CHALLENGES IN IMPLEMENTATION OF BUSINESS PROCESS RE-ENGINEERING IN BOTSWANA PUBLIC HOSPITALS

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Abstract *Public hospitals in Botswana are faced with many challenges. Amongst them are long queues and long waiting time at the out-patients clinics. Long queues and waiting time are a result of uncoordinated internal processes. In order to address the long queues and patient waiting time, the management of one hospital introduced Business Process Reengineering (BPR). The implementation of BPR resulted in improvement as service level was at about ~87%. The change in top level of the management at the hospital led to regression of some of the gains that the hospital had experienced. The key factors which drive BPR success are top management and coherent understanding of the urgency of the situation.*

The purpose of this paper is to identify the causes of BPR failure and proposals of new interventions to address the problems. Failure factors which have been identified include organizational resistance, lack of organizational readiness to change, lack of training and education, problems related to commitment support and leadership, problems related to championship, problems related to integration mechanism, jobs' definition and responsibilities allocation, problems related to BPR resources, and ineffective use of consultants. .

In conclusion it has been observed that the institution prematurely declared the success of BPR even before change became part of the institution's culture. This is reflected by the action taken by the current top management as it does not seem to personify the change effort.

It is recommended that the top management get the employee buy-in and ownership; appoint and empower a champion; engage supervisors in the re-engineered departments to work with the champion; appoint a BPR team, train them and then make the team to benchmark with other public sector organizations; secure resources for BPR.

Keywords: *Business Process Re-engineering, Public Hospital, Botswana, Implementation.*

1. INTRODUCTION

Public hospitals especially referral and district hospitals in Botswana are faced with many challenges. Amongst them are long queues and waiting time at Pharmacy, Accident & Emergency, X-ray, Infectious Disease Control Clinic (IDCC), Medical Clinic, Surgical Clinic, and Sexual and Reproductive Health clinic. These delays led to customer dissatisfaction. In some cases, the district and referral hospitals serve at three different levels: referral hospital, district hospital, and a primary hospital. Owing to this, congestion is one of the main problems that these hospitals are faced with at in-patients and out-patients departments. Long queues and waiting time were a result of haphazard coordination of internal processes such as waiting time before registration, during registration of patients, and actual receiving of services.

Introduction of BPR which involves re-thinking and re-designing of business processes to achieve improvements in critical measures of performance-time, quality and cost, and focuses at optimizing organizational performance by setting and monitoring public service performance standards. Like other reforms before, it was not easily accepted by all staff thus confirming the findings that adoption and implementation of quality reforms in public sector have not improved the level of service quality and customer satisfaction (Pansiri and Mmereki, 2010).

The employees felt that they were being tasked with more work and their supervisors were not providing them with necessary support, and generally shut out the change. In response to this, by way of helping to sustain the positive changes that are made, the then management team through coaching, supported focal persons in the implementation of BPR recommendations. To do this a standardized reporting instrument was developed for use by all focal persons (Annexure **1)**.

The benefits of BPR implementation were that waiting times for the different clinics were reduced markedly. For instance the waiting time of the Pharmacy main dispensary was 1 hour, Pharmacy IDCC 45 minutes, A&E priority 1 was less than one minute, A&E priority 2 was 90 minutes, and X-ray 35 minutes. The waiting periods at the Surgical clinic and Medical clinic were reduced from about seven months to 2 weeks and 1 week respectively over the past 2 years, a marked reduction after introducing bookings (Princess Marina Hospital, 2010c). Queues became short as health workers monitored and managed queuing by ensuring that it was only those who were booked for the day who queued and by redirecting those who were on wrong queues. Previously bookings were made for 7:30 a.m. for all patients referred to doctors, regardless of the number booked for the day. Patients were now block booked, that is, 10 patients booked per hour.

The problem diagnosis was done by hospital management team members. They did this through conducting ad-hoc visits to the outpatient clinics and sampling outpatient clinics and as well as outpatient cards to find out whether bookings were done by date and time, and whether appropriate corrective measures were taken.

