcher.


1.8 Thesis structure

Chapter 1: Introduction

This chapter presents the context of the private cancer care system facing reform of health policy in SA, an overview of the healthcare reform taking place, the research problem identified, the purpose of the research and in turn, the research question. In addition, this chapter summarises the literature and alludes to the research framework developed for the multi-level construct of the cancer care system involving the micro, meso and macro levels, in order to understand the sources of inertia shaping the response to reform. The research study design, including the philosophical stance, and qualitative-based methodology utilise AR as a method to generate an understanding of the sources of inertia and elucidate barriers to adaption. The chapter discusses the researcher's background and role in the research study.

Chapter 2: Methodology

This chapter defends the choice of philosophical stance based on the researcher's belief system and presents the research design using the research onion model designed by Saunders et al. (2009). This encompasses the philosophical paradigm, the approach to theory development, the qualitative methodology used and action research method, and details the data collection and data analysis approach including sampling, participant selection and



recruitment, ethical considerations, and data interpretation approach. It concludes with a chapter summary.

Chapter 3: Literature review

Chapter 3 is the literature review, commencing with the theoretical approach used, namely the multi-level framework involving the micro, meso and macro levels. The literature review then examines the sources of organisational inertia and identifies resource and routine rigidity, threat perception, and action and insight inertia as sources of resisting change. The chapter discusses healthcare reform as discontinuous change. Having examined the literature and identified multiple frameworks, the chapter presents the conceptual framework developed by the researcher and lastly concludes with a chapter summary.

Chapter 4: Data collection and findings


This chapter focuses on analysis and discussion of the findings from the data collection process. Data collection methods include interviews, documentary examination, review of artefacts such as reports, documents, media releases, and market analysis. Its findings are categorised into:

- (1) Micro-level: Organisational rigidity due to resource and routine rigidity underpinned by insight inertia, action inertia and psychological inertia are found to be the sources influencing the response to healthcare reform at a micro-level;
- (2) Meso-level: Challenges found in the wider cancer environment involve fragmented services, disjointed business models and loss aversion as sources of inertia;
- (3) Macro-level: Complexity of healthcare reform with socioeconomic factors, together with dysfunction, distrust and polarisation are identified as sources of inertia.

Chapter 5: Conclusion

Given the outcomes and analysis of these data in Chapter 4, Chapter 5 presents the conclusion of the research study. The chapter discusses the findings from the three AR cycles, at micro, meso and macro levels, and presents recommendations to address the inertia as a means to maintaining the status quo as well as highlighting the enablers for adaption to reform.

Chapter 6: Reflection of the thesis journey



Chapter 6 is the last chapter of the thesis, constituting a reflection of the researcher on the thesis study journey, as well as a reflection of the inquiry journey.

1.9 Chapter summary

Chapter 1 outlines the context and landscape of the private cancer care HCO faced with the external pressure of reform of healthcare policy in SA. By maintaining the status quo, a gap widens between the reform goals and the private cancer HCO response. The objective of this study is to investigate and understand why—despite the need to transform to qualify for the NHI Fund—the response is to revert to the status quo by means of organisational inertia. By applying a multi-level framework, the study aims to understand the sources of the inertia and how these are influencing the response to reform at a micro, meso and macro level. Understanding these sources will enable development of effective strategies for recommendations and, in future, responding more effectively to healthcare reform. As such, this research study provided the opportunity to contribute to both the practice environment and academia.

2 Research design and methodology

2.1 Introduction

Chapter 2 outlines and examines the research design. Applying the metaphor of the “research onion” by Saunders et al. (2009), the research design includes discussing the philosophical position of the research study, the rationale of the research methodology and the research methods used in relation to the research question (RQ). The chapter furthermore describes the process used by the researcher to gather, analyse, and interpret data, to construct actionable and practical knowledge.

In this chapter the AR approach is presented employing three (3) research cycles by drawing on a multi-level construct of the cancer care system in SA. The three research cycles encompass Cycle (1), a micro-level inquiry, Cycle (2), a meso-level inquiry, and Cycle (3), a macro-level inquiry, all to identify the sources of inertia and thus identifying the barriers and enablers of reform adaptation.

To look more deeply at this framework, the system includes: (1) the micro level, the healthcare provision level to identify the elements, behaviours and actions as sources of inertia influencing the response to reform at the cancer HCO; (2) the meso level, the wider cancer care system, to identify the sources of inertia shaping the response to reform; and (3) the macro level, the environmental level involving the regulatory and policy framework, which aims to illuminate sources of inertia influencing the response to healthcare reform. Moreover, it then looks at learning in practice, where the knowledge generated from this multi-level inquiry is used to construct recommendations for effective interventions and actions to support adaptation to reform (discussed in Chapter 5).

2.2 Research design

To demonstrate the elements of the research design while ensuring research rigour, the researcher employed the “research onion” model, a metaphor to elucidate the layers of research design and to illustrate its core elements, according to Saunders et al. (2018). Figure 2 below illustrates the model, showing the outer layer as the philosophical stance. From there, we delve inwards into the theory development and research methodology layers, after which comes the research strategy, and lastly the research method and techniques.

The researcher found the model useful as it supports understanding of the context and philosophical stance underpinning the methodological choices of a research study. Without this understanding, the approach taken to methodology, methods and data collection can be vague and filled with ambiguity, and thus it may not support the research aims so successfully. The researcher commenced the research design process by first examining these outer boundaries of the research design including the research philosophical stance and theory development methods first; as mentioned above, they inform the methodological approach, data collection and analysis techniques (Saunders et al., 2018). Informed by these choices, the data collection and analysis techniques and procedures are then examined and presented.

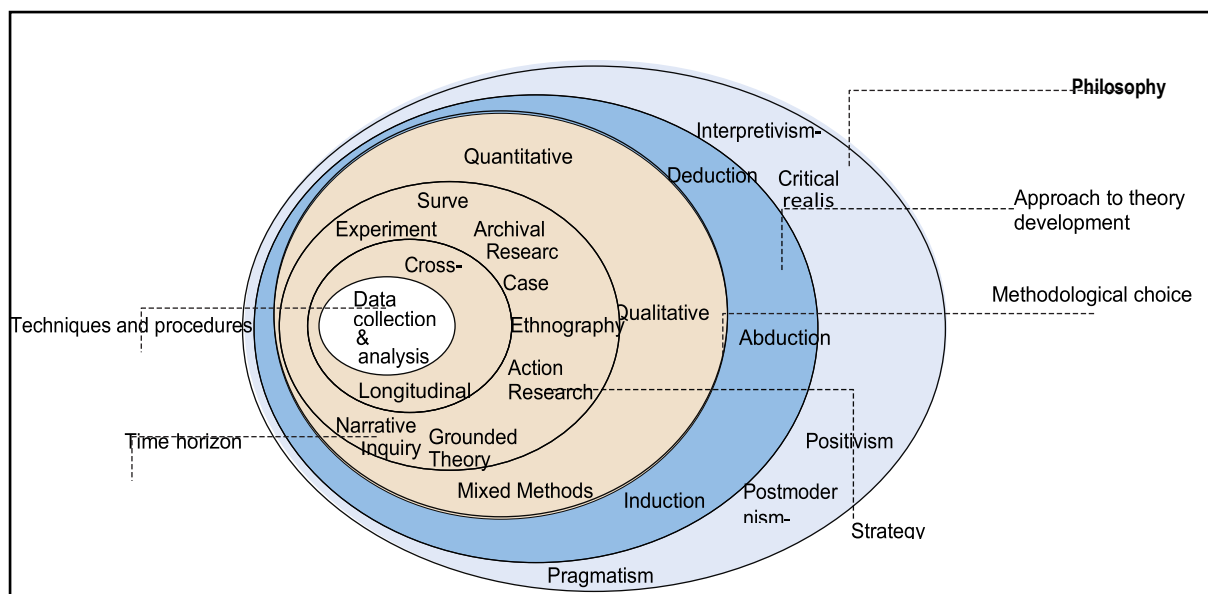



Figure 2: The research onion (adapted from Saunders and Tosey, 2012)

2.3 Assumptions influencing the research philosophical position.

Understanding the philosophical roots and epistemological foundations which underscore and motivate this research study provided the assumptive base from which to generate knowledge; they shape the study problem and research questions and help formulate the methodology used in this research (Broom and Willis, 2007). The philosophical assumptions inform the nature of the world and how we come to know certain things about the world, according to Kawulich (2012). Bearing the above in mind, as well as the RQ and acknowledging that the researcher’s own world view influences the philosophical stance, the researcher thus dedicated time to understanding and examining these assumptions and how they inform the study—including how they will shape the research questions, methodology, methods and data collection and interpretation.



To understand this, the researcher's approach was to first distinguish the research philosophical paradigms in a general sense and then more specifically in the context of this research study. This includes examining the ontology, epistemology, and axiology, as discussed in sections 2.3.1, 2.3.2, 2.3.3, and section 2.4.

The researcher first set about better understanding what is meant by research philosophy. Saunders et al. (2009) describe the research philosophy as the development and nature of knowledge while similarly, Schwandt (2001, pp.183-184) defines research philosophy as: *“a shared worldview that represents the beliefs and values in a discipline and that guides how problems are solved”*. This definition by Schwandt (2001) resonates with the researcher; it not only brings clarity on what the meaning of a research philosophy is but also emphasises the “action” element of developing knowledge which is relevant in a study based on an AR orientation.

One of the most important learnings for the researcher was in Chapter 4 of Saunders et al. (2009, p.133), which distinguishes ontology and epistemology clearly: *“ontology refers to the assumptions about the nature of reality and epistemology refers to assumptions about knowledge and what constitutes legitimate knowledge and how it is communicated to others”*.

As will be discussed in Chapter 6 in more detail, despite having participated in research studies, the researcher had not previously spent much time examining and reflecting on the researcher's position and beliefs on how knowledge is constructed. As such, following the research onion metaphor and the recommendations by Saunders et al. (2009) was extremely useful for learning and structuring this chapter 2. The researcher therefore set about examining the ontology, epistemology, and axiology of research in section 2.3.1 to 2.3.3.

2.3.1 Ontology

When exploring the researcher's own view of the nature and structure of reality and how the world operates, the researcher took a step back and reviewed the literature, in order to understand the characteristics that shape the nature of existence, the structure of reality and the way the world operates (Snape and Spence, 2003). When reflecting on ontology, the researcher considered the study aims, the RQ and objectives. As an action-orientated study focused more on learning from others, the intent was not to keep distant from the context, but rather to be immersed in it. This involved engaging in dialogue with others across the multi-level cancer care framework to learn and understand how they experience the discontinuous

change triggered by healthcare reform, and to build a narrative of the sources influencing the response to reform by individuals and the organisation.

By examining the literature on research design and methods, the researcher identified two assumptions associated with ontology of research, the first being subjectivism, a view which assumes that social reality is experienced and alternatively objectivism which assumes social reality exists independently of the researcher (Saunders et al., 2018). In addition, the nature of the AR study incorporating research cycles required that the researcher take a position on how truth and facts are created, and what will be most appropriate for the study, the practice environment and for learning in action.

As such the researcher examined the expanded definition of ontology, looking at the four different ontology positions delineated in natural science philosophy, between realism and internal realism, and in social science philosophy, between relativism and nominalism, as explained by Easterby-Smith et al. (2012). A table from Easterby-Smith et al. (2012, p.19) illustrates these ontology positions, and was helpful to the researcher in positioning the ontological approach for this research study.

Ontology	Realism	Internal Realism	Relativism	Nominalism
Truth	Single Truth	Truth exists but obscure	Truths are many truths	There is no truth
Facts	Facts exist and can be revealed	Facts are concrete, but cannot be accessed directly	Facts depend on viewpoint of observer	Facts are human creation

Figure 3: Ontology position adapted from Easterby-Smith et al. (2012)

Having explored and gained an understanding of ontology and its relevance to this research study design and approach, the ontology assumption made by the researcher is based on a relativist subjectivist view, interested more in the behaviour of people than in observing and predicting outcomes, as in a realist objectivist ontology.

Rather than taken a nominalist extreme, the researcher’s approach to the study and learning was to engage and interact with the agents across the multi-levels of the cancer care system with the aim of creating shared meanings and multiple realities. This approach aligned not only with the AR orientation, but with the narrative and discourse of the reform taking place; very rich in debate, this approach helped to uncover deeper understandings and perspectives of the reform and thus the sources of inertia. As such, the researcher took a social constructivist position.

2.3.2 Epistemology

As briefly described above, the epistemological position is concerned with the nature and structure of knowledge and the assumptions of how knowledge is acquired, as well as the validity and legitimacy of the knowledge and how this knowledge is communicated (Creswell, 2013; Burrell and Morgan, 2017). As a social science project, the researcher considered two contrasting epistemological views based on the assumptions of how research should be conducted. The positivist epistemology assumption uses a linear, reductionist approach based on the belief that reality exists independent of our beliefs and understanding of the world and should therefore be observed objectively to reveal findings. Its roots can be traced back to Plato, according to Aliyu et al. (2014).

Based on theory and empirical facts, a positivist approach to research encompasses a single reality that is both context- and value-free, with the researcher remaining distant and objectively observing the phenomena under investigation. Quantitative methodologies are employed to detect causal mechanisms through a deductive process of hypothesis testing. In contrast, an interpretivist-based research philosophy is a dominant paradigm used in qualitative research; it is not only concerned with understanding various parts of a whole but at its core is about obtaining a holistic understanding of the area under study by allowing subjective and shared meanings to emerge, according to Goldkuhl (2012).

The interpretivist paradigm is associated with a subjective-based inquiry of human behaviour within natural settings, with the social phenomena in this inquiry encompassing multiple realities and multiple stories. Here, the view of the world is socially constructed, with data generated and analysed inductively using qualitative methodologies to allow shared meanings and thus a more holistic understanding to emerge. It is also worth discussing pragmatism, a research philosophy which holds the belief there is no one viewpoint but multiple realities, with a research design that enables the generation of credible, reliable, and relevant data for action, according to Saunders and Tosey (2012).

With the above supporting a more informed approach to decision-making on the research approach, the researcher then reflected and considered the study aims, the context, the researcher's own view of the world and nature of knowledge, including how data is collected and interpreted. The researcher identified that an epistemology of practice is more reflective of this study's approach. It is focused on a qualitative methodology that enables gaining rich insights from people to construct meanings (Saunders and Tosey, 2012) and thus enhances understanding of the how and importantly the why, while also leveraging from practice-as-learning (Ramsey, 2014).

2.3.3 Axiology

Axiology considers the values and ethics of the research study, reflected both in the research topic and in the context (in this study, the private cancer care services in SA), as well as in the choice of data collection methods, for example, using face-to-face interviews or surveys (Saunders et al., 2009). As an insider researcher, one of the axiological choices considered was the extent of the researcher's own values and beliefs on the research study. The researcher honed the skills of axiology and reflexivity (discussed in more depth in Chapter 6) by consistently questioning the researcher's own beliefs, values and thinking during the research study. The topic selection reflects a decision based on the belief and motivation to be an active participant as a health executive, a citizen of the country and a scholar in championing better access to quality care for cancer patients, and to ensure that providers of health are sustainable and successful in achieving this goal.

The above discussion clarifies the assumptions made about human knowledge and the nature of reality, and this shapes the RQ and research design. However, according to Saunders and Tosey (2012), the main influence is on the researcher's own philosophy. The authors argue there are two main extremes in relation to the three assumptions, namely objectivism, which is more likely to reflect a positivist philosophy, and subjectivism, which is more likely to reflect an interpretivist philosophy. Chapter 2.4 discusses the philosophical paradigm of the research, both in general and more specific to this research study.

2.4 Philosophical paradigm

When considering the most appropriate philosophical stance, the researcher kept in mind the research context and RQ, as well as the approach used by healthcare research studies in the literature.

Policy reforms within healthcare and healthcare systems are constructed through human behaviour and interpretation and do not exist independently; they are derived from political decision-making. Furthermore, the routines found in healthcare result from the relationships and interactions of the agents engaged in, managing, delivering, and accessing healthcare throughout all the levels of the system, according to Gilson et al., (2011), i.e., at the micro, meso, and macro levels of the healthcare system.

The researcher also scanned the literature and found that healthcare research commonly uses a reductionist approach employing an objectivism ontology, based on positivist-type paradigms (Aliyu et al., 2014). Described by many authors, for example Aliyu et al. (2014), Gilson et al. (2011), Snape and Spencer (2003) and Yin (2012), the positivist paradigm follows a similar position as approaches used in the natural and physical sciences for clinical, biomedical research.

However, the aims and approach of the study are more aligned to a subjectivist ontology. The researcher was seeking to engage with the participants, using questions which are broad and general, to allow the research interview participants to construct meaning from the “situation” (Creswell, 2013). The situation, in this context, is the healthcare reform including the NHI, its measures and terms, and in turn its implications and impact.

A diagram by Gilson et al. (2011, p3) demonstrates the core differences in the paradigms and as such helped the researcher gain a better understanding of these philosophical stances to consider. See Figure 4.

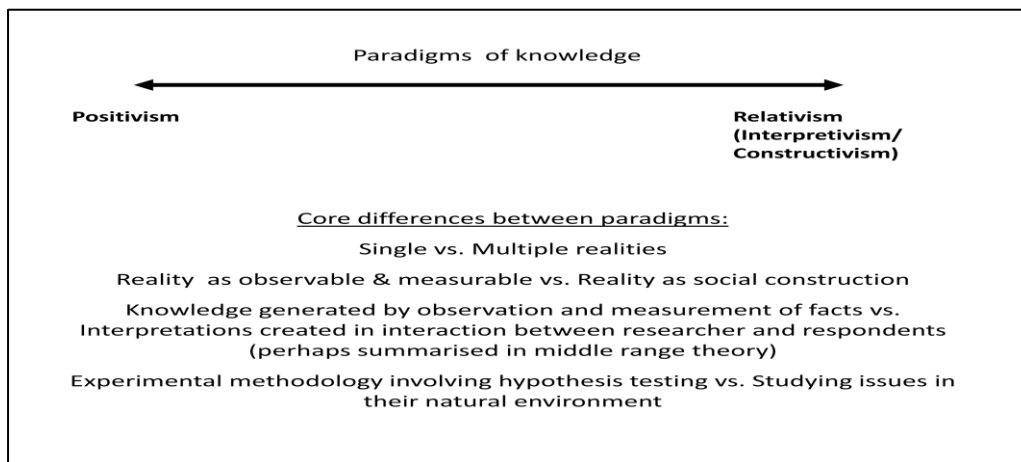



Figure 4: Core differences between research paradigms (Gilson et al., 2011, p3)

Taking the above into consideration, the researcher has framed the philosophical stance of this research study as interpretivist grounded in a social constructivist paradigm (Crabtree et al., 2001, Creswell, 2013). The social constructivist paradigm also recognises the role of the researcher in the research context (Creswell, 2013) and supports the action research orientation of the study, with authors such as Vidgen (1999) and Mårtensson and Lee (2004) demonstrating an affinity between the social constructivist/interpretivist philosophical stance with action research approach.



Selecting an interpretivist social constructivism philosophical stance provided the foundation required to explore, collect data from agents across multi-levels of the cancer care framework at the micro, meso and macro levels, and by analysing the data collected by engaging with others across the holistic whole of the cancer care system, all in order to understand the elements influencing the response to and adaption of reform.

2.5 Development of theory

The approach taken to reasoning and sensemaking of the data collection and interpretation of its findings is more thoroughly discussed later in Chapter 2. However, following the metaphor of the research onion in designing this research study, the next “layer” involved the understanding of the nature of the theory development. While considering the RQ, the AR and qualitative orientation of the study, as well as the philosophical stance adopted, the researcher considered the most appropriate method for sensemaking and reasoning by interrogating the best strategies to achieve optimal conceptualisation and analysis of the data.

Two contrasting approaches to theory development are apparent in the literature (Easterby-Smith et al., 2008; Saunders et al., 2009; Creswell, 2013), namely deductive logic and inductive logic. Deductive logic is characterised by deducing a hypothesis to explain causal relationships between variables, involves controls for testing and applies objectivity and quantitative research methodology (Easterby-Smith et al., 2008, and Saunders et al., 2009).

By contrast, inductive logic is characterised by theory building in which the researcher considers the way humans build their world, allowing for the possibility of alternative explanations to what is going on, rumination on the context of events, and using qualitative methodology with a variety of data collection methods (Creswell, 2013; Saunders et al., 2009).

A third approach is adopting an abductive logic to theory development and reasoning which, according to Saunders and Tosey (2012) , involves collection and interpretation of data to explore a phenomenon, identify themes and explain patterns. Figure 4 below illustrates all three approaches

	Deduction	Induction	Abduction
Logic	In a deductive inference, when the premises are true, the conclusion must also be true	In an inductive inference, known premises are used to generate untested conclusions	In an abductive inference, known premises are used to generate testable conclusions
Generalisability	Generalising from the general to the specific	Generalising from the specific to the general	Generalising from the interactions between the specific and the general
Use of data	Data collection is used to evaluate propositions or hypotheses related to an existing theory	Data collection is used to explore a phenomenon, identify themes and patterns and create a conceptual framework	Data collection is used to explore a phenomenon, identify themes and patterns, locate these in a conceptual framework and test this through subsequent data collection and so forth
Theory	Theory falsification or verification	Theory generation and building	Theory generation or modification; incorporating existing theory where appropriate, to build new theory or modify existing theory


Figure 5: Theory development approaches by Creswell (2013)

In considering the correct approach to take, the researcher draws on empirically based knowledge. For example, authors such as Morrison (2012) suggest that the interpretive approach to data involves a deductive logic, whereas authors Best and Kahn,(2006) and Creswell (2013) suggest data interpretation involves both inductive and deductive logic to establish patterns or themes. Braun and Clark (2019) and Saunders et al. (2009) highlight that those two contrasting orientations exist; with the inductive process, the coding commences from the data rather than from existing concepts or theories, whereas the deductive process commences from pre-determined concepts, ideas, and theorising.

The researcher was able to establish that the study suited an inductive approach to theory development with the research process involving data collection using a triangulation of methods and sources to explore a phenomenon, identify themes, and explain patterns, ultimately to generate understanding of the phenomena occurring.

2.6 Qualitative methodology

Following the Saunders et al. (2009) research onion model, the next research design decision for the researcher was to consider the research methodology approach. These include whether the research will follow a quantitative, qualitative, or mixed methods methodology. The researcher explored all three, as discussed below.




The basic tenets, distinguishing characteristics and nature of qualitative methodology are that it involves a process of elaborative interpretative practices, using the researcher as the instrument to collect large amounts of data within a natural setting, utilising a variety of methods including field notes, interviews and research interviews, artefacts, etc. This aims to reveal the perspectives of the participants, and their subjective meanings, by using an inductive analysis to find patterns and themes and thus revealing a holistic, complex view of the context and the research problem, while at the same time supporting an action and transformation orientation and encouraging reflexivity of the researcher (Creswell, 2013; Pope and Mays, 2006).

Furthermore, a qualitative-based approach is premised on the understanding that multiple realities will emerge reflecting the agents' varied and diverse understandings of the research problem. Moreover, the tradition of qualitative research embraces the concept of not only identifying and reporting research findings, but also thorough analysis and interpretation. According to Pope et al. (2006), qualitative research involves sequential analysis and interim analysis, providing the researcher with the advantage of allowing an analytical process to begin during data collection which helps to drive understanding and explanation, thereby supporting research rigour. In contrast to qualitative methodology, in quantitative methodology the researcher is independent of the study; social reality is viewed as objective, and it takes a deductive process to theory development.

A mixed method approach utilises a combination of both qualitative and quantitative methodology, according to Creswell (2013). In considering the best methodology approach, the researcher reviewed empirical studies in the literature, focusing on the type of methodologies used, more specifically studies exploring healthcare settings. According to Pope and Mays (2006), qualitative methods are becoming a more popular research method in healthcare settings. The aim was to gain insights from these studies to inform the most suitable research methodological approach.

For example, Gilson et al. (2011), Gilbert (2005), and Wang et al. (2015) utilised qualitative-based methodologies to investigate the implications and impact of reform in the context of HCOs. These studies demonstrated the use of qualitative-based methodology to investigate the complexity of healthcare reform, to explore the intricate relationships between the system components and the agents and their dynamic relationships, and ultimately to study how all this impacts and contributes to the behaviour and in turn actions when facing change triggered by reform.




Furthermore, studies by Glouberman and Zimmerman (2002), Mechanic and McAlpine (2010), and Van Eyk et al. (2001) demonstrate that a qualitative-based methodology in healthcare studies enabled their research to generate knowledge of the everyday realities of the different agents in HCOs and/or healthcare systems, and to understand the different circumstances created by the reform, while at the same time capturing the systemic views and perspectives, which would otherwise not be captured using a quantitative-based methodology and a reductionist approach to the research. The above studies show that qualitative methodology is valuable when researchers are exploring phenomena, striving for new insights into phenomena occurring; it offers rich nuances of the phenomena under inquiry (Bettis et al., 2014).

Taking the nature of the research problem together with the complex and dynamic context described above, the intention of this study was not to enumerate by reducing the factors influencing the response to healthcare reform to statistical measures as in quantitative research approaches, but instead to explore and draw out deeper insights and allow understanding and for explanations to emerge (Yin, 2009). According to Pope and Mays (2006, p5) qualitative methods are increasingly used to answer the “why, what or how” questions.

Deliberating on the best methodology approach to support this research study to achieve the type of insights and understandings envisaged and required as an action research orientated study, and keeping in mind the empirical studies discussed above, a qualitative methodology was selected as most suitable. A qualitative methodology would best support exploring, investigating, and identifying elements and drivers influencing and/or impacting the response to change triggered by the reform; it would also help explain the inertia and thus reveal practical knowledge for action required in the context of an AR-orientated study.

Furthermore, the qualitative methodology is aligned with the constructivist interpretivist philosophical position taken by the researcher and compatible with a realist view of causation, as firstly it recognises that some casual processes can be observed and interpreted directly. Secondly, it supports the value the researcher has placed on explaining the context rather than reducing the context to extraneous variables with the context informing the data collection process. Thirdly, it recognises that mental models, patterns, and structures are real phenomena which influence and/or cause behaviour and bring meaning and intention to how these are interpreted and understood, thereby supporting the research inquiry. And fourthly the qualitative research offers flexibility to the inductive research design and methods used.



In order to demonstrate the authenticity, validity and reliability of the study, and mitigate risks associated with qualitative-based study, the researcher focused on honing the craft required of a qualitative researcher by following recommendations and principles presented by Yin (2005), namely: transparency, a methodical and fastidious approach to data collection and evidence gathering, and cultivating skills and attributes such as listening, questioning and in-depth knowledge of the cancer care context in order to generate readiness conditions.

As alluded to above, listening skills were an imperative, which may at face value seem simple; however, as an insider researcher with much years' knowledge of the context at all three levels of the cancer care context, and as a senior manager/leader in practice where less time is spent on listening and more on dialogue and directing, the researcher worked on improving observation and listening skills rather than verbalising. It was also important to improve questioning methods by improving knowledge of healthcare reform, including conducting a critical literature review of the topic (Yin, 2015). While resilience, perseverance, and ability to perform multiple and parallel tasks are attributes of the researcher's leadership role in practice, the researcher honed and enhanced these skills by practising reflective techniques during the research process, including journaling, and using a study group for reflection.

In addition to the above techniques, the researcher relied on a framework developed by Weinberg (2001) encompassing three questions, namely "what do I see?", "why do things stay the same?", and "why do things change?", throughout the research process. A poorly designed study can lead to inadequate and inappropriate application of the qualitative research and the outcomes of the study. Therefore, guided by recommendations from Pope and Mays (2006) to improve validity of the research, the researcher incorporated key attributes into the research process; see Table 1 below.

Principle	Example
Engagement: drawing on lengthy interviews and research group engagements across multiple levels of the micro, meso and macro levels	Interviews held with participants together with documentary and artefacts examination involving collecting data from the multi-levels of the cancer system construct, i.e., the micro, meso and macro levels.
Use of theory	A conceptual framework was derived from literature based on previous studies of inertia as a response to change and more specifically inertia as a response to facing healthcare reform. Review of empirical studies using qualitative methodology.
Multiple methods	Data collection methods involved multiple methods of interviews, documentary and artefact examination and market analysis.
Multi-level analysis	Recognising the interconnectedness, the study involved data collection and analysis at a multi-level construct: micro, meso and macro levels.
Transparency	Methodical and fastidious data collection process.
Listening skills	Honing listening skills. Listening and relistening to each interview prior to next interview and prior to transcribing to learn and reflect.
Sampling	Use of MSE to identify key stakeholders in the cancer healthcare system.
Triangulation: involved looking for patterns of convergence and divergence	Using coding techniques to identify patterns.
Record of data collection and analysis	Keep record and report of field notes and data collection and analysis.
Reflection	Journaling, study group discussions, and peer group support (regular check-in with a peer study group). As an insider researcher involved in healthcare delivery for many years, these biases were identified in part by listening to initial participant interviews, reflecting on how the researcher conducted and responded during these interviews, and using learnings from these initial interviews for the interviews going forward.

