AN ASSESSMENT OF THE ROLE OF ORGANISATIONAL CULTURE IN HEALTH CARE PROVISION IN SAUDI ARABIA

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ABSTRACT

The health care system in Saudi Arabia has faced a variety of problems affecting its services, especially in the management area, for example in coordination, duplication of services, authority and leadership. These problems have resulted in patients having difficulty accessing services, in long waiting lists, in medical malpractice and in dissatisfaction among patients and employees. At fault appears to be the organisational culture in the Saudi public sector. To understand this culture and to be able to change it in a positive way, this study applies the Competing Values Framework (CVF) to health care providers in Saudi Arabia. Since this application goes beyond the original Western context of the CVF, it is important to analyse the national culture of Saudi Arabia. Using a critical application of Hofstede's framework, it was characterised by high power distance, collectivism, femininity and risk aversion. The organisational culture of the health service and its hospitals reflects these societal characteristics. Application of the CVF revealed a balance between the four types of organisational culture in the Saudi health care provision, in both the current and preferred situations. The findings also revealed that a hierarchy culture had slight prevalence when compared to other types in the current situation, while clan culture was slightly more prevalent in the preferred situation. To improve Saudi health care provision, a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy) is required. The findings of the research will be of use across Arab countries in a variety of public service settings. In addition, this research makes a considerable addition to a rather sparse stock of empirical studies in the management of culture in the Arab Gulf states.

DECLARATION

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

This thesis is dedicated to my parents,

my wife Norah,

my children

Faisal, Fares and Leen, and

my brothers and sister.

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CHAPTER 1 RESEARCH OVERVIEW

1.1 Introduction

Saudi Arabia is one of the few countries which have witnessed accelerated of economic development in a short period of time beginning in the 20th century. Since the discovery of oil in the early 1900s, the country has exploited this resource, attracting the modern technologies of the world in favour of its economic, social and cultural advancement. This vast development has enabled the country's citizens to reap the fruits of modern civilization, including improved governmental and health services, with the result that today Saudi Arabia can boast of many developed clinics and hospitals with ongoing modernization of health care delivery systems that are scattered all over the country (Alyemeni, 2003).

Nowadays, reform in public sector organisations is necessary to help them to improve and develop their services. Therefore, the Saudi government tries as much as it can to cope with worldwide changes and to improve the workplace environment and health care services. Despite these efforts, however, problems persist with health care management (Mufti, 2000). The management literature indicates that culture plays an important role in determining the success of an organisation. Understanding the management of culture should be the key element in any attempt to initiate and manage organisational change (Schein, 1984; Saffold, 1988; Kotter and Heskett, 1992; Gross et al., 1993; Cameron and Quinn, 1999; Deal and Kennedy, 2000; Kane-Urrabazo, 2006; Senior and Fleming, 2006). An assumption regarding this study is that a primary cause of the problems associated with health care provision in Saudi Arabia today is that it is heavily influenced by the prevailing organisational culture within the country.

The focus of the study is to explore and investigate the role of organisational culture and to assess its impact on health care provision in Saudi Arabia. There is a serious gap in the literature on health care management available in Saudi Arabia because this issue is currently unexplored. This study aims to help to fill this gap and to identify the cultural type which would best support efforts to improve health care services in Saudi Arabia. It is hoped that the research findings will provide useful suggestions and guidelines that will contribute to solving the current problems faced by health care facilities in Saudi Arabia. In addition, this research applies organisational culture theory that has been developed in Western countries, aiming to determine its suitability for the Saudi cultural context.

1.2 Research Problem

Public management reforms often are portrayed as part of a global wave of change (Wise, 2002). Common (2001) cites Salleh (1992) as arguing that globalization stimulates demand for new public goods and services. This, according to Common (2001) is due to the changes in social perceptions, values, pressure groups and alternative political agendas. Therefore, globalization could be seen as enhancing the shifting of the values and patterns of demand, to which public administrations should respond. Furthermore, Cameron and Quinn (1999) argue that a change in organisations is pervasive because of the rapidity of change in the external environment. According to Pollitt and Bouckaert (2004), change may include improvements in the setting of quality standards for health care or educational services to citizens, or the introduction of new policy and procedures for budgeting to encourage public servants to be more cost-conscious and/or to monitor more closely the results of expenditure. In the context of the present study, it appears that health care systems around the world are continuously changing in terms of technology, management, etc. Globalisation means that any such changes may influence the Saudi health care system.