It was discovered that some of the findings identified were beyond the departments' and the hospital management's scopes and these were referred to the Director of Clinical Services at Ministry of Health Headquarters. To measure percentage of implementation, the departments tackled only issues which were within their control. Sadly, no records are currently kept to monitor the implementation of BPR. Weekly verification sessions are no longer conducted and there are no management briefings on the progress of the BPR effort. .

A sudden change in the management team of the hospital somehow contributed to the collapse of the implementation of BPR recommendations. Some senior management team members were transferred to the Ministry of Health to coordinate services at national level and subsequently replaced with those not familiar with the planned change, and in some cases they were replaced by people who had given notice of retirement from service.

2. PROBLEM STATEMENT AND PROPOSITION

Outpatients at district and referral hospitals in Botswana were waiting for more than five (5) hours for them to receive services in hospitals. It is on this basis that in 2007, the health officials made a proposal to the Directorate of Public Service Management (DPSM) requesting for assistance to re-engineer these departments.

When Business Process Reengineering (BPR) was introduced, it was not positively accepted by hospital employees and this impacted its take off. The fact that BPR involves re-thinking and re-designing of business processes to achieve improvements in critical measures of performance such as time, quality and cost, and focuses at optimising organisational performance by setting and monitoring public service performance standards, it met resistance as the employees were used to routine way of doing things. The employees were expected to implement issues which were identified during BPR mapping, record the changes made, monitor and evaluate the processes, account for any lags and make further suggestions on how to improve the situation. It took more than three months for the different departments to start implementing the BPR recommendations. The employees felt that they were tasked with more work and their supervisors were not providing them with necessary support and generally shut out the change.

3. METHODOLOGY

The research strategy followed is case study approach. A multiple-case was adopted for investigation because of the peculiarity of sites. Public referral and/or district hospitals respectively serve at three different levels: referral hospital, district hospital, and a primary hospital. It is in this regard that congestion is one of the main problems that these public hospitals are faced with at in-patients and out-patients departments. Case study is a methodology that makes use of personal and group interviews as well as organizational documentary analysis to understand an organization or situation (Copper & Schindler, 2011). It is relevant in that the focus was to understand through observation and description of the dynamics at public hospitals that led to the introduction of BPR and the resultant effects (Hubberman & Miles, 2002; Robson, 2002). Further, because of the nature of the problem at hand which could not be "removed" from the context within which it is taking place, and the fact that an in-depth understanding was required, case study approach was found to be relevant (Cameron & Price, 2009). And additionally the number of variables—long queues and waiting time before registration and during registration of patients, and actual receiving of services at Pharmacy, Accident & Emergency, X-ray, Infectious Disease Control Clinic (IDCC), Medical Clinic, Surgical Clinic, and Sexual and Reproductive Health clinic—under consideration was large, thus demanding a large number of observations (Blumberg, Cooper & Schindler, 2011). Yin (1994) has identified six primary sources of evidence for case study research namely documentation, archival records, interviews, direct observation, participant observation, and physical artifacts. It must however be noted that even though use of multiple sources of data is important in enhancement of reliability and validity of the study, it is not a requirement that all be used at once in a case study (Stake, 1995; Yin, 1994). Secondary data were collected from published literature relevant to BPR. Factors like BPR's failure and success, BPR in public sector, BPR in healthcare / hospitals were taken into consideration. Records of BPR Implementation were accessed and analyzed. Primary data were collected through interviews of employees in the re-engineered departments at hospitals. These were those not involved in preparation of secondary sources of data. Data analysis was carried out at the same time as data were collected. The analysis was done in order to identify key factors which may have led to the failure of BPR in the re-engineered departments.

In order to address the initial propositions of the study, data analysis consisted of examination, categorization, tabulation, and recombination of the evidence (Yin, 1994). Since analysis of case study is one of the least developed aspects of the case study methodology and because statistical analysis is not necessarily used in all case studies and in order to mitigate this gap, the researchers relied on their experience and the available literature and used various interpretations to present the evidence in various ways. The decision of the researchers is supported by Miles and Huberman (1984) who have suggested alternative analytic techniques of analysis in such situations, such as using arrays to display the data, creating displays, tabulating the frequency of events, ordering the information, and other methods.