Table 1: Validity attributes of qualitative research

2.7 Action research to problem solving

Persisting with the research onion model to research design by Saunders et al. (2009), the researcher considered the next “layer “of the study’s research design, the research method.

As a DBA study in the scholar-practitioner’s practice, the study employed an AR orientation firmly set within the interpretivist constructivist stance of this research study, postulated on a reflective approach for practice-based learning and action by drawing on field theory (Antwi and Kale, 2014) underpinned by the researcher’s knowledge and depth of pre-understanding of the cancer healthcare system in SA, an important attribute of an AR study (Coughlan and Coughlan, 2002). In applying the iterative cycles of AR, the researcher selected to use the

model adapted from Saunders et al. (2009) and Coughlan and Brannick (2005, see Figure 6), where the authors propose a pre-stage of setting the context and purpose of the problem before entering the cyclical process of diagnosing, planning, acting, and evaluating.

2.7.1 Action research Introduction

As a DBA research study undertaken within the researcher’s own practice, this study was conducted with the premise that gathering and analysis of data embedded in the researcher’s practice context “created knowledge in action” (Coughlan and Coughlan, 2002). The researcher found this to be true by using an AR orientation constructing knowledge and understanding informed decisions and actions taken by the researcher-practitioner.

AR is an emergent development process—one of the common themes found in the AR method demonstrates the use of iterative cycles to explain and report on the activities of an AR based research study. First commencing with context setting and research purpose—a pre-phase—and diagnosis of the problem requiring research, the AR iterative cycles involve (1) a phase of planning, (2) a phase of action involving data collection, (3) a phase of evaluating this data, and (4) a phase of reflection.

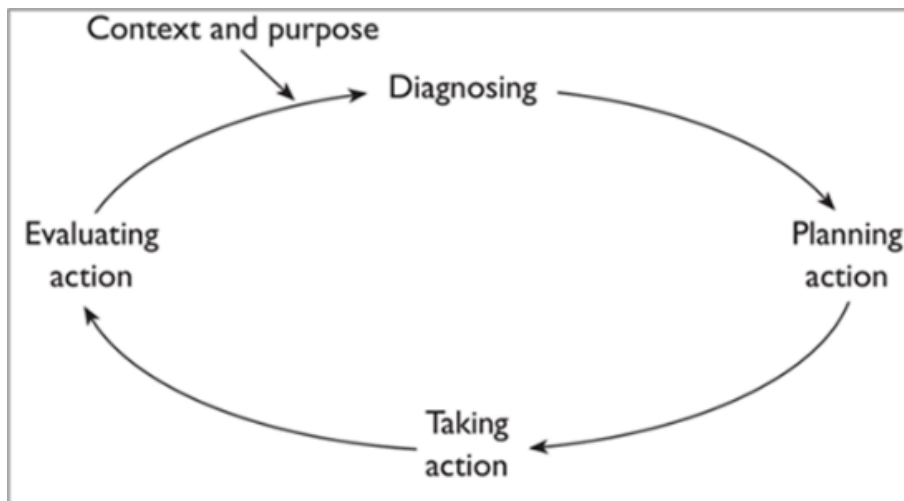



Figure 6: Action-research cycles (Saunders et al., 2009; Coughlan & Coughlan, 2002)

Using the AR method informed a flexible and reflexive data collection and analysis process while also encouraging and supporting reflexive practice (Coughlan,2003). The AR method encouraged the researcher to organise the inquiry findings for learnings to enable development of recommendations for action and change, while also bridging the gap between theory and practice (Baron, 2014; Coughlan, 2003). In practical terms using an AR method was



advantageous to both the researcher's practice as well as the academic community as it contributed to the development of emergent theory within the cancer healthcare system (and wider healthcare systems) faced with change due to reform of healthcare policy (Huxham, 2003). In this context, AR helped to: (1) conceptualise what is happening in the researcher's practice (i.e., inertia as a response to healthcare reform) and the reasons for it; (2) generate actionable knowledge required to address the research problem/RQ (Zuber-Skerrit and Perry, 2002); and (3) draw emergent theoretical insights from the data collected within this research study practice context (Huxham, 2003). With the above being said, their AR also has challenges, more specifically for example, learning to practice engagement in action while also reflecting to contribute to theory (Coughlan and Coughlan, 2002). Chapter 6 discusses the reflexivity practice in more detail.


Initially used for research for social related issues and educational research, AR has increasingly been adopted as an effective research method for organisational learning, facilitating change within organisations and management (Thorpe and Holt, 2007), including healthcare research, for example, research based within the National Health System (NHS) of the United Kingdom (UK). Employing an AR orientation is also advocated by Zuber-Skerrit and Perry (2002) and Revans (1972) as more relevant than traditional research approaches for learning and improvement in practice, as it facilitates problem solving and change through collaborative inquiry and reflection.

Recognising the complexity of the cancer healthcare system, the researcher found AR a useful research method to develop a more holistic view, thus developing a more complete and broader picture of the situation and causes in this case. The researcher extended the AR study by drawing on a scholarship of practice posited by Ramsey (2014, p1) by centring the inquiry on a learning-in-practice approach discussed in more detail in Chapter 2.7.4.

2.7.2 Origins of AR

Although there is some debate of the originator of AR, Kurt Lewin (1951) is commonly acknowledged by authors such as Coughlan and Coughlan (2002) and Bargal (2006) as initially encouraging the use of action-based research methodology for management research to bring about change within organisations.

Lewin (1951) introduced AR to challenge the existing management theories introduced by Taylor in the late 1800s and early 1900s, which exemplified the lack of autonomy but also




challenging so-called “scientific management” by introducing a new methodological approach to studying social problems which involved comparing the conditions of the research field and relating them to various research challenges.

Initially, AR was used as a research method primarily for social issues and educational research, however, authors Argyris and Schön (1978) espoused AR research as a research method for management and organisational studies (Thorpe and Holt, 2007). Given that this inquiry is in healthcare taking place within a healthcare context, the researcher was reassured to find that both Parkin (2009) and Koshy et al. (2011) had demonstrated the effectiveness of using AR to bring about change and improvement in healthcare. Kemmis (1985), Carr and Kemmis (2003), Meyer (2000), Reason and Bradbury (2001) and Bradbury and Reason (2008) also argue that the nature of the AR approach may assist with the hierarchy which exists amongst healthcare professionals and other participants; for example, in this research study between healthcare professionals and management of the cancer HCO, the hierarchy may ordinarily constitute a barrier to the researcher.

2.7.3 Employing AR as a research method

A variety of different action research characteristics has been developed over time, however, for the researcher the definition by Coughlan and Coghlan (2002, p222) summarises AR succinctly: “research in action, rather than research about action; participative; concurrent with action; a sequence of events and an approach to problem-solving”.


The literature shows many themes associated with AR research, but amongst these the researcher found some relevant to this inquiry: firstly, as advocated by several studies (Coghlan and Casey, 2001; Revans, 1972; Zuber-Skerritt and Perry, 2002), the research identified a real-life problem within the researcher’s social context, and by taking action the intention was to find solutions. Secondly, rather than an objective and independent observer based on objectivism, the research-scholar used a subjective, collaborative, and qualitative approach, employing the AR method to address a problem identified in the researcher’s practice, encouraging practiced-centred-learning instead of applying management theory to solve a problem in practice (Ramsey, 2014). Thirdly, as an AR inquiry the researcher employed a cyclical process of identifying, analysing, and redefining the problem, followed by planning, acting, and evaluating (Revans, 1982, 2011; Saunders et al., 2009); the AR cycles are discussed in more detail later in Chapter 2. Fourthly, the outcome of the inquiry may potentially inform other contexts and close the gap between practice and academia.



According to Herr and Anderson (2014, Zuber-Skerritt and Perry (2002) and French (2009), an AR-based inquiry has implications beyond the improvement in practice problem, by allowing all levels within the practice environment to be involved in identifying the problem and developing improvement strategies. More specific to this study context of cancer healthcare faced with change due to reform and responding by maintaining the status quo by means of inertia, the AR method was particularly useful; it helps with creating deep conceptualisations and thus provides an opportunity to use the learnings from the findings to revisit theory and design relevant interventions (Huxham, 2003).

To support the researcher with any uncertainty experienced in using AR, the principles of Coughlan and Coughlan (2002) provided the researcher with a type of guide, clarity, and support. These included following the principles whereby the study is problem-focused, context-specific, participative, and supports organisational improvement and development. These are discussed below in more detail:

- i. **Problem-focused:** The research problem identified is within the researcher's practice environment of private cancer care delivery in SA facing reform of healthcare policy. The research focused on understanding why the response to healthcare reform is to maintain the status quo by means of inertia despite the threat of organisational failure through not being eligible to qualify for participating in the NHI. More specifically, it seeks to understand reasons for this inertia at a micro, meso and macro level of the private cancer care system in SA to generate practical knowledge for action.
- ii. **Context-specific:** The study was conducted within the scholar-practitioner's professional context employing a multi-level construct involving collecting data at the micro, meso and macro levels of the private cancer care system in SA.
- iii. **Participative:** The research study included individual participants and a research group across three layers of the cancer care system, including within a cancer HCO at the micro-level, the wider cancer care network structure at the meso-level and the environmental level considering the complexity of the healthcare regulation and policy reform found at the macro-level.
- iv. **Supports organisational learning:** Through the process of AR the outcomes of the findings generated learnings first at the micro-level of the organisation. However, learnings from outcomes in Cycle (1) led to broadening of the study to include the wider cancer care network level and the regulatory and health policy framework environment level. Thus, because of using an AR approach based on learning in practice, the study evolved to generate learnings across the multiple levels of the cancer care ecosystem



to facilitate change and improvement for practice. In addition, there was improvement in learning and reflective practice for the researcher with learning also contributing to the academic community.

2.7.4 Learning in practice

Given the AR orientation of the DBA study, the research objectives, and the researcher's aim to construct knowledge from learning in practice instead of using theory for sensemaking, the study adopted a practice-centred learning approach (Ramsey, 2014), or alternatively called learning-by-doing (Zuber-Skerritt and Fletcher, 2007), to generate theory and practical knowledge. This involved the researcher employing a more intentional approach during the research study by centring the inquiry. It enables the "location" of the problem by distinguishing the observed condition, i.e., inertia as a response discontinuous change (healthcare reform) despite threat of incumbent failure from the desired state, hopefully to lead to transformation of the current orientation (inertia) to where the private cancer HCO qualifies to participate in the NHI Fund.


In addition, the researcher came to understand and practically employ the epistemology of practice underpinned by intentionally making judgement and deciding what to do next (Beckett and Hager, 2000).

By identifying the sources of inertia, the study aimed to find solution(s) that will narrow the gap between what is, and then the desired state (Rittel and Webber, 1973). Additionally, the planning phase also included locating the problem within a theoretical framework conceptualised from theory based in the literature, to support sensemaking and action planning (Coghlan and Brannick, 2005).

2.7.5 Moments of inquiry

Before presenting the details of the three research cycles employed in the study, the researcher wishes to articulate the "moments of inquiry" (Ramsey, 2014) experienced during this research study which benefited the study and the practitioner-researcher.

Because of the "moments" of learning, the study evolved from an inquiry at the cancer HCO (micro-level) to an "interaction with the world" (Cook and Brown, p393, cited by Ramsey, 2014); this broadened the study to include the meso-level and macro-level of the private cancer care system. As a result of the reflexivity practice made during the first research cycle,



the study moved to include the multiple levels of the cancer care construct. The AR-orientated study moved from one cycle to constructing knowledge from iterative cycles of gathering knowledge to inform problem solving.

In addition, because of the reflexivity and learning and engaging in relationships, the researcher “paused” and considered “where to next?” in the researcher’s career pathway. As a result, the researcher accepted a role in the wider cancer care and healthcare landscape in SA, as will be discussed in Chapter 6.

2.7.6 Critics of action research

AR is not without critics according to Berger and Rose (2015). One such criticism is that, in terms of a positivist philosophical stance, AR is not viewed as scientific by so-called “orthodox” researchers who conduct scientifically based research, with arguments that given AR leads to practice-based findings which cannot be generalised beyond the research setting; the researcher is merely telling a story and not “science” (Greenwood et al., 1993). There is concern that an insider researcher does risk becoming overly involved and influences the research outcomes, i.e., researcher bias (Kelley et al., 2003). The ethics and the principle of consent as an insider researcher can be challenging and must be addressed during the informed consent phase. AR is dynamic, and this research study itself demonstrated how the research can evolve given the research commenced at the organisation level, i.e., micro level, and evolved to include the wider cancer care system (meso-level) and included the environment (macro-level) to better inform the research. As such, awareness of boundaries is an essential element in this AR study, to avoid the consequences of organisational politics.

2.8 The AR-based research study

Chapter 2.8 discusses the AR orientation used in the study in more detail, before we will look at the three research cycles undertaken. As a DBA research study, the objectives included developing practice-oriented theory that will be of value to practice and the practitioners in this context of the multi-level construct of the private cancer HCO in SA. The inquiry aimed to identify the sources of inertia to understand the reasons for maintaining the status quo as a response to facing healthcare reform, despite the threat of organisational failure this led to. Furthermore, the study aimed to draw on the findings and design recommendations for interventions, to inform successful adaption to policy reform, while also meeting the criteria for rigorous research (Huxham, 2003).

For this study, the Coghlan and Brannick (2010) cyclical model of AR informed the research approach. The study followed a collective approach involving the participation of agents across the multi-level construct of the cancer care system facing reform with three research cycles, with each cycle informing the next. This approach made the research study more manageable while also enhancing the study outcomes through a process of inquiry, reflection, and action cycles in the first, second and third person (Coghlan and Brannick, 2014). Figure 7 below illustrates the cycles used.

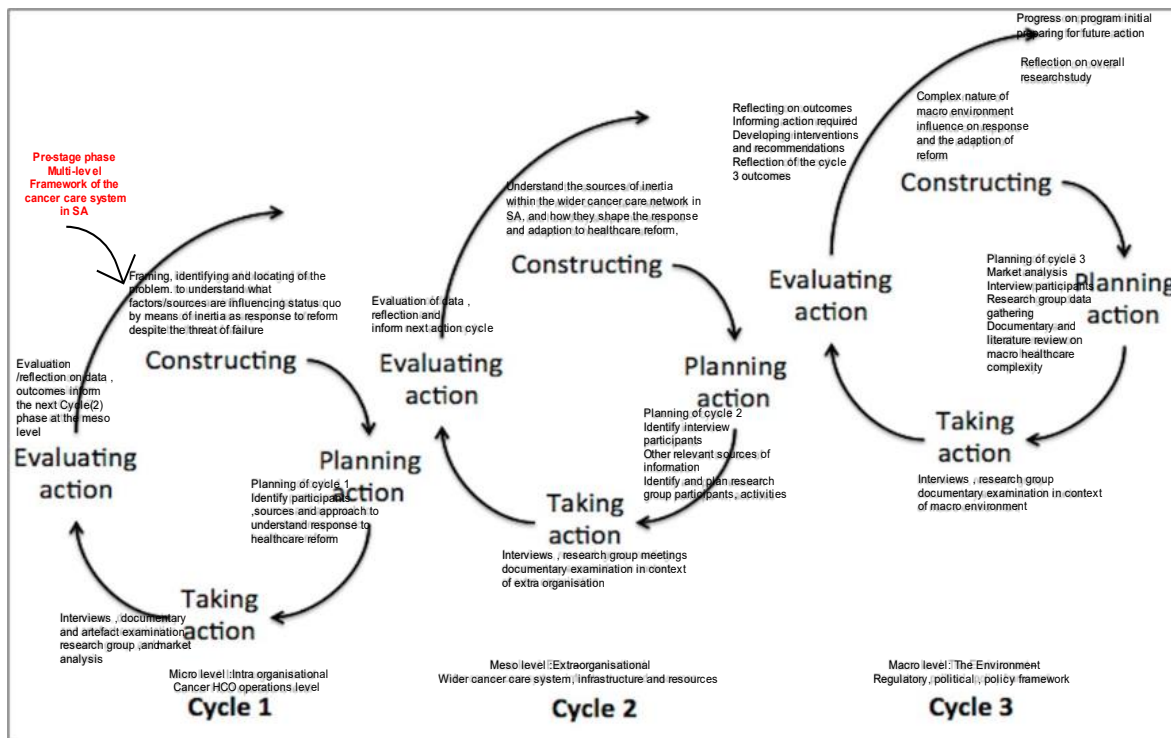



Figure 7: AR Cycles adapted from the cycles of action research by Coghlan and Brannick (2010, p10) and Saunders and Tosey (2009)

The researcher employed first-person voice by a process of self-inquiry to create self-awareness and purposefulness, and thus gain self-understanding of the researcher's own assumptions, behaviour, intention, and philosophical stance, as well as how these impact the research (discussed in Chapter 6). In this first-person voice, the researcher experienced moments of inquiry significantly shaping the research and the researcher (discussed previously). The foundation of this AR-based study is the second-person voice with researcher engaging through face-to-face interviews and dialoguing with the research group participants in the role of a scholar-researcher with the intention of identifying the sources of inertia and adaption barriers and enablers. Aimed at creating communities of inquiry, the third-person



voice of the research process moved beyond the first and second person by reporting on the study in this thesis and, where appropriate, generalising these outcomes for academic purposes (Coghlan and Brannick, 2010), leading to its contribution to organisational inertia-based theory.

In the following, the framing phase and three AR cycles are presented in more detail.


2.8.1 AR cycle 1

a) Constructing phase: framing of the problem and locating the problem

As mentioned previously, based on the AR frameworks by Saunders et al. (2009) and Coghlan and Brannick (2010), as well as the practice-centred learning approach discussed by Ramsey (2014), the research study commenced with first “locating” and framing the problem in the practice context using reflective practice and other tools. The researcher was extremely focused on not identifying a solution to a problem, as recommended by Saunders et al. (2009) and Pedlar (2008). In practice this involved an iterative process involving preparatory and essential groundwork.

This was a source of learning-in-practice, engaging with the agents and colleagues within the cancer and healthcare system in SA facing reform. This phase included reading artefacts and reports including media articles, the NHI regulatory documents and policies as well as gathering market-related information and attending several workshops on the NHI including one arranged by the Department of Health NHI in 2017, and a second, the President Health Summit, in 2018. The researcher used field notes and journaling during this phase to aid reflexive techniques. In addition, the researcher followed an iterative process of problem identification with the help of the researcher’s thesis supervisor. This phase involved “moments of learning” (Ramsey, 2014), for example, understanding the healthcare reform and its implications on the private cancer HCO, reflecting on the cancer HCO response to the reform and identifying the problem requiring research. An important learning in practice was not to consider the solution but to understand the sources of inertia and barriers to reform adaptation. In line with guidance from the DBA thesis booklet and aligned with the framing phase of Cycle (1), an initial review of the literature also took place.

This initial review, discussed above, revealed that maintaining the status quo by means of inertia as a response to healthcare reform is not effective; the inertia is, in turn, a threat to



organisational failure. As a result of the above actions and practice-centred learning rather than applying scholarly theory to a practice, the research problem was diagnosed.

As mentioned previously, framing the problem involved identifying the observed condition and distinguishing it from the desired condition while being careful not to be solution-orientated at this stage. The observed condition was presented as organisational inertia, a threat to organisational sustainability, which can result in incumbent failure (Rumelt, 1995). The desired state was then to adapt to change to be eligible and qualifying to participate in the new policy framework as a healthcare provider to the NHI.

Post the pre-phase framing, the researcher then put in place the problem for research, i.e., the micro-level inquiry in the first phase of the research, Cycle (1).


b) Planning

Based on this diagnosis and problem identification phase, the planning phase followed. This phase comprised of planning the research design for the study by employing the research onion model as a framework (Saunders and Tosey, 2012). In practice, this phase of research design included the research philosophical stance, research methodology and research methods, data collection tools, including participant sampling and recruitment, analysis, interpretation of the outcome's addition planning the most appropriate methods for data collection, participant sampling techniques, recruitment procedures of participants, and analysis and interpretation of the data.

c) Taking action

After the planning phase of Cycle (1) the researcher commenced with the data collection process using data collection methods including: semi-structured in-depth interviews with participants identified in the sampling process; a research group being established and an initial meeting held (in February 2019); review and examination of company reports and other relevant company-related artefacts; examination of the NHI and other applicable regulatory and policy-based documents; analysis of other relevant documents and artefacts; and market analysis of the SA oncology market. The researcher aimed to achieve open and honest insights and views of the healthcare regulation, including the NHI measures and the organisation's response to this change, to reveal the sources of inertia as a means to maintaining the status quo.

d) Evaluation, observation, and reflection



The findings from this research provided valuable insights for the cancer HCO. On reflecting on these outcomes, including the narratives that emerged and the multi-level construct of the cancer care system, the researcher identified that the study would benefit from expanding to a multi-level inquiry, broadening the scope and focus beyond the micro-level of the cancer HCO to include a multi-level inquiry incorporating the meso and macro levels too. This involved gathering data at both levels to understand if maintaining the status quo and sources of inertia is valid across the system, and if there are sources of inertia influencing the response by the cancer HCO facing healthcare reform. As such the research evolved from a single AR cycle at the micro-level inquiry to include an inquiry at the meso-level, research Cycle (2), and a macro-level inquiry, research Cycle (3).

2.8.2 AR cycle 2

a) Constructing: framing of the problem and identifying the problem


As mentioned above, the outcomes, learnings and themes identified in research Cycle (1) led the researcher to commence with research Cycle (2), a meso-level inquiry. This second research cycle sought to further explore and understand if the outcomes identified at a micro-level and the status quo are valid across the wider cancer care network, and if the sources of inertia at the meso level shape the response reform of healthcare policy.

b) Planning

The second action research cycle's planning involved expanding the research and ensuring the research design was aligned with gathering further insights and understanding of the key reasons for inertia as a response to the discontinuous change triggered by healthcare reform. As such, planning included mapping of the stakeholders/agents and organisations of the wider cancer care and its agents, sampling techniques, as well as data collection tools and data analysis techniques.

c) Taking action

Similar to in research Cycle (1) but now focused on the meso-level, the data collection here involved semi-structured interviews involving participants from the wider cancer healthcare system. Data were collected from dialogue and meetings (2 to 3 meetings per month) with the research group over a six-month period (eleven months in total including Cycles 1 and 3). Data were also collected from documentary examination and other artefacts and reports, specifically focused on cancer policy frameworks.



Research Cycle (2) was abound with sources for learning in practice, in that there were many “moments of action learning”—these included, for example, mapping the cancer care patient journey, the pain points and desired outcomes and the agents along the journey from the cancer HCO to the meso-level (wider cancer system). There were multi-agent participant interviews gathering knowledge across the wider cancer care system, including market analysis of the wider cancer care system: the structure, operations, business models, agents, routines, norms, and practices of the wider ecosystem.

d) Evaluation, observation, and reflection

On evaluating the findings from AR Cycle (2) and engaging in reflexivity practice the research in AR Cycle (2) contributed not only to further understanding of themes emerging from the meso-level, but also the themes and sources influencing and shaping the organisational-level, i.e., the micro-level, response to healthcare reform. Sources of inertia identified at both levels indicating the status quo are valid across the micro- and meso-level and are barriers to reform adaption. It is also important to indicate these results contributed towards the development of recommendations and interventions relevant to the cancer HCO facing reform.

2.8.3 AR cycle 3

a) Constructing and framing


Outcomes and learnings from research Cycle (1) and research Cycle (2) informed initiating a macro-level inquiry, and as such research Cycle (3). In this cycle the researcher investigated further insights into key sources of inertia as a response to change due to facing discontinuous change triggered by reform, as well as identifying barriers and enablers of reform adaption. By locating the problem in the macro level, the researcher aimed to understand how the complexity of healthcare delivery and healthcare reform influences the response to reform, as well as to identify actions to limit inertia and support adaption.

b) Planning

This diagnosis of the problem at the macro level was followed by the planning phase involving the research design aimed at data collection, sampling, recruitment of participants, interpretation, etc., as discussed in detail below.

c) Taking action

Data collection tools included participant interviews, continuing dialogue with the research group meetings, and documentary and artefact examination, especially related to the macro-



level cancer care environment. As in Cycle (1) and Cycle (2), analysis of the data collected takes place within the AR cycle and in which the researcher “acts”.

d) Evaluation, observation, and reflection

Research Cycle (3) involved investigating and understanding the macro level and if there were sources of inertia impacting the response to reform at the environmental level, i.e., examine the policy reform and the various cancer policy frameworks which are in place in SA but not necessary enabling the adaptation of the reform.

The observation phase in Cycle (3) connected the findings from the previous research cycles with the development of recommendations and interventions required to limit inertia by engaging in knowledge construction as well as the action of reflection generated from the research cycles. This aimed to develop recommendations and interventions grounded in theory, to identify enablers for adaption when an organisation faces change due to healthcare reforms.


2.9 Data collection

Aligned with the research design process, using the research onion metaphor by Saunders et al. (2009), the researcher next considered the data collection methods as well as sampling and recruitment of research participants.

2.9.1 Introduction

Initially the problem identified was located at the organisation level, i.e., the micro level, however, as the AR study evolved, the researcher remained alert to the possibility that data important to knowledge generation and theory development could emerge from various sources and thus, in response to the outcomes of research Cycle (1), the data collection expanded with the study’s needs. This is similar to the approach used by Huxham (2003) in a study involving policy and healthcare reform adaption.

The approach to data collection therefore focused on harvesting and synthesising perspectives, interpretations, and descriptions from across multiple levels of the cancer care continuum, incorporating multi-disciplinary and multi-stakeholder engagement, in order to identify all the possible intertwined components (factors, dimensions, elements, relationships/connections). It also sought to incorporate all the views, possible descriptions,




and interpretations (Nogueira et al., 2017) influencing the response and levels of adaption to the healthcare reform faced, then use the findings from data collection to inform recommendations for interventions and actions.

By employing this approach, the data collection was able to draw on perspectives from the cancer HCO including employees and leadership team members, the cancer patient population, physicians (oncologists and general practitioners), cancer care agents and organisations, including independent and corporate owned providers, the associations (non-profits and professional) from within the wider cancer care structure. Furthermore, the researcher was able to examine documentary and artefact data from the policy and government level in order to strengthen the understanding of what is taking place. This approach considered the multi-level cancer care system at the micro, meso and macro levels discussed below. By collecting data at multiple levels, the research study was more rigorous and richer in both design and outcomes.

- **Micro-level:** Represents the internal environment of the private cancer HCO, i.e., the cancer HCO, its routines, structures, impacted by healthcare reform. In response to this reform, it is maintaining the status quo as demonstrated by inertia despite the threat of organisational failure.
- **Meso-level:** This refers to the wider cancer care system. It is the inter-relational level, interconnected, interdependent with the other levels, consisting of the market forces in the multi-level cancer construct. It includes the wider cancer network, its structures, resources, infrastructure, and other agents such as doctor associations, non-profit organisations, as well as their interconnectedness, interdependencies, and interaction with the micro and macro levels.
- **Macro-level:** This refers to the overarching environment encompassing the institutions of the national healthcare system, and national-level issues related to health and social care policy, governance legislation, and payors.

The researcher adapted the 7Ps multi-stakeholder matrix used in stakeholder analysis and used it as a guide to ensure all agents for participating in the study are identified. Using this 7Ps MSE framework as a foundation, the researcher identified the research participants comprising representatives of the cancer HCO, leadership of HCOs, physicians & healthcare professionals, and patients. More specifically, the research participants represented the professional association of oncologists in SA, non-profit organisations (NPOs) involved in




breast cancer and breast health, and a representative from the policy framework environment. The executive/leadership of the organisations across the micro and meso levels in the system and industry are professional associations, for example, South African Oncology Consortium (SAOC), non-profit groups, and support groups.

2.9.2 Data collection methods

Data collected not only involved the triangulation at the multiple levels of the cancer care system as discussed above, but also a triangulation of data collection methods, including interviews, documentary, and artefact examination (internal to the cancer HCO and external), a cancer market analysis, as well as a research/discussion group to generate in-depth and practical knowledge in support of the preparation of recommendations for action and interventions.