The health care system in Saudi Arabia is free to all Saudi citizens. The state delivers health care for all of its citizens through the development of particular

socioeconomic and health policies. Saudi health policy is generally committed to the Health For All (HFA) objectives set by the World Health Organisation (WHO) in the 1980s (Al-Yousuf et al., 2002).

Since the implementation of Saudi Arabia's first five-year-development plan in 1970, its health care systems have improved greatly. Under the plan, the Saudi government improved the standards of sanitation and diet, expanded preventive health services and increased the number of active health professionals, employing them in a more effective manner. It also undertook a policy study to produce scientifically based plans for the development of health services that would improve health standards and reduce the morbidity and mortality caused by infectious diseases and nutritional deficiencies. Saudi Arabia has achieved remarkable progress in providing health services to a population growing at an average rate of 2.3 percent per year. Communicable diseases have been brought under control and immunization coverage for all vaccine-preventable diseases is very high. Antenatal coverage is good and only six percent of babies are born weighing under 2,500 grams. Ninety-five percent of Saudis have access to safe drinking water. Many improvements have been implemented in the health care sector in Saudi Arabia. For instance, the number of primary health care centres, including dispensaries and clinics, rose from 599 in 1971 to 1848 in 2005, while the number of physicians and dentists (combined) rose in the same period from 1,316 to 40,265, with 21.3% of them (8558 physicians) being Saudi. For nurses during the same period, the corresponding figures are 3,355 and 78,587, with 18,805 (24%) being Saudi. There were 75 hospitals in 1971 and 364 in 2005; and for hospital beds the corresponding figures are 9,837 and 51,130 (MOH, 2007). These figures make it clear that the health care system has undergone a rapid expansion in physical facilities, professional personnel and benefits delivered to the public. This is a form of change that should be regarded as positive in its impact upon the population (Gallagher, 2002).

However, during this period of rapid transition since 1970, health care systems in Saudi Arabia, like those in other countries, have faced and continue to face many

challenges. Mufti (2000) argues that the last three decades of the century saw a massive expansion of the country's infrastructure until the later stages, when resources dwindled because the drop in oil prices in the mid-1980s, resulting in a need for more efficiency and care in the proper utilization of the available resources. In this regard, despite the Saudi government allocating 12% of its 2008 budget to health and social services (MOF, 2008), health care provision is facing critical problems which are threatening and indeed affecting services.

Among the many problems facing the health care system in Saudi Arabia are growing demand, rising costs, public pressure for better services, poor professional and managerial development strategies, a lack of independent decision-making due to unclear lines of accountability, dissatisfaction with management practices, employee and patient dissatisfaction, a high staff turnover, a lack of career development, stressful work conditions, the duplication of services (duality of tasks) and a lack of authority and leadership (Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Al-Ahmadi and Roland, 2005).

These problems are obviously reflected in the current output of the Saudi health care system. For example, despite the increase noted above in facilities such as hospitals, beds and manpower, the system is currently not able to meet in full the public demand for access to its services. Al Shehri (2008), president of the Saudi Society for Medical Education, warns of a serious shortage of medical employees such as physicians, nurses and technicians. For example, Saudi physicians alone can cater for only 15-20% of the population's needs.

One of the major problems facing the health care system in Saudi Arabia is the difficulty of access because of the long waiting lists of patients. Al-Ahmadi and Roland (2005) state that targets for access to programmes specialising in chronic illnesses were not being met; for example, very few hypertension patients were attending primary health centres for treatment. In general, referral rates were found to be low, which meant that in many cases patients were denied the appropriate access to specialist hospitals, and there was also limited access to health education.

Moreover, Afet (2009) cites a recent Ministry of Health (MOH) report as stating that approximately 480,000 people across the Kingdom were unable to use health care services mainly due to the difficult terrain of mountains and desert, meaning that about 2% of the population of 24 million could not be reached. Hassan (2006) found that the waiting list for orthodontic treatment generally ranged from two to four years long. A member of the Majlis Al-Shura (Consultative Council) (Jafri, 2009) complained recently of a significant number of patients having to wait for many months due to a shortage of hospital beds, while a widely published author (Al-Salman, 2009) who is a well known critic of the services provided by Saudi public organisations has stated that many ordinary patients, who ought to be transferred to beds in large referral and specialist hospitals in major cities like Riyadh to complete their treatment, remain in the intensive care units of district hospitals because there are no such vacant beds.