4. LITERATURE REVIEW

According to Johansson, et al. (1993), BPR is the means by which an organization can achieve radical change in performance by applying a variety of tools and techniques which focus on the business as a set of related customer-oriented core business processes, rather than a set of organizational functions. This is measured by cost, cycle time, service, and quality. Its major focus is on improving business processes through implementing changes radically and rapidly, including creating new ones to replace old ones (Khoong, 1999). As an intensive system, BPR requires a continual top management commitment, leadership, and support for it to be successful (Selladurai, 2002).

The BPR philosophy has historically been applied by private sector organizations world-wide, and the results have shown significant improvement in business performance and sustainable competitive advantage (Johansson et al., 1993). There is however evidence of significant improvement in performance public sector organizations (Lai, Khoong, and Aw, 1999). The benefits included enhanced customer service, improved employee morale, time savings for customers as well as transformation in the image. Other benefits of BPR include improved productivity, reduced cost and compressed cycle time (Grover et al., 1995).

Thong et al., (2000) have pointed out that "public organizations are increasingly finding it difficult to meet the demands of a better educated customer in a fast changing social environment" (p.246). It is therefore in the interest of an organization to re-engineer core business processes to achieve internal effectiveness above and beyond what has been attained through other quality reforms such as Work Improvement Teams (WITS), Total Quality Management (TQM), Balance Score Card, and Performance Management System (PMS).

Rainey et al., (1976) as cited by Thong et al (2000) have established that private and public organizations have critical environmental and organizational differences. Thus they are not homogeneous. Public organizations have less market exposure which leads to less incentive for productivity and effectiveness, higher political influences, less decision-making autonomy of managers, less authority over subordinates, and lower work satisfaction and organizational commitment. Hutton (1996) as cited by McAdam and Donaghy (1999) has pointed out a number of specific characteristics of public sector organizations which may have a bearing on BPR or any change initiative. These include:

"rigid hierarchies; multiple stakeholders for many processes – boundaries cannot be crossed; changes in policy direction can be sudden and dramatic; overlap of initiatives, for example market testing; wide scope of activities – unrealistic expectations; staff are a crucial part of sector organizations" (p.34)

Below follows a summary of relevant lessons from the study by Thong et al. (2000):

1. "Public organizations are highly resistant to change. Social and political changes are the main pressures on them to reengineer their processes.
2. The use of a group of neutral staff officers to form the core reengineering team that draws on the expertise of other departments is an attractive arrangement for structuring a reengineering team in public organizations.
3. Performance measures in public organizations should be simple and highly focused on the end result.
4. The Public organizations undertaking BPR should commit sufficient time and resources to retraining of staff.
5. Public organizations need to plan the rollout of designed processes throughout the organizations carefully

6. Public organizations undertaking BPR need to educate and prepare all staff for the forthcoming changes through an intensive communication program …" (p.265).

Chamberlain (2010) posits that "without effective leadership, there can be no successful change initiative" (p.19). The responsibilities of management therefore are to define the steps which will enable the organization to complete the BPR effort; identify and recruit the appropriate talent to complete the effort; use cross-functional teams to implement the effort; provide direction and feedback to keep the effort on track; and select processes for re-engineering that are in line with the organization's strategic goals (Chamberlain, 2010). Factors which contribute to successful implementation of BPR include top management commitment and support, an incremental implementation of radical plans, a reduction in the gap between espoused and practiced strategies, commitment from all members of the BPR team and the existing organizational culture must be adaptable to change and resource adequacy (McAdam & Donaghy, 1999).

Although there are successful BPR efforts, it has been criticized as violating some good management fundamentals and it has been considered to be unnecessary if companies and/or organizations practiced good quality management (Selladurai, 2002). Dean (2000) in a study conducted in a large public sector organization found that JIT had significant gains in productivity and customer satisfaction. However, this was not realized with BPR. There is evidence suggesting that BPR errs on being socially insensitive and this is a possible reason why most re-engineering efforts have had little measurable impact on the overall business (Rogerson, 1996), and hence, the need to manage organizational change in order to reduce resistance.