Semi-structured interview questions took the form of a discussion about the healthcare reform and its measures, and implications for those within the private cancer care system impacted, to identify the perspective of the interviewee. To support the researcher in the interview process, the researcher relied on the COREQ checklist designed by Tong et al. (2007) consisting of a 32-item checklist. This checklist helped with important aspects of the qualitative research interviews as it encompasses several domains useful to supporting a qualitative-based methodology incorporating interviews. The checklist is comprised of three domains including: Domain 1, supporting and driving reflexivity, encompassing understanding of the characteristics of the research participants and interviewer; Domain 2, the study design including methodology, sampling, the data collection setting, the data collection process including the interview guide, recordings and transcripts, field notes; and Domain 3, the analysis of the data.

The documentary and artefact examination included identifying and exploring relevant documents crucial to understanding the reform of healthcare policy in SA and its attributes and measures, as well as the healthcare and cancer care system in SA facing reform. Documentary and artefact examination therefore included company and industry reports, media releases and other transcripts, reviews of the published regulations and policies including the NHI Bill, NHI policy, the Health Act of 2003, the Medical Schemes Act of 1998 and amendments, as well as a market analysis of the cancer system in SA. This analysis was presented and discussed at the cancer HCO and at the research/discussion group during the research process, as well as being updated according to input obtained, in order to reflect an



accurate overview of the SA cancer care sector. The data and knowledge generated from documentary and artefact examination and the market analysis were vital in this research study in generating the knowledge required to identify the reasons and sources of inertia from the multiple levels, which in turn drive the status quo as a response to facing change in healthcare reform.

2.9.3 Sampling

A purposive sampling approach encompassing the sub-category, expert sampling, was employed with recruitment. Purposive techniques according to Neuman (2010) are useful for in-depth investigation of specialised populations, which makes sense to this study, considering the research participant population was specific to cancer healthcare. The researcher was concerned with ensuring participants with expert knowledge and/or experience from across the three levels, i.e., micro, meso and macro levels, of the private cancer care system were included. As such, as a useful tool, the researcher adapted the 7Ps Multi-Stakeholder Engagement Framework from Concannon² et al. (2014). Figure 8 illustrates how the MSE framework was adapted for this use.

² For clarity, the matrix refers to stakeholders, whereas the research uses the term agents. In terms of using the framework, however, the terms agent and stakeholder are considered synonymous.

	Stakeholder	Description	Study Participant
1	Patients, the public	Represents the current and potential consumers of (cancer) health care , their significant others, he community /population	This study included cancer patients Healthcare marketing executive and NPO represer
2	Providers	Involves many diverse individuals and organisations that provide (cancer) healthcare services and other healthcare services to cancer patients and support to their families and significant others and caregivers.	Cancer HCO members Owner of independent oncology network Leaders from HCO's Hospital Manager Private and public oncologists Primary care doctors Treatment therapists Oncology Surgeon Oncology Navigator
3	Purchasers	The individuals and organisations under writing or subsidize or manage the costs of healthcare medical administrators who manage benefits for cancer treatment	In SA these include the managed care organis (MCO)
4	Payors	Responsible for reimbursement of cancer services	Medical insurers, out-of-pocket payors, governme non-profit organisation's(NPO)
5	Policy makers	Policy makers and advocate's for cancer care	Representative on NHI sub committee Representative of doctor association
6	Product makers	Representatives of product makers e.g., drugs, radiation equipment specific to cancer treatment	In SA this includes drug manufacturers and su (note for study product /drug /equipment supplie incorporated within the documentary examination. a regulated industry with rules on pricing and s based regulation
7	Principle researcher	The researcher	Insider researcher of this AR based study


Figure 8: Adapted from the 7Ps MSE Framework by Concannon et al. (2014)

Using the tools as discussed above, the six key research participant groups emerged from using the above approach, namely: 1) medical professionals; 2) healthcare caregivers; 3) corporate-owned cancer providers (representatives from the private cancer HCO and representatives from other cancer HCOs); 4) independent-owned cancer providers; 5) patients; and 6) associations (professional and non-profit). For more information, see Table 3: Research participants. In addition to the participants, a research group was also used comprising ten participants.

2.9.4 Recruitment of participants

As an insider researcher, the participants were known to the researcher. The researcher telephonically contacted them to arrange interviews. The researcher explained the intention of the research, as well as the research process, emphasising that the role of the researcher is as a scholar conducting research and not in her functional practice role. The potential participants were informed there was no obligation on participants to participate, and as such participation in the study was voluntary.

Appointments were made with participants at a date and time convenient to the participant. Interviews took place at the participants' workplace, mostly after hours, with four participants interviewed at a mutually agreed venue. Participants were informed of the objective of the study and that they were free to participate and free to withdraw at any time; all participants



provided consent. Demographic data included the participants' role/function and their experience in participation, for example, a radiation oncologist in private, or a medical oncologist in public. Other demographics such as gender and age were noted but not relevant to the research. The research group involved a diverse group of participants across the multi-level cancer care construct in SA.

2.9.5 Research team

A research action learning set comprising a (constant) group of team members is a common feature when using AR to address a problem identified at an organisation, seek alternative actions, evaluate these actions, and support change required (Pedlar, 2008). Given that this AR study took place across the multi-level cancer care context in SA, rather than establish a learning set from the cancer HCO, an interdisciplinary research team was established. The researcher employed the principles, methods, and procedures of learning sets. The contribution of interdisciplinary peers supported thinking and questioning leading to learning and insights, which in turn encouraged reflection, new questioning, and new insights (Revens, 2011).

By using a "research team" to explore and understand the research problem, the researcher was able to gain multiple perspectives on the problem, as well as actions and outcomes, from participants representing the wider cancer system (meso-level), the policy level (macro), and the organisation (micro), including the researcher (1), a general practitioner physician (1), a healthcare executive (1), strategic healthcare marketing executives (2) a cancer care navigator (1), head of cancer NPO, patient (1), and cancer patients (2).

Stakeholder group	Participant details and function in the cancer care system	Number of participants
1. Medical professionals		(6)
Doctors: oncologists (public & private)	Dr GQ: Medical Oncologist in public and private	1
	Dr S: Radiation Oncologist in private	1
	Dr Z: Clinical Oncologist in private	1
Surgeon	Dr W: Breast Cancer Surgeon	1
General practitioner	Dr A: Primary Care Physician	1
Physician	Dr B: Physician	1
2. Caregivers		(3)
Radiation therapist	Ms T: Radiation caregiver	1
Registered nurse	Registered Nurse in oncology Sr A:	1
Cancer patient navigator	Patient navigator: Ms O	1
3. Healthcare / hospital group (manage and own cancer facilities and other hospital-based and healthcare services)		(5)
HealthCo exec 1 (independent)	Mr C: Executive at HealthCo	1
HealthCo exec 2 (stock exchange listed)	Ms M: Executive HealthCo	1
HealthCo exec 3 (stock exchange listed)	Dr P: Executive HealthCo 3	1
Hospital management	Mr M: Hospital Manager	1
Manager: Network of hospital-based cancer services	Ms LR: Senior manager responsible for operational management of cancer facilities	1
4. Independent-owned network of cancer facilities (chemo and radiation)		(2)
Owner independent network of radiation facilities	Dr W: Owner of network of private radiation facilities and other healthcare services in private	1
Practising oncologist / shareholder in several oncology facilities, and managing partner in doctor group practice	Dr S: Practising Oncologist, shareholder in out-patient oncology facilities (chemotherapy and radiation)	1
5. Associations		(3)
Cancer NPO	Ms L: Chief Operating Officer of cancer NPO	1
Oncologist association	Dr S: Representative/Director of Oncology Doctor Ass.	1
NHI subcommittee	Dr K: Representative of NHI subcommittee	1
6. Patients		(3)
Cancer survivors/patients: Private	Ms J, Ms O	2
Cancer survivor/patient: Public	Ms O: private diagnosis but treated in public	1
Total Interviewee participants		22

Table 2: Research participants

2.9 Data collection methods

The data collection was aimed at using the knowledge generated and its interpretation, to engender transformation and foster action by developing recommendations for enablers of reform adaption (Chadwick, 2010; Braithwaite et al., 2017).

As an exploratory study aiming to examine in-depth the reasons for responding to healthcare reform by maintaining the status quo through inertia, despite the threat of failure, the approach involved collecting qualitative data using more than one method, namely interviews, documentary examination and research group. The team was selected based on their specific skill set and/or training and experience, as well as the willingness of the individual to participate.

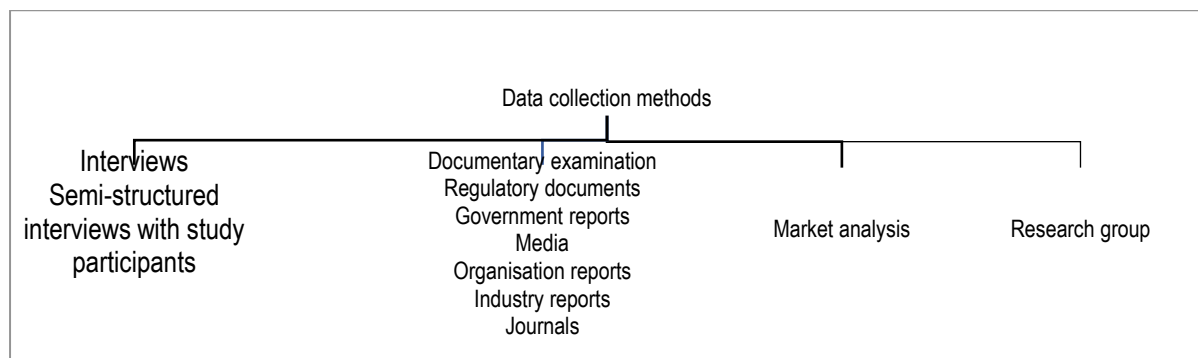



Figure 9: Data collection methods

2.9.6 Semi-structured interviews

Face-to-face interviews were conducted using semi-structured questions with the interviews ranging from 40 to 90 minutes; only two participants declined to be recorded and therefore manual notes were taken. Commonly used in qualitative research, the semi-structured interview approach encompassing open-ended questions was selected. With the researcher having preunderstanding of the topic (as an insider researcher and literature review), a semi-structured interview approach allowed the researcher to prepare and outline topics to be covered that aligned to the research problem under inquiry, while simultaneously allowing for the participant (interviewee) to determine the way the interview developed, i.e., it allows the interviewees to express views and understanding in their own words, thereby guiding new understandings and insights to emerge (Cohen and Crabtree, 2006).



The semi-structured interview guideline was designed to gain insights into the barriers, enablers and factors influencing the response to NHI and other health reform measures the participants face in SA. The recorded interviews were transcribed and added to the two non-audio (handwritten) interviews.

2.9.7 Research group

Data collection from the research group involved transcripts of meetings and actions held during the research project period, from February to August 2019. An example of one of the data outcomes and actions was identifying the cancer care system agents (stakeholders) and the cancer care policy framework for SA (2017) and mapping out the cancer care journey for a breast cancer patient in SA. The research group doubled up as both a data collection method and an intervention tool as the various perspectives captured from the participants, the market analysis and documentary examination were used to facilitate strategic thinking discussions and a workshop. According to Huxham (2003, p243) , this is “an ideal situation” in an AR project. Rich data emerged from the research group, including from notetaking during and after meetings, reports developed from strategic thinking discussions, as well as post-it notes, field notes and flipchart papers used during workshop and meetings and subsequent discussions.

2.9.8 Documentary and artefact examination

Data collection also included examining documents, company reports, regulatory and policy publications, field notes and a market analysis of the private cancer care industry in SA. Documents included NHI Bill, NHI Policy, NHI Green Paper, NHI White Paper, media artefacts and the market analysis which constituted six main domains, as well as the research group meeting reports.

2.9.9 Market analysis

As shown in Figure 9, below is a summary of the main domains included in the market analysis:

- Cancer trends
- PESTLE
- Resources and infrastructure
- Customers

- Products and technology
- Competitive landscape

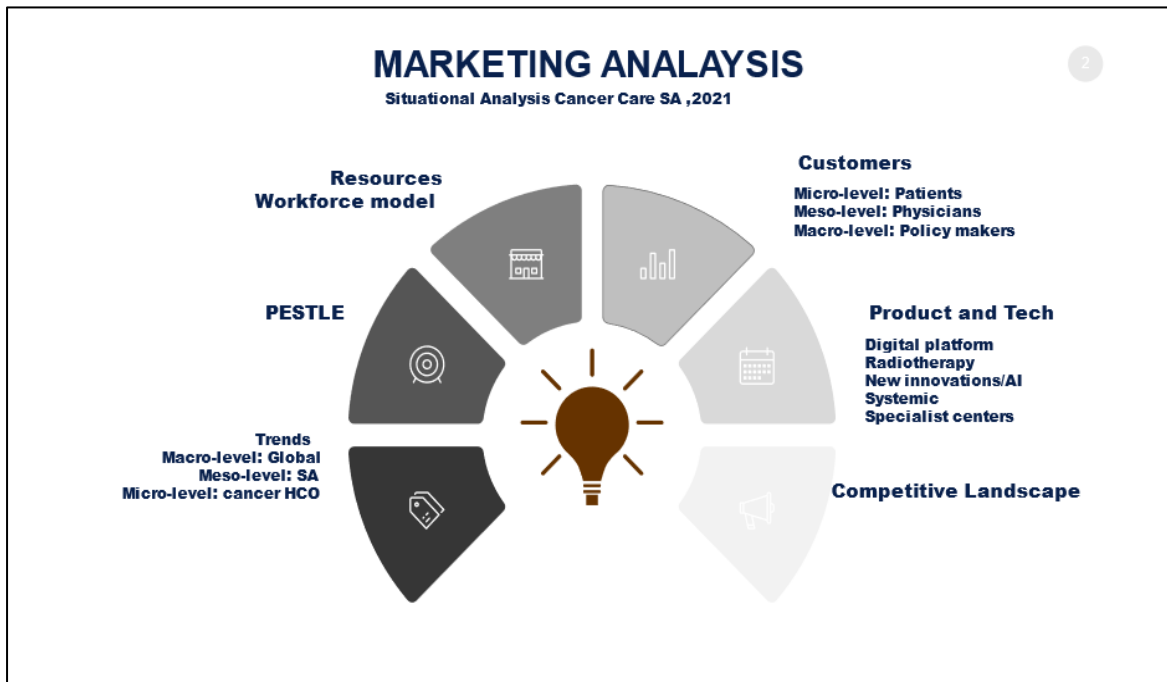



Figure 10: Market analysis domains

2.10 Ethical considerations

Ethical considerations were addressed by first obtaining ethical approval from the University of Liverpool (UOL) Ethics Committee, and also by obtaining consent from the participants which included providing participant information (see Annexures A and B). The participants were informed of the intention of the study, that participation in the research is voluntary and they could withdraw at any time, and importantly that the information is kept confidential and anonymised including the measures of de-identifying the participant and using a pseudonym for the organisations. In addition, no information was accessible to any organisation or individuals, with the data secured by password protecting any stored electronic information or transcripts, and any physical worksheets were kept in a locked drawer in the researcher's locked home office.

To avoid risk of perceived coercion, the researcher reinforced that the role and function within the research context was that of researcher and not practitioner when engaging with the employees or leadership/management from the cancer HCO. As far as the employees were concerned, reassurances were given on confidentiality, as well as emphasising that the role of the researcher is separate from the practice functional role and that participating in the




research will not have practice or other related consequences. The research also bears no relevance to the work of the employees, as such there is no threat to the employees standing within the organisation; importantly, the RQ did not involve personal performance-related issues but rather was seeking sources of inertia at the cancer HCO. With other participants/agents working with the cancer HCO or with the meso-macro levels, they are autonomous and work independently (at the meso-level). The researcher therefore was not in a position to “coerce” these participants to participate or to influence their responses.

Again, it was emphasised that participation was on a voluntary basis. As far as patients were concerned, in addition to not having access to any clinical treatment and any other patient records and reports, the researcher does not directly or indirectly provide or impact or influence treatment and/or the care regime of patients. During the interview process, all participants remained engaged and continued with interviews until the interview conclusion.

2.11 Interpretation and analysis of data

Having employed a qualitative-based methodology to the inquiry, it was imperative to demonstrate that the researcher followed a rigorous and methodical process which, as an AR-orientated study, yielded meaningful and useful outcomes for practice. The interpretation of the data gathered was a challenging and time-consuming exercise. It involved analysis and transformation of copious amounts of rich data into clear, understandable, insightful, trustworthy, and original analysis (Gibbs, 2007). According to Huxham (2003), one of the most challenging attributes of AR is turning the data collected into theoretical conceptualisation that involves reframing the data gathered from various sources (Thomas, 1983, p.43 cited in Huxham, 2003).

The goal of data interpretation and analysis centred on sensemaking of all the information, insights and ideas gathered from the data collection phase of the study to be something useful and meaningful. According to Weick (1995, p8), sensemaking “includes the construction and bracketing of the text-like cues that are interpreted, as well as the revision of those interpretations based on action and its consequences”. Weick (1993, p635) further explains the basic idea of sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs”, or more simply said by Rosenberg (1982), “learning by doing”. Given the AR orientation of this study and the research process employed by the researcher, these definitions not only resonate with the researcher



but also with the approach taken in this study, as it encompasses practice-centred learning and learning in practice, as espoused by Ramsey (2014).

The data collection resulted in a rich set of data, albeit one that was large in volume and lacking structure. As such, the researcher's imperative was to bring structure in order to support a comprehensive data analysis process; thus, a thematic analysis framework was applied to underpin the data interpretation. Thematic analysis is not only aligned with the constructivist philosophical paradigm of this study and as such suited to qualitative policy-orientated research (Rashidian et al., 2008), it also offers the flexibility to support the data collection methods selected for this research study.

Furthermore, as a tool, the thematic analysis framework fostered a rich description of the data collected at multi-level cancer care construct (at the micro, meso and macro levels), from multiple stakeholders, while bringing meaning and a sense of the predominant and essential elements influencing the response to healthcare reform. It helped reveal the sources and reasons for inertia despite the threat of incumbent failure. Importantly, thematic analysis also aligned with the AR nature of the study, not only because of its reflexive nature, but also because the thematic analysis process involved substantial analytic effort by the researcher where the researcher was active in a rigorous process of sensemaking, knowledge production and as such bringing meaning to the research outcomes beyond the descriptive, semantic content of the data collected (Braun and Clarke, 2019).

The researcher used a latent thematic approach in order to collate the data into smaller units through a process of coding and thus generating themes from patterns in the data which reflected shared meaning. This sensemaking process of the actionable knowledge generated within the researcher's practice was aligned with the theory of learning in practice as described above and supported the researcher-practitioner's practice-centred learning.

To bring structure to the data analysis, the researcher drew on a combination of the six steps for thematic analysis recommended by Braun and Clarke (2006), and also considered the five steps for thematic analysis by Dey (1993), as described by Lacey and Luff (2007). As mentioned, the data was rich and the researcher wanted to engage more closely with it; as such, the researcher selected a manual coding approach using a thematic analysis approach, rather than using coding software.

While always keeping in mind the research question and inquiry throughout the data analysis, the researcher employed the six-step process developed by Braun and Clarke (2006): 1)

familiarisation; 2) coding; 3) searching for themes; 4) generating themes; 5) reviewing and naming themes; and 6) the write-up. Five of the six are discussed below, with the write-up of the outcomes discussed in detail in Chapter 4. Figure 11 below illustrates the data analysis process followed.

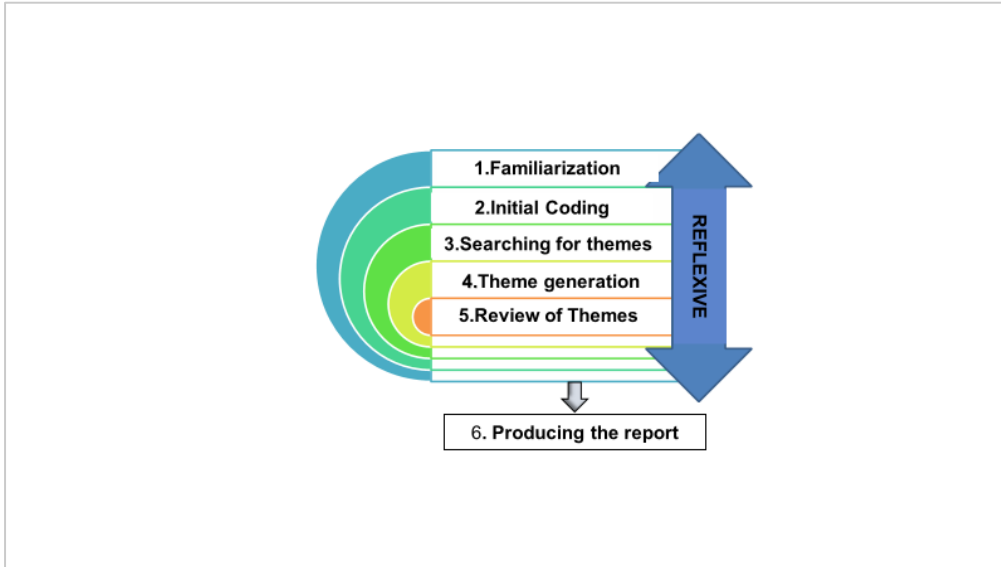



Figure 11: Thematic analysis approach (adapted from Braun and Clarke (2006), and Archer (2018))

In practice, this analysis process involved the following:

1. Familiarisation

After transcribing the audio data collected, the researcher moved from data generation to analysis of the data by immersing and engaging in the breadth and depth of the data in order to familiarise herself with the content, as recommended by Braun and Clarke (2006).

Familiarisation with the data helped with preliminary identification of commonalities and recurring features. It was the start of finding shared meanings and patterns in the data. The researcher used a technique suggested by Kuckartz, (2014a, p. 19), called the hermeneutic circle/spiral; the author suggests “the understanding of individual statements is improved by understanding of the entire interview, and the understanding of the entire interview is improved by your understanding of individual passages”. In practical terms this meant, while keeping the whole and the research question in mind throughout, the researcher followed the iterative cycles of listening and then re-listening to the audio interviews, reading and re-reading the printed copies of the transcriptions of these interviews, and reading data collected from the documentary examination and market analysis as well as the researcher’s handwritten field notes.



The researcher highlighted text (words, sentences, paragraphs) and made notes during the familiarisation process. While following the iterative cycles above, the researcher also kept in mind that the nature of this research study involves reflexive practice, and as such actively remained aware of their own biases, beliefs and perspectives which may have influence. This was done by keeping notes alongside the highlighted words, phrases, journaling questions and noting thoughts and feelings, as well as engaging regularly with peer-scholar researchers (Starks and Trinidad, 2007, cited in Braun and Clark 2019).

2. Coding

Moving beyond the superficial level of familiarisation with the data, the researcher commenced with the more systematic analysis of categorising the data into smaller pieces and units, moving from a semantic level (descriptive) to a more latent level of data analysis (Archer, 2018) and finding meaning beyond the obvious (Braun and Clark, , 2019).

Rather than follow a mechanistic, reductionist approach, the researcher purposefully focused on exploring, organising, sifting, and interrogating the data aimed at sensemaking by drawing inferences from relationships (Hatch, 2002) and breaking the data into meaningful sections. The intention was to gain insight by looking for coding ideas and patterns and even identification of anomalies. For example, in one of the interviews Dr J mentioned “*the reform is not really any different to working within the current medical aid ‘rules’*”, which was not mentioned by other interviewees or in the documentary examination. Meanwhile, other participants, mainly physicians such as Dr P said, “*the lack of including quality measures with cost measures in the NHI measures as a source of concern which in turn in influencing him to continue as is*”, i.e., maintaining the status quo. More detailed examination of the NHI Bill (2019) found quality measures such as this to be included.

The researcher manually highlighted (with different colours) words, passages and sentences. This process was then followed by reading the electronic format of the data, digitally highlighting text (as above). After completing both approaches, the researcher then compared the outcomes of each process and developed codes to describe the content, by creating a spreadsheet of each research method and participant for interviews and related documents from documentary examination, while also including the literature review and the market analysis outcomes where relevant. The above process may seem drawn out and tedious, but to ensure rigour of this coding process and in turn theme development (discussed below) the researcher opted to thoroughly engage in the data set, conducting a detailed interrogation of the highlighted text (Archer, 2018). The researcher coded the highlighted text at this stage.

Development of the codes involved grouping the same set of concepts together and then naming the groups. This process involved searching the text for shared meaning and elaborating on the set of generalisations made from these by examining which concepts identified relate to each other; the overt repetition of similarities in the concepts helped to identify patterns from the data (Archer, 2018). As a manual process of coding was followed, the researcher wanted to ensure the relationships in the analysis held firm, the coding process therefore also involved running a concurrent process of drawing on empirical-based knowledge (included in the spreadsheet as discussed above) to better understand the classifications in more general terms.

In practice, a wide variety of codes were initially generated and then refined throughout the analysis process. Below is an extract of an interview with management of one of the executives of the holding HCO, illustrating where data was broken down, highlighted, and then coded.


<i>Interview extract from HCO management</i>	<i>Initial coding</i>
<i>"Doctors are central to the design and implementation of an ARMs."</i>	<ul style="list-style-type: none"> • <i>High influence of doctor (agent)</i>
<i>"We have to be seen to show support of the doctor's response to the NHI, as our business success depends on them."</i>	<ul style="list-style-type: none"> • <i>High influence of doctor (agent)</i> • <i>Interdependencies</i>
<i>"We support the principle but honestly, I am yet to be convinced how it will work for us (the organisation) and given the government's history with other reforms, it is difficult to trust them."</i>	<ul style="list-style-type: none"> • <i>Tendency to maintain the status quo</i> • <i>Lack of trust in regulator</i>

Table 3: Extract of interview for coding

The output of the above coding process was used for the development of themes (discussed below), in order to make sense of the overall phenomenon under investigation in this study.

3. Theme construction

As mentioned above, the output of sensemaking and finding meaning by reducing the data into smaller units is coding; the output of this coding process was to generate themes in order to capture the essence and illustrate the meaning discovered from the data to inform the inquiry taking place (Braun and Clark, 2019). The aim of the researcher was to develop themes which are coherent and insightful, while also bringing meaning to the data generated in relation to the research problem and research question (Braun and Clarke, 2019).



In practice this meant using codes as building blocks by structuring the output of the coding process; collating similar codes together in order to drive meaning from the data set. The researcher followed an iterative process again, to ensure meanings were identified rather than features from the data set. At first, themes did not emerge fully formed but instead they emerged either as features as discussed above, or at a superficial level, with the process initially producing aspirational themes, or as Braun and Clarke (2018) refer to them: candidate themes. Discussions with colleagues, the research group and the researcher's supervisor, (often on a to-and-fro) but again incorporating important "moments of inquiry" (Ramsey, 2014), triggered insights for the researcher. For example, distrust as a theme emerged when discussing a group of codes which had come about around strong opinions held about the NHI by interviewee participants during a research team discussion.

Cognisant that the themes identified needed to shift beyond being descriptive about the data emerging in the above process at the semantic level, the researcher set about categorisation into groups sharing characteristics, similarities, and relationships, and shifting these themes from description of the data to a more latent level in order to derive meaning from the data set.

It is worth highlighting at this stage the researcher working with the research supervisor used the term domain to denote a theme, and determinant to denote subthemes; these words are interchangeable with the concept of a theme and subtheme (Archer, 2018). Following the above process, the researcher allotted definitions to these aspirational or candidate themes, as recommended by Braun and Clarke (2018). The researcher went on at a later stage to denote themes as: main themes and sub-themes.

4. Revising and defining of the themes

Phase 4 was about further refining of the themes identified above in phase 3. In phase 4 of the analysis the themes were revised and refined to ensure the final "story" and meanings emerged from the data set were relevant to the inquiry. This robust sensemaking process involved trial and testing, with the researcher making herself increasingly familiar and more confident and, over a period of time, through a process leading to a more succinctly generated set of themes. In practical terms this process took six to seven weeks incorporating reflexive practice as discussed in Chapter 6.

Despite the above refinement and time, the researcher consistently revised and defined the themes as mentioned, referring to existing research and literature and even during the write-

up phase of the analysis chapter, revisiting the high-level theme and subthemes in turn triggered revisions. Table 4 below illustrates an example of one theme resulting from the initial generation of the aspirational themes and subthemes.

