

# Resistance to organizational change in Saudi private and public hospitals.

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# Resistance to Organizational Change in Saudi Private and Public Hospitals

**By**

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# Dedication

This thesis is sincerely dedicated to my dear wife and my children, Yaser, Reem, Albandari and Alwaleed who showed their supports and exerted outstanding efforts to enable me shoulder perfectly my duties in conducting this study.

# Acknowledgment

I am very much grateful to all those who contributed to this work with their academic expertise, substantive help or moral support in the long painstaking journey which this present thesis has involved.

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# Abstract

The Saudi health sector was subjected to new government regulations, "The Cooperative Health Insurance (CHI) Law" which was issued in 1999, where healthcare coverage was extended to about seven million people. The new law has a noticeable impact on the Saudi healthcare system, which created a momentum for change in healthcare organizations. This study aims at investigating the organisational change in the Saudi private and public hospitals from the point of views of five main groups included in the study; the private hospitals, insurance companies, Ministry of Health, and Ministry of Health hospitals and National Guard hospital. Areas of study include aspects of change, causes of resistance to change, and strategies to cope with resistance and the role of culture in introducing the change and overcoming any staff resistance.

A qualitative research design was implemented in this study to guarantee reliability of the study. The sampling of the study was purposive and consisted of a total of thirty-six participants who participated in semi-structured interviews. The collected data was analysed using content analysis.

The study mainly showed positive effects for introducing the CHI to the healthcare providers, the community and health services standards. These effects included an increased numbers of covered patients, increased hospital capacity, creating billing

centres, business offices, rejection centres and developing IT systems. Also hospitals increased the number of doctors, nurses and clinics.

Causes of resistance included bureaucracy, more workload, job security fears, high cost of automation, and lack of staff IT skills. In addition, some decision makers thought that the CHI was a fad that would fade away.

Strategies for coping with resistance to change included, providing orientation courses, providing financial incentives to medical staff, using various communication methods, automating systems, creating new insurance related jobs and changing management attitude towards continuous quality improvement.

The findings showed that medical insurance is a cooperative business, which is approved by Islamic Scholars, which led people to participate in the CHI programmes and to accept jobs in the health insurance field.

Finally, the main recommendations of the study included, providing staff with appropriate orientation courses and training programmes, adopting standards and accreditation programmes, introducing educational health insurance programmes in schools and colleges, applying continuous quality improvement in the Saudi healthcare system, introducing fair pay and incentives, continuing systems improvement, investing in new health facilities and privatising some hospitals.

# Contents

# Chapter One

# Introduction

The Kingdom of Saudi Arabia (KSA) was established by King Abdul Aziz Ben Saud in 1932 as an Islamic country. Oil discovery in the Kingdom of Saudi Arabia (KSA) has created fast advancements in all sectors (**McHan, 1998**). It is assumed that KSA has about a quarter of the world's oil reserves (**Dodd, 1986**). KSA occupies around four-fifths of the Arabian Peninsula; an area that exceeds 2 million square kilometres (**Saeed, 1990**). The population of Saudi Arabia reached 23.7 million in 2005, with 36% of the population are less than 15 years **(MOH, 2006).** The estimated population size is expected to increase by the year 2020 to 33.5 million (**MOEP, 2005**).

## 1.1 The Saudi Health System

Saudi Arabia is divided into 19 health regions, each of which is headed by a Regional Director General of Health Services (**Al-Yousuf, et. al. 2002).** All Saudi citizens are enjoying free healthcare services provided by the government (**MOP, 1980**). The Ministry of Health (MOH) is the major government agency entrusted with providing preventive, curative, and rehabilitative healthcare for the population, its services cover more than 60% of the population (**Memish, 2002**), and the MOH is considered the uppermost national body responsible for the Saudi healthcare system, with a

decentralized organizational and administrative structure. Its responsibilities include strategic planning, setting health policies, and supervision of the entire health service delivery programmes. In addition, the MOH monitors and controls all other health-related activities (**Al-Yousuf, et. al. 2002**). Healthcare in KSA has been financed primarily by government (75%) and out-of-pocket and other payer contributions are about 25% (**Walston, et. al. 2008**).

The MOH is headed by the Minister, who manages through Deputies, General Managers and Directors. Beside the MOH and the private health sector, some other governmental agencies also provide healthcare services. These include the Ministry of Defence and Aviation, the National Guard, and the Ministry of the Interior who are responsible for providing health services to their employees and their dependants, each one of them has its own health facilities. Also, the Ministry of Higher Education carries responsibility for all medical schools and operations in all hospitals related to universities. In addition, King Faisal Specialist Hospital & Research Centre and King Khalid Eye Specialist Hospital, both provide highly specialized health care services to Saudis. There are other health services that are provided by The Saudi Red Crescent Society which handles ambulance services for the public. Finally, the Royal Commission of Jubail and Yanbu has its own health care facilities, which provides health services to the entire population of the largest two industrial cities in the Kingdom (**Kutubkhanh, 2002)**

Health services provided by Saudi hospitals and dispensaries before 1980 were mostly curative (**Al-Swailem, 1990**). In the early 1980s, the concept of primary health care (PHC) became fashionable; a ministerial decree in 1980 led to the creation of the health

centers, administratively putting together the dispensaries, health offices and maternal and child health (MCH) centers into one unit. At the same time, health posts were upgraded to health centers, which paved the way for the initiation of the PHC approach (**Al-Yousuf, et. al. 2002**). Currently the number of PHC centers is 1925 (**MOH, 2007**); by the year 2009, the planned target is to have a total of 2104 PHC centers (**MOEP, 2007**).

Health services are provided in every region of the Kingdom, such services consist of Primary Health Care (PHC) centers, general hospitals and specialized hospitals (**Saeed, 1990**).

The Saudi health sector faces several challenges to its development and to achieving high standards. This includes increased demand for health services, quality and efficiency of healthcare services, geographical coverage of healthcare services, Saudization of healthcare manpower, and health services data base. The development strategy for the Saudi health sector is well defined in the Eighth Development Plan (2005-2010) which aims at bringing healthcare services to the quality and level of countries with high human development standards as fast as possible (**MOEP, 2007**).

The main objectives of the government's Eighth Development Plan regarding the Health Sector are mainly focused on the development and upgrading the efficiency of healthcare services, promoting the role of the private sector in providing healthcare services, increasing the scope of health service decentralization to ensuring that powers are commensurate with responsibilities, developing adequate regulations for operating

hospitals on commercial principles, developing mechanisms and procedures for quality assurance of services, implementing the Cooperative Health Insurance (CHI) system and transferring ownership of some MOH hospitals to the private sector (**MOEP, 2007**).

## 1.2 The Cooperative Health Insurance

The pressing new facts about health economics has forced many countries to review their policies of offering free health services to the entire population. The high cost of healthcare forced governments to seek alternatives for financing health services; hence, health insurance programmes were introduced as a means to achieve this.

Though the Saudi government continues to offer free health services to its citizens in a similar way to some other countries, the new reality of the massive cost of this programme is putting major constraints on the Saudi Government to find another means of financing health services for the public.