Another major problem in the Saudi health care system is medical malpractice. For example, Khaznadar (2009) cites an authoritative report as estimating the number of medical malpractice cases in Saudi hospitals in the past six years at 26,000, due to wrong diagnosis and treatment by unqualified medical staff. Moreover, Al-Ahmadi and Roland (2005) criticise Saudi diagnostic, treatment and referral practices. One example of this is that the percentage of diabetic patients being referred to eye clinics was around 40 to 68%, in spite of the high prevalence of diabetic retinopathy.

Such problems, according to Mufti (2000), arise from the country's ever increasing population, the escalating cost of service delivery and organisational problems. Al-Asheikh (2000) argues that if the current problems being experienced in health care institutions in Saudi Arabia are not addressed quickly they will threaten the ability of the state to provide its citizens with an effective health service. Mufti (2000) indicates that because these problems are adversely affecting patient satisfaction with services, strong steps should be taken to solve them and to improve services.

It could be argued that most of the organisational problems identified above have arisen from the dominant culture of Saudi public organisations, which the literature

indicates is marked by a high level of bureaucracy, high power distance and control, avoidance of responsibility, a collectivism which allows individuals to use their position to benefit their relatives, and the predominance of loyalty to one's friends, village or region. This is because leadership and management in Saudi Arabia are influenced principally by inherited tribal traditions, which in turn encourage routine nepotism (Al-Awaji, 1971; Bjerke and Al-Meer, 1993; Pillai et al., 1999; Bhuian et al., 2001; Jabbra and Dwivedi, 2004; Jabbra and Jabbra, 2005; Mellahi, 2006; Common, 2008; Al-Yahya, 2009).

Although this argument from the literature concerns public management in general, the researcher believes that the situation in health care is to some extent similar. This is supported by the researcher's firsthand experience of working for 15 years in the Riyadh Armed Forces Hospital, first as a member of staff and then as head of several departments. It is the researcher's contention that many of these problems can be traced back to the influence of the organisational culture that shapes these systems. A case in point is the distribution of health care provision around the country, which is heavily influenced by the power that the region exerts and by its relationship with headquarter agencies. In some cases, little consideration is given to the actual needs of the services themselves. Understandably, this situation causes large disparities between regions and cities in terms of health care services. With these points in mind, it is necessary to examine the role of organisational culture and to identify its impact on the process of health care delivery. Various authors argue the importance of organisational culture in efforts to:

- understand the existing culture and subcultures before attempting to change them (Cartwright and Cooper, 1993);
- manage organisational change (Cameron and Quinn, 1999);
- shape the life of the organisation (Saffold, 1988);
- understand the failure of implementation in major improvement strategies (e.g. TQM, downsizing, reengineering) (Cameron and Quinn, 1999);
- determine the success or failure of an organisation (Schein, 1984; Senior and Fleming, 2006).

These studies indicate the importance of assessing the organisational culture in order to facilitate the change effort and so to improve the services delivered by an organisation.

Studies carried out in the health care sector in Saudi Arabia (Mufti, 2000; Al-Asheikh 2000; Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Al-Ahmadi and Roland, 2005) indicate that systemic changes are needed in order to improve services, but these studies do not mention organisational culture as a tool with the potential to facilitate and ensure the success of any such change effort.

Therefore, the purpose of the present study is to assess critically and to contribute to the understanding of the role of organisational culture in health care provision in Saudi Arabia, using the Competing Values Framework (CVF) in this exploration. There is a serious gap in the literature on health care management in Saudi Arabia and it is hoped that this study will help to fill it. In addition, although culture change is not an easy task, the assessment of culture using the CVF will provide useful suggestions to the policy makers concerning health care provision in Saudi Arabia and will highlight where change is needed.

1.3 Research Aim and Objectives

The aims of this study are to understand the role of organisational culture in the delivery of health care in Saudi Arabia and to identify effective ways to diagnose and change the culture, thus enhancing organisational performance.