Domain	Key determinants & variables	Participants / agents	Findings	Methodology
Rigidity of organisation	High influence of agents	Organisational healthcare professionals/employees Leadership / owners of oncology facilities Leadership Healthcare professionals (referring doctors, surgeons, oncologists, other doctors) Support healthcare workers, medical schemes Associations: SAOC & BHF	Doctors work as independent practitioners in the private sector, i.e., are not employed by providers, making these organisations dependent on them for referral. Reverting to the fee for service (FFS), i.e., status quo rather than developing new alternative payment models	Data collection from: Interviews, review of micro process at cancer HCO, reviewing relevant documents, reports, and artefacts: micro-meso-macro level

Table 4: Extract of theme generation

5. Reviewing and renaming themes

After revising data using a theme mapping technique, the fifth stage then progressed by linking theories from the literature (while keeping the research problem and question in mind) to support better developed interpretation and a deeper understanding of the data set. Table 5 illustrates an example where themes are refined and the theory woven in.

From the exercise described above, three main themes emerged as sources of inertia at the micro, meso and macro levels: 1) at the micro level, organisation rigidity; (2) at the meso level, the challenges of healthcare reform; and (3) at the macro level, complexity of the healthcare and healthcare reform. See Table 6 for more, and these are unpacked in more depth in Chapter 4 through the analysis and interpretation of findings.




High level	Sub level	Findings of data collection	Analysis of key outcomes	Evaluation against the literature
Micro-level				
Organisational Rigidity	Resource dependency on high influence agents	Interviewees: Physicians have been identified as valuable agents central to cancer HCO.	High power of doctors is influencing the behaviour of the cancer HCO and in turn their response to reform creating a barrier to transforming existing norms and routines.as such contributing to the inertia at the organisation.	Studies by Braithwaite et al. (2017), Glouberman and Zimmermann (2002,), and Mechanic and McAlpine (2010) demonstrate agents with high influence and power influence the behaviour and actions of other agents in the system, and in turn response to change (reform). In these studies, doctors were specifically identified as impacting reform efforts.
Meso-level				
Challenges of healthcare reform in SA	Fragmented and disjointed cancer care system in SA	Market analysis, documentary examination, interviewees. The data shows the wider cancer care system in SA operates within a fragmented system made more so by the dual system (private and public) encompassing disjointed operational and business models, and fragmented structures with multiple sites and multiple providers found along the continuum of cancer care.	Fragmentation of services and facilities together with multiple structures and disintegrated operational and business models and organisations impacts the behaviour and actions of the agents in the cancer care system creating inertia, and barriers to the reform adaption.	Fragmentation in healthcare facing reform leads to dispersed accountability by the agents across the healthcare system including cancer care and is a source of inertia influencing adaption to reform.

Table 5: Extract reviewing themes

2.12 Chapter summary

This chapter demonstrates how the researcher designed the study by employing the metaphor of the research onion—a metaphor suggested by Saunders et al. (2009)—as a framework to guide a research study. It helped ensure the inner layers, i.e., the data collection and interpretation methods are supported by first considering the researcher’s philosophical approach to the research, the research methodology, research method, and data collection. Chapter 2 presents the use of three research cycles used iteratively with one informing the other. Ultimately, it enabled the study to map the cancer care terrain using a multi-level construct to identify the sources of inertia influencing the response to facing healthcare reform by maintaining the status quo despite the threat of inertia.

By understanding the sources of inertia, the researcher was able to use the data uncovered to develop themes and subthemes as reasons for maintaining the status quo. Importantly, the research revealed the barriers to, and enablers of, reform adaption, helping the researcher



develop recommendations for interventions and actions. Thus, the research design, through the research onion, worked well for the researcher and achieved the aims of the data collection phase of this AR-orientated study.

3 Thesis literature review

3.1 Introduction

As discussed in the introduction, the intention of the research review is to critically examine the existing literature to support framing of the research context and problem. Key to the literature examination was to identify the sources of inertia as a means to maintaining the status quo when faced with change. The literature review's aims were thus to be relevant, support the development of actionable and transferable knowledge, and to be adaptable to this research study, the researcher's practice problem, and RQ identified by the scholar-practitioner.


3.2 The multi-level construct

To constitute effective knowledge generation, understanding of the knowledge construction and implementation of actions derived from this must be shared in all directions, between people at various levels of the healthcare provider system, argue Parkhurst et al. (2010). As such the researcher examined healthcare provision and the healthcare systems as a multi-level framework, taking into consideration that there are communities of practice involving agents from the different levels of the healthcare system. These communities stimulate knowing with doing through interacting and influencing the behaviour and actions of each other and between the levels, for example: patient-provider interactions; the organisation of individual health facilities; the local networks of health facilities; and the interaction between the operational services at the meso-level and the macro-level.

3.2.1 Introduction: multi-level frameworks

In addressing the RQ, the researcher first reviewed the literature to identify theoretical frameworks or models found in empirical studies to inform the conceptual framework and model relevant and appropriate for this study and its subsequent analysis.

The review commenced with first better understanding healthcare provision and, more specifically, HCOs providing healthcare. The purpose of healthcare provision comprises multiple factors, including providing and coordinating care, improving access to and the quality of healthcare while at the same time reducing costs, preventing errors, and managing the population's health. As such, argues Drucker (2002, p1), healthcare provision "is one of the




most complex sectors in the economy”, and HCOs (healthcare providers) are “complex human organisations”. Van Eyk et al. (2011) expand on the above, describing healthcare provision as a subsystem of a whole, encompassing several interdependent parts with competing demands on the structures; it is all underpinned by the needs, values, and behaviours of a wide range of complex stakeholders, ranging from community members, to service providers and national policy makers.

Furthermore, within this interdependent system the literature (Weick, 1995) shows that agents, actions and how their inputs are combined at one level to create outputs at another level influence how organisational reality is enacted. Additionally, the relationships between agents in HCOs are open to external influence, according to Sheikh et al. (2014).

Based on the above, the researcher surmised that—in HCOs and in systems that provide healthcare—meanings are generated at multiple loci across multiple levels, with organisational forces, their interaction and relationships influencing organisational and agent action (Pope, et al. 2006). In reflecting on the above, a “moment” of learning occurred with the researcher identifying that a comprehensive multilevel approach will be useful to generate deeper system knowledge and understanding, and enhance sensemaking while also developing the researcher’s competence, improving collaborative learning, and in turn supporting change.

Examining diverse processes, elements and competencies at individual and group level, as well as the coherence between structural and social aspects identifies the influential factors shaping the HCOs’ capacity for change and adaption (Ferlie and Shortell, 2001). In other words, using a multi-level framework involving multiple engagements within and beyond the micro-level of one organisation will help the researcher to understand the response and adaption to change, and strengthen this AR-based study by generating actionable and practical knowledge for the development of interventions and recommendations.

As such, the researcher moved the literature review beyond a narrow focus, to conceptualise the research problem within a multi-level framework aimed at increasing the researcher’s understanding of the observed behaviour and developing actions for the desired state (Batalden and Mohr, 1997; Bove and Armstrong, 2017). Multi-level framework approaches are applied in several theoretical fields such as evolutionary, economics, systems thinking theory and general systems theory.



In their study of understanding HCOs as learning organisations, Harrison and Shortell (2021) argue that applying a multi-level analysis supports investigating and identifying interactions, interdependence, and influential forces both within and across the system levels, as well as the effects of leadership, incentives, and culture. This sort of analysis may also highlight external factors which would otherwise have gone unnoticed as influential forces. The researcher was then tasked with exploring multi-level frameworks used in healthcare system analysis in the literature to identify frameworks relevant to the RQ.

3.2.2 Types of multi-level healthcare frameworks

To advance this research study and inform the investigation into the research problem, the researcher examined existing multi-level frameworks employed in healthcare, relying in part on models reviewed by Harrison and Shortell (2021); their study of healthcare providers as learning organisations aligns with the learning-in-practice lens held by the researcher. At the same time, the researcher also considered other frameworks relevant to the study context and research approach.

Commencing with a review of the Consolidated Framework for Implementation Research (CFIR), which according to Ndejjo et al. (2020) encompasses 39 constructs organised around five major domains: 1) inner setting; 2) outer setting; 3) intervention characteristics; 4) characteristics of individuals involved; and 5) process factors. The advantage of this framework is that it incorporates a distinction between formal, informal and opinion leaders and is also aligned to an AR-type study supporting reflective thinking, evaluation and processes involved in change and learning within a healthcare system. However, the limitations of CFIR, according to Harrison and Shortell (2021), are that it does not consider market forces, knowledge, technology, social norms, and values. Although gaining popularity as a tool for research of HCOs and healthcare systems facing change, the researcher found it more commonly used in research to understand healthcare-related implementation projects.

Ndejjo et al. (2020) successfully applied the CFIR in their study to identify barriers and facilitators of implementing a community cardiovascular disease prevention programme in Uganda. They identified complexity, lack of compatibility with community culture, and lack of enablers in the environment as barriers to support behaviour change and to mitigate mistrust of the community members. Figure 12 illustrates the CFIR Framework.

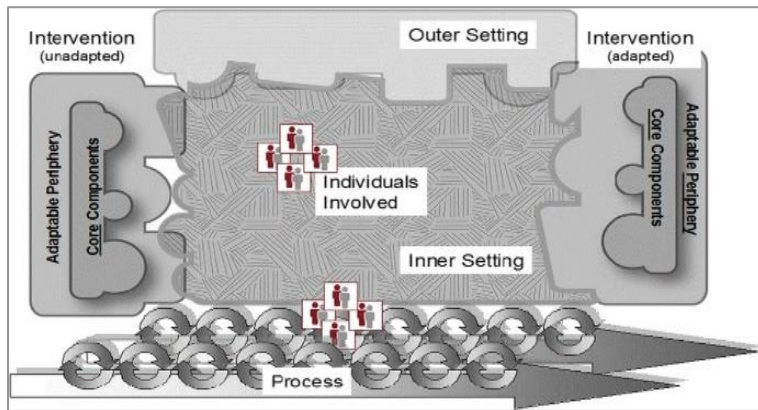


Figure 12: CFIR Framework adapted from Ndejjo et al. (2020)

The next framework the researcher considered is the Social Ecological Framework (SEF). This is a conceptual framework rooted in general systems theory and based on two principles, namely complex interaction and interdependence and their influence on behaviour, within and across levels the healthcare system, as described by Weiner et al. (2012). Interdependence is a characteristic of multi-level perspectives, and the SEF model distinguishes this interdependence into three factors: firstly, influence does not follow only in one direction; secondly, determinants at one level of influence can modify the effects of determinants at other levels; and thirdly, changes at one level of influence can bring about changes at another level of influence. For example, macro policy can lead to changes impacting HCOs at a meso level which in turn can bring about change in the way individual's behaviour at a micro level.

The key principle of the SEF is that it is a multi-level ecological perspective and thus reveals multi-level interventions involving a combination of environmental and behavioural factors to work synergistically or in complementary ways. This, according to Weiner et al. (2012) and Harrison and Shortell (2021), is more effective than a single-level approach. Often represented by nested circles, the SEF makes deductions of the complex interactions characterised by levels of influence involving four contextual layers: 1) intrapersonal, 2) organisational, 3) the community, and 4) the macro-environment. Weiner et al. (2012) and Harrison and Shortell (2021) illustrate the SEF model distinguishing the levels in healthcare provision as: 1) the individual, 2) the organisation (including hospitals, service organisations), 3) the community (local policymakers), and 4) system (e.g., hospital system and government/policy).

The advantage of the SEF model is that it focuses the researcher on how influential factors interact. It does, however, mean that the SEF is more commonly used in understanding and exploring individual health behaviour; for example, Weiner et al. (2012) used it to understand quality-related outcomes in cancer treatment.

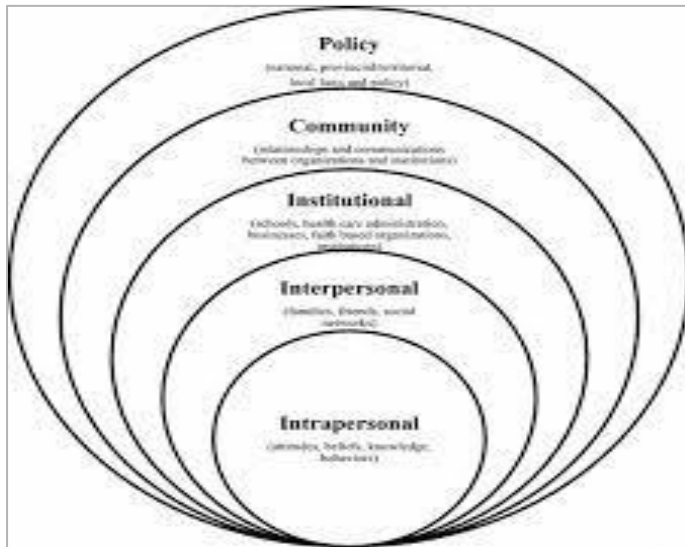


Figure 13: Socio Ecological Framework, adapted from Ferlie and Shortell (2021)

Derived from research on organisational change in healthcare, a third multi-level framework examined in the Harrison and Shortell (2021) research study is the Organisational Change Framework (OCF). In this framework, healthcare provision is made up of four interrelated and interacting levels, namely: the micro-levels incorporating (1) the patient, and the (2) care team (including family members, significant others, healthcare professionals and health provider organisations); (3) the meso-level made up of infrastructure and resources; and (4) the macro-level involving the regulatory, policy framework and societal issues (Ferlie and Shortell, 2001; Proctor et al., 2009). In their study of employing added information and communication technologies for the US healthcare system, Reid (2006) employed a four-level model by Ferlie and Shortell (2001) derived from the OCF model, in order to understand and identify barriers in adaption to reform taking place in the United States (US) healthcare system. According to the authors clarifying the structure and dynamics of the health care system, the interdependencies, interactions, and elements of the system are required in order to realise the vision of a patient-centred health care system.

Similarly, Ferlie and Shortell (2001) adapted this framework and employed a four-level framework to understand and investigate the cancer care system. The authors' model shows that the micro level encompasses the cancer care system as well as the caregiver team (healthcare professionals and providers together with the significant others and family), with the meso level including the wider institutional infrastructure and resources, and lastly the environmental level involving the regulators, the payors, funders and public. In their study, the authors argued this four-level framework based on the OCF illustrates that the boundaries of

the cancer care system go beyond one cancer HCO (the micro level) and extend across healthcare providers, professionals, and the infrastructure (meso level) as well as the environment (macro level). There are interdependencies and interactions between the various levels and stakeholders working together to provide patients with coordinated care across the cancer continuum. These levels enact and thus influence and impact assumptions, actions, mental models, and behaviours and thus response to change occurring in the system, such as when facing healthcare reform. Figure 14 shows the OCF model adapted by Ferlie and Shortell (2001) to demonstrate how the cancer care system goes beyond one level.

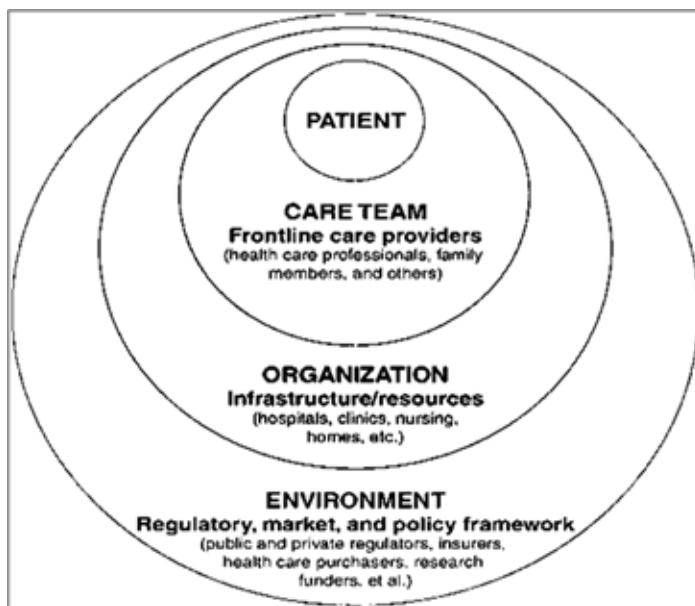


Figure 14: Conceptual four-level cancer care system from Ferlie and Shortell (2001)

Next, the researcher reviewed the Health System Dynamics Framework (HSDF), a framework useful as a tool in healthcare research for both analysis and modelling (Van Olmen et al., 2012). Firstly, the HSDF recognises the importance of healthcare research, and secondly holds the notion healthcare delivery and healthcare systems are complex adaptive systems with agents, elements and organisations interacting (Paina and Peters, 2011). The benefits of the HSDF model are: (1) it recognises healthcare providers and systems encompass multi-levels, and interventions or events at one level influence other elements and other levels in the system; 2) it places importance on values; 3) it links governance, human resources, service delivery and population; and 4) it takes into account that there is complexity involved in analysis and development of strategies when responding to events such as facing change. Figure 15 below illustrates the HSDF.

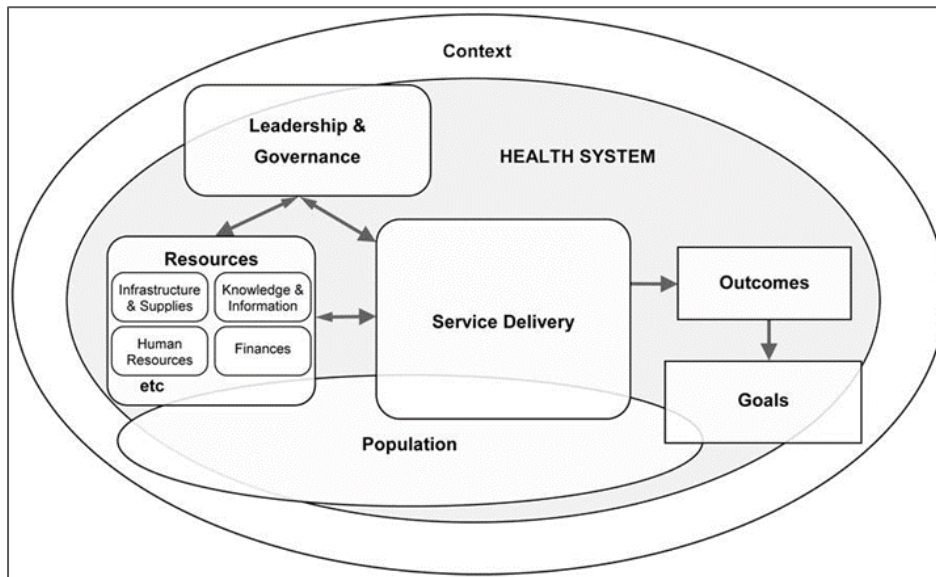


Figure 15: The health system dynamics framework

Lastly, the author considered a multi-level framework identified by Sutherland and Tull (1993) investigating patient-reported quality outcomes in healthcare. More recently, Kapiriri et al. (2007) and Pope et al. (2006) likewise suggest the healthcare system comprises these same three levels, namely the micro level (clinical care program-healthcare provision level), meso level (institutional level) and the macro level (environment: the health systems policy level). See Figure 16 below adapted from the multi-level framework of healthcare (Sunderland and Tull, 1993). The researcher discusses these levels in more detail in Chapter 3.2.3.

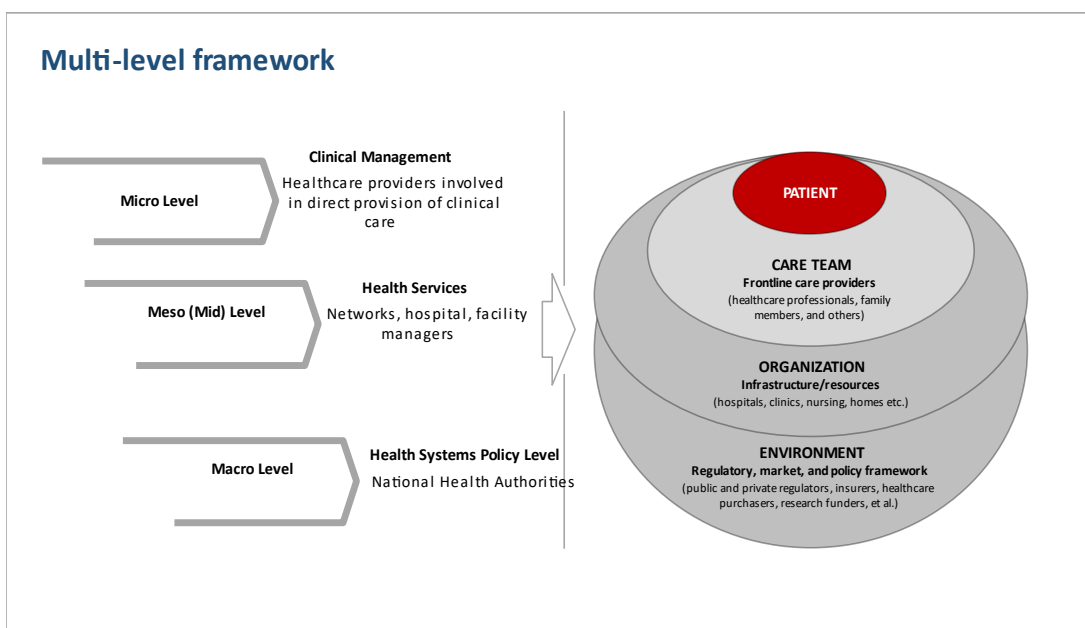


Figure 16: Multi-level network (adapted from model of healthcare services by Sutherland and Tull, 1993 and Jabaar, 2021)


3.2.3 Micro-, meso- and macro-level framework

Drawing on the study of organisations with a focus on real-world phenomena from a practitioner perspective, the term “micro level” is commonly acknowledged to refer to the organisation (Molloy et al., 2010); more specifically in a healthcare context, the micro level or micro clinical system encompasses the care team comprising the professional and family caregivers, support staff, equipment, and facilities (Nelson et al., 1998) together with interactive processes closest to the ground providing patient care. It is the level where the ideas and policies of the government policy (at least in theory) are directly enacted, with individual behaviour and decision-making taking place according to Pope et al. (2006). Reid (2006) suggests that slow adaptation to change is influenced by several factors at the micro-level including the absence of tools, infrastructure, and incentives to facilitate change.

The so-called in-between / inter-relational level is referred to as the meso level, encompassing market forces and infrastructure, and the social institutions supporting the interaction with the micro and macro levels. All of this influences the system dynamics and is responsible for changes in agents’ behaviours and the relationships among them (Anderson, 2016). The researcher postulates that, based on this multi-level model of healthcare, the meso level includes the industry infrastructure and the resources (human and other), business and operating models, processes and systems (including informational systems and clinical systems) to support and coordinate the activities across multiple care teams (Ferlie and Shortell, 2001), for example: industry infrastructure and organisations, professional associations and non-profit/patient advocate groups, healthcare practitioners as well as allied healthcare workers.

As such, change, including the like of the reform of healthcare policy and adaptation thereto, is influenced by a number of elements. These include the ingrained culture of professionals, trust levels between healthcare professionals and healthcare management, the inherent hierarchical nature of the health system, healthcare reimbursement models as well as the diverse and varied organisational cultures and their leadership (Reid, 2006; Ferlie and Shortell, 2012). The meso-level characteristics could result in a number of challenges and barriers.

Lastly, the macro level refers to overarching institutions of the national healthcare system, and national-level issues related to health and social care policy, governance legislation and funding, according to Sallum (2005). The macro level is concerned with processes at the



government, political, regulatory and policy levels. The origins of policy reform lie in the macro level of the healthcare system enacted by policy makers within a wider context of health services, according to Pope et al. (2006). Therefore, the macro level is the political driver behind the policy formation undertaken by the DOH within government structures.

A study of policy change within a healthcare system (in the specific context of the NHS Treatment Centres) by Pope et al. (2006) illustrated how shifting from a single-level focus at the micro level, to include exploring the multiple levels including the meso and macro levels of the healthcare system, revealed the linkages between the levels and also showed how the dynamics enacting within these three levels of the healthcare system influence the success or failure of organisational change.


3.3 Healthcare reform as discontinuous change

Working under the premise that healthcare reform is discontinuous change, the researcher will briefly examine discontinuous change theory and then explore healthcare reform in more detail, ultimately with a view to a better understanding of healthcare reform, and how it will help with identifying the response to healthcare reform, informing the conceptual framework of the research study.

3.3.1 Discontinuous change

Healthcare reform can be explained as disruptive innovation according to Christensen (2006), and as such the researcher postulates it to be discontinuous change. According to Gilbert (2005, p742), discontinuous change is defined as “external change that requires internal adaptation along a path that is nonlinear relative to a firm’s traditional innovation trajectory”.

Building on Gilbert (2005) and König et al.’s (2021) account of discontinuous change in healthcare reform as challenging existing paradigms held by healthcare providers (including entrenched and engrained patterns, principles, mental models, norms, assumptions, and beliefs), we can see that it introduces new processes and structures, requiring a set of new skills and competencies. As such, it requires transformation of how healthcare providers create and contribute value (Christensen, 2006; König et al., 2021).



According to König et al. (2012) the literature shows organisational adaption to discontinuous change is bounded by the decision-makers' knowledge structure, with studies indicating a tendency to maintain the established status quo rather than adopting new ways and mindsets.

3.3.2 The origin of healthcare reform


According to Van Eyk et al. (2001), the origins of healthcare reform are based on a set of efforts of government policy to improve access to quality healthcare, to constrain cost, and to manage demand. Despite policy makers assuming that their healthcare reform is unique, the literature review shows reform aims have common features, including improving the provision of better quality, more cost-effective and safer healthcare. Policy makers often implement measures and efforts in parallel comprising new funding mechanisms, updating of legislation and policies, restructuring of systems and organisational structures, and resource enhancement, for example, recruitment of healthcare professionals and the employment of new processes and systems (e.g., innovative new IT solutions) (Braithwaite et al., 2016, 2017; Merican and bin Yon, 2002; Mechanic and McAlpine, 2010).

Based on the literature review, the researcher summarises healthcare reform as an intentional process involving political frameworks, cultural shifts, socioeconomic circumstances and power mobilisation, aiming to improve healthcare delivery and services by focusing on structure and policy change involving three or four interrelated areas including: 1) developing and implementing of systems; 2) utilizing processes, operations, and other mechanisms to drive efficiency and improve quality; and 3) involving financing, regulation, and behaviour change.

3.3.3 The response to healthcare reform

As shown above, the reform of healthcare policy is multifaceted, multivariable, and abundant with complexity, influencing the behaviour and in turn the response to those impacted by the reform efforts. As such, some agents attempt to hold onto the status quo while others adapt (Marchildon and Fletcher, 2016). Moreover, this response to healthcare reform is influenced by the power-interest structures and relationships between participating agents, their interactions, and the nature of these interactions, argues (Baron, 2014).

The literature review identified several studies demonstrating this influence on the response to healthcare reform across the multiple levels. For example, a study by Mechanic and



McAlpine (2010) clearly demonstrates the impact of the nature of agent relationships on the behaviour and actions of other agents of the HCO facing reform, finding that without physician participation there is risk that the reform efforts can result in disintegration. Other studies such as Braithwaite et al. (2016, 2017), Sturmberg et al. (2014), Dougherty and Dunne (2011), and Glouberman and Zimmerman (2002) identified that both internal and external environment influences impact reform adaption, including the ability to overcome considerable and inflexible constraints such as socio-economic and political powers, the operating and business models of health providers, as well as inter- and intra-organisational values and interests. All of these influence the response to policy reform in healthcare.

The studies show that underpinning all the above are the factors influencing the response to reform and adaption, at the micro-, meso- and macro-level construct of the healthcare system as discussed in Chapter 3.1. Studies by Gilbert (2005), Plsek and Greenhalgh (2001), and Wang et al. (2015) highlight the implications and impact of continuing with the same trajectory at the micro and meso levels, such as persisting with established organisational processes and routines, as well as maintaining operational and business models, and existing infrastructure and resources all contributing to organisational inertia. In a similar way, the macro-level factors, including the complex nature of healthcare provision and healthcare reform, also impact adaption to reform. In other words, if policy makers delineate the problems in healthcare as complicated and thus employ reform interventions based on the rationale of “one size fits all” and/or put in place reform strategies inconsistent with the complexity of healthcare, then adaption to the reform is likely to be limited. Studies by Glouberman and Zimmerman (2002) and Lipsitz (2016) found a barrier to reform adaption is if the healthcare reform design is simplistic and mechanistic in nature.

The researcher also identified other factors limiting adaption to reform of healthcare policy by agents and organisations, including the lack of resilience and perseverance, poor communication, and linking of improvement in quality (Braithwaite et al., 2017).