The government started to offer management contracts for health projects to the private sector, and new channels were opened in the Saudi health economy when CHI was introduced for expatriates in 1999 **(Al Omair, 2002)**

Introducing the Cooperative Health Insurance Laws has created a major change that affected all parties involved in the Saudi Healthcare System. The government of KSA was subsidizing 70% of the healthcare provided to expatriates through the MOH facilities **(WB, 2005).** The new laws has forced employers to insure their employees, thus, creating

more demand on health insurance coverage, as well as creating more demand for healthcare services in the private health sector.

A new dynamic situation has been created by introducing CHI and it presents many challenges for all the stakeholders involved. The private healthcare sector was put under more pressure to improve services, implement quality standards, and to be efficient. On the other hand, the MOH started to rehabilitate its hospitals in a step to participate in providing healthcare services to insured patients through direct contracting with insurance companies. Rehabilitation of MOH hospitals involves major areas in infrastructure, management, systems and procedures. KSA, when talking about development, is considered in a leading position in the whole Middle East region **(WB, 2005)**.

## 1.3 The Research Problem

Implementation of the compulsory health insurance in the Saudi health sector presents a giant leap for the government, intended to ensure health care complies with global developments. Therefore, the study was to scrutinise this process, estimate the extent to which it was successful and identify any obstacles that might prevent development of appropriate health services.

Accordingly, this research aimed to show aspects of change introduced in both private and public hospitals due to the application of the Compulsory Health Insurance Laws,

and also to identify deficiencies that may have occurred during the introduction of change. In addition, this research was to measure the level of resistance to organizational change.

Furthermore, the research was intended to explore causes of staff resistance to organizational change in the private and public hospitals, as well as to determine the strategies used by hospitals in order to cope with staff resistance to organizational change. Determining the causes of staff resistance to the introduced changes should help in rooting out such resistance and accelerate the process.

KSA is an Arab and Islamic country; it has a unique position in the Arab and Islamic world, being the heart of the Islamic faith and the Arabic culture and traditions; and is also one of the world largest oil producers (**Cavallo, 2004**). Furthermore, KSA has an important regional role in the Middle East as well as internationally, which gives this research greater importance and value.

The research was to uncover the role of culture in the management of change, as well as to find out the role of culture in coping with resistance to change in the Saudi public and private hospitals.

It is clear that findings of the this study are crucial and significant for decision-makers and people concerned in the development and elevating quality of healthcare services in Saudi Arabia.

## 1.4 Main Objectives of the Study

This research aimed at achieving the following main objectives:

- To identify the aspects of change introduced in both private and public hospitals in order to pinpoint the shortcomings during the introduction of change,
- To determine the causes of staff resistance to organizational change in both sectors,
- To determine the strategies used by Saudi hospitals in coping with staff resistance to organizational change,
- To uncover the role of culture in the management of change, and
- To find out the role of culture in coping with resistance to changes

## 1.5 Questions of the Study

The study attempted to answer the following questions related to each one of the five groups included in the study:

1. What are the positive aspects of change observed in the provision of health services after introducing the compulsory health insurance?
2. What are the causes of staff resistance to the changes since the introduction of the compulsory health insurance?
3. What are the strategies implemented to cope with the causes of staff resistance to the introduced changes?

4. What is the role of culture in introducing the changes?

5. What is the role of culture in managing resistance to changes?

## 1.6 Significance of the Study

Generally speaking, organizations nowadays face more change than ever before (**Wanberg & Banas, 2000**), and organizations in KSA are no exception. The newly implemented CHI in KSA was expected to cause many organizational changes in healthcare organizations; especially hospitals. On the other hand difficulties associated with introducing such organisational changes were also expected. Many studies have been carried on the topic of organisational change and the introduction of health insurance programmes, but what makes this research original is the chosen settings. The decision to conduct the research on both private and MOH hospitals and precisely KSA is what makes this study unique. A search for similar studies or publications on this topic in the KSA or neighbouring countries found few, and none were about MOH hospitals because they have only recently been given the opportunity to provide health services to insured patients.

Limitations and gaps in the current knowledge:

The current published knowledge concerning resistance to organizational change in Saudi Arabia focused mainly on the non-health public sector. Other studies in the current knowledge were also found with applications related to the economic system and in the

health insurance area. This indicates that the current knowledge about resistance to organizational change in the Saudi health sector is limited. This limited knowledge about change in the Saudi health sector does not match the apparent intentions of the government as reflected by the development strategy for the health sector in the Eighth Development Plan (2005-2010). This plan aims at bringing healthcare services to the quality and level of countries with high human development standards as fast as possible **(MOEP, 2007).** Therefore, this research contributes to bridging the gaps in current knowledge about resistance to organizational change in the Saudi public and private health sectors.

Having presented this introduction about the settings and background of the study here, Chapter Two presents a literature review concerning organizational change and resistance.

# Chapter Two

# Literature Review

The spread of health insurance, the need for more accountability, concerns about healthcare quality and patient safety, and the need for better cost containment strategies require all healthcare organizations to be watchful and ready to respond to change. The topic of organizational change and change management has received high attention from practitioners and academics since management emerged as a discipline at the start of the twentieth century. A large body of thinking about change has developed over the past fifty years along with the growth of large and complex organizations. The challenges facing the healthcare sectors are many, and it may well be beneficial to apply concepts that were developed over several decades ago. Most of the literature on the subject of change management is prescriptive, anecdotal, and published to meet transitory market demand, rather than produced following good research. In addition, the majority of the published literature is Western-based, but it is scarce in the Middle East including Saudi Arabia; and in particular in healthcare. The health care system in the Kingdom of Saudi Arabia (KSA) is likely to require huge organizational change because the current structure of the healthcare organizations grew gradually but was not designed to meet the sorts of demands which may be associated with the newly introduced mandatory CHI. Since this change is expected to touch both private and public sectors, resistance to change is also expected from people in both sectors. This chapter provides a detailed review of several bodies of

literature discussing this issue such as change management, organizational change characteristics and principles, types of change, change process, managing change, introducing change, resisting change, causes of resistance and strategies to cope with the resistance...etc. Reviewing the literature on change management showed that every organization ought to change in order to survive and retain its relevance in a competitive world characterized by fast communication and continuous scientific advancement. However, in order for change to bring a benefit and advance an organization to a higher level of performance, that change must be driven by knowledge. Reviewing the relevant literature required the researcher to use significant databases including: PubMed, http://proquest.umi.com/login, www.journals.cambridge.org, www.oxfordjournals.org, and http://www.Blackwell-Synergy.com/. In addition to published governmental plans and statistical reports, international organizations reports and unpublished/internal private sector reports, the literature review included books and journals written in both English and Arabic languages. The oldest book goes back to 1920, and the most recent was in 2007. On the other hand the oldest journal goes back to 1963, while the most recent was in 2008. The religious books such as the Holly Qur'an and The Hadeeth (Prophet Mohammad PBUH sayings) were also used.

Since the study is aimed at identifying the resistance level to introducing healthcare quality standards to the healthcare delivery system in KSA, the sequence of discussion in this chapter is developed steadily from general issues to specific. It starts with introductory information about the concept of organizations, change in healthcare organizations, covering the issue of resistance to organizational change in hospitals, healthcare quality in

the wake of change Saudi hospitals, and finishing the chapter by reviewing the literature about religion and culture.