Saudi Arabia has identified the health care system as essential to its economic and social development. In order to provide good health services to society, it has established many hospitals and some positive outcomes have been achieved. However, as mentioned above, some negative outcomes have been identified, such as barriers to quality and patient dissatisfaction. To address these issues, this study has a number of objectives.

1. To critically examine the strategic environment of health care provision in Saudi Arabia.
2. To assess the types of organisational culture currently dominant in health care provision in Saudi Arabia, using Riyadh as the focus of empirical study.
3. To identify the type of organisational culture which would best support efforts to improve health care services in Saudi Arabia
4. To identify which personal characteristics of health services' employees are more influential in the organisational culture in Saudi Arabia.
5. To suggest ways in which to improve health care provision in Saudi Arabia on the basis of culture.

1.4 Research Questions

In order to explain why some aspects of organisational culture can play a vital role in the effectiveness of health care provision in Saudi Arabia, this study will address the following questions:

1. What is the environment of health care provision in Saudi Arabia?
2. What are the current dominant types of organisational culture in health care provision in Saudi Arabia?
3. What types of organisational culture which would best support efforts to improve health care services in Saudi Arabia?
4. Is there a relationship between health service employees' personal characteristics and their judgments of organisational cultures in health care provision in Saudi Arabia as expressed in their responses to the CVF questionnaire?
5. What are the problems and recommendations provided for Saudi policy makers regarding the problems facing the Saudi health system in order to be able to improve its services?

In addressing the first question, to understand the complexity of organisations, their external environments need to be analyzed. Whatever the nature of their business,

organisations cannot exist in isolation from the other organisations or individuals around them, be they customers, employees or suppliers (Capon, 2000). Therefore, in order to understand the environmental factors affecting health care provision in Saudi Arabia, the study includes a critical review of secondary data on these factors, supplemented by interviews concerning the types of organisational culture that are dominant in health care provision in Saudi Arabia. The views expressed in the interviews are considered with reference to Hofstede's cultural indices framework. The justification for using Hofstede's model will be explained in the Chapter Five. In a country such as Saudi Arabia, where strong values and beliefs shape the organisational culture of health care provision, the researcher expects that these values will play a vital role in such systems.

In answering question two, the researcher used the CVF to examine the role of organisational culture in health care provision in Saudi Arabia, through a survey employing the Organisational Cultural Assessment Instrument (OCAI). The framework assumes that there are four different models of organisational culture (hierarchy, market culture, clan culture and adhocracy), and six essential dimensions of culture (dominant characteristics, organisational leadership, management of employees, organisation glue, strategic emphases and criteria of success). The justification for using the CVF will be explained in the literature review chapter. In answering this question the researcher also used semi-structured interviews with questions based on the CVF.

The CVF was also used to address question three, eliciting views on the current situation and desired future of the organisational culture in order to identify the gap between these two positions. This will help to anticipate types of organisational culture which would best support efforts to improve health care services in Saudi Arabia. Once again, semi-structured interviews based on the CVF were used to identify cultural types in the hospitals which would best support efforts to improve their services.

In answering question number four, the researcher will use multiple questions to determine in which hospitals the research participants are working. In addition, the researcher will also use multiple questions to choose which one of the demographic characteristics that can best describe the participants such as gender, nationality etc.

With regard to question five, the researcher asked participants to identify problems facing the Saudi health system and to make policy recommendations to help to resolve them and to improve services. Health care practitioners and senior managers involved in health care provision were considered to have the experience, background knowledge and depth of understanding necessary to answer such questions.

1.5 Importance of the study

Public management in Saudi Arabia and in the Arab world generally has not been the topic of much literature. The main reason for this is that research in this area is hindered by the lack of any official documentation concerning reform efforts, and what there is may not be available to the public. It is interesting to note that this is typical of Arab culture and of management culture in particular, which is based on talking, not writing (Tayeb, 2005; Common, 2008). However, as the purpose of this study is to assess critically the role of organisational culture in health care provision in Saudi Arabia, it is hoped that the study may contribute to understanding the role of organisational culture. There is a serious gap in the literature on health care management available in Saudi Arabia.