In summary, the literature and outcomes of empirical studies focused on understanding healthcare reform assisted the researcher to identify that any reform of healthcare policy is characterised by a period of uncertain, chaotic and at times tumultuous change. The common themes and complex nature of reform signal upheaval at a micro, meso and macro level of familiar processes and structures, and this impacts and influences the behaviour of agents and organisations across the multi-level construct, which in turn impacts the response and adaption to the reform efforts.

3.4 Organisational inertia

Given that the basis of the research problem identified is inertia, and a tendency towards maintaining the status quo despite the threat of organisational failure, the researcher explored the literature thoroughly to identify empirical studies on this topic. This approach is supported by Gilbert (2005) who argues that, by distinguishing the types of inertia, their unique implication for the organisational response is better understood.


Chapter 3.4 sets out to describe the fundamental characteristics and debates on the sources and reasons for organisational inertia manifested, when faced by discontinuous change. Organisational inertia represents the price for maintaining stable and reproducible structures that guarantee reliability and accountability for organisations.

A study by Coiera (2011) associated the resistance and challenges associated with healthcare reform and adaption thereof, with organisational inertia.

Although this is not the case in this study's context, the researcher does want to highlight the literature review identified that, when faced with discontinuous change, there are benefits of maintaining the status quo, including maintaining stability and certainty in the face of change. In some cases, this may be more profitable than the emerging alternative.

Alternatively (as identified in this research problem), facing change can be a signal for the need for organisational transformation and adaption, where inertia as a response may be a threat or cause for organisational failure (Rumelt, 1995). Weick and Quinn (1999) describe organisational inertia as the "*misalignment between the internal practices of the organisation and the needs of the external environment*". In other words, the organisation's inability to keep up with the change faced can in some circumstance be a threat for organisational failure.

Theoretical and empirical case studies in the literature about strategy, organisations and more specifically within the context of healthcare reform, identified that the sources and characteristics of organisational inertia are multiple and diverse. A common theme revealed in the literature on organisational inertia is a propensity for organisational inertia as a response to change despite the threat of incumbent failure, and also in spite of the management awareness of the need for change; there is a tendency to preserve dominant organisational routines and to continue with the same organisational trajectory (Wang et al., 2015). In the




study by Coiera (2011) mentioned earlier in this chapter, the author found there is a tendency of HCOs facing reform and policy change to respond with rigidity and inertia.

In considering the sources and understanding of organisational inertia, the researcher considered the various debates and views in the literature. Hannan and Freeman (1984) focus on inertia based on physical investments and social structures, Rumelt (1995) comprehensively classifies inertia as “a strong persistence of existing form and function”, classifying inertia according to five frictions that might occur and influence the response to change faced, including: 1) distorted perception, 2) dulled motivation, 3) failed creative response, 4) political deadlocks, and 5) action disconnects. Meanwhile, Gilbert (2005, p.741) defines organisational inertia as “*the inability to enact internal change in the face of significant external change*”. Gilbert (2005) goes on to differentiate between resource and routine rigidity describing these as “an organisation’s incapability to break investment habits and organisational processes respectively”. The author argues inertia stems from two elements, i.e., resource rigidity, defined as failure to change resource investment patterns, and routine rigidity, an unwillingness or failure to change organisational routines and processes. These are discussed in more detail below.

With Gilbert’s (2005) definition as well as the debates and input from other authors, the researcher examined the characteristics and sources of organisational inertia in more depth relevant to this study’s context, the research problem identified and the subsequent RQ within the researcher’s practice context.

3.4.1 Resource rigidity

Starting with examination of resource rigidity, Gilbert (2005) stated that two important sources of resource rigidity are: 1) resource dependency; and 2) incumbent reinvestment incentives. The theory of resource dependency originating from Pferrer and Salancik (1978) presents external resources as including customers, capital, as well as the market having influence on the internal strategic decisions made by the organisation and how they respond to external change and adapt internally. Firstly, using the external resources highlighted by Gilbert (2005), the researcher postulates that the customer as a resource in healthcare influencing the response to change may include but not be limited to a physician, patient, payor, policy makers and even employees. For example, in a study by Mechanic and McAlpine (2010), the authors identified physicians as influential agents in the healthcare delivery system; if they undermine reform adaption efforts, it impacts the response to reform and may thus be a source of



organisational inertia. Secondly, capital as a source influencing the response to change may include a willingness and/or ability to invest in infrastructure, resources, modern technologies, change in business models, etc. Thirdly, in terms of market factors as sources of inertia, one can consider the debate on market power found in economic literature theory, i.e., if investment in change alters the organisation's dominant position, consideration will be given to whether there is a strategic incentive or disincentive to invest in preserving this dominant position, considering short-term and long-term strategic performance.

In summary, the above discussion highlighted to the researcher that resource dependency and/or preservation of market position are both sources of inertia. In fact, Gilbert (2005) refers to them as powerful forces; they both in turn influence response to change and may support or constrain adaption efforts.

3.4.2 Routine rigidity

Continuing with the same organisational trajectory by persisting with the same form and function as described by Rumelt (1995), or persistence with the same routines referred to as routine rigidity by Gilbert (2005), is characterised by the inflexibility of routines in organisations. To understand the meaning of routine rigidity, the researcher first explored what is meant by "routine" here. The literature describes routines as repeated and learned patterns of response—cognitively ingrained mental models, encompassing interdependent activities embedded in the organisation and often reinforced by the organisation's structures. They are commonly characterised by inflexibility, therefore making it difficult to adapt when faced with change. In other words, a dynamic organisation can respond to changing environments and external forces, whereas structurally static organisations will have a tendency towards inertia (Goethe, 2014).


Moreover, Sydow et al., (2020) argue that, over time, organisations may lose their ability to change as structural inertia sets the organisation on a predetermined path (i.e., path dependency) as it replicates inefficient solutions. As can be observed from the above discussion, routine rigidity, or inflexibility to change routines and patterns, is also a source of organisational inertia impacting the response to change.

3.4.3 Threat perception, or psychological Inertia

In reviewing the literature, the researcher found resource rigidity and routine rigidity are given much attention in the literature whereas less attention is given to the perception of threat as a source of inertia in and of itself. Gilbert (2005) makes note of this as well in discussing the factors influencing organisational inertia. It is not only the organisation but also the agents within the organisation that influence the response to change. Threat perception describes a situation when an identified group or individual impacted by a change perceive they may be worse off than before the change, they revert to the status quo by means of inertia.

Authors Denis and Forest (2012) found healthcare reform and its accompanying outcome measures have significant implications for those impacted, and that can influence the response to reform. Likewise, Van Eck et al. (2001) concluded that reform has long-term and significant implications, as well as risk for the agents and the organisations, for example, meeting performance targets, financial and non-financial performance, and/or their competency and capability to ensure that the organisation is sustainable.

Similarly, a literature review identified the term psychological inertia, as described by Godkin and Allcorn (2008), with the same attributes as threat perception above. Psychological inertia is characterised by members of the organisation resisting change despite the extent of the need. This could include the threat of organisational failure and is associated with fear and threat of change in things they consider having value, for example long-term professional relationships, a job change or new skills needing to be acquired. As such they show a tendency to revert to the status quo. This is supported by studies on reform adaption by Coiera (2011), Mechanic and McAlpine (2010) and Braithwaite et al. (2017). These authors identified there is a tendency by individuals impacted by the reform to revert to the status quo by means of inertia, or that adaption is unpredictable and slow. Studies in the literature highlight this perception of threat as a source of inertia. In a case study by Van Eck et al. (2001) employing a qualitative research approach, the authors aimed to understand the perceptions and experiences of healthcare service providers, from front-line staff to managers, impacted by discontinuous cycles of change due to healthcare reform. Using several methods of data collection, including focus groups, interviews and surveys, the above studies show initial support for the reform by individuals but then a tendency to revert to the status quo because of distrust and perceived threat, which then leads to inertia.



Studies also uncovered that a loss aversion bias is influencing the response to reform, as first identified by Tversky and Kahneman (1974). Loss aversion is the tendency to focus more on the potential for loss than the potential for gains or benefits; as explained by Kahneman and Tversky (1979), “the losses loom larger than the gains”. In contrast to the perceived minimal risk associated with continuing with the same behaviours and habits, the participants view the “switching costs” as high and risky, and fear being worse off. The cost of change is viewed as greater than the reward, as also found elsewhere in the literature (O’Toole, 1995, p161).

In line with the above discussion, a premise put forward by Godkin and Allcorn (2008) is that organisational resistance to change translates into psychological inertia. The authors suggest it is common for members of organisations to resist change despite or regardless of the need to change. Much like the discussion on threat perception, Godkin and Allcorn (2008) argue that change has an impact on the agents of organisations which alerts them to a threat and thus drives a psychologically defensive response characterised by fear, anxiety, distrust, and polarising mentalities. A study by Sturmberg et al. (2014) on the Canadian healthcare system facing reform, including cancer care services, found that blame-shifting contributed to inertia and in turn maintaining the status quo; for example, the executives of the Canadian hospital system “blamed” the government for lack of policy direction, whereas the policy makers “blamed” the competing demands on government resources for other public services, such as housing and education needs.

The literature review also identified more specific causes in healthcare as sources for organisational rigidity and in turn inertia. There is complexity found in HCOs causing the system to be filled with competing demands on structures, which leads to rigidity. In other words, when environmental drivers such as reforms are designed and implemented using a linear approach—particularly to address complex, non-linear problems as found in healthcare—organisational inertia results and thus the status quo is maintained, argue Plsek and Greenhalgh (2001). Furthermore, findings from studies examined in the literature found other factors or reasons which may contribute to the risk for organisational inertia, including organisational age, poorly organised or blunt interventions (e.g., corporate restructuring such as downsizing), and changes in ownership.

The researcher identified that organisational inertia is also influenced by an organisation’s ability to successfully respond and transform in the face of reform, i.e., culture and leadership, as discussed in the following sections.

3.4.4 Insight inertia


Insight inertia occurs when the management or leadership of the organisation facing change may lack understanding or lack the appropriate insight and interpretation of the external changes occurring; as such, they can be blind to what is required to adapt to the demands for change. Huang et al. (2013) defined this problem as one where the members of the organisation do not adequately understand the environment and the cause of the changes.

According to researchers (Argyris and Schön, 1974; Nonaka, 2002; Kim, 2009; Huang et al., 2013), insight inertia results from an interruption in the cycle of organisational learning. The researcher postulates that organisational culture is informed by theories of action, mental models, values and behaviours and assumptions (some long-held and tacit), and these things can contribute to or detract from organisational insight. Godkin and Allcorn (2008) argue that underpinning insight inertia are “incomplete mental models and insufficient theories of action” leading to poor insight into the drivers of change occurring in the environment and thus ineffective generation of actionable knowledge in practice, i.e., poor or lack of learning-in-practice (Ramsey, 2014), and thus continuing with the status quo, which can be a threat for organisational failure.

To overcome insight inertia, previous research has suggested drawing on double-loop learning espoused by Argyris and Schön (1974, 1978). Double-loop learning is enhanced at organisations by shifting from System 1 thinking to System 2 thinking, moving from decision making influenced by stored institutional memory and experience, to one characterised by questioning, challenging long-held assumptions and reflection. Godkin and Allcorn (2008) and Ramsey (2014) recommend and emphasise the benefits of reflexivity practice in the workplace, and as Ramsey (2014) postulates, moments of action can contribute significantly to informing informed action for complex and uncertain change. Reflection includes learning from experience, by examining to gain new perspectives, and curiously promoting individual and group learning.

3.4.5 Action inertia

In contrast to insight inertia, action inertia occurs despite awareness or observation of the drivers of change taking place in the external environment, usually because of a slow, incomplete, and ineffective response or decision-making by the leadership and management



of organisations. This can often be due to compromised organisational learning and memory (Godkin and Allcorn, 2008).

March and Olsen (1975) identified that organisational learning and memory is compromised by interruption of three cycles of learning, namely: 1) role-constrained learning, an inability to act on the new knowledge acquired; 2) audience learning, poor influence on others to adopt new learning; and 3) fictitious learning, drawing wrong conclusions or rhetoric. Kim (2009) identified an additional three, namely: 4) situational learning, where best practice is not discovered or adopted; 5) fragmented learning, a lack of integration in learning; and 6) opportunistic learning, which results from a lack of flexibility in organisational routines, patterns, policies, and mental frameworks.


According to Godkin and Allcorn (2008), the impact of the above can lead to dysfunction, and each individually—or multiple in combination—are sources of action inertia. Furthermore, given that management and leadership dominate the strategic direction and decision-making at organisations (specifically in this context), the response to external change by managerial leadership assumptions, and leadership capacity contribute to action inertia.

3.4.6 Other factors

Other factors identified by studies in the literature as sources of inertia include political ideologies, leadership capacity, provider incentives (including physicians and pharmaceutical companies), the ability or inability to attract high-quality staff, and market competition driving distrust (Braithwaite et al., 2016, 2017). The literature review also found inertia is more likely to occur within an organisation or system which by its nature provides a specialised service, for example a cancer care provider versus a general HCO, which provides multiple services; this is because adding or removing a service impacts a specialised service more significantly. The above discussion based on the literature shows that organisational inertia as a means to maintaining the status quo can create a barrier to reform adaption, increasing the possibility of organisations facing change becoming disconnected from the environment in which they operate and compete, and placing their sustainability at risk.

3.5 Organisational adaption

Building on the theory of organisational inertia and the inhibiting influence on adaption to healthcare reform, organisational adaption is a concept developed over many years and found



in a multitude of theoretical perspectives, including organisational theory, ecological theory, behavioural theory, resource-based theory, evolutionary economics, and contingency theory, as well as in variation-selection-retention models and strategic management.

Organisational adaption theory is also concerned with intra-organisational and extra-organisational levels of the wider populations of organisations and organisational fields according to Sarta et al. (2021), aligning with the multi-level construct discussed previously.

In relating and linking organisational inertia and organisational adaption, the definition developed in an inductive-based study by Sarta et al. (2021) was helpful to the researcher. The authors defined organisational adaption as “intentional decision making undertaken by organisational members, leading to observable actions that aim to reduce the distance between an organisation and its economic and institutional environments.” With this definition, the authors focus organisational adaption on three principal questions: (1) how do organisations pursue adaption with an emphasis on the role of the manager in adaption and strategic perspectives? ; (2) what are the internal factors that enable or constrain adaption and the outcomes of performance, survival and legitimacy of organisations? ; and (3) what is the influence of the environment, especially given their evolutionary nature?

How, then, does successful reform and reform adaption occur? A study by Glouberman and Zimmerman (2002) focused on successful reform adaption in a case study of cancer care services in the Canadian Medicare system. In their study, the researchers found that when policy makers and those impacted by the reform acknowledge the complexity of cancer care, recognising that rational one-size-fits-all planning strategies are ineffective and inconsistent with the complexity, they were able to develop measures and drive adaption.

Christensen et al. (2009) argue that disruptive innovation theory can benefit adaption to healthcare reform. Innovation more commonly found in the sciences and technology can also be disruptive in the ways healthcare is accessed, delivered, and financed. Studies of for-profit healthcare providers facing reform demonstrate organisations responding to the reform of finance mechanisms by transforming finance and billing models. For example, rather than maintaining the status quo, the Mayo Clinic in the United States transformed from traditional purchasing arrangements to value-based purchasing (VBP).

The above studies also highlight that understanding adaption to reform of healthcare policy requires understanding of the agents, including how they interact, their inter-dependencies, decision-making processes and the collaboration efforts that take place between the agents.

3.6 Conceptual framework

The research study aims to identify, understand, and describe these underlying interdependencies, ideas, and actions (Capra, 2003; Lee, 1997) influencing the inertia, and as such leading to the status quo as a response to organisational inertia. The premise is based on a study by Mechanic and McAlpine (2010) which recommends the research of healthcare systems and Healthcare Organisations (HCOs) facing reform, to understand how the micro-processes characterising the cancer care system function and the influence of the agents' behaviour, and in turn the response to the reform. The behaviour of agents in a healthcare system underpins how an organisation addresses and controls or limits inertia of those impacted by reform, according to Coiera (2011) and Van Eyk et al. (2001).

Data collection therefore aimed to understand the interaction, interconnectedness and interdependencies of the agents and the relationship between them by identifying the agents, and the dimensions of the relationships to understand their behaviour, the level of influence, and actions of other agents in the private cancer HCO ecosystem, as well as the impact and influence on the private cancer HCO's response to reform. As illustrated in the literature, this influence occurs across the multiple levels of the cancer care system and as such the conceptual framework was designed with a multi-level approach.

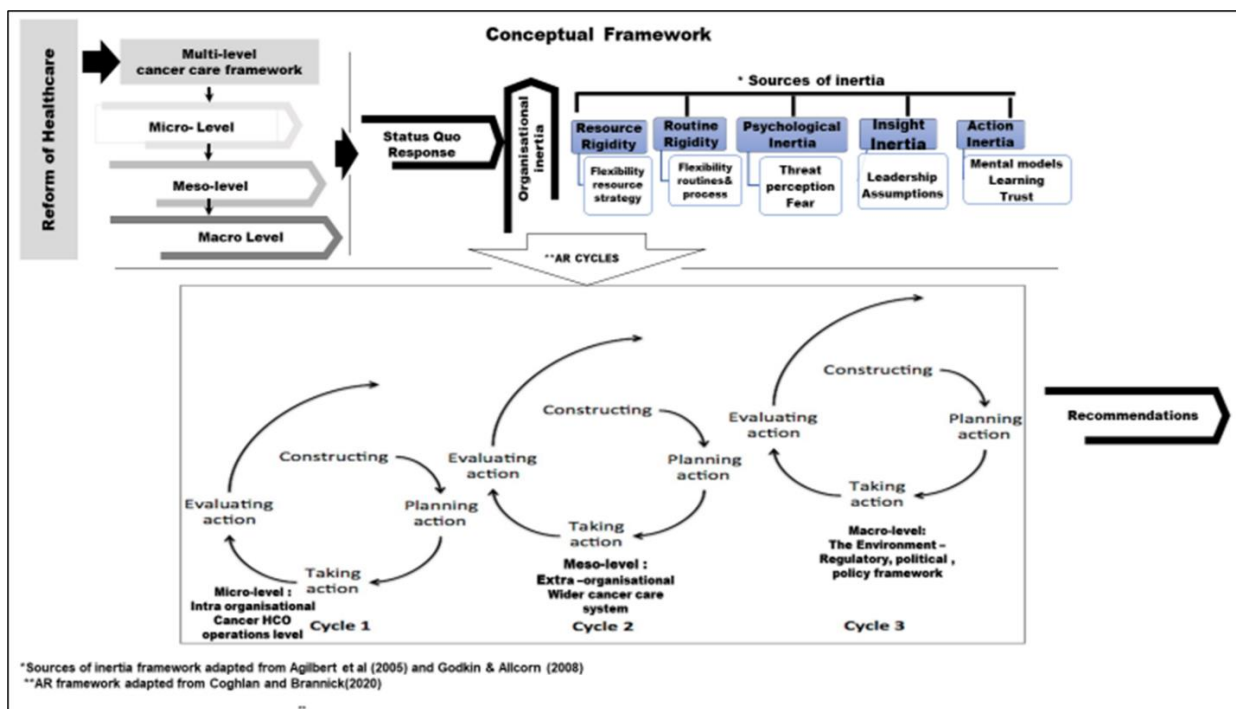


Figure 17: Conceptual framework


3.6.1 Description of the research framework

The conceptual framework aims to guide the research process and the interpretation of the research results by linking the conceptual framework for this study with the theory explored. In developing the conceptual research framework, the researcher's starting point is that healthcare policy reform taking place in SA has evoked a response by the private cancer system. The response is to maintain the status quo by means of inertia.

Guided by the theory (as discussed in the literature review) the researcher recognises the private cancer care system is a multi-level construct extending beyond the boundary of the micro level, to include the meso level and macro level cancer construct. Thus, the researcher's premise is that meanings are generated at these multiple loci (Pope et al., 2006) and thus the multi-level framework and the agents interacting across the levels may influence and impact the response to reform faced. Hence, the conceptual framework is built by applying a multi-level cancer care framework adapted from Sutherland and Tull (1993), Kapiriri et al. (2007) and Pope et al., (2006) to guide the researcher to identify and understand if the interdependencies, interconnectedness, and interactions influence the response and/or create barriers to reform adaption.

This multi-level framework encompasses three domains organised around the patient: 1) the micro level referring to the organisation directly providing care (Molloy et al., 2020); 2) the meso level encompassing the market forces, infrastructure, and network of institutions (Anderson, 2016); and 3) the macro level, referring to the national healthcare system, policy makers, policy development, legislation, and government. To explore and understand the reasons for the maintaining status quo by means of inertia, the researcher employs a framework based on Gilbert et al (2005) which distinguishes the sources of inertia into: resource rigidity characterised by resource dependency and incumbent reinvestment incentives; and routine rigidity characterised by inflexibility of organisational routines and processes. The conceptual framework also incorporates action inertia characterised by learning; insight inertia characterised by mental models and psychological inertia adapted from the Godkin and Allcorn (2008) framework.

As an AR-oriented study incorporating reflective practice, the conceptual framework employs three AR cycles to explore and identify the sources of inertia and how these sources of inertia influence the response to healthcare reform at a micro, meso and macro level. The three cycles each involve a process of constructing, taking action, and evaluating action, with AR cycle 1 at the micro level, the organisational level, AR cycle 2 at the meso level, in the wider



cancer care system, and AR cycle 3 at the macro level, the policy and regulatory level. The outcomes of the AR cycles not only inform the RQ, but also inform recommendations to limit inertia, support adaption to the reform faced and mitigate the threat of organisational failure.

3.7 Chapter summary

The literature review started with a broad-based exploration using key terms of the problem identified, and then narrowing the scope down to examine and review the existing knowledge by drawing on the parallels of other studies in the literature. Through this process the researcher identified a framework encompassing several approaches to better understand the context and the response to reform, by adapting existing multi-level healthcare frameworks in the literature, and organisational inertia theories found in studies, to examine the sources of inertia influencing the response to change triggered by healthcare reform in SA. As such, we seek to generate knowledge for learning and to develop recommendations for action and intervention.

4 Data collection findings and analysis

4.1 Introduction


The intention of Chapter 4 is to present the main research findings and analysis derived from the data collection process.

The findings and analysis emerged through the process of three cycles of AR process adapted from the Coghlan and Brannick (2010) and Saunders et al. (2009) models. As recommended by these authors, the researcher first commenced with a pre-stage phase of framing and constructing to “locate” the problem and understand the context. As presented in Chapter 4.2, the initial phase of learning-in-practice by locating and framing the problem identified that the cancer HCO facing reform does not exist in a vacuum but within a multi-level construct comprising the micro, meso and macro levels of the cancer care system in SA. It is interconnected, with interactions and interdependencies amongst and between the levels and the agents influencing behaviours and responses to change.

Chapters 4.3 to 4.5 present the findings structured according to the outcomes of a multi-level investigation comprising three research cycles involving: Cycle (1) the micro level; Cycle (2) the meso level; and Cycle (3) the macro level.

Chapter 4.3 is relevant to the underlying problem identified at the cancer HCO from Cycle (1). The research focused on identifying the sources of inertia, and gaining an understanding of why the organisation is maintaining the status quo despite the threat of organisational failure. Based on the responses from interviews and from other data collection methods, organisational rigidity emerged as the main theme characterised by resource and routine rigidity, psychological inertia, or threat perception, as well as action inertia and insight inertia.

Chapter 4.4 presents results from AR Cycle (2), the meso-level inquiry. Based on the outcomes of Cycle (1), including learning, and recognising the interconnectedness between the micro and meso levels, the study expanded to include the wider cancer care system, to understand whether the status quo is valid across the cancer care sector. It also identifies if there are shared reasons and meanings, and looks into how these shape the response to reform by the cancer HCO. Based on the responses from interviews and other research data collection methods, the data are organised according to the main theme which emerged, the challenges of healthcare reform faced by the private cancer care system in SA with three subthemes identified as sources of inertia, namely: 1) fragmented oncology services and



disjointed and diverse operational models; 2) threat inertia leading to a tendency of those impacted by the reform to maintain the status quo; and 3) fear and loss aversion.

Chapter 4.5 encompasses the findings from AR Cycle (3) identified at the macro level of the cancer care system, the sources of inertia influencing the response to change due to reform of healthcare policy. These range from the complexity of healthcare and healthcare reform itself, polarisation, distrust of the healthcare reform, and scarcity of resources.

4.2 The SA cancer care system

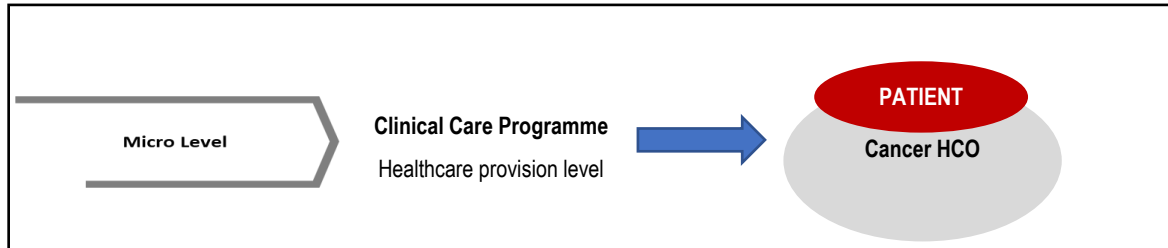
The present research found that the cancer care system is distinguished by a multi-level construct and similar to the previous literature, we findings found deep contextual richness. The cancer HCO is part of a bigger whole, extending beyond the boundary of the micro level to encompass a meso level, including the wider private cancer care network, as well as the macro-level environment including regulatory and policy frameworks. Within this multi-level construct there are interdependencies, interactions, interconnections between the various levels, and agents working together across the continuum of care with the purpose of providing cancer care. The findings show the multiple levels are interlinked, and interconnected with the agents, parts, patterns, functions, elements, resources, and infrastructure interdependent and interacting, all of which is influencing actions and behaviours.

The research found a contextual richness. At the micro level is the cancer HCO and its agents, with its routines, patterns, processes, infrastructure, and resources working and relating to each other for the purpose of providing cancer care to the patient. Next is the meso level, which is made up of the wider cancer care system with a network of agents, infrastructure and resources collaborating with each other across the continuum of cancer care. Lastly is the macro level, the environment level involving the regulators, policy framework, funders, payors, and the public.

The framing of the cancer care system demonstrates how the cancer care ecosystem, and its agents are interdependent, interacting with decision-making processes and the collaboration efforts taking place between the agents along the entire continuum of cancer care. For example, these include interactions between the cancer patient and the healthcare providers, and interdependencies between the patient, the provider, and the role of the payor (medical aid insurer). This has implications then for reform adaption; it is important, therefore, to acknowledge and recognise the linkages and understand the implications when faced with

change, not only for successful adaptation but also for sustainability and survival of the healthcare organisation into the future.

4.3 Micro-level findings



4.3.1 Main theme: organisational rigidity

This section discusses the findings from research Cycle (1), the micro-level inquiry aimed to understand the sources of inertia in the cancer HCO, and thus maintaining the status quo despite the threat of organisational failure, in response to facing reform of healthcare policy.

Based on the responses and narratives from interviewees, documentary and artefact examination, the findings identified organisational rigidity as the main theme characterised by both resource and routine rigidity, action, and psychological inertia at the cancer HCO. The action and insight inertia are characterised by inept leadership, organisational resistance to change, and poor organisational learning. Psychological inertia is characterised by a tendency to maintain the status quo by those impacted by reform. Likewise, the literature review identified routine and resource rigidity as sources of organisational inertia influencing adaptation when faced with change (Gilbert, 2005), while action inertia and psychological inertia are barriers to adaptation, as found by Godkin and Allcorn (2008).

The next section presents the outcomes which emerged from the interviews and narratives, the documentary examination and market analysis, all of which informed the main theme and subthemes at the micro level: influencing the cancer HCO's response to reform in healthcare policy.

4.3.2 Sub-theme: resource rigidity due to dependency on a high-influence agent

The respondents in Cycle 1 consider doctors as central and valuable agents in the cancer care system. As one respondent HealthCo Exec(2), Ms M, stated: *"The cancer care provider*

organisations are dependent on the physician for business growth, the medical scheme is dependent on the doctors for providing treatment to their members and managing the cost of cancer care of the member for the scheme, the patient is dependent on the doctor for the cancer treatment and referral to the providers in the cancer care treatment pathway.”