## 2.1. Significance of Change in Organizations

Change is an important process for the development of both people and organizations; if change is planned well it can help people to grow and organizations to expand (**Stadtländer, 2006**). In the present time, health care organizations are facing the problem of coping with making available the necessary resources or inputs in order to achieve their desired output (**Al-Omar and Choudary, 1997**). This problem emerged from the fact that nearly all health care systems are facing the challenge of financing their health services differently from before. With the accelerating costs of health services and technology, the achievement of the system's desired outputs is questionable; which may negatively influence the quality of performance and outcomes of the systems. That is, a significant gap between actual and desired outputs may be anticipated. One way of looking at organizations is described as open systems that require the continuous process of improvement in order to deal well with the dynamic healthcare environment (**Al-Omar and Choudary, 1997**). This is useful in considering today's healthcare organizations as they focus on introducing change across the health care system, not simply the component parts, to improve performance quality and maintain desired objectives.

Many researchers have identified the factors causing organizational change into external and internal environmental factors. Political, social, technological and economic factors are the main external environmental factors that can encourage and cause organizational change. On the other hand, the organization's management policies and styles, systems, procedures, and employee attitudes represent the internal environmental factors (**Cliff Notes, 2008**). Hence, we need to look at organizational change across the system, not at individual organisations, or on bases of distinction between external and internal factors.

**Kreitner and Kinicki (2007)** suggested that the external forces that carry out a general change in an organization comprise change in employee demographics, technology, competition, social and political pressures, and government regulations. On the other hand, they suggested that the internal forces for change emerge from human resource pressures and managerial behaviour/decisions.

The atmosphere, the form, origin and strength of competition have been changing fast. During former periods companies simply faced competition within their local atmosphere. But nowadays with increased globalization, companies are forced to compete with organizations from different countries in the world (**Stadtlander, 2006**). Such competition is clear in healthcare, health insurance and health tourism. **Kanter (1999)** argued that new concepts are generated from the clash between global and local ideas, where local companies are required to react to international competitors, whereas foreign companies try to accommodate to local practices. In a global business atmosphere the forces and pressures are enormous and much stronger than in a domestic business (**Stadtlander, 2006**). In the same context **Jick (1993)** mentioned that in a global situation, the cause of change is related to intense competition and the establishment of more complex relations between

companies, however, it has been argued that countries should restructure their health and welfare in order to have cheaper but effective systems which could attract investment. **Judson (1991)** has a different and more comprehensive view of classifying the types of factors likely to cause change; they include: 1) improving market offerings (products and services), 2) reducing costs, 3) improving the quality of products and services, 4) changing productive capacity to match the market changes, 5) improving organizational efficiency, 6) improving the ability of the organization to innovate and learn from the past in order to predict or respond to market opportunities, demands and changes, changes in technology equipment, materials and methods, and changes in its economic, political and social environment, 7) improving the organization's public image and reputation, and 8) changing the business(s) by redefining the product or service concept, changing markets and customer served, changing the mix of market offerings (goods versus services), and changing the portfolio mix.

According to Judson, the reasons or causes that force organizations and individuals to change can also be classified as follows:

### 2.1.1. Technical Environment Reasons

According to **Alodaili (1998),** the acceleration and significance of today's information technology coupled with enormous competition in the healthcare sector is seen as a sound legitimacy for management to seek change in order to survive within a changing environment. In addition, new discoveries, technical inventions, and computers affected the organization's work environment, objectives, practices and lead to the desired change; such change could be in the production methods, organizational structure, or workers' feelings,

behaviour, needs and expectations. KSA is not different from any other country in regard to adopting new discoveries and technical inventions such as the new health information systems (HIS) in both clinical and administrative functions, which will also improve the process of diagnostic technologies. It remains to be seen how far these changes could influence Saudi healthcare organizational performance.

### 2.1.2. Social and Political Environment Reasons

According to **Alodaili, 1998 and Al-Attiyat, 2006** a community's behaviour is normally influenced by the political and social trends/changes that participate in shifting the community from individual to group thinking; which influences the needs and behaviour of people inside their work settings. In addition to work directions, values, culture and social responsibility, social environment reasons could include habits, traditions, principles and values. Also, it is represented by population growth and their interrelations, the presence of expatriates, globalization and government policies and other social factors (**Alodaili, 1998 and Al-Attiyat, 2006**).

### 2.1.3. Organizational Reasons

**Judson, 1991, and Al-Saadi, 1996** mentioned that organizational reasons are also found inside and outside the organization, such as; workers and managers' attitudes, needs for participation, increasing staff skills, changing values and attitudes, the organization culture, and the need to participate in decision making. They also stated that changing the

organization's objectives and structure are considered among the causes of change in the organization.

### 2.1.4. Economic Reasons

This type of causes includes the internal and external economic causes such as economic resources, international market movements, production circumstances, business and marketing, individual income increments, scarcity of resources, local and international competition, war, economic crises, and economic factors (**Judson, 1991; Alodaili, 1998**). The above mentioned reasons/causes for change are very well seen in the Saudi healthcare system. The introduction of CHI in the Saudi health system caused health-related organizations (public and private healthcare providers, health insurance companies, and Third Party Administrators (TPAs.) to struggle to meet new demands of volume, quality, diversity, technology and accessibility which required new offerings for the health market. The introduction of CHI without the proper infrastructure for such complex system caused the services' prices to go out of control, which caused a new dispute between providers and payers. This situation in the Saudi healthcare system indicates the need for a proper change that lead to rationalizing prices, improving quality of services, changing productive capacity to meet the new needs of the market, improving organizational efficiency, and improving the ability of the organization to predict or respond to market opportunities, demands and changes.

## 2.2 Definitions of Organizational Change

Change has become an important part of strategic management in many organizations, because we live in a society that requires an ongoing introduction of change which gives organizations a competitive advantage. Initially, one might think that it is somewhat easy to define organizational change. Yet, the literature has many definitions of change, each one describes different characteristics. Many authors reviewed the various descriptions of organizational change (OC) that emerged from business literature. **Stadtländer (2006)** quoted **MacKechnie (1978)** arguing that the theoretical concepts and methods of organizational change were created mainly from social psychology. For successful management of organisational change **Judson (1991)** claimed psychological support and social tactics are among strategies that managers can employ to minimize employees' resistance to organizational change. In the same way of thinking **Kets de Vries and Balazs (1999)**, cited similar strategies for reducing resistance to organizational change, however, they asserted the significance of providing staff with instrumental and emotional support; which entails offering staff the needed resources in order to deal with the new responsibilities of executing change, and reassuring staff of the value of the new change, boosting their self-esteem, giving them time to express their distress, and encourage an open environment to discuss worries and doubts. In his article, **Stadtländer (2006)** mentioned that in recent years, extensive studies have been done on many perspectives of organizational change, such as the consequences of change on the organizational environment, structure, communication, performance, and survival. However, he stated

that, at present, change became a significant component of strategic management in many settings simply due to the fact that decision makers started to realize that bringing in change can boost organizations to a competitive lead in market both internally and externally.