Potential problems that an institution can encounter during the implementation stage of BPR include: unmanageable project scope, the inability to demonstrate benefits quickly, lack of top management commitment and support, lack of BPR champion, lack of strategic vision and appropriate planning, a non-supportive social culture to make the needed radical change, inadequate resources, and need for managing change not recognized (Grover, Jeong, Kettinger, & Teng, 1995; Al-Mashari & Zairi, 1999). Hammer & Champy (1993) as cited by Al-Mashari and Zairi (1999) estimated that about 70% of the organizations which embark on BPR projects do not achieve the desired results.

Grover et al., (1995) in their study on the implementation of BPR showed that management of change is critical in the success of a re-engineering project. Thus, to realize change, one can strengthen the driving forces and weaken the restraining forces.

Kotter (1999) cautions organizations to be careful by not declaring victory too soon, as change has to sink deeply into an organization's culture. Organizational culture which is a set of assumptions, norms, patterns of beliefs, principles, values reflecting commonality in people working together that give each organization a distinctive character also comprises of the attitude, behaviors, and experiences of organizations acquired through social learning that control the way individuals and groups interact with one another and parties outside it and are formed and transformed over time (Serrat, 2009; Willcoxson & Millett, 2000). Change should be anchored into the organization's culture, thus in support of this Kotter (1995:66) posits that "until new behaviors are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed" and hence new approaches are fragile and are subject to regression.

Two factors are therefore important in institutionalizing change in organizational culture. These are to show people in the organization how the new approaches, behaviors, and attitudes have helped improve performance, and to take sufficient time to make sure that the next generation of top management personifies the transformation.

Since the implementation of BPR, an intervention that government had employed to reduce long queues and waiting time amongst other challenges in public health hospitals, had failed, there is need to find the reasons why this occurred. It is therefore the purpose of this paper, to identify the causes of failure of the implementation of BPR and come up with a new intervention to rectify the problems.

5. RESULTS

The following are the factors that hospital employees' perceive to be the causes of failure of the implementation of BPR:

1. **Organizational resistance**

   There was a lot of resistance when BPR was introduced in 2007, as the selected departments perceived this as an extra workload for them. Though the focal persons were able to drive the BPR activities, their supervisors were reluctant to assist their subordinates and were not willing to conduct verification sessions. The rest of the employees in the re-engineered departments perceived BPR as the focal persons' and supervisors' duties and not theirs. Therefore, there was resistance to change and there still is. This is because there was clash of culture, that is, the employees were used to doing things their way and the new culture required them to implement what was considered a solution to the problems that the organization had. The employees found the implementation of the BPR recommendations to tedious at first, but after three months it had to comply with the directive from the management.

2. **Lack of organizational readiness for change**

   Hospitals were not ready to implement BPR. Though BPR initiative was incorporated into hospitals' strategy, funds were not availed to execute BPR activities. There was lack of continuity and support by top management as there was no little or no progress after the departure of the agents of change.

3. **Problems related to creating a culture for change**

   Hospitals declared victory too soon, before change became part of the culture, that is, "the way we do things around here". The management team had not persisted with the BPR effort.

4. **Lack of training and education**

   The hospital management did not appoint a re-engineering team to assist the coordinator and this team could have been appointed and trained as facilitators of BPR initiative.

5. **Problems related to commitment support and leadership**

   The current hospital management did not with continue what was already in place, causing the BPR initiative to collapse.

6. **Problems related to continuity**

   Although the BPR "champion" coached and mentored the successor, a vacuum was created by the transfer of the "champion", retirement of the successor, and non-replacement thereof, and hence no continuity of the planned change.

7. **Problems related to integration mechanism, jobs' definition, and responsibilities allocation**

   Although at the beginning of the BPR initiative, officers were assigned issues to handle, during the implementation some assignments became irrelevant and this hampered the implementation exercise as relevant officers were possibly re-assigned. Some issues which were identified during the re-engineering process were beyond the departments, some beyond the hospital management and some beyond MoH; making it impossible to achieve all the recommendations.

8. **Problem related to planning and project management**

   After the selected departments were re-engineered, there was no plan of how the project was going to be implemented and communicated to the focal persons, supervisors of the re-engineered departments, and the employees in the hospitals at large. The re-engineering team was not trained in project management.