A second respondent, Patient J, said: *“The doctors are the most valuable healthcare professional in my and other cancer patients’ life, treatment, and our outcomes. My surgeon and the other doctors and the oncology provider she referred me to save my life, I am fine with the NHI rules telling me which primary care doctor to use but not for which doctor to see for breast cancer and where to go for treatment.”*

The interviews show several interactions and interdependencies between the agents, with the high influence of one agent on the behaviour and actions of other agents and the organisation. The data shows the physicians, who are customers (and as such resources) of the cancer HCO, have power. They influence the behaviour and actions of the cancer HCOs and its agents. For example, the hospital manager highlighted: *“The organisation’s growth and success are dependent on retaining the referral relationship with the doctor. The doctor is key to ensuring organisational targets and performance indicators are met, as well as return on investment. The relationship with the referring doctor cannot be placed at risk, especially with the uncertainty and ambiguity around the NHI and proposed new policies. As such the organisation is continuing as we always have.”*

Ms M, the HealthCo Exec (2), went on further to say: *“We support the principle of alternative reimbursement models but to create those we need the doctors as part of the solution. They are central to the design of the ARM within the current market structure not able to employ the doctor, and the doctors also feel that they want to maintain clinical independence. If the doctor does not feel he is rewarded or has not got appropriate clinical independence as they have in the FFS context, he/she will refer to other facility or organisation. We are in a situation that to ensure short-term growth in our business, we are dependent on the referrals of oncologists. Until we can employ doctors, we will continue as is, or else we are at risk of losing the doctor referral to another facility/organisation continuing with an FFS reimbursement approach.”*

Results of documentary examination support the challenges identified around resource dependency on the doctors, as they cannot be employed. According to the current regulations and the views of the physician association, the Health Care Professional Council of SA (HPCSA), the Ethical Rules of Conduct for Professional Registered under the Health Professionals Act (1974) state that *“the employment of medical professionals by non-medical*

practitioner is an undesirable practice". This view is supported by the South Africa Medical Association (SAMA): "SAMA does not support the employment of doctors and agrees with HPCSA [that] doctors should practice autonomously."

A treatment therapist and manager, Ms T, said: "The doctors are happy to continue with FFS. They are quite nervous about NHI and its impact, we need to show them support or else the business is at risk at least until the government is clearer and/or makes the necessary changes required to support change at the organisation that does not place it at risk, until then we are not willing to 'rock the boat' or upset the doctors."

Interviews with doctors who refer patients to the cancer HCO revealed the doctors are continuing with the FFS reimbursement, for example, here is Dr GQ: "I am going to continue with the fee-for-service (FFS), as long as it is still in place, if not I could consider leaving private practice." While an interview with a regulatory representative (and doctor by training) confirms the behaviour and actions of the doctors. Dr K agrees: "If the doctor doesn't feel he is rewarded or hasn't got appropriate clinical independence in the ARM as they enjoyed in the FFS context, the doctor will not support the reform efforts, they will not move away from FFS until there is no choice and there may even be a risk of the doctor leaving private practice."

As shown in the findings above, the literature studies also suggest that high-influence agents, more specifically physicians in this case, have power which impacts and influences the behaviour and actions of organisations and agents facing change in healthcare, such as reform of policy. The literature indicates the same as Gilbert (2005), who argues resource dependency, including dependency on customers, impacts the organisation's internal strategy in responding to external change.

4.3.2.1 Analysis and discussion of findings

The research findings show resource dependency on a customer: the physicians who are high-influence agents with distorted power. The responses from the interviewees, and narratives which emerged from the documentary examination and market analysis, indicate this resource dependency is impacting the behaviour of the private cancer HCO and driving selective inertia as a strategy.

While selective inertia creates certainty and stability at the cancer HCO and between its agents, the consequent organisational rigidity is creating a barrier to change and is a deterrent to the transformation required when faced with reform. The unintended consequence of this

choice is the threat of organisational failure, as the cancer HCO will not qualify for participation in the NHI. In the literature, Gilbert (2005) argues that response to external change and the internal strategy is informed by resource dependency and can be a source of resource rigidity. As shown in Chapter 3, Mechanic and McAlpine (2010) and Kaplan and Babad (2011) identified in the context of HCOs and healthcare systems facing reform, doctors have high influence which can be a risk to reform efforts, and/or a bottleneck to reform adaptation.


4.3.3 Sub-theme: routine rigidity by preserving dominant routines, structures, and processes

The data collection illustrates that the cancer HCO is persisting with the same patterns and routines by continuing with the FFS reimbursement model: *“FFS is a reimbursement model we know, our systems are set up for it, we use the cancer billing codes,”* according to Ms S, an agent at the cancer HCO. This, however, contrasts with the criteria stipulated for qualifying health providers according to the NHI Bill (2019): *“The NHI Fund can refuse to work with establishments or workers (includes physicians and facilities/providers) that: fail to or are unable to adhere to treatment protocol and guidelines; fail to adhere to financing/payment regimen for services delivered; or deliver services that are not acceptable to the fund.”* As noted from the interview with the hospital manager Mr VH HM, *“the organisation has a reliance on the doctors, therefore is continuing with the physicians’ response to continue with FFS.”*

Furthermore, according to research group discussions on the 5th June 2019, around exploring a move from FFS to ARM more specifically for breast cancer: *“Besides needing to change systems like finance and billing there is also a dependency on a number of all providers working together across the breast cancer care continuum to be part of an ARM including the cancer HCO oncologist, the breast and plastic surgeon, anaesthetists, and allied HCPs, for example, wound care and physio.”* Examination of company artefacts shows *“a change in the reimbursement model first requires signed approval according to the corporate governance policy and processes of the holding HCO.”* Further examination found as mentioned by Ms S above, information technology and information system accommodate FFS billing, and new models will require changes and updates.

4.3.3.1 Analysis and discussion of findings

The analysis of the data shows the cancer HCO is preserving dominant institutionalised routines, norms, and processes, by continuing with a well-entrenched FFS reimbursement model and not adopting new reimbursement models despite the threat of not being eligible to



qualify for the NHI. Reasons include inflexibility to change, the challenges associated with the changes required internally as well as interdependency on other agents in the multi-level cancer care system construct, and lack of motivation to change to ARM. In other words, it is a tried and tested model.


The existing FFS reimbursement model safeguards organisational and other agents' personal stakes, including certainty in income and helping to achieve performance targets. The current benefits of and barriers to changing the organisational routines and processes are leading to organisational rigidity and thus are sources of inertia. Likewise, in the literature, FFS is found to be a well-entrenched process which offers benefits of certainty and clarity, and thus is a driver towards the status quo (Silversmith, 2011). The subthemes are aligned with the research studies in the literature review, indicating there are critical levers impacting the range of strategic choices and flexibility influencing the response to reform, including the organisation's financial, administrative, and clinical processes.

4.3.4 Sub-theme: pathway dependency—schemata of the cancer HCO operational and business model

Results from data collection, more specifically from company artefacts (for example, the company website), indicates a disjointed clinical, operational, and business model. Examination of documentation and market analysis done by the researcher show the cancer HCO manages and operates ten radiotherapy-based facilities, owns, and manages six chemotherapy centres and otherwise outsources chemotherapy to around 20+ doctor-managed chemotherapy facilities in the HealthCo network.

The market analysis conducted by the researcher and internal artefacts show the HCO business model is disjointed and results in a complicated shareholder model structure which differs at each radiotherapy facility across the network. For example, some cancer facilities are majority-owned, include both radiotherapy and chemotherapy, and are placed within the 100% acute hospital care (includes surgical and medical oncology). On the other hand, there are facilities with multiple shareholders for the radiotherapy units, several third-party owned chemotherapy units within the hospital or in proximity. As such, each facility in the cancer HCO has its own goals, needs, legal and financial structures. In addition, the IT systems differ between facilities, as does the technology (treatment and information systems).

These findings also show the cancer HCO is fragmented at a clinical and business level, with the patients' journey along the full continuum of cancer care supported by multiple providers



at multiple sites and not integrated within the organisation and between the agents, as Ms O shared with the researcher: *“At a routine gynae appointment at another hospital group the doctor was not happy with a symptom and sent me for a mammogram at a free standing centre, after the imaging and biopsy I was sent to the surgeon at a different hospital, thereafter my chemotherapy was done at an independent doctor because he does trials and lastly my radiation again at other hospital group. Now I am followed up in the public sector.”*


In addition, as indicated in market reports, the cancer, surgical and hospital admissions, including palliative, is managed by another division of the holding HealthCo, and not incentivised to align with the transformation required to adapt to the reform. Data from company artefacts show that *the IT and finance systems are not integrated with each other within the boundaries of the cancer HCO and outside the boundaries of the HCO with each individual provider along the cancer continuum of care, billing the payor and/or patient for each service/treatment/procedure.*

A respondent noted the IT and software systems at the HCO are fragmented and disjointed: *“Our planning systems at the units are different versions of software, making it challenging for patients to move between units. We do not have the same standard for the management of patient data and the treatment flow at each unit, and simple things like billing system and the equipment used for treatment are not integrated.”* Company artefacts show billing is manual, in that a manual patient register drives billing, rather than a digital system integrated with the treatment equipment, raising the risk of human error. According to one shareholder, Dr S, the treatment statistics as reported by the finance manager are not an accurate representation of actual data.

Interviews also show dispersed accountability and lack of agreement amongst the shareholders of the oncology facilities, for example respondent Dr P, who is *“taking a wait and see approach until there is more certainty on the reimbursement and approach to billing. I don’t see a need to change until forced to.”* Whereas, in contrast, the breast surgeon Dr B is campaigning for “readiness” for the NHI, including planning and modelling new finance and reimbursement models.

4.3.4.1 Analysis and discussion of findings

Internal and external artefacts indicate the organisation is constrained by its pathway dependency, with poor strategic flexibility and ability to switch between strategic options. The incongruent finance and IT system places further constraints on the organisation, and as such,



it is challenging for the private cancer HCO to switch between strategic options, espousing the inertia and in turn organisational rigidity.

The literature indicates that the ability and flexibility of the private cancer HCO to adapt to healthcare reform is influenced by the characteristics and schemata of the organisation. Furthermore, fragmentation of services and facilities, together with multiple structures and disintegrated operational and business models, impacts the behaviour and actions of the agents. The literature supports this conclusion, that fragmentation is a source of inertia when faced with reform of healthcare policy, with studies by Plsek and Greenhalgh (2001), Braithwaite (2016) and Wei et al. (2014) all finding that fragmentation contributes to organisational rigidity.

4.3.5 Organisational cultures and leadership with an adversity to change

By taking a “*wait and see approach*,” as remarked by a number of the respondents, the data is indicating the leadership is not responding to the reform proactively. One respondent, Dr Z, remarked how “*the leadership is not dealing with the reform and consequent change required*,” whilst another respondent, Dr GQ, said “*there is an organisational culture that both does not embrace change but also one of ‘a culture to do less’*”. This is supported by the documentary examination as, according to the NHI White Paper (2017) and the Health Market Inquiry (Competition Commission, 2019) into the private healthcare market in SA, it was found that there is a culture that lacks leadership, with poor management skills and weak systems of governance, and a lack of accountability in private healthcare.

4.3.5.1 Summary and discussion of findings

The findings from the data collection indicate the cancer HCO organisation is showing a preference for inertia. There are indications the leadership insight into the external change is either lacking, i.e., insight inertia, or the leadership is aware but is slow or unable to react, i.e., action inertia. A culture which demonstrates resistance to change or lack of perseverance is an indication that the action theories and mental models at the organisation, as well as a poor learning organisation, all attributes of action inertia, are influencing its response to the reform faced (Godkin and Allcorn, 2008).

4.3.6 Micro-level summary: key reasons for organisational rigidity

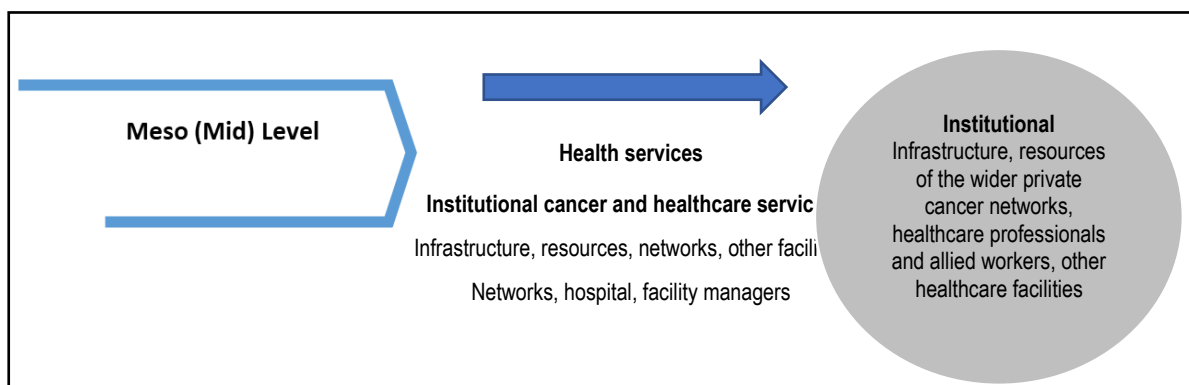
Critical levers are impacting the range of strategic choices and flexibility for the private cancer HCO to respond to reform (including resource rigidity, routine rigidity, and path dependency),


as demonstrated by their reliance on or persistence to continue with inappropriate or outdated or institutionalised processes, routines, and patterns, including financial and administrative, clinical business.

The leadership and culture, and the decision-making systems are subject to action and insight inertia with operating systems, information systems, human resource practices, and constraints on resources all proving to be sources of inertia. This is leading to selective inertia as strategy and while this may be creating certainty and stability between the agents, the consequent organisational rigidity is creating a bottleneck and is a deterrent to both the learning and transformation required; all of this can lead to the unintended consequence of the private cancer HCO underperforming. Like studies found in the literature, the research findings in Chapter 4 so far reveal rigid structures due to underlying mental models and patterns of the cancer care system in SA, which are influencing its response to reform and stifling the transformation required. Unlike dynamic organisations which are flexible and responsive to change, the rigidity of the structures is causing an inflexibility to face the complexities of the reform and therefore the capability to move beyond the status quo of the current situation and, similar to the Wang et al. (2015) study discussed in the literature chapter, the private cancer care system is persisting with institutionalised organisational routines, norms and behaviours, entrenched in SA since the 1970s. This makes it difficult to transform the operational models and business processes in response to the reform.

The analysis uncovered that there is high complexity and entanglement of the relationships between the agents at the private cancer HCO and the other levels in the cancer care multi-level framework, and thus there is a need to expand the research to understand how this shapes the response to reform, and whether the status quo is valid across the system.

4.4 Meso-level inquiry findings: challenges in the wider cancer care network





As mentioned in Chapter 4.3.6, the pre-phase cycle together with the results of research Cycle (1) led to broadening the level of inquiry to enhance learning-in-practice and knowledge construction for problem-solving. As such, a second cycle commenced with research Cycle (2), taking into consideration the meso level. This encompasses the wider cancer care system to understand whether the status quo is valid across the cancer care sector, and to identify if there are shared reasons and meanings between the micro and meso levels which are shaping the response to the reform faced. The researcher also leveraged the outcomes of the knowledge generated at the meso level with the development of interventions and recommendations required for transformation and adaptation according to the literature.

To uncover the underlying systemic forces influencing the response to reform, in addition to interviews, data examination and market analysis, the researcher included a focus/research group. The meso-level analysis presents a broad understanding of the underlying mechanisms of inertia.


4.4.1 Main theme: the challenges of healthcare reform faced by the cancer care system in SA

The main theme which emerged from the interviews is the challenge of healthcare reform faced by the private cancer care system, which in turn influence the response to the healthcare reform faced. Three subthemes were identified and are discussed in more detail in Chapters 4.4.2 to 4.4.4, namely: fragmented oncology services with diverse operational models, a lack of resources, and fear and loss aversion.

4.4.2 Fragmented oncology services and disjointed models of care

The literature indicates that the characteristic of the system influences the response to the reform, as does the access to resources and infrastructure. Data from the market analysis and documentary examination, and from meetings with the research group specifically examine and explore the wider cancer care market. For example, the meeting in April 2019 identified a fragmented cancer care system, further splintered by the two-tiered SA healthcare system causing skewed access: skewed towards the private sector and then even more skewed towards urban-based versus rural-based cancer care services.

Respondents highlighted this fragmentation, including Dr S, Director of an oncologist association: *“Cancer care is an exceedingly difficult environment with multiple players. What*



you get is uncoordinated distribution of practice and skills, for example, three single practices setting up in the same urban area, but under-servicing outlying/rural areas. The cancer service provision is not coordinated.” Moreover, Dr Z commented that *“there is a lack of knowledge of how fragmented and complex the current private cancer care system in SA is. How will they (the government) design and integrate such a fragmented system for the NHI reform environment?”* And HealthCo2 Executive mentioned in his interview that *“the current cancer care system is not designed to offer cancer services as proposed by the NHI policy, it is unrealistic to think that the fragmented model can operate within the NHI environment and the proposed new finance mechanisms.”*

The market analysis reveals more about the wider cancer care system in SA. A patient with cancer requiring treatment enters a system where cancer care treatments are taking place at multiple sites by multiple providers, with medical interventions and services for diagnostics, surgery, radiation, chemotherapy procedures and palliative care taking place and separated by geography and skewed even more with more urban facilities than rural facilities. The organisations and providers of cancer care employ varied operational and organisational structures. In this multiple provider system, FFS volume-based reimbursement models are used, for example, cancer surgery is performed at one hospital, radiation at another and if chemotherapy is required yet be other facility, with palliative care offered at non-profit facilities such as Hospice facilities, but also at for-profit facilities such as step-down facilities or patients are admitted to acute private hospitals for symptom management.

The market analysis conducted by the researcher together with and a stakeholder mapping of the research/focus group showed, similar to the cancer HCO, the operational and business models are diverse with organisations participating in the private cancer care market having different organisational structures, operational and business models. For example, large, listed hospital groups may focus on in-patient admissions, whereas the corporate-owned cancer HCO may be more focused on growing their managed care organisations, while doctors or independent owners may be aiming to generate profit to boost earnings. See Table 6 below, a summary of characteristics of the SA cancer system.

Provider	Revenue Model	Ownership	Managed Care	Chemo	Radiation	Surgery	In-Hospital Admission	Navigation	Palliative	Urban	Rural
A	FFS	Hospital Owned 1		X	X	X	X	X		X	
B	FFS	Joint Venture			X					X	
C	FFS	Independent			X					X	X
D	FFS	Corporate	X	X	X						
E	FFS	Doctor		X							X
F	FFS	Hospital owned 2			X	X		X	x	X	
H	FFS/non profit	NGO							x		

Table 6: Characteristics of cancer care system in SA


In addition, there is mal-distribution, not only between more urban versus rural facilities but also between the provinces across the country. For example, the market analysis shows there are higher doctor-to-population and cancer-care-facility-to-population ratios in Gauteng and Western Cape than in the other seven provinces, leading to poor access in these regions.

Examination of the artefacts and documentary examination show fragmentation is extended to the payors in the market with funding provided through myriad medical aid schemes (medical insurers), with 70 different schemes, offering more than 100 different benefit plans, and rules for cancer care treatment. Most cancer care treatment services are paid for using an FFS model paid for by the medical schemes in the capacity as a third-party payer. The private cancer care system is also faced with managed care organisations appointed or owned by the insurers to manage the clinical and cost effectiveness of cancer care, using several diverse tools, for example, network arrangements, drug, and treatment formularies, etc.

4.4.2.1 Summary and discussion of findings

The fragmented and complex cancer care system in SA revealed by the data is influencing the wider cancer care system's response to the healthcare reform in SA.

The disjointed services and structures extend across a system characterised by fragmentation across many levels, including clinical, operational, service, and geographical disproportion differentiated by various organisational structures. There are many diverse agents and stakeholders with different business goals, and incongruent and disintegrated finance and IT/IS are causing dispersed accountability and ambiguity, and leading to inertia and reverting to the status quo. This is partly what is creating barriers to the adaptation of the NHI reform efforts.



Fragmentation of services and facilities together with multiple structures and disintegrated operational and business models and organisations impacts the behaviour and actions of the agents in the cancer care system, creating inertia and barriers to the reform adaption. Fragmentation in healthcare facing reform leads to dispersed accountability by the agents of the system. It becomes a source of inertia and, because of the interdependencies and interactions amongst the system's agents, it influences adaption to reform by the cancer care system.


4.4.3 High influence of agents

As in the private cancer HCO ecosystem, the data show that physicians hold positions of high power and influence because of the value they hold in the system. As such, they are main contributors to inertia in the wider cancer system as Mr C HealthCo 3, remarked: *“The doctors are central to the design and their full collaboration is needed for implementation of an ARMs, i.e., if the doctors do not participate in developing the ARM and support the implementation thereof, the cancer care system efforts with different models and ideas is impacted significantly.”*

4.4.3.1 Summary and discussion of findings

The data identified that the relationships and interactions between the agents in the cancer care system, their interdependencies and the components are contributing to organisational rigidity, inertia and driving the status quo as a response to the reform faced by the cancer care system in SA. The high influence and distorted power physicians also drive this have in the cancer care system in SA. This high influence and power are due to the high value given to them, and the reliance and dependency the cancer care system has on these agents. In addition, the analysis shows that developing, designing, and implementing actions in response to the healthcare reform, more so the ARMs, will require engagement, and interdependent and collaborative relationships between the diverse agents and organisations in the cancer care system. The physicians must play a central role and without their participation in the reform efforts, disintegration by the organisation is likely to occur.

The development of actions in response to reform and implementation of these is challenging for the private cancer HCO and the wider cancer care system, given that the doctors are demonstrating slow adaption. This appears to be due to several factors, including a persistent culture of professional autonomy in SA, and the absence of incentives to support the change from the current situation and persisting with the FFS.



Studies, for example Silversmith (2011), demonstrate the reward of continuing with FFS is certainty and securing income, autonomy, and other vested interests. FFS is a well-entrenched practice which has been “tried and evaluated and repeated” since the early 1970s. It offers benefits related to reimbursement and clarity, both financial and non-financial incentives. Continuing with the existing FFS reimbursement model safeguards vested interests, such as certainty in income and helping to achieve organisational performance targets. As such, there is less motivation to move to ARM reimbursement. The benefits of maintaining the FFS reimbursement model is a reason for inertia, a source for organisational rigidity and in turn the status quo as a response by the private cancer HCO to reform.

The components and outcomes of the agent relationships influence the behaviour of the agents in the systems. In the wider cancer care system, the high influence and power of doctors influences the behaviour of the other agents in the system. The physicians are reverting to the status quo, and in turn the other agents are acting and behaving the same, in order to maintain the relationship with the doctors, secure business performance and earnings. Studies by Wang et al. (2015), Braithwaite et al. (2016, 2017), Mechanic and McAlpine (2010), Stacey (1996) and Sturmburg et al. (2014) show how the relationships and interactions between agents and the influence of agents with power impact the behaviour and actions of other agents in the system and in turn the response to reform.

4.4.4 Fear of loss / loss aversion bias to healthcare reform

Data collection paid attention to understanding how participants view reform and in turn if it influences the response, even more so the inertia. Examination of NHI documents and interviews with stakeholders found specifically the change in reimbursement strategies together with the uncertainty of provider incentives and the vagueness of the reform measures are causing fear, unhappiness, and concern of loss, especially the impact on earnings and lifestyle. According to Dr K, *“the policy makers have not put forward enough of a business case. If you are in the private cancer business, whether a doctor or provider, there is no first mover advantage, why would you gear yourself up, rather than wait to change. Instead, I am going sit back and wait it out and ensure I earn on FFS as long as possible.”*

The fear or loss aversion bias is a source of inertia, with several interviewees mentioning the preference for a “wait and see approach” rather than the fear and potential risk of “being worse off.” The participants, especially doctors, articulated how the NHI and the ARM payment framework is associated with risk and loss; they do not foresee “advantage” or gain, as

outlined by Dr GQ: *“I don’t know if I will be getting the same amount of money as somebody else who sees two patients whereas in Joburg I see 20 patients a day/clinic because of the bigger population. I’d rather continue with the FFS system until I can find out more or make sure that as a doctor, I will get reimbursed appropriately from the NHI fund.”*


4.4.4.1 Summary and discussion of findings

The participants highlighted loss rather than gain from the reform with the reward for maintaining the status quo specifically continuing with FFS reimbursement as a tried and tested model. It offers certainty of earnings, at least for now, in turn securing the lifestyle of healthcare professionals, and continued commercial success for providers and organisations. The participants do not see the reform as likely to advance their interests. This, together with the uncertainty and risks, makes continuing with the current order more viable for them.

As seen in the findings and discussed above, the agents and organisations of the private cancer care system have considered the pros and cons of the reform change and prefer the default ideological position of maintaining the status quo, because the current policy has incentives and market structures which support their vested interests. This is like studies in the literature on loss aversion when facing change; Eidelman and Crandall (2012) conclude the fear of loss rather than the potential gains of reform measures leads to inertia and influences the response to reform. This uncertainty and fear of loss is found in other literature sources; according to O’Toole (1995, p161), those impacted by reform focus on the potential for loss rather than potential for gains or benefits, especially if losses are seen to be larger than gains, as according to Kahneman and Tversky (1979).

4.4.5 Tendency of those impacted by reform to revert to the status quo

Further to the above, the data collected show there is a tendency from those impacted by reform to revert to the status quo, despite supporting the ideology of providing affordable quality healthcare for all South Africans. While acknowledging improved access to cancer care is beneficial for SA citizens, the interviewees identified risks and implications of reform for them specifically, such as the ability to achieve financial and non-financial performance, and fear of loss in autonomy, as well as the security of income and in turn lifestyle for individual agents such as physicians. For example, Dr F (Hospital/Healthcare Group Executive) says: *“I was responsible for engaging with practitioners and I built reimbursement models to launch network models and was therefore fortunate to experience the good, the bad and the ugly. The reality is that the specialists and all doctors want to do good but there is a balance of*



being reimbursed and not having an administrative headache. As doctors they do not want to chase money but rather use time on patients, however, the fear is the NHI reimbursement, and that does not ensure security of earnings and lifestyle.”

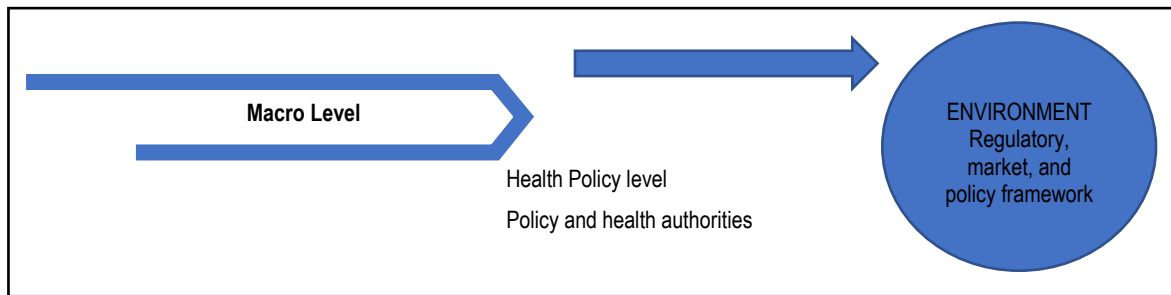
While reports in the media and other sources show there is agreement that SA needs a functioning and accessible cancer care system, the research study findings at a meso-level inquiry show that the means and the how to achieve this varies depending on the viewpoint, role, and function across the cancer care system in SA. For example, policy makers are aiming to improve equity to affordable, quality healthcare, whereas the private cancer care system expressed lack of trust in the policy makers and the ability to achieve reform aims.

The market analysis shows the cancer organisations in the wider cancer level are not making investment decisions and persisting with the same business models and dominant routines, such as continuing to persist with the FFS billing and to measure performance against stagnant metrics, income, and profit targets. This tendency to revert to the status quo is seen in the literature with studies by Van Eck et al. (2001), Anderson (2005) and Braithwaite et al. (2016 & 2017) discussed in Chapter 3; all can be related to fear or change. It is the same attributes described in psychological inertia (Godkin and Allcorn, 2008).

4.4.6 Summary and discussion of key findings at a meso level

Analysis at a meso-level, i.e., at a wider cancer sector level, reveal that there are challenges in the SA healthcare reform with the agents and organisations showing a preference for maintaining the current situation, due to a range of factors discussed in the analysis above. These include lack of resources and infrastructure, politics and intransigence, a lack of congruence of the business, finance, and operational systems, as well as the impact, risk, uncertainty and even fear and loss aversion associated with the reform measures.