**Spencer and Sofer (1964)** defined three main kinds of change, namely; the first is change related to the flexibility of the organization; the second is change related to the level of centralization; and the third is change related to the lateral sharing of authority between various departments. However, **Schein (1970)** looked at organizational change as an introduction of new patterns of behaviour, principle, values and attitudes among large numbers of people. It is worth saying that the above mentioned views appear not unrelated, but often confused and mixed up in the literature. **DeBettignies and Boddewyn (1971)** looked at organizational change in the same way; they see it as a process of adaptation by the organization to respond to changing situations in both internal and external environment. **Jick (1993)** also looks at change in its broadest sense as a planned or unplanned reaction to driving forces, such as technical, financial, social, regulatory, political, and competitive forces; such forces can be obstacles or challenges, either threats or opportunities. This definition goes along with the current situation in the Saudi healthcare system; the introduction of CHI, the beginning of the healthcare quality era, the increased public demand for services, and the increase in the volume of medical errors are all seen as environmental driving forces towards well planned organizational change. If such change emerges in the Saudi healthcare system it will positively affect the current situation to new policies, behaviours, performance, methods, services, and products which matches the idea of recognizing the vagueness of change and therefore emphasizing the

idea of innovation **(Kanter, 1983)**. In her view, **Kanter** reasons that change involves the crystallization of new accomplishment possibilities based on reconceptualising arrangements and patterns in the organization. **Ackerman (1986)** categorized organizational change into three types: 1) Developmental change, which leads to improving the current status quo, 2) Transitional change, which leads to the implementation of a known new state and requires reorganizing or dismantling old operational means, and 3) Transformational change, which leads to the development of a new status, unidentified until it takes shape. However, **Quinn (1996)** stated that transformational change can lead to a large level of uncertainty and vagueness because this type of change lies outside normal expectations. As mentioned by **Senge (1999)** some decision makers look for the accelerating, creative thinking, or smart organization, while other decision makers look for the innovative or transformational organization. Such healthcare organizations' leaders are expected to appear in the wake of the current changing environment in the Saudi healthcare market. **Kerber and Buono (2005)** scrutinized three kinds of organizational change; they classified them as: 1) Directed change which is motivated from the top management of the organization; it depends on authority, power, and conformity, and concentrates on dealing with workers' emotional reactions and responses to the expected change; 2) Directed change which reflects a rapid and decisive method to induce change into the organization which can have significant difficulties; and 3) Planned change which is motivated from any level in the organization but is eventually supported by the top management.

**Stadtländer (2006)** concluded that there are crucial factors influencing organizational change. He recognized and summarized such factors as follows:

- Leadership style in introducing and dealing with organizational change,

- Organizational culture and change management,
- Communication and ethics during the period of organizational change,
- Ability of inspecting or scanning dynamic environment,
- Persistence and flexibility towards completing organizational change,
- Total staff involvement and market orientation mentality.

In regard to the above factors, **Kotter (1995)** argued that many decision makers lack the proper know-how in bringing in organizational change and hence commit vital errors. **Kotter** stressed that errors may include the absence of creating a sense of urgency for the desired change; failure to create a influential enough steering coalition; lack of well defined and communicated vision; inadequately effort to eliminating barriers; lack of a well defined plan for making short term gains; absence of a systematic plan for the short-term gains; declaring victory of induced change before the success becomes a reality; and forgetting to embed changes within the culture of the organization. The mistakes or errors mentioned by **Kotter (1995)** are highly expected to occur in many hospitals in KSA in the wake of introducing CHI simply because this change took place without the involvement of all stakeholders in the healthcare system (including the public). This reflects on the absence of well defined vision, and therefore may negatively influence the creation of influential steering coalition.

In regard to the organizational culture role in change management **Collins and Porras (1996)** think that a crucial factor for victory in introducing change into organizations is to balance continuity and change; which is closely linked to the organization's culture in the sense of its ability to develop a vision and grow. In the same vein **Voelpel, Leibold, and**

**Streb (2005)** consider that organizations need to create an innovation culture and to produce creators of innovation thinking, which should be communicated and anchored into the organization. In addition, **Spector (1989)** thinks that if decision makers communicate and persuade staff that the status quo is dissatisfying, then the change process is expected to be facilitated. **Larkin and Larkin (1996)** emphasized that communication during the change process is significant. Therefore, it is clear that Saudi hospitals need to create a new culture that encompasses a very effective communication system, ensuring smooth information flow, to help in convincing staff about the significance of change for survival within the dynamic new era for the healthcare system.

**Moen (2003)** believes in the significance of environmental inspecting or scanning as a search tool for indications about how the environment is changing and how these changes are expected to influence the organization. The environmental inspecting or scanning has a favourable influence on the organization's continuity. Such scanning when coupled with effective communication system is expected to facilitate the fast and reliable transition of such significant information within the organization. The process of environmental scanning is a vital prior to, during, and post organizational change.

Persistence in managing change is seen as an essential driving factor in organizational change. **Quinn (2000)** stated that committed individuals are those who perform while facing uncertainty; they do not give up in the face of resistance and make change despite external restrictions and institutional obstacles. Though persistence and flexibility are critical factors in organizational change, both need to be well balanced otherwise a change process may fail. Finally, **Nordin (1989)** stated that followers in an organization need to be more involved in today's and tomorrow's organizations, especially in regard to

organizational change processes. Thus, he suggested the idea of change management that utilizes all staff members with a focus on the market as centre of attention. This type of change management requires that all staff are more actively involved in the making of strategic decisions.

The above discussion suggests strongly that leaders of Saudi hospitals need to encourage all members of their organizations to be more actively involved in inspecting or scanning the internal and external environment for better performance (quality) and future development. They also need to understand that achieving the desired change requires them to be persistent and flexible in facing obstacles and difficulties, and in managing resistance.

## 2.3. Characteristics of Organizational Change

According to **Mohammed (1981)** the main characteristics of organizational change include the following:

a) It is a planned and organized process. The planned change is not necessarily successful if not properly organized. This is true simply because organizing implies assigning the right jobs, tasks, and activities to the right people and equips them with the right technologies and tools.

b) It is a comprehensive process that covers the entire organization or parts of it as needed.

c) It is a continuous process related to the continuity of the organizations activities.

Though not all change programmes are planned change, **Al-Harbi (2001)** added that the following organizational change characteristics are needed for planned change programmes :

d) It is a process aiming to achieve the following:

- A balance between the organization and its internal and external environment.
- Continuous development of all aspects of the organization.
- More effective and efficient utilization of available resources.
- Increase the organization's ability to survive within a changing environment.

Its success is measured by increasing levels of organizational effectiveness and efficiency.

Using inter-mediator (both internal and external) to prepare, execute and follow up the process of organizational change.

Achieving organizational change tasks depends on the participation of workers in preparing, executing and understanding of the change tasks.

Organizational change depends on the top management support to its programmes and plans.

Organizational change process depends on the status of the organization which determines the degree of change required. That is, no ideal model for this process is suitable for all organizations (one-size-fits-all).

The introduction of CHI in July 2006 forced the Saudi health system into a new era of changes (dynamic environment) in accessibility, structure, staffing requirements and human resources development, quality measures, new information technology requirements, new payment system(s), and patient safety. In addition, the new CHI allowed the governmental hospitals to be involved in the health insurance equation by providing

healthcare services to insured patients; and therefore they are also expected to go through true transformational change due to the fact that they never had been involved in the business environment. Therefore, for Saudi healthcare organizations/hospitals to cope well with such dynamic environment they need to start conducting organizational change that is well planned and organized comprehensive and continuous for the purpose of better services and more efficient performance of tasks in order to achieve desired objectives. Saudi hospitals need to realize that achieving organizational change tasks and objectives depends on top management support and the participation of staff in preparing, executing and understanding of the change process. Finally, they also need to understand that the organizational change process depends heavily on the characteristics of the organization which determines the degree of change required; which means there is no ideal model of organizational change suitable for all hospitals/organizations.