9. **Problems related to BPR resources**

   Funds were not allocated to BPR initiative though the departments were expected to achieve the recommendations made by the DPSM BPR.

10. **Ineffective use of consultants**

    The DPSM team was not monitoring the progress of the BPR implementation. Though there were officers who have specifically been seconded to MoH (Ministry of Health), these officers conducted an audit only once since BPR was initiated, and did not monitor BPR implementation.

11. **Improper Information Systems (IS) integration**

    Integrated Patient Management System (IPMS) is being used in most of the departments in hospitals, but still the departments of pharmacy and x-ray were using a totally different IT system, thus leading to information fragmentation.

6. Conclusion

Although public sector hospitals embarked on BPR project and were on their way to achieving recommendations made by the DPSM BPR team, the client organizations experienced challenges primarily as a result of the transfer of the drivers of change and non-replacement of the core staff.

It is clear from the study that BPR as an intervention for change in hospitals has collapsed mainly because the recommendation for successful implementation as made by Al-Mashiri and Zairi (1999) to organizations taking or planning to undertake BPR efforts to ensure that BPR-related change efforts are comprehensive, well-implemented, and have the minimum chance of failure, have not been followed. In order to avoid regression of gains of BPR, organizations initiating change should be careful not to declare victory before change has be incorporated into an organization's culture

7. RECOMMENDATIONS

In order to gain from change initiatives, restraining forces (failure factors) should be reduced. A series of localized changes should be introduced after which refreezing of the transformations will be done. Efforts should be made to reduce resistance to change, that is, restraining forces should be negated by the driving forces (success factors) in order for hospitals to experience change. The institutions should be prepared for change through creation of a culture for change.

For a change initiative to be successful, the top management of an organization needs to be committed and should take a lead in implementing the BPR effort. The commitment should not only be by way of resources (financial, human, tangible, and non-tangible), but should also be through the support they give to employees to whom they have assigned the responsibility to execute the assignment. It is also important for top management team to re-appoint re-engineering leaders (champions) in replacement of those who have been transferred to the Ministry of Health headquarters. It is critical that resources are channeled to the critical recovery of processes and departments that are still implementing BPR initiatives, including those that have failed. Failure to make resources available will render the exercise futile.

Further, there should be role clarity on who is responsible for what and when. These changes should be institutionalized into the culture of the hospital as they are critical for the success and sustainability of these changes over time. Supervisors/middle managers should be encouraged to work hand-in-hand with the appointed champion for change to be realized.

Training of BPR "champions", middle managers, and the BPR team will help the team to successfully implement BPR recommendations with understanding. Also, there is need to have an empowered champion to drive the change. The change agents need to be properly trained so as to be able to carry out their mandate. They need skills in project management.

The hospital top management teams should re-visit the BPR efforts that were implemented with the view of having the project to be successfully implemented for the benefit of hospital clients. The BPR team needs to benchmark with public sector organizations that have successfully implemented BPR. In order to gain wider employee buy-in, top management should communicate all forthcoming BPR activities and the benefits of that to all employees on time. This will not only minimize resistance, it will also ensure continuity and ownership. Increased employee involvement can lead to quicker, more responsive decisions, continuous performance improvement, greater employee flexibility, commitment, and satisfaction (Cummings & Worley, 2009).

The current setup not only allows Performance Improvement Committee (PIC) to coordinate other change reforms, but also BPR. To effectively benefit from change initiatives such as BPR, its implementation should be integrated with other change reforms to avoid overlap and reduce resistance to change, for example, the hospitals' PIC should be involved.

For the change to be sustained, it is important to introduce incentives and rewards. Employees who excel in implementing the BPR effort should be rewarded thus more employees will be motivated to get involved in the implementation of the initiative. For instance, employees who achieve higher implementation rate of BPR should be recognized and be promoted.

BPR strategy and information technology infrastructure should be aligned to maximize the benefits. Further, Information Systems in use should be integrated and synchronized as technology is known to drive reforms.

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Annexure 1 : Business Process Reengineering Reporting Format

Date: ------------------------------------

Department: ------------------------------------

Findings	Recommendations	Achievements	Constraints	Wayforward