This study is significant because of the importance of its subject: organisational culture. From the 1990s onwards, a number of key writers have identified culture as a key determinant of organisational performance (Ouchi, 1981; Denison, 1990; Cameron and Quinn, 1999; Deal and Kennedy, 2000; Baker et al., 2003).

In addition, to the best of the researcher's knowledge, it is the first attempted replication of the CVF developed by Cameron and Quinn (1999) regarding the assessment of the role of organisational culture in health care provision in Saudi

Arabia. The CVF was developed and has been used in Western countries, which have very different organisational cultures from that of Saudi Arabia. This study thus attempts to determine its suitability for the Arab world in general and Saudi Arabia in particular.

It also attempts to answer many questions raised by practitioners and researchers concerned with the effectiveness of health care provision in Saudi Arabia. Its findings will be useful for Saudi health care managers and policy makers to reform the current situation of health care provision and to solve the many problems facing them today (Mufti, 2000). Finally, it is conceivable that the findings which emerge from this study will be useful to employees involved in the provision of health care in Saudi Arabia. The study will create a heightened awareness of the organisational culture that exists within their hospitals. It is also anticipated that this awareness will enhance organisational effectiveness by improving commitment and performance. Goodman et al. (2001) describe group cultural values as being positively related to organisational commitment, job involvement, empowerment and job satisfaction, and negatively related to turnover intention. As mentioned previously, many studies have indicated that organisational culture plays an essential role in service provision. In turn, this will have a negative or positive impact on the public who use these organisations.

1.6 Conclusion

Health care systems in Saudi Arabia face many problems that affect their services, despite the efforts of the government. Therefore, radical and systemic change is needed to improve services and to ensure the success of these efforts, especially in aspects of management such as coordination, duplication of services, authority and leadership, because problems in these areas result in patients having difficulties accessing the services, in long waiting lists, in medical malpractice and in dissatisfaction among patients and employees (Al-Asheikh, 2000; Mufti, 2000; Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Al-Ahmadi and Roland, 2005). Several studies indicate that an assessment of organisational culture is required before any

change takes place to ensure the success of efforts to improve the organisation's services (Deal and Kennedy, 2000; Schein, 1984; Saffold, 1988; Kotter and Heskett, 1992; Gross et al., 1993; Cameron and Quinn, 1999; Kane-Urrabazo, 2006; Senior and Fleming, 2006).

Accordingly, this study explores the role of organisational culture and assesses its impact on health care services in Saudi Arabia. Its findings are intended to provide the basis for sound recommendations and suggestions to health policy makers in Saudi Arabia which will help them to improve services and provide a good health service that will match their objectives and the large financial resources devoted to health in Saudi Arabia.

As a first step, it is necessary to review critically the literature on management reform and organisational culture that focuses on public management in general and health management in particular, to identify methods appropriate for the present study to achieve its objectives. The next chapter focuses on this.

1.7 Thesis structure

The thesis comprises nine chapters, as follows.

Chapter One: Research overview

This chapter began with an overview of the topic of the study the covers the research problem, the aim and objectives, the research questions and the importance of the study. The aim of the chapter was to demonstrate that since the health care system in Saudi Arabia faces many problems that affect the delivery of services, a change in the system is needed to improve services and to ensure the success of reform efforts. The problem is partly cultural; therefore, an assessment of organisational culture is required before any change is attempted, to ensure the success of such an attempt to improve services.

Chapter Two: Literature review

Chapter two presents a comprehensive review of the main concepts relating to this study, namely, public management reform, health care reform, Saudi public reform, organisational culture, organisational culture in health care organisations, organisational culture in Saudi public organisations and organisational culture in Saudi health care organisations. It examines the main theories of organisational culture and provides a justification for adopting the CVF to assess the organisational culture.

Chapter Three: Methodology

The third chapter explains the choice of study methods, the mix of qualitative and quantitative techniques, the use of Hofstede's model to assess the national culture and the CVF to assess organisational culture. It also examines the time horizon, the research sample, the sample size and ethical issues.

Chapter Four: The context of public management in Saudi Arabia

This chapter presents a critical examination of the strategic environment of health care provision in Saudi Arabia and of how it shapes and influences the organisational culture, in order to explain better how Saudi public management operates in such an environment. The environmental factors considered include Saudi Arabia's geography, population and history, as well as