## 2.4. Principles of Organizational Change

According to **Halawani (1990),** managers and top leaders need to consider the following principles for a successful planned change:

Study the current organizational problem and analyze its dimensions and understand its consequences.

Study the motivations that lead the leaders to the process of change.

Study all possible factors that may cause individuals to support the process of change or resists it.

Ensure that leaders have the required resources that enable them to execute the required change.

Ensure the awareness of organization's workforce of change objectives.

Allow others in the organization to express freely their feelings and objections towards the process of change.

Allow those who will be influenced by the intended change to participate in the planning of change.

Ensure the leaders' knowledge of required process in order to sustain the intended change.

Accordingly, since CHI is a fact now, decision makers at all levels and sectors in the Saudi healthcare system are required to consider the above principles for better coping with such change. They need to understand the present organizational problem and further analyze its dimensions. It is true that it might be more complicated in the public sector hospitals as this change is seen as transformational change. Decision makers also need to understand the motivations behind the introduction of CHI that lead the regulators to introduce the current change in KSA. Awareness of all possible factors that may cause individuals to support the change or resists it and the realization of all required resources are essential for hospital leaders/management to cooperate well with inducing the desired change. Finally, allowing those who will be influenced by the desired change to participate in the planning of change is important in order to reduce the level of resistance.

## 2.5. Types of Change

Change is a technical process that requires experience and personal capabilities in the leader in order to support him/her in achieving a successful change process and hence achieve the desired organization's objectives. The nature and types of change varies depending on the used parameters or aspects as follows:

**a) Types of change from the planning aspect:**

Under this type of change **Al-Harbi (2001)** stated that there are two kinds of change. The first is called "planned change", which implies a purposeful and conscious administrative initiative aiming to cause a specific change to the organization or to one of its elements, according to a precise plan (**Al-Harbi, 2001**). The second is called "unplanned change" which involves actions taken by some organizations as a sudden reaction to threat or urgent events (**Al-Saadi, 1996**). In the eighth Saudi five-year development plan, the decision of the government to implement CHI was strategically planned for **(MOEP2005).** However, the question that can be raised is, has the public and private hospitals planned their organizational change as they should?

**b) Types of change according to comprehensiveness:**

Under this type of change **Al-omiyan (2004)** mentioned that there are also two kinds of change; the first is "the comprehensive change" which includes all aspects and areas in the organization, and characterized by its high cost. The second is "the partial change" which is limited to one aspect or section in the organization; the risk of this type of change is that it could create some kind of imbalance in the organization.

**c) Types of change according to subject matter:**

When subject matter is taken into consideration there are two kinds of change. The first is "physical change" which involves the change in the work physical environment such as changing machines, tools, technology and similar items. According to **Halawani (1990),** the other kind is "the moral change" which includes the change of positions, directions of individual and groups like psychological and social changes.

**d) Types of change according to change of pace:**

There are three kinds of changes when the change pace is taken into consideration. These kinds include "short term change (fast)" which is considered as a practical procedure rather than structural, aiming to adapt to an urgent situation facing the organization. This type of change is a circumstantial and momentary fast and not permanent or continuous. The second kind is the "medium term change" which is related to the different organization policies to a great extent. The third kind is the slow change or "long term change" which extends for a long period of time, and is related to the organization strategy and restructuring processes. These previous three types are usually mixed together; long term change includes the other two types aiming to achieve the required change (**Al-Khadairy, 2003**).

**e) Types of change according to degree of necessity and urgency:**

As described by **Al-Khadairy (2003)** there are two kinds of change under this type. The first type is "the eventual urgent change". This change cannot be stopped and it must occur, this type of change is related to the destiny and survival of the organization. The second type is the change that can be temporarily postponed. This change is related to the presence of suitable circumstances before going into change in order not to have undesirable side effects; this type of change is characterized by not having a strong resistance to it (**Al-Khadairy, 2003**).

**f) Types of change according to organizations reaction towards change:**

If change occurs due to organizations' reaction towards change, there are two kinds of change. The first is "the expected change" which was expected and the organization is prepared for it by studying and analyzing conditions, internal and external environmental factors. On the other hand the second is called "the unexpected change" which involves that the organization did not forecast and did not prepare for such change **(Al-Saadi, 1996).** In general, in Saudi Arabia, hospitals can be classified into three types when dealing with change. Some hospitals expected change and initiated change early by means of introducing standards, developing hospital information system, developing procedures and training of staff...etc. Some other hospitals started change when the government implemented the CHI law, while another group is still lagging behind without any real change. The first type can be considered of the expecting change category, whilst the last two types are considered from the non-expecting category.

**g) Types of change according to anticipated objectives to be achieved:**

If the organization's anticipated objectives are to be used in classifying change, there are two kinds of change. The first is called "the deep structural change" which penetrates into the depth and base of the administrative structure. It requires great efforts, immense resources, and time for its application. This type targets behaviour and conviction of individuals, the impact and effect of this type of change will be deep. The second type of change is "the superficial change" and it is a circumstantial temporary arrangement that requires a particular incident or circumstances; then it remains the surface of events and does not penetrate into it. The aim of this could be to prepare for other deeper changes (**Al-Khadairy, 1992**).

**h) Types of change according to targeted areas:**

According to **Hareem (2003)** if targeted areas of the organization are used for classifying change there are four kinds of change. The first is "the organization structure change". It focuses on improving work performance by clarifying, specifying, and finding the suitable relationship between different job positions and stating authorities and responsibilities. The second is "the technical change" which focuses on operational research, information systems and methods and means of the modern technology. The third is "the change of individuals" which concentrates on modifying the behaviour and directions of individuals. Finally, the fourth kind of change here is called "the business change" which involves changing individuals and groups practice inside the organization.

**i) Types of change according to source of change:**

**Al-Harbi (2001)** mentioned that types of change can also be divided into two kinds depending on the source of change. Accordingly, there is what is called "the internal change" which is motivated and stimulated from within the organization that forces it to perform the required changes. In addition, the other kind of change is called "the external change"; this refers to the outside pressure put on the organization, which forces it to do the required change.

**j) Changes according to degree of complexity:**

**Al-Khadairy (2003)** stated that if the degree of complexity is taken into consideration in classifying the types of change then there are two types or kinds of change. The first is "the changing mix factors" where causes and motives are mixed up as well as results and side effects, this usually is carried out by a specialized team with a large mix of experiences in order to implement the change effectively. The second is "the simple change" which is related to one as a limited number of factors, at the same time it is clear, and the administration leader can do it alone without assistance or consulting others.