4.5 Macro-level inquiry



By framing the research at a multi-level inquiry, the research evolved to include a third cycle including a macro-level inquiry. A macro-level inquiry aimed to identify, understand, and compare commonalities of the outcomes found at the micro and meso levels, and to generate knowledge to better inform learning. It sought to understand the sources of inertia, to support the development of recommendations, and to drive successful adaptation to reform.


4.5.1 Macro-level factors' influence on inertia

The macro-level inquiry identified sources of inertia due to factors in the macro level, including the complex healthcare system and healthcare reform. The subthemes identified and discussed in more detail in the following include scarcity of resources, blame-shifting, distrust and polarisation, and poor linking of quality with reform efforts and measures.

The data collection comes mainly from company artefacts, market analysis, interviews, and the research group, which revealed a scarcity of skilled cancer care professionals and caregivers in SA. According to a report by Econex (2008) there is only a finite number of healthcare professionals and resources, with only 251 oncologists to serve a population of 59 million (i.e., one oncologist per 235 000 patients for the private and public cancer sector). This lack of resources places constraints on all oncology providers.

4.5.2 Blame-shifting

The findings also uncovered that there is a shifting of blame contributing to the inertia, specifically the blame shifted to the policy makers for not providing adequate economic resources to ensure access to cancer care, with the participants raising the allocation of funds to other healthcare needs such as HIV rather than cancer care services. The blame-shifting is also taking place in the opposite direction, with policy makers shifting blame for inadequate cancer care services to the “expensive” private sector.




The blame-shifting, more so at an economic level, is a source of inertia and a preference for maintaining the status quo is not unique to SA, as shown by Mechanic and McAlpine (2010). They demonstrate that, in the context of the USA healthcare facing reform, policy makers have been "blamed" by healthcare executives for the lack of economic resources or allocating funds to competing demands on the public services budget. Mechanic and McAlpine (2010) cite this blame-shifting as contributing to the inertia and status quo in the USA healthcare environment.

The data collection process found the stakeholders having radically different ideas of the reform, depending on which aspect an agent is dealing with. According to examination of artefacts, including conferences and media reports, one of the main drivers of poor access to cancer care treatment and the lack of affordability of cancer care (and other healthcare in SA) is due to the duality of the healthcare system and funding mechanism. The private sector serves 20% of the population accounts for 50% of the GDP healthcare spend, based on an FFS reimbursement. Blaming the private sector for high healthcare costs has become commonplace, and as one NHI sub-committee member, Dr K, indicates: *"however, the bubble is going to burst as the current fee-for-service model is going to reach a point that it is not sustainable. Already, there are many people on private medical aid where funds are running out sooner during the year. As that gets worse and there is no more cash running into the private system, people are going to leave the private sector and go to the public sector. The private sector must restructure especially the medical aids to benefit the majority."*

According to policy makers, the increase in private healthcare expenditure is within its mandate to resolve, and the unequal distribution of resources should be rectified. Moreover, the government's perspective is such that the private sector is contributing to, and largely to be blamed for, the national health crisis and the inequality in healthcare delivery to all.

In contrast, the agents in the private cancer care system believe they offer value as providers and to the economy. Notes from a telephonic interview with an independent oncology centre owner, Dr S, show that *"we offer value, high-quality access, whilst at the same time contributing to the SA economy, employ many SA citizens, however they also need to deliver ROI and shareholder value as they are privately owned or publicly listed companies."*

Ms L, from the non-profit association (and a cancer survivor), added in an interview: *"As a patient with medical insurance with access currently to private cancer services, there is a fear NHI will lead to losing access to high-quality services and choice. Whereas the poorer population see reform as an opportunity to access healthcare services not previously"*



accessible, medical insurers see reform as a threat to their business model and sustainability. Whilst government and policy makers believe it is affordable, most citizens, opposition political parties and even some government officials believe NHI is not affordable. The privately insured population fear losing access to high-quality services, whereas the poorer see an opportunity to access quality healthcare.”

4.5.3 Dysfunction, polarisation, and distrust

The data found the agents have diverse political ideologies, a lack of confidence and a distrust in the policy makers’ ability to implement and manage the reform measures and the NHI, and as such are shifting blame. For instance, Dr K feels *“[p]eople are sitting back saying there is no political will because it changes the power dynamics between national health and the provincial departments of health, moving the dynamics away from the provincial leadership.”*

In addition, Dr S, head of the oncology doctor association, voiced the following: *“This is lack of confidence in policy makers’ ability to galvanise the NHI reform and implement reform within the timelines, as to date, the reform efforts such as amendment of regulations and pilot projects have been slow and protracted.”*

Much of the discourse about NHI is centred on corruption in public sector services and the lack of resources and quality care in current public facilities, using examples of the SA government’s poor history in managing state owned enterprises (SOE) and corruption. The participants referenced a number of examples, namely: the state-managed electricity giant (Eskom), state-owned broadcasting organisation (SABC) and state-owned transport organisation (Transco).

Dr Z remarked: *“The public sector service does not currently work. There is poor access, lack of leadership, resources, clinical services, and equipment together with poor quality, how can we be expected to transition from a system that works, i.e., the private, into a system that doesn’t work, i.e., the public sector?”* Patient J agrees: *“Honestly, I am yet to be convinced it will work, for me it is just an idea that will never be fully implemented because the logistics of it are far-fetched and there isn’t leadership to get it done.”* As does Dr S: *“If you look how state health services are now and you were to introduce new reimbursement payments, say a fixed bundle, it will be problematic because there is already a culture so ingrained to do less?”*

4.5.4 Poor linking of quality outcomes with reform

A participant from the research group identified poor quality as an implication for patients: *“In an NHI environment how does success look from a quality point of view for patients? If the specialised cancer doctors are told where to refer to in the NHI system, and the patient is managed poorly by the hospital, or healthcare professionals, who will be penalised? How will this be measured?”* Dr K points out further issues: *“The components of case management for a cancer patient must be thought out carefully. Will there be a symbiotic relationship between the cancer healthcare team that will be good for the patient?”* As does Dr J: *“I do not see how the cancer treatments are going to be any better than what the state currently providing as it is still the same funding pool that will have to spread across more people. At some point funds do wither away because funding is not finite. I do not see why in an NHI environment everyone thinks suddenly there is going to be access to better care.”*


Dr P, one of the first doctors interviewed, said *“I am concerned that the reform is ambiguous and lacks detail on mandatory reporting of outcomes versus cost which means there is no data to evaluate and reward quality and appropriate care. There is also nothing in the reform about measuring quality and treatment timeline, i.e., how long does it take to access care as a cancer patient? We have a well-known history in South Africa of cancer patients on long waiting lists for cancer treatment which impacts outcomes negatively.”*

Dr P goes on to say, *“Oncology in SA needs quality at an international benchmark. I am concerned the NHI focus is on high volume and low pricing which leads to compromising of quality. Regulators must address quality risks; the Office of Healthcare Quality and Standards needs to be more effective.”*

However, in contrast to the participants’ interviews, the NHI White Paper (2018) does refer to not only improving access to affordable healthcare but also that the provision of care based on scientific evidence, implementation of clinical guidelines and protocols together with the establishment of an Office of Health Standards Compliance (OHSC) to enable inspection and ensure compliance with the norms and standards.

4.5.5 Summary and discussion of findings

Given that this perceived poor linking of specific reform initiatives with outcomes for improvement—and quality measurement—is associated with poor reform adaption and a



reason for inertia identified by the respondents, the research study shows a preference by the participants, in particular the HCPs and patient respondents, that they will opt for the current order (status quo), where quality is immersed in private practice and monitored by insurance payers. Thus, the researcher concludes that linking cost and quality measures with reform efforts to address and resolve the past and current irrationalities in the cancer care system is contributing to poor reform adaption. This is supported by studies found in the literature, which identify that linking reform initiatives with quality monitoring drives successful adoption (Braithwaite et al., 2016, 2018).

4.6 Chapter summary

The findings and analysis above identified several sources influencing the response to healthcare reform, namely: organisational rigidity at a micro level, mainly due to resource and routine rigidity as sources of inertia; at a meso level, the perception of threat and/or psychological inertia; and at a macro level, the complex nature of reform and of the healthcare environment.

The micro-, meso- and macro-level inquiry and analysis help bring to light the findings from this research study and inform the research problem, all aimed at understanding why the agents and organisations of the private cancer care system in SA faced with reform are reverting to the status quo by means of inertia, despite the threat of organisational failure.

5 Conclusions

5.1 Introduction

As a feature of learning-in-action, the study included identifying the sources of inertia and, by so doing, identifying the features needed to support adaptation to change. As discussed in Chapters 1 to 4, using an action-orientated approach, the study investigated the sources for inertia which are shaping the response to reform by the private cancer HCO. The research study employed an adapted multi-level healthcare framework encompassing the micro, meso and macro levels of the private cancer care system of SA to frame the problem; analysis identified the sources of inertia as a means for maintaining the status quo despite the threat of organisational failure.

Chapter 5 presents a conclusion by summarizing the sources of inertia deduced through the inquiry process and thus in a way offers a “diagnosis” of the research problem; by learning from these outcomes, it develops and presents recommendations to address the barriers and implement enablers of reform adaptation. The discussion of these follows using this same multi-framework approach to ensure consistency: 1) micro-level: organisational rigidity; 2) meso-level: challenges of the wider cancer care system; and 3) macro-level: socioeconomic and political sources of inertia.

In Chapter 5 the researcher delves deeper into the how these sources of inertia influence the private cancer HCO organisation’s response to reform, and thereafter presents recommendations for action and interventions. The analysis also uncovers that the private cancer HCO does not exist in a vacuum but within a national and local context which causes significant challenges for the organisation’s behaviour and actions; these challenges include the strategic change required in responding to the reform. More specifically, the need to improve organisational learning, develop and design new strategies, such as ARMs and alternative cancer care delivery models, and establish collective leadership focused on overcoming barriers to adaptation and supporting organisational sustainability.

Reasons for inertia at the private cancer HCO	
Micro-level: Organisational rigidity	Resource rigidity: resource dependency
	Routine rigidity: habits and behaviours
	Resource rigidity
	Defensive mechanisms due to threat perception and psychological inertia
	Structural inertia: action and insight inertia
	Leadership and culture
Meso-level: wider system factors	
Challenges in the wider cancer care system in SA	Fragmentation, multiple business models
	Inflexible process and structures
	Threat perception and defensive mechanisms
Macro-level	
Environmental-level complexity	Diverse socio-economic challenges
	Dysfunction, polarisation, and distrust

Table 7: Reasons for inertia by the private cancer HCO


Based on the objectives of the research, the following questions are addressed and analysed at a micro, meso and macro level with recommendations employed in practice discussed:

5.2 Micro level: organisational rigidity

RQ 1: What are the sources of inertia at the organisational level, and how are these influencing the response to healthcare reform and reform adaption by the cancer HCO?

At a micro-level, the dominant theme identified as a source for inertia to maintain the status quo is organisational rigidity characterised by resource rigidity; this is due mainly to resource dependency and routine rigidity by persisting with institutionalised routines, patterns, norms, and structures. Threat perception and psychological inertia, together with action inertia and insight inertia, contribute to both resource and routine inflexibility.

The findings show that, at a micro level, organisational rigidity, and inertia as a response to reform faced by the private cancer HCO is due to number of sources characterised by routine rigidity and resource rigidity.



Structural inertia and organisational rigidity are made up of several factors, including complex internal structural arrangements; the pluralistic and fragmented private cancer HCO system and operational model; constraints in resources; the internal and external political landscape; the availability of information; and the organisation's historical path. These are among a number of factors limiting the ability for the private cancer HCO to innovate and adapt to reform, and instead the private cancer HCO instead reverts to the status quo.


5.2.1 Resource dependency

The research study identified that the interaction and interferences amongst the system agents at the private cancer HCO influence and impact the response to reform, with physicians being identified as having high influence and distorted power. In turn this influences the inertia of the agents and organisations in the system including the researched organisation, and its response to reform. With the doctors preserving current norms and routines, including continuing with FSS models of reimbursement, the private cancer HCO is also continuing with the same behaviour.

The selective inertia and reverting to the status quo are a strategic choice made by the private cancer HCO to lower risk and maximise utility for day-to-day management and decision making (Samuelson and Zeckhauser, 1988) aimed at achieving current financial and non-financial targets for the researched organisation.

At the micro level, the research findings identified that resource dependency is causing resource rigidity and thus inflexibility to respond to the discontinuous change of healthcare reform at the cancer HCO. This resource dependency is stemming from the customer (i.e., the physician), who is a powerful, high influence agent with influence on behaviour and actions of the organisations and its agents; this has huge implications for cancer HCO. Furthermore, the study shows these are interlinked and relational with the meso and macro levels, with elements of the routine and resource rigidity interlaced with psychological inertia and threat perception, action inertia and insight inertia, as discussed below.

Resource dependency theory has important implications for the cancer HCO, and how they manage the implications impacts the organisation's competitiveness and organisational survival (Pfeffer and Salancik, 1978). These implications are stated explicitly in this research, as the aims of the study are underpinned by the need to identify and understand the sources



of organisational inertia; this is because inertia has been identified as a threat for organisational failure by maintaining the status quo.


Pfeffer and Salancik (1978) developed resource dependency theory, explaining that organisations' behaviour is affected by external resources. The theory goes on to highlight that power and resource dependency are linked, and that it is also relational and situational. The research outcomes at a multi-level analysis demonstrate the links.

It is not only that the physicians are high-influence agents whose power and influence impact the organisational rigidity at the micro level (the cancer HCO); even more so, it is that the physician's behaviour is influenced by factors and elements identified at the meso and macro levels. The data analysis shows that threat perception and psychological inertia at the micro level and the meso level are drivers of the physician's behaviour resulting from fear, anxiety, uncertainty and "looking after their vested interest." As such, there is a tendency to revert to the status quo. This in turn is impacting the cancer HCO strategy of selective inertia as a response to resource dependency on the physicians. At a macro level, distrust, polarisation and dysfunction, lack of resources and lack of enabling policy frameworks are also influencing the physicians' behaviour.

This is further exacerbated by action inertia and insight inertia. The data indicate insight inertia with leadership, in that—despite awareness of the reform and its implications—they are slow in developing strategies and innovations. Simultaneously, action inertia is not only contributing to the micro-level response of the organisation but also impacting the physicians' behaviour; as mentioned at the start, this is a source of resource dependency and thus organisational rigidity. These observations also demonstrate the interconnectedness and interlinking of the multiple levels of the cancer care framework.

5.2.2 Routine inflexibility

At a micro level, the research study identified that institutionalised behaviours and habits are the reason for the routine inertia, and in turn the source for the status quo response to reform. Likewise, the literature has identified that rules and behaviours may be so entrenched that it limits action, making the organisation static, inflexible and resistant to discontinuous change (Edmondson et al., 2001).



The findings of the data collection and analysis at the micro level, as discussed in chapter 4.2, identified routine inertia and defensive mechanisms due to fear, anxiety, and uncertainty. As a result, the cancer HCO and its agents are continuing with existing habits and behaviours as they offer certainty, comfort and both financial and non-financial benefits, as well as a sense of stability (Hodgson, 2004; Samuelson and Zeckhauser, 1988). In contrast, the research outcomes show that adapting to change is associated with moving away from tried and tested models; this is characterised by uncertainty, high risk, ambiguity, discomfort and protecting vested interests. As far back as the 1800s, James (1893, cited in Samuelson and Zeckhauser, 1988) argued that “habits can become the most precious conservative agent in the society and prevent change”. It was interesting to note how many times the respondents mentioned a preference for the “tried and tested;” see chapter 4 for more. As shown in both the study outcomes and the literature, behaviours and habits are a source of routine rigidity and in turn organisational inertia as a response to healthcare reform faced by the researched organisation (Hannan and Freeman, 1984).

5.2.3 Other sources of inertia

The researcher also considered that the private cancer HCO has been in operation for over 20 years, and by its nature, it is a specialized organisation. As such, making changes such as adding or removing a service offered or making structural changes can have a significant impact on the organisation. At the same time, poorly organised or blunt interventions (e.g., corporate restructuring, such as downsizing, change in ownership or leadership changes) are not necessarily a solution and is type 1 mode thinking. Effective change incorporates double-loop learning as an organisational culture (discussed further later in this chapter).

In addition to institutionalised habits, the research indicated that structural inertia is contributing to the ability of the cancer HCO to respond to change. Structural inertia (similar to attributes of action inertia and insight inertia) relates to the effectiveness of learning and adjusting structures in response to change which, according to Hannan and Freeman (1984), must be commensurate with the change occurring in the environment. This is illustrated in the findings with the data indicating both action and insight inertia occurring at the micro level, as demonstrated by the leadership not responding to the change effectively and efficiently; as a result, the organisation is slow to learn in response to the changing environment.


5.2.4 Recommendations and interventions: micro-level

Persisting with the conservation of organisational inertia has implications and impacts both performance and sustainability (Singh and Lumsden, 1990). As discussed in chapter 4, outcomes from AR Cycle (1) at the micro level harnessed valuable findings, to ameliorate the response to the healthcare reform faced by the cancer HCO and to develop recommendations and interventions for the organisation to remain relevant and sustainable within the new landscape (Midgley, 2003).

Underpinned by the research outcomes and fortified by explanatory theory, and aiming to reduce defensive routines and promote organisational and individual change at the cancer HCO, a five-step framework adapted from Friedman (2003) provides the foundation for development and implementation of recommendations : (1) problem identification—the study allowed participants to describe the problem of reform and inertia as they see it; (2) management perception of the problem—the researcher engaged with the management level to see if the data gathered reflects the problem accurately from the management perspective; (3) gap identification—based on steps 1 and 2, dialogue helped to identify gaps and differentials and this then illuminated the “current situation at the organisation versus the desired situation”; (4) clearly identifying the reasons for inertia, organisational rigidity—the study outcomes found the sources of the organisational inertia are routine rigidity and resource rigidity underpinned by insight inertia, action inertia, and threat perception based on long-held mental models, assumptions and biases engrained in the current operational and business model; and lastly (5) develop a plan based on outcomes of steps 1 to 4. to address the organisational change, and the tools required for supporting adaption to the healthcare reform faced at the organisation.

With the above as a foundation, and keeping in mind the plan and tools i.e., “the how” to limit inertia and mitigate the barriers to reform adaption, the interventions include harnessing the change by shifting organisational learning from single loop to double loop learning by promoting a culture of questioning and challenging (Friedman et al., 2015). Especially around current routines and practices i.e., “we have also done it that way” and entrenching reflective practice to embed a culture of learning (Godkin and Allcorn, 2008) at the cancer HCO.

As such, the recommendation focuses on encouraging the organisation and its management to challenge and re-evaluate the core organisational routines, and embedded assumptions. This helps the cancer HCO address the defensive mechanisms and identify problems and




opportunities and in turn informs action. To generate knowledge, promote a learning organisational culture and reflective practice which informs more efficient and effective decision making and action, the organisation has established cross functional learning teams/groups (Friedman, et al.,2015). Representatives participate, sharing ideas and experiences from multiple perspectives including: nurses, treatment therapists, navigators, the wider cancer care network agents, organisational management , physicians and if relevant policy makers and patients.

As a start, the organisation has established and/or revived various functional groups/panels and steering committees (using an AR approach). These include the more clinical-based steering committees, such as the Quality and Clinical Governance Committee, and the Community of Practice (COP) focused mainly on enhancing clinical care, standards, and policies, education, and upskilling. Although these are clinically focused, they are proving to be a catalyst for sharing ideas and experiences on a regular basis, not only informing action and learning, but increasing trust amongst colleagues as it is providing a platform to acknowledge emotions rather than a culture of “silence”.

In addition, to the clinical-focused panels, other opportunities which are enabling reflective practice are learning groups (each with steering committees) concentrating on various strategic projects under development at the organisation, with representatives from across the organisation including: the oncology business function, operational representatives, subject matter experts, finance and product development. Once such learning group is the project team developing the VBC model (discussed in 5.3.3). As discussed below, the VBC model addresses sources of inertia and barriers to reform adaption at a meso level whilst also addressing the micro level factors identified in the study; importantly the resource dependency and routine inflexibility. Furthermore, there are cross functional employee committees focused on employee equity, health, and safety, learning and development which also contribute to enhancing reflective practice at the organisation.

The various learning groups and steering committees are questioning the long held assumptions and established routines, structures, and processes at the organisation, and are constructively challenging the status quo. These include exploring current and future models for reimbursement, digital and IT platforms, marketing, workforce models and financial processes as well as organisational policies and routines.

Aligned with entrenching of reflective practice at the organisation, a reflective lens has been employed to identify challenges in the learning groups, for example, distrust has emerged and



thus a need to create an environment of trust amongst diverse set of colleagues, as well as logistical concerns needing to be addressed to an extent: the learning teams are hosted both in-person and on digital platforms. In contrast to the challenges identified, management are identifying problems faced by the organisation sooner and are thus aware of opportunities for action earlier, as an example, the lack of consistency in patient pathways. By embedding reflective practice, a shift is taking place from poor and slow learning to generating actionable knowledge at the organisation, which is shifting the culture of single-loop learning to double-loop learning (Godkin and Allcorn, 2008). As a result, the HCO is learning to be more capable of responding to change such as healthcare reform.


Given the nature of the multi-level cancer framework and its interconnectedness, there are interlacing elements between the levels (and agents) which extend to the sources of inertia and thus recommendations are designed to extend across the multi levels. Therefore, recommendations at the meso level discussed next, also address the sources of inertia at the micro level, as mentioned above; resource dependency due to the high influence of the physicians, and embedded routines and processes (reimbursement strategies).

5.3 Meso level: complex cancer care ecosystem

RQ 2: Does the status quo hold valid across the wider cancer care system, and what are the sources of inertia which shape the response to healthcare reform?

5.3.1 Fragmentation, indecipherable business models, and intransigent systems and processes

Research findings and analysis at the meso level (that is the institutional level, the wider cancer care system) is comprised of fragmentation, a mix of multiple business models with intransigence of structures, and indecipherable systems and processes. This is not dissimilar to a study by Christensen and Hwang (2006), which found jumbled business models and fragmentation to be sources for the lack of innovation when responding to change triggered by healthcare reform. The fragmentation is accentuated by an imbalance in access to cancer care due to the dual healthcare system, and service delivery being skewed towards urban-based services. This system imbalance contributes as a source of inertia, as the private sector will continue to show a preference for maintaining the status quo driven by short-term financial and profit objectives (Kaplan and Babad, 2011). Furthermore, the system imbalance demonstrates the impact of macro-level factors including policy frameworks and a lack of



enabling reform; together with the current healthcare system, this is influencing the behaviour, actions and assumptions of agents and organisations at the meso level, which in turn is influencing the behavior and actions at the micro level.

5.3.2 Threat perception and defensive mechanisms


Threat perception and psychological inertia due to feelings of risk and uncertainty, fear, and loss aversion—as well as vested interest—are a motivation to maintain the status quo; it not only supports financial incentives, but provides professionals and patients access to the most recent technologies whilst also providing a perception of certainty and autonomy. Cancer provider organisations are sources of inertia impacting not only the response by the wider cancer care network but also the response at a micro level as discussed in 5.2.1.

In response to RQ 2 the findings show the status quo holds valid across the wider cancer care system, influenced by several sources as discussed above. In addition, the meso level is not only interconnected and interacting with the micro and macro levels, but the sources of inertia found at the meso level influence and contribute to maintaining the status quo as a response to healthcare reform.

5.3.3 Meso-level recommendations

To support reform adaption, and drive readiness for the NHI, the recommendations and interventions address the challenges and barriers to reform adaption identified in the research at the meso level, characterised by fragmentation, disjointed business models, intransigency, and psychological inertia. The recommendations also keep in mind the study data revealed the high influence of physicians on the behaviour and actions of other agents. Thus, critical to the recommendation here is gaining the participation and support of the physicians.

Fortified by the knowledge generated from the research findings, the cancer HCO commenced with the development of a value-based cancer care model. The VBC model development is an intervention which addresses barriers to adoption of reform across the multi-level cancer care framework including those identified at the meso level such as fragmentation of care, and physician (and patient) experience, whilst maintaining commercial sustainability of the cancer HCO, and importantly drives readiness for NHI. According to Porter (2010, p.2477): “value in healthcare is defined as “outcomes relative to costs, thus value encompasses efficiency”.




To operationalise the VBC model within the practice environment of the cancer HCO, the recommendation involves narrowing the scope by orientating the development of a VBC model to breast cancer. However, one of the goals is to ensure that the VBC model developed for breast cancer can be employed across all cancer services in the future. Breast cancer is the most prevalent and highest incidence of cancer in SA, according to the Globocan report (Bray, 2018), and sees the highest cancer-related patient treatment admissions. The focus thus shifted to organizing a breast cancer model incorporating a multidisciplinary, integrated, and comprehensive breast care service, underpinned by the triple aim framework: cost, quality, and efficiency. This redesign of the breast cancer journey incorporates transitioning from a volume-based, disjointed FFS model with redundancy, to a holistic, integrated and patient-centric breast cancer care model based on a global fee payment model.

This process of shifting to a global fee commenced with a multi-pronged and comprehensive approach commencing with building enhanced patient journey by first defining the breast cancer pathways to indicate the different clinical scenarios, including combinations of procedures and tariff codes currently employed in clinical practice. In parallel, there is a process of conducting analysis of the financial flows, including drivers of cost. The model addresses the fragmented nature of cancer care by integrating services including surgical oncology, plastic / reconstruction surgery, hospitalisation, and radiation oncology into one care and payment model. Due to the complexity of chemotherapy regimens, the initial VBC does not include chemotherapy, but it is under consideration.

In addressing the fragmentation of care , the VBC model introduces care coordination employing navigators to navigate patients through the end-to-end breast cancer journey and the complexities of the health system. This navigation role ensures a holistic approach to care integrating physical, behavioural, and psychological care. Quality (found in the study to contribute to inertia) is addressed by first identifying and employing both process and quality measures, for example, monitoring 30 day post-surgery readmission rate. Furthermore, a patient education manual together with staff training is in development with the aim to improve disease management and outcomes. Patient experience is measured by an international benchmarked patient survey and a PROMS (patient reported outcomes) tool is in concept phase. International accreditation of breast cancer centres and programmes will further support the design of a quality outcomes-based model.

By creating shared purpose and appealing to the physician vested interests the recommendations use a behaviour economics and a social capital approach (Lee and Cosgrove, 2014). Achieved using a three prong approach to address the physician-related



sources of inertia (identified in the study), including their angst with the changes faced, (discussed in 5.2.1), and also gaining their support and participation in the implementation of the VBC model (discussed above). This involves firstly engaging with the physicians, with the initial meetings focused on the VBC design, regular one-one and joint meetings, brain storming sessions/workshops as well as including physician suggestions in the ARM design. This has been followed up with facilitating of more formal multi-disciplinary teams (MDT) with improved governance comprising of core roles delivering care to the breast cancer patient: the surgeon, the oncologist, the pathologist, the radiologist, radiotherapist, nurses, navigators, and allied care givers.


Data and technology have been incorporated enabling a holistic view of the patient and as such optimising patient care, enhancing communication across the care team and providing an opportunity to remove waste, for example, duplication of investigations, and thus becoming more efficient. Secondly, it includes incentivising and rewarding physicians for financial and non-financial based drivers by linking a shared value opportunity for achieving performance targets. Practically, this means a portion of the global fee will compensate the physician for achieving pre-determined and agreed quality performance and value targets. Thirdly, physicians are given feedback on non-financial performance and benchmarking their individual performance, as well as feedback on patient experience. Development of the breast cancer VBC model is providing a lever for the organisation to address the status quo by addressing the sources of inertia identified.

5.4 Macro level: complexity of the macro environment

RQ 3: Does the complex nature of healthcare reform and the associated complexity influence the response to and adaption in light of healthcare reform?

5.4.1 Socioeconomic sources of inertia

Findings from the macro-level inquiry, the environmental level, uncover that challenging socio-economic factors, the diverse socio-economic needs of the population, and complex political issues are all leading to resource constraints and austerity measures. Within this context, the research participants including healthcare providers, patients, the NPO and doctor associations acknowledge a need for change and to improve access to cancer care via a new policy reform but then went on to strongly raise concerns about the affordability of NHI. Even



more so in terms of the SA economy that is struggling, and the diverse and many demands of the country's budget, including education, security, and housing.

To function effectively, health systems such as cancer care systems need to share characteristics of effective leadership, sufficient resources such as skilled healthcare workers and physicians, and sound financial systems, according to the World Healthcare Organisation (2010).