The time allowed by the regulator in the Saudi healthcare system for the gradual implementation of CHI gives the chance to all hospitals in both sectors to plan their change process and properly implement it. In Saudi healthcare system, the change process need to be comprehensive in accordance to the fact that the required infrastructure elements were not yet made available. In his paper, **Al Omair (2006)** stressed that smooth operation of CHI in KSA requires the availability of all infrastructure elements to be taken into consideration. He also argued that improving health services and products in KSA requires

a lot of diverse activities, practices, techniques and organizational change processes. In addition, **Al Omair** also believes that proper CHI requires properly planned health insurance awareness and training programmes, healthcare providers' rehabilitation, healthcare quality standards implementation, implementing the ICD-10-AM, cost containment strategies, insurance companies/providers relationships, and private-mentality management. He further postulated that data exchange through a standard electronic communication system is extremely needed to establish an electronic media for connecting payers, providers, and members of the healthcare to enable data exchange through a standard communication mechanism. He also mentioned that disease management is an integrated approach in providing care to patients; it provides a strategy to improve patient health outcomes and limit health care costs by identifying and observing care, helping patients and providers by adopting proven medical practices (**Al Omair, 2006**). Such issues require a deep structural planned change, that is comprehensive, and uses a mix of long (slow), medium and short (fast) term change that is targeted at organizations and individuals.

## 2.6. Change Process

Before talking about the change process it is probably helpful to distinguish three basic dimensions of change, namely content (objectives, purpose and goals), process (implementation) and context (the internal and external environment) (**Pettigrew and Whipp, 1991**). However, according to **Pettigrew** and **Whipp**, it is important to mention that there is continuous interaction between the dimensions. Regardless of dimensions, a

well defined change process has the following phases: recognition of challenge, identification of promising practice, adapting and testing desired practices, implementing the desired practices and scaling up the victorious new practices (**Bahamon, 2006**). However, institutionalization of power and the conduct of interest groups influence the organizational change processes (**Mintzberg, 1983; Pettigrew, 1973, Pfeffer, 1992**). All interest groups influence the change process depending on their position in the organization, departmental power, and their interests. In change processes, both the organization's structure and systems and the balance of power are normally the main concerns during the change process. In the process, different alliances will direct their concentration at protecting their power positions, interests, and goals (**Kanter, 1993; Steensma & Boer, 1997**).

### 2.6.1 Stages of Change

Many writers and researchers talked about the stages and steps of the change process, where many of them contributed valuable models and ideas for stages of organizational change.

#### 2.6.1.1 Kurt Lewin

One of the key models in change management comes from **Kurt Lewin**. He suggested a three-phase approach of change, which has been distilled into the following framework: Unfreeze, Change/Transition, and Refreeze. **Lewin** suggests that any conscious and planned change process includes the following three phases:

1. Unfreeze

This stage excludes all attitudes, values, traditions, practices and current behaviour of individuals which will give the feeling for a new thing; this is a very important stage and plays a major role in the success of change process. The aim of this stage is to find out readiness and motivation of individuals for change and to learn new knowledge, skills or new methods by cancelling or excluding present knowledge, skills and present direction, so this could result in a vacuum in the individuals' mind that allows him/her to learn new skills and knowledge to fill in this vacuum.

2. Change/Transition

At this stage individuals will learn new ideas, methods, and skills and have more information by which they will have a new behaviour or perform the work in a new way. At this stage there is an actual change of duties, tasks, performance, technicalities or the organizations structure. **Lewin** warns that fast proceeding to this stage and changing things in a very rapid way will lead to the rise of resistance to change, if the present situation has not been already altered.

It means unfreezing in the right way. This stage carries with it hesitation and uncertainties and a mixture of hope and worries.

3. Refreezing

It means stability of change stage, and the integration in actual practice of what individuals have learned in the form of new ideas, skills and new directions in this stage. This stage

aims to fix and stabilize change with the help of individuals to mix attitudes, ideas and behaviours they have learned in the methods and ways of work. Positive engagements should be used to support the favourable change. At this stage, evaluation is considered a basic step that should not be neglected and feedback should be given to individuals about the benefits of change and its cost which helps to provide opportunities and potentials to create constructive adjustment by time (**Huse, 1997**).

**Lewin's** model has been criticized by some authors who argued that **Lewin** extremely simplified the process of organizational change to the extent that it is easy to plainly freeze it in time. If this is possible, then ideas, attitudes and principles could be removed from individuals. So then, one can remove practices, routines, and habits from groups; and remove frameworks, codes, and systems from the organization; organizational change would then be an easy venture. Then, all these components of the system can be replaced with new ones at every level that reflect the target of the change thought (**Kanter, 1992 and Molinsky, 1999**). Though **Lewin's** model was popular – probably because it provided a simple model to understand - this criticism seems logical in that dealing with human beings is far from being a subject where the laws of physics can be applied.

2.6.1.2. Kotter's Model

Another key model in change management comes from **Kotter (1992)**. He suggests that a successful organizational change passes through eight stages:

Indicating the necessity for change: through indicating and examining the present crisis, main possible opportunities and competitors.

Formation of a strong work team: organizational change requires efforts of a strong team in the organization to direct and lead change and to encourage the work group to work together as a team.

A creative joint vision and strategy: the successful change leader has to have a clear vision and strategy to lead and direct the change.

Communicating the change vision: by using all possible means to correlate the new vision with the strategy and to learn a new behaviour by the example and the model.

Allowing other people to understand and support the vision: effort to change requires getting rid of obstacles, changing systems and structure that stands in front of the vision, taking control of initiatives, new ideas and the active practical execution.

Planning to make benefits in the short term: It is essential to plan for a serious improvement of performance and to show those improvements, to recognize the efforts of the participating employees in the process of improvement and to reward them.

Integrate Improvement and Search for new Change: Take advantage of Credibility build up to transform systems, structures and policies that do not go along with the vision. Motivate, promote and develop staff that can implement the vision and amalgamate the process with the new themes, projects and change agents.

Establishing new programmes in the organization culture: The successful leadership of change carefully explains the connection between new behaviours and organization success and seeks for procedures that can make change efforts sustainable and not limited to the presence of one person (**Kotter, 1998**).

An example of **Kotter's** model used in practice is the experience of the National Company for Cooperative Insurance (NCCI). NCCI was the first government owned and licensed insurance company in the country; it was established in 1987. The organization of NCCI was designed on the bases of geographical set-up in the three main regions of KSA; Central Regional Office, Eastern Regional Office and Western Regional Office. The operation was based on two main arms, namely the technical and marketing; where the technical arm was the underwriting authority who determines the rates and the marketing was the client contact and the selling arm.

NCCI experienced a major change process in 1995 which was called "the Re-engineering Project". This project started with a clear vision in mind and that vision was well communicated to the organization to buy-in. The organizational change phases implemented by NCCI in 1995 went along with **Kotter's** phases of change. NCCI management started by creating an understanding for urgency and necessity for change and communicated clear vision[1]. One of the main factors of success of NCCI change experience was the top management commitment and full support, which indicated the availability of what is called "change agent". People way of thinking was influenced and new initiatives and programmes were introduced in that stage of the change process where business growth was evident and as a result change was sustained for long time (i.e. anchoring the change to the culture of the organization). This type of change goes with the first classification of change of **Kerber and Buono (2005)** as it is a classical example of a

[1] The NCCI communicated vision of the intended change was "creating a segment based organization"

directed change that is motivated from the top of the organization and at the same time took in consideration workers' reactions and responses to the expected change.

The difference between NCCI experiences in 1995 and 2005 was very interesting to witness during the researcher's employment in NCCI from 1993 to 2006. The 2005 experience was based on hiring an international consultant who knows little of the culture, and used the best practice method of how business should be conducted and how the organization should be reformed. The whole discussion regarding the change process and methods was held mainly with two levels of management; the Board of Directors and the Executive Management, the rest was only surveys. Vision and objectives were poorly communicated; the vision of NCCI change process in this experience was stated as "taking the organization to be a product based organization". It is worth mentioning that the change process was based on client segments in 1995 (**NCCI, 2005**). Thus, as a result of poorly communicated vision and objectives of change confusion was created in the organization, and fear in different levels of the organization. Few bad examples were demonstrated by eliminating functions or cutting off staff even before the change process completed. This goes totally against **Kotter's** idea of short term gains realization (1992), this was short term losses which could damaged the change process. This type of change also goes with the second classification of change of **Kerber and Buono (2005)** as it is a directed change which reflects a rapid and decisive method to induce change into the organization which can have significant difficulties but it lacks the workers full involvement and support.

To conclude this section before moving onto the management of change, it could be mentioned that the **Lewin's** Model of creating a vacuum during the unfreezing stage of

change is a very difficult idea to be applied in the KSA culture due to the fact that values and traditions--especially religious values--play a significant role in the society, in general, and make it difficult to use **Lewin's** Model. On the other hand, **Kotter's** model is applicable to a great extent in this society as it follows a very practical approach of sensing the urgency, the need for the change, and starting with a collection of a team who believe, understand the vision and can lead the organization into the change process. **Kotter's** model is a human relationship based model which in this part of the world it has more chance to succeed based on the different major organizational change experience witnessed in the past three decades in KSA.

Though **Kotter's** model of change management, with its eight-step theory, has attracted popularity among researchers; it will not substitute the perception and opinion of excellent leaders, but it is a well-designed set of ideas which outlines a way of managing organizational change (**Metcalfe, 2007**). The change process in **Kotter's** model takes a long time and passes through some different sequential phases in a successful change effort, but a mistake occurring at any phase of the change attempt can cause a negative effect on the organization and may take it back into the preliminary position (**Adhikari, 2007**). In Saudi culture, the eight-Phase model of **Kotter** could face challenges, especially in relation to the issue of good leadership to manage the change in many organizations due to the fact that the majority of hospitals (both public and private) are managed by physicians who lack the administrative knowledge and experience which is the corner stone of change as indicated by **Kotter**. This is true since the leadership, as indicated by **Kotter (1996)**, can make a way into the hearts and minds of the people and guide them to change.

Having evaluated **Kotter's** and **Lewin's** ideas, the topic of managing change can be introduced.

## 2.7. Managing Change

There is no single approach to managing change. Change can be approached in a number of methods depending on the culture and history of the organization, and the nature of the change being implemented. Decision makers in organizations should do their best to develop flexibility within the organization's workforce, technology, systems and mentality in order to have an environment that is ready to adopt change. Key points that can help decision makers to effectively manage change include the determination of the appropriate environment for change, develop commitment and support for desired change, create promising vision, and develop specific goals and approaches. In addition, Pasmore **(1994)** argued that managers first need to be concerned with impact of change on staff. Then, they need to prepare staff (by proper education) for the desired change. Thirdly, managers have to maximize staff engagement in the change process. Lastly, **Pasmore** indicated that managers have to start changing what needs to be changed **(Pasmore, 1994).**

## 2.8. Strategies of Introducing Change

It has to be mentioned that changing an existing organization is a difficult process. Whenever people are threatened by change in organizations, they start resisting in order to preventing changing the current status of the system. Though fear from change can be understood, the dynamic nature of the environment means that change cannot be avoided **(Kotter and Schlesinger, 1992).** Therefore, organizations must adopt particular strategies to create change successfully. Literature includes several approaches to change strategies; some of the most important ones are as follows:

### 2.8.1. Strategies of Benne and Chin

**Benne and Chin (1976)** put forward three important types of strategies for change management based on empirical rational, normative re-educative, and power-coercive:

a. The Empirical-Rational Strategy

The primary assumption of this strategy is that individuals are rational and are motivated by self-interest. That is, if the change can be shown to be beneficial to the individual(s) they will be more willingly to accept the change **(Benne & Chin, 1976)**.

b. Normative-Re-educative Strategy:

**Al Tajm (2000) s**tated that this strategy is based on several hypotheses; one is that the individual's behaviour and his acts are affected by values, habits, and standards he is abiding by. If targets of change contradict with the individual's values and attitudes, the result will be resistance to change. So what to be changed should be specified with the development expert. There are two types of approaches to use this strategy; the first is

developing the ability of organization to solve its human and technical problems, this could help achieving targets. The second is increasing the capabilities of individuals who are the base of the organization, the growth of the human element will release innovation energy; this will increase the efficiency of the organization **(Al Tajm, 2000).**

c. Power-Coercive Strategy:

These types of strategies use political or economic power to influence in some forms coercively change and manipulate individuals or groups into the change process. Both the type of organisation and environment to which change is being conducted will influence the type of change strategy used. For example, in public organisation a power-coercive strategy is more likely to be used because of the high level of bureaucracy **(Benne & Chin, 1976).**

### 2.8.2. Honey's Approach

Honey argues that successful change is achieved by the skilful use of various strategies. Employing strategies that are suitable to the types of resistance is the key to success. In general, there is an appropriate strategy for each type of resistance to change. If reality shows a mixture of different types of resistance, then a mixture of strategies is needed. If the resistance is originated from narrow self-interest, then negotiation is the appropriate strategy. If the resistance comes from misinterpretation or absence of trust, then the appropriate strategy is to educate and inform resistors about the reasons for, and benefits of, the desired change. If the resistance emerges from different assessments and perceptions of the changes that are necessary, then the suggested strategy is to involve both resistors and potential resistors, in some form of programmes to ensure their participation in the

change process. This is very important simply because involving resistors and sharing information with them increases their commitment and the support of others to design and execute the desired change. Finally, if the resistance originates from fear of change, than the most suitable strategy is to force the desired change through and sustain and emphasize the resulting behaviours (**Honey, 1988).**

Honey's approach was observed when the Saudi regulators introduced the new CHI as the major change trigger; the Saudi Ministry of Health (MOH) started the initiative by introducing the change through the utilization of conferences, workshops, symposiums, industry meetings, and through the utilization of mass media in order to establish the base of education, research and studies as the major factor of change. It could be argued that this was done because they believed that the population of KSA has little knowledge about insurance as no formal education in this field is available; such ignorance of such an important issue may have been anticipated to cause resistance and therefore the Saudi regulators used such programmes to increase public awareness.

Another significant factor expected to cause resistance was the religious influence as insurance, in principle, was considered as forbidden by religion. According, the regulator Council of Cooperative Health Insurance (CCHI) which is chaired by the MOH, in anticipation of strong resistance, set out to explain the benefits of such cooperative insurance programmes to the community. This paved the way and influenced religious scholars to issue a "Fatwa" (a license) indicating that cooperative insurance was consistent with Islamic teaching. This Fatwa probably contributed to reduce community resistance to such change. The regulator's approach matches **Honey's (1988)** to some extent. On the other hand, introducing change in hospitals (private and public) requires them to employ

strategies that are suitable to the types of expected resistance and therefore, they need to understand the causes of resistance.

As was mentioned before, the Saudi MOH used different approaches to enhance the public awareness of CHI through symposiums, seminars and media in addition to getting a religious clearance to reassure the public of its reliability and legitimacy. This approach was useful at the beginning, but present and future challenges may require different approaches.