5.4.2 Distrust, dysfunction, and polarisation


As seen from the outcomes discussed in chapter 4, organisational inertia is further exacerbated by the strong narrative and discourse of distrust of the policymakers; as such, we see polarisation and dysfunction characterised by blame shifting. The lack of a policy framework is not only constraining the implementation tactics and NHI phases, but also contributing to the ambiguity and uncertainty around the reforms; this in turn is leading to defence mechanisms due to lack of trust, uncertainty, and fear.

Despite the NHI Bill (2019) clearly outlining the plan to ensure a high quality of care is associated with the reform measures, including cost savings, the research outcomes surprisingly show participants are concerned with quality measures not being linked with reform measures. This perception is in turn contributing to the resistance of the reform, resulting in the inertia and in turn the choice to maintain the status quo.

These macro-level findings clearly demonstrate the elements and factors at the complex macro level are sources of inertia influencing and impacting the response to the reform of healthcare policy faced.

5.4.3 Recommendations: macro-level

The macro-level analysis identifies leadership and trust as playing a key role in the response to reform and the adaption to it. Common attributes for successful adaption of reform include: perseverance; engaged stakeholders who communicate and collaborate effectively; strong leadership and accountability; skilled, initiative-taking individuals; a culture which is receptive to change, and a willingness to drive adaption efforts when faced by reform (Braithwaite, 2016). Thus, the recommendation is to address leadership which in turn addresses the tendency to revert to the status quo and the barriers to adaption of reform.




The recommendation is focused on building a culture of trust, and leadership apt to manage the characteristics and attributes of threat perception and psychological inertia, such as distrust, blame, fear, anxiety, and uncertainty. In other words, it is seeking to build a type of transitional leadership, with the ambition is to take it one step further to a collective leadership. The intention is for the agents of the multi-level cancer care framework to participate in understanding the problems, building trust, and finding the solutions together. Constructing this collective leadership therefore encompasses agents from across the multi-level framework in SA: policy makers, local government representatives, physicians, allied HCWs, NPO, and organisation management.

A collective leadership culture is characterised by purpose, distribution of power, intention to share responsibility, drawing on capabilities and expertise, with the agents striving to improve quality and costs of the cancer care. This contrasts with the research outcomes which show, the agents and organisations work in “silos,” in a fragmented, disjointed way characterised by inflexibility, and complexity and exacerbated by threat perception amongst the multi-level agents. Building a shared vision of the future NHI landscape is therefore critical.

Leveraging on the breast cancer VBC learnings, the initial scope for the collective leadership has narrowed to breast cancer. The dialogue commenced with confronting the current reality versus the desired outcomes i.e., closing the gaps in access to breast cancer care in SA, for private and public patients in urban and rural based settings. The collective vision enunciates and shares the forces and drivers for change juxtaposed with the challenges and barriers underlying this vision, for example, resource constraints, logistics (transport and hospital infrastructure) and socio-economic challenges in SA.

Having completed defining of the breast cancer patient journey (actual and aspirational) for a rural patient cohort, the next steps include commencing with the training of rural based healthcare workers on early detection of breast cancer together with screening campaigns at this rural setting, and in future under-served urban areas, Entrenching reflective practice in the collective leadership includes creating awareness of the attitudes and beliefs influencing the sources of inertia and barriers to reform adaption. There is regular shared dialogue which includes evaluation and reflection on actions with the aim of informing learning and thus future action.

5.5 Chapter summary



Chapter 5 presents the sources of inertia identified by the research study's data collection and analysis. More specifically, it discusses the micro-, meso- and macro-level sources of inertia in more detail.

At a micro level, the source of inertia is organisational rigidity due to resource dependency (on the physician), routine rigidity with the cancer HCO routines and structures inflexible to change. This is exacerbated by action and insight inertia, and a tendency to maintain the status quo due to fear (psychological inertia). The meso-level sources of inertia are due to the fragmentation, disjointedness, and intransigence. At a macro level, the socio-economic distrust, polarisation, and dysfunction are sources of inertia.

Using the outcomes and knowledge constructed, the researcher suggests efforts are placed on improving organisational learning with reflective practice at a micro level; at a meso level, addressing the fragmented model of care by creating value propositions for cancer care with a VBC model for cancer care focused initially on designing an ARM for breast cancer; and lastly at a macro level, establishing collective leadership with a shared vision across the multi-level construct of the cancer care framework in SA.

Chapter 6 provides an account of the reflexivity journey of the researcher during the research journey and process.

6 Reflections

6.1 Introduction


This chapter concludes the thesis by reflecting on the research journey. In chapters 1 to 5, the research study is presented in the third person which allows for a more academic stance to the research paper, whereas chapter 6 encompasses the reflective process and therefore presents the researcher in the first person.

6.2 Reflections on AR process

Having employed an AR research orientation to this research study aligned with the University of Liverpool's construct held throughout the DBA program and thus the approach to study thesis, I must point out that I found this to be transformational. As mentioned in the Introduction of chapter 1, the AR study incorporated learning for both the practice and me as a practitioner-researcher. The AR study process challenged my assumptions, my way of thinking, my behaviour, and positively impacted my leadership role in practice and in my non-professional roles. As a result of the AR process, I had "moments" as referred to by Ramsey (2014) of learning which I had not initially anticipated. These "moments" of learning not only impacted the practice-centred approach to the study and thus learning as a researcher in practice but significantly impacted my career choices going forward—as discussed below.

Given that the knowledge construction and learning was taking place in my organisation, I found the role of an insider researcher challenging to begin with. After completing the DBA modules including a residency research study, reviewing volumes of AR-based studies and literature on AR, I gained some understanding of AR and a level of expectation around learning-by-action. I now understand this approach was based on my experience during the DBA modules.

With this awareness of the theory of AR and of the purpose and expectations of an insider research including not "reconstituting understanding" but rather using the opportunity to acquire "understanding in use" (Coghlan, 2007), I was not initially confident in how to take up on this AR opportunity. Given my preunderstanding, I was also concerned not to make assumptions and rely on biases, some which are long-held. I was also determined not only to be active in knowledge generation but also to authentically use the study as a learning-in-practice opportunity, both for my thesis study and my professional role. By stepping back,




discussing this with my supervisor, and reflecting on my researcher skills, I explored and examined these assumptions and biases. For the first time, I really reflected on my own belief system and worldview, as well as how these will influence and impact the research. I used reflexivity to better understand my effect as an insider researcher on the data collection, findings, and analysis as well. This reflexivity continued throughout the study, not only so as to understand my effect on the research, but also to learn and adapt the study based on these learnings from the data.

Feeling uncertain before commencing, I made notes highlighting what I understood I knew, or I thought was expected. What I did know from the above and the guidelines of the DBA programme and DBA handbook is that the research would be based in my practice environment; I would need to identify a problem requiring research, I would need to be careful not be solution-orientated during the process but rather engaged in learning, and I would need to be aware of how my own experience, assumptions, and biases impact and influence the study. Importantly, I would need to practice reflexivity throughout the study process.

With the above as a foundation, I commenced the AR process I would say more aligned to the traditional mechanistic-orientated AR approach. However, this approach evolved from identifying a problem and generating knowledge for problem-resolving, to a study orientated towards learning; as such the AR approach had both mechanistic and organistic attributes (Coghlan, 2007).

My learning commenced at the problematizing process. I initially struggled to make the shift away from being solution-driven to problem identification. I therefore spent quite some time on problem identification, I engaged with others (my supervisor and peer researchers), attended tutorial sessions on problem identification, and kept notes not only to help guide the process but to garner feedback from my supervisor and to gather my own thoughts and ideas. For example, here is a note from my problematising document in October 2017: *1) Solution-focused—should be problem-focused, 2)Uff, difficult to grasp... not that clear what is broke in here?!?* In writing about the problematising process and engaging with others, I was acting, and I was learning. It was through this process of reflecting, engaging with others and going back to the literature that my breakthrough occurred—or, as Ramsey (2014) describes, the “moment” of learning. I used a pre-phase approach and focused on “locating” and thus framing the problem in the context.

After feeling anxious and overwhelmed previously, I now felt more confident about the way forward. My notes show this, for example: having identified the problem and sent it back to my




supervisor and he responded positively, my response to his comment was *Yes!!!! Yes!!!! At last!!!!*. I started to feel more comfortable about progressing.

I was learning the value of questioning, probing, and testing my assumptions and ideas with others and then reflecting on these engagements during the research. By engaging in an AR study also I learnt to consider my own viewpoints, belief system, my philosophical standpoint, and reflect on the nature of knowledge and how knowledge is constructed; this occurred when I began the research design phase (see Chapter 2). Prior to the study I was aware of methodologies and methods used in research, but had not really considered my own belief system, its impact on learning and then more specifically own research (Creswell, 2013). Using journaling—a method honed during my DBA program and residency research study—and keeping notes on discussions with peers (especially useful when feeling overwhelmed), I came to recognise that as a researcher employing a qualitative methodology, the narrative emerging from the study could not be separated from the research, or me as the researcher. At the same time, I was identifying that the research narrative was also being influenced by my interpretation based on my own personal and professional experiences as a practitioner in cancer healthcare, as well as my scholar-practitioner role.

My initial plan for the AR study was to generate knowledge by collecting data from the cancer HCO for learning and informing action at the organisation level. However, as described in Chapter 2 and Chapter 4, the study expanded from a narrow focus bounded by one cancer HCO to reframing the research study as a multi-level inquiry, thus generating much richer data collection and deeper understanding. It is in this learning-in-action that this “moment” of learning (Ramsey, 2014) occurred, which shaped the study and impacted my learning as researcher-practitioner. It was in this sensemaking of outcomes from research Cycle (1), in the dialogue and engaging with agents in the cancer care system about ideas and my perspectives, and in hearing about their insights, this relational approach to the study is where the action-of-learning occurred not only to inform the study but resulted in learning for me as the researcher. Because of this evolution I had to engage with colleagues within and across the cancer care system to obtain support—firstly for the study, to set up a research group and have regular engagements demonstrating the strength of my relations and relationships, and then secondly to support expansion of the study rather than limiting the study to the micro level.

This process of the study evolution and the learnings and reflection impacted me on a more personal and professional level. I made a change in my professional role, moving to a new position within cancer care with wider oversight of the multiple levels of the cancer care system



in SA. By employing self-reflection and analysis, which included integrating my academic and professional learning during the research process (Brannick and Coghlan, 2007), valuable learning took place which contributed to developing my capacity as a scholar-practitioner and contributed to the generating of knowledge beyond a “problem and solution”.

To minimise bias, I brought to the research study debiasing techniques throughout the process. In practical terms this involved using a critical listening approach to the interview recordings after each interview, identifying biases such as overconfidence or any anchoring that may have emerged during the interview process. Interventions included delineating critical research thinking by leveraging system 1 thinking. I thus progressed from type 1 thinking to type 2 thinking, employing strategies to enhance this deeper thinking, for example, mapping of the initial candidate themes by note-taking and journaling throughout the analysis, thus moving from a simple description of outcomes to identifying patterns and themes.

As an insider using an AR-orientated approach underpinned by practice-centred learning (Ramsey, 2014), I thus focused on being aware of drawing on “moments of inquiry” to promote the emergence of new and creative insights. In my research study these moments really felt most palpable when engaging with the research group. It was in the research group that I was able to more easily not to allow pre-understanding and pre-defined conceptualisations and theory to influence the data collection and theory building (Ramsey, 2014; and Huxham, 2003). This was because the discussions were robust and had a genuine sense of wanting to learn from each other. Each member also offered their own unique perspective on the reform of healthcare policy.

In addition to pre-understanding of my practice, there is also existing theoretical understanding I gained from the literature. As such I needed to balance this predefined theory to support my research study whilst at the same time not having too much reliance on this theory or allowing it to influence research my study or inhibit the study and its outcomes (Huxham, 2003).

Key actions in the planning phase included framing of the problem by “locating” it within the complex causal networks of the cancer care system and healthcare reform. This aimed to discover the source of the problem, i.e., the reasons for inertia, and to find solution(s) that will narrow the gap between what is, and the desired state (Rittel and Webber, 1973). Planning also included a review of the literature and empirical studies discussed in chapter 3 relevant to the problem, with the intention of both locating the problem but also in terms of relevance to theory as well, developing the conceptualization framework I employed for sensemaking and action planning (Coghlan and Brannick, 2014).


6.3 Reflections on methodology and data collection

I gathered multiple perspectives and descriptions of the problem from multiple participants and found this was effective in exploring and understanding the problem and also in informing the action required. Considering my research study employs a qualitative methodology using interviews, a research group, documentary examination and market analysis, before commencing the data collection I began the process by first planning on how this would take place.

Given the reflexive approach employed in this AR orientated study (and the DBA overall), even before commencing with the data collection plan, I first considered my thoughts, feelings and values as a scholar-practitioner and insider researcher, noting these in my thesis journal and discussing them with my DBA peers and supervisor. I also found reading about these methods especially useful, such as how to go about engaging with the participants known to me. I read several textbooks and journal articles describing and guiding qualitative methodology, for example Yin (2009).

When first planning and reflecting on these plans for the data collection, I was initially less uncomfortable with the participant interviews and more uncomfortable with the data collection from other methods (as discussed above). Given the critical analysis I followed prior to the first interview, the advantages I discussed above and considering past research projects, as well as the planning process I followed, I went to conduct my first interview feeling comfortable. Despite awareness of the disadvantages of being an insider researcher—more especially, role duality because of the combination of my role and function as practitioner and my role as a scholar and researcher.

I acquired valuable primary data research skills during conducting this thesis study relevant not only as a scholar but also in my practice environment. Although I had conducted research before this study, I had limited knowledge of research design and the importance thereof, including the philosophical stance, the methodology, the methods, sampling, and data collection processes. I learnt about research design and more specifically the research design model by Saunders et al. (2009): the research onion. The scale that involved collecting primary data and analysis of this was more so than in my prior research. The practical experience of conducting interviews became more effective during the study, not only because of the doing, but also by reflecting after each interview, making notes of both the interview and my feelings




during the interview. For example, in my first interview as noted above, role duality became much clearer, and with each interview I noted how I participated. I learned how to use the participant sheet more effectively which, on reflection, is not only useful for research but also in practice. It provides context, and the “why” is as important as what and how, when working as a practitioner—even more so in a manager/leadership role.

Although the most common method used in the primary data collection was via interviews, I also reflected on the advantages and disadvantages of the research group. Making observations during the group sessions by keeping minutes of the meetings (shared with the group) whilst also keeping my own notes in my journal helped me with planning and conducting the next group meetings.

As discussed in chapter 2, sampling is important. As such I critically analysed the most common and relevant sampling techniques. By reflecting on the analysis, I followed in choosing the most relevant sampling technique for this study. I not only identified the relevant sampling technique for my study but also recognised that I had honed my critical thinking and analysis skills. Additionally, I recognise I had improved my knowledge of sampling techniques for future studies and/or when collecting primary data for information required in practice.

When reflecting on the study and my engagement in primary data collection and analysis, I recognise how much this process has contributed to my development as a scholar and researcher but also importantly I find myself using these learnings daily in practice. This process not only improved my knowledge about data collection methods, and my skills in data collection for this study purposes, but I cannot stress enough how much it has contributed to my development and growth as a practitioner. In addition, the knowledge I acquired at a micro, meso and macro level is valuable and advantageous to my practice environment. It is useful for various aspects of private cancer care, and even healthcare strategy development—especially in facing discontinuous change and change triggered by reform of healthcare policy.

As a result of the thesis study, my competency, and skills in collecting secondary data have improved too. As noted above, when planning and reflecting on the data collection methods, I was less comfortable with collecting secondary data. Again, by first thinking and reflecting about secondary data collection I first acknowledged (and noted) my concerns. More specifically, I recognised that in the collection from documentary examination and artefacts as well as the market analysis, there would be significant amounts of data and I would need to prioritise the secondary data relevant to my research study.



By reflecting on these feelings of discomfort and my concerns, I realized I had developed skills when conducting the literature review; as such I used this same set of skills and processes. For example, with regard to the NHI regulatory documents, I prioritised the data collection only using government-gazetted papers, bills, policies etc., and arranged them according to publication date. The skill of prioritising and using criteria led to increasing the validity of secondary research findings. I felt more comfortable as the data collection progressed. When feeling overwhelmed, I discussed this with peers too—not only my fellow scholar peers, but also colleagues and experts in my practice environment.

Another contribution to my research skills was critical analysis and reflection on the data collected.


6.4 Practice of reflexivity

This process of reflexivity also helped me to acknowledge my own feelings and values, distinguish my philosophical stance (which prior to the study was not as clear), and importantly recognise my contribution to the construction of knowledge relevant to my practice.

Before engaging in this thesis journey, I had developed research skills in completing a master's degree, during the DBA journey as well as at a practice level (having completed research studies at a practice level). However, these skills have been improved significantly by this research inquiry. I enhanced my research skills beyond the level I first anticipated when commencing this thesis study, firstly by the process of gathering primary data from participants as an insider researcher.

6.5 Reflections as an insider researcher

Having read about the advantages and disadvantages associated with being an insider researcher, it is important to reflect on how this played out. The advantages I experienced as included extensive experience and knowledge of the context, established long-standing relationships which provided a form of professional intimacy, and the respect of peers in the context which also helped to promote trust and honesty. I was also able leverage my extensive knowledge of how things work and “politics” across the micro and meso levels, i.e., in the cancer HCO, and the wider cancer care eco-system in SA, respectively. Given these advantages I was able to gain easy access to most relevant and appropriate participants for




the primary research, including physicians, and heads of industry and professional associations.

However, there were also disadvantages, including role duality, which I read about but came to understand more clearly after reflecting on my first interview. At this point, I not only identified and acknowledged role duality in the practical situation, but also realized the importance of addressing role duality going forward—both for the interviews and the research group data collection. I used several techniques which I identified in the literature and on discussing with my scholar peers, including the importance of planning, and preparing for each of the interviews by making appointments with participants outside of “normal working hours” and /or outside of the normal place of work. For example, with more than one doctor participant I met them at a neutral venue, i.e., not their consulting rooms. When collecting the data from the participants I made the reason for the appointment clear, along with my role as a researcher and the study aims and objectives. I realised how helpful the participant information sheet was in addressing the role duality.

Based on this experience of the first interview, I listened and re-listened to participant interviews, making notes in my journal to improve my approach for the next interview. It is through this process my skills and competency improved during the inquiry process. Given the healthcare professionals participating in the study are independent practitioners, I identified there was minimal risk for these participants to not be honest and truthful as I have no influence on these role and functions in the system. However, for participants working at the cancer HCO, I also addressed the role duality by explaining and highlighting to them the research study has no impact on the day-to-day function and I was interviewing them in my capacity as a researcher, not in my role as a practitioner/senior manager; their participation presented no risk to their function or work status. I reassured the participant they would be anonymised and that they could withdraw at any time. One participant, a manager at one HealthCo, preferred not to be recorded and as such I took notes instead. I did notice that when my role changed and I moved into a different role at a higher level across the system, the above was less of an issue, with participation being enthusiastic and honest. At all interviews, I repeated the above with all participants.

6.6 Double loop learning

One of the significant changes because of the thesis research process is instilling an AR or action learning approach encompassing the iterative cycles of planning, action, observation,



and reflection, not only as a scholar but in my day-to-day practice environment. Moving from single loop learning to double loop learning helped me to develop a deeper knowledge of myself and challenged some of my long-held assumptions and biases which I have developed over time. This unlocked a more creative self, deeper learning and alternative paradigms of thinking and action. The practice of reflexivity has equipped me with better insights and tools to respond to disruption and change, and to challenge the status quo, including a shift from working in healthcare and the cancer care business specifically, to working on the business I work in every day.

By using a reflective practice of questioning, reframing and harnessing insights, as well as drawing on type 1 and 2 thinking skills, I was able to learn, improve my scholar-research skills, which then also transcended to my role in practice and helped me in completing the thesis study. The concept of single and double loop learning underpinned the process of learning for me as a scholar-practitioner during the DBA course work and the thesis research process, and it helped develop my leadership skills in practice by encouraging me to question, probe, reflect and reframe assumptions.


6.7 Limitations of the research

The research was context-based, concentrating first on one cancer HCO facing reform, then expanding to the wider cancer care context. Although the study evolved to include the macro level, it was in the context of the regulatory and policy framework in relation to the cancer care context in SA.

As such the study aim was not to generalize findings but utilize learnings from the study to bridge the gap between theory and practice; more specifically, it sought to generate knowledge for the private cancer HCO by seeking to understand the reason for inertia and maintaining the status quo as a response to healthcare reform. Therefore, the limitation of the study is that the outcomes are not generalized, but specific to the context. It did however generate knowledge useful to academia, specifically for healthcare-related research and within the theory on organisational inertia.

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Annexures

Annexure A-

Participation Information Sheet

1. Title of Study

Understanding Health System Reform: A South African Private Cancer Care Perspective

2. Version Number and Date Version 3 February 2018

3. Invitation Paragraph


My name is Noeleen Phillipson, an executive of the researched organisation, and a student at the University of Liverpool (UOL) completing a Doctorate in Business Administration (DBA). In partial fulfilment of my DBA, I am conducting a study: Understanding Health System Reform: A South African Private Cancer Care Perspective.

You are invited to participate in a study to understand the private cancer care delivery system facing reform and policy changes in South Africa. The qualitative study involves interviews and review of transcripts and artefacts.

Your participation will be highly valued, but completely voluntary. Before agreeing to participate it is important for you to understand what the research involves, please carefully consider the information below and feel free to request clarification or additional information from the researcher.

4. What is the purpose of the study?

The aim of the study is to examine the organisation's adaption to reform, based on the premise that the private cancer HCO is a private cancer care provider, and is ill-prepared to respond to the external pressures of reform and policy changes. By understanding the organisation's system and the system it operates in, the aim is to help identify the internal capabilities and strategic flexibility required to respond to reform and change.



The study employs a qualitative approach involving a complexity adaptive system framework, based on action research principles to enable feedback that will generate knowledge and create action (change) through research.

5. Why have I been chosen to take part?

You have been selected as a valuable participant in the study because you are an active participant (agent) within the cancer care ecosystem and the system it operates in, as such your participation is valuable to the study.

6. Do I have to take part?

Your participation is completely voluntary, and you are free to withdraw at any time.

7. What will happen if I take part?

Your participation will contribute to the literature and understanding of organisations facing reform, and specifically healthcare and cancer care organisations facing reform and their adaption.


Research findings will assist with understanding cancer care delivery as a complex adaptive system (CAS), and actionable knowledge from the study will assist with the organisation in understanding its ability and flexibility to respond to reform and change. In addition, recommendations for more effective cancer care delivery may be revealed. Knowledge generated from the study may lead to actionable knowledge which may guide the improvement in adaption to reform by the organisation.

8. Expenses and/or payments

You will not incur any expenses, but the interviews will require your time. Individual interviews will be no longer than 40-60 minutes at a time. Group interviews may take up to 90 minutes. I expect to conduct two or three interviews.

9. Are there any risks in taking part?

As the researcher of this study, I will strive to fulfil my duty of minimising any risk associated with the study. Risks associated with research include:




Privacy and confidentiality are a risk associated qualitative research. As a participant you have the right to protection and confidentiality of your personal information. The risk includes the unintended breach of confidential information or deductive disclosure of personal information. To minimise the risk, personal information about participants will be de-identified and anonymised for this study. Furthermore, confidential information will be stored electronically, and password protected. Any physical notes will be stored in a locked cabinet, in a locked office in the researcher's personal office only accessed by the researcher.

Organisational and facility demographics will be masked to avoid unintended disclosure of the participant's identity.

Psychological risk is also a risk needing mitigation when conducting qualitative research. Informed consent is explicit for participation in this study, as is making sure the aims of the study are well explained and understood from the start of the study. Participants will have an opportunity to raise any concerns, which will be addressed.

As a cancer patient, participating in the interview process of the data collection may lead you to opening about your personal illness and journey. In this case, I will follow guidelines suggested in the literature. The patient will be empowered to make the decision to participate or not; during the interview, the patient will be given the option to stop the interview or continue the interview. Although this research is within the context of social science research, as the researcher I am also clinically trained and experienced, which is useful in a study involving the cancer care delivery system. During the data dissemination the data will be de-identified to ensure confidentiality for all participants, including patients.

As an insider researcher there are relationships between the researcher and the research participants. These relationships include the researcher's professional relationship with co-workers, or as a manager of the employee participants. To address this risk the researcher will clearly outline and disclose the research intent to co-workers and the employee participants stressing that participation is: (1) voluntary and (2) the participant's job standing will not be compromised whether they participate or choose non-participation. The researcher does not foresee any disclosure that will violate company policies. Another relationship that may be considered a risk is the professional relationship between the researcher as an organisational I executive and the organisation's client - the healthcare professionals including the physician/s and surgeons involved in the study. To avoid impacting dynamics of the existing relationships, I will as the researcher ensure the participants are able to delineate



between my role as the researcher and that of my role as the executive. The aims of the study will be reinforced as well as the social science research context of the research.

Legal risks are not present as the data collection will not violate laws.

Professional risk related to data collection is also a consideration when conducting qualitative research. Data collection in this study will not place participants at risk for violating company policies and will not reveal professional or medical practice and approaches to treating cancer. Informed consent will be obtained, and the researcher will ensure any concerns are understood and clarified, by ensuring an informed decision process is followed.

10. Are there any benefits in taking part?

There is no financial benefit or compensation for your participation. However, the study will be providing valuable information for alternative reimbursement models for healthcare and add to the literature on VBHC.

11. What if I am unhappy or if there is a problem?


Participation in the study is completely voluntary and you may withdraw from the study process at any time.

Any complaints or problems may be raised with the researcher, Noeleen Phillipson. Contact details: (Tel): +27 82570 2834. E-mail: noeleen.phillipson@online.liverpool.ac.uk

If your problem/complaint has not been addressed adequately or you feel it is inappropriate to raise the problem/complaint directly with the researcher, you should then contact: **The Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher involved, and the details of the complaint you wish to make.**”

12. Will my participation be kept confidential?

Data collection will include the use of business transcripts, database reports, and interviews. Data collected will be confidential and participants will not be named in transcripts, reports, or



publications. Participant and facility demographics will be masked. Personal identity of participants will be de-identified. Only the researcher will have access to the data.

Data will be stored electronically, and password protected.

13. What will happen to the results of the study?

The study results will be used by the researcher in completing a thesis in partial fulfilment for a Degree: Doctor of Business Administration. The information will be used for the expressed purpose of this study.

The study results may produce actionable knowledge and in so contribute to the development of recommendations or inform how organisations, specifically healthcare and cancer care providers facing reform in South Africa, adapt. Furthermore, the study may inform viewing a cancer care delivery system in South Africa through a CAS lens.

14. What will happen if I want to stop taking part?

As a participant you may withdraw at any time from the study. If you agree, the results up to the period before you withdraw from the study may be used. If you do not consent, the data collected from you will be destroyed.

Please note as the results will be anonymised, the withdrawal of the results will only be implemented prior to the anonymisation process.

15. Who can I contact if I have further questions?

If you have any queries do not hesitate to contact the researcher:

Noeleen Phillipson

Tel: +27 82 570 2834

E-mail: Noeleen.phillipson@netcare.co.za

Annexure B: Consent Form

PARTICIPANT CONSENT FORM

Title of Research: *Understanding Health System Reform: A South African Private Cancer Care Perspective*

Researcher(s): Noeleen Phillipson

**Please
initial
box**

- 1. I confirm that I have read and have understood the information sheet dated [DATE] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any question or questions, I am free to decline.

- 3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide, and I can also request the destruction of that information if I wish.

- 4. I agree to take part in the above study.

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature.
_____	_____	_____
Researcher	Date	Signature

Principal Investigator:

Name

Work Address

Work Telephone

Work E-mail

Student Researcher:

Name

Work Address

Work Telephone

Work E-mail

Optional statements

- The information you have submitted will be published as a report; please indicate whether you would like to receive a copy.

- I understand that confidentiality and anonymity will be maintained, and it will not be possible to identify me in any publications **[or explain the possible anonymity options that you are offering participants and provide appropriate tick box options accordingly]**.

- I agree for the data collected from me to be used in future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee.

- I understand and agree that my participation will be audio recorded/video recorded **(please delete as appropriate)** and I am aware of and consent to your use of these recordings for the following purposes **(which must be specified)**

- I agree for the data collected from me to be used in relevant future research.

- I understand that my responses will be kept strictly confidential **[only if true]**. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

- I understand and agree that once I submit my data it will become anonymised, and I will therefore no longer be able to withdraw my data.