## 2.9. Resistance to Change

**Hareem (2003)** affirmed that resistance to change is considered to be certain and change is also certain and a must. Man by nature leans towards resisting change to the present situation due to change acting as a source of confusion, discomfort, worries, fear and other emotions. **Hareem** argued the reality that should be clarified is that resistance to change by itself is related to expectations accompanying the change process. If change is expected to produce positive results, it will be accepted and supported by all employees, but if the results of change are expected to be negative, it is resisted in all means and ways (**Al-Fawzan, and Al-Aamiri, 1999).** Resistance is a natural reaction and depends on the nature of change and as long as change is originated externally, the less the resistance. This means that if change is forced by an official body regulating work (such as new government law) it is less internally resisted (**Shareef, 2004).**

## 2.10. Definition of Resistance to Change

Resistance to organizational change is defined by several researchers and in different ways. **Abu Hamdiah (1994)** defined resistance as that behaviour aiming to protect the individual from a real or imagined change influence. Resistance was also defined as not abiding by change, and so keeping status quo, or rejecting change by practices antagonizing and rejecting the change process in the organization (**Al-A'araji, 1995).** Some scholars defined resistance from the perspective of individual behaviour. Therefore resistance was defined as individuals' negative reactions towards change that could occur or actually occurred in the organization (**Al-Saadi, 1996).** In this context, resistance was also defined as an emotional behavioural response towards a real or expected danger that threatens the present way of work (**Hareem, 1997**). However, resistance may also depend on expectations **(Carlisle, 1979).**

## 2.11. Dimensions of Resistance to change

Dimensions of resistance to organizational change can be classified into the following:

### 2.11.1. Positives and Negatives

Not all sorts of resistance to change can be considered negative; resistance could have positive benefits that support the management of the change process. For example, when employees resist change, the management will review the change propositions to make sure of its accuracy and soundness. The negative resistance shows up when the individuals

reject a positive change needed for the benefit of work, or when the results of change are positive with good effect on the employee and the organization compared to cost (**Al-Fawzan and Al-Aamiri, 1999).**

### 2.11.2. Individual and Group

Resistance is classified as "individual resistance" when it occurs at the level of individuals (not groups); employees' attitudes range between supporting change or not according to the personal view of the suggested change. However, group resistance means not to abide by the change where resistance takes on a group character and where the change is resisted by the majority of employees in the concerned department or section (**Al-Fawzan and Al-Aamiri, 1999).**

### 2.11.3. Apparent and Hidden Resistance

The degree of such resistance to change is determined according to the leadership philosophy and the general environment of the organization. Yet, **Al-Aamiri and Al-Fawzan (1997)** mentioned that dealing with the hidden resistance is a must, though it is difficult as employees behind this type of resistance are unknown.

### 2.11.4. Resistance to change or change initiator

Resistance could be against change itself or against the person(s) who is initiated the change process; and what to be done depends on how much the resistance is allowed in the organization (**Al-Saadi, 1996).**

## 2.12. Causes of Resistance to Change

Resistance to organizational change can be classified into the following types:

### 2.12.1. The Natural Type

The natural type of resistance means that the rise of resistance emerges as a natural reaction of humans to new circumstance in the organization.

### 2.12.2. The Emotional Behavioural Type

The emotional behavioural type is a subconscious fear of change, inability to tolerate the burden of change and ill trust in people supervising change.

### 2.12.3. Social and Interest Groups Type

Social and interest groups type is a contradiction to the ruling group values and its stable interests, introversion and the narrow views, and preserving friendship and present relations **(Hassan, 1999)**.

Accordingly, unplanned change seems to be of particular relevance to this study due to the fact that some hospitals were forced to change due to the volume of business triggered by the implementation of CHI. On the other hand resistance to change is expected, however, the source of such resistance, the policies of dealing with such resistance, and the role of culture will be uncovered and discussed in the findings chapter.

## 2.13. Reasons to Resist Change

The general view of reasons that affect resistance to change emerged from the need to understand organizational dynamics and improve organizational efficiency (**Coch and French, 1948**). The literature identified many reasons for resistance to change (**Gray, 1984**); the most cited of these reasons include staff involvement in the change process, communication, information availability, and trust in management (**Argyris, 1970; Coch and French, 1948; Lewin, 1947; Ott, 1996; and Weinbach, 1994**). These authors also assumed that an open communication system in the organization and staff involvement improves trust in management among staff and hence indirectly influences employee resistance to change (**Coch and French, 1948; Lewin, 1947; Grensing, 2000; Applebaum et al., 1999; and DiFonzo and Bordia, 1998**).

Organizational change is expected—by nature—to be resisted due to several causes. The most common causes are included next:

1. Comfort with the known and fear of the unknown; people usually tend to like to preserve the status quo, as they feel satisfied and comfortable. People fear change as it brings along new unfamiliar situations.
2. The different education theories indicate that the individual forms habits and behavioural characters that dictate their way of behaving, and the way they respond to situations.
3. Inability to realize areas of weakness and limitation in the present situation, and also inability to realize areas of strength and benefits of the new situation that makes this a large obstacle in the face of change.

4. The individuals' interests sometimes are closely attached to the present situation, which will make them resist any change or alteration, because this means a personal loss in different forms such as influence loss, loss of position, financial and moral losses.
5. Sometimes resistance to change arises when the individual or the group feels that the traditions and standards of another friend group are threatened because of new changes **(Al-omiyan, 2004).**
6. Laziness or not having the desire or readiness to respond to the additional load upon them (i.e. training, studying, and practice). So they develop the motive to resist.
7. When the personal and social relationship among workers is strong, and they want such relationship to continue with the some strength, they tend to resist any change that they perceive to threat such strong relationships **(Abu idrees, 2001).**
8. Distrustful environment and leadership weakness: it is for certain that misunderstanding the targets and results of organizational change, when trust is missing between the individuals and the change designer (planner) whether that it is the direct boss or the change consultant.
9. Ignorance of the subject of change, its objectives and comprehensiveness.
10. Presence of personal reasons such as hatred and jealousy, which can cause struggle and resistance to the process of change.
11. Some individuals and organizations object to new changes due to the presence of previous legal commitments with other individuals or organizations **(Al-Saadi, 1996).**
12. Threats to efficiency and job security.
13. Surprise: The feeling of no need to change, and surprise or bad timing, and lack of resources necessary for the process of change.

14. Pressure: It is the pressure made by colleagues on the individual to resist change **(Hareem, 2003).**

**Alguaifli (2005)** found in his study of resistance to change in Saudi MOH hospitals that many factors could cause resistance to organizational change, including poor communication and coordination, ambiguous technical and procedural processes, staff perception of the need for change, political and power issues, organizational readiness for change, staff social relationship issues, economic effects, cultural and value issues, and unclear change results.

## 2.14. Strategies for Coping with Resistance

**Kotter and Schlesinger (1992)** elaborated on the strategies for coping with resistance to organizational change (see the following table). In KSA, both public and private hospitals started to adopt change in response to the regulatory requirements. This change was also boosted by the requirements of health insurance companies. Therefore, it is important for this research to verify strategies used by Saudi public and private hospitals in coping with the staff foreseen resistance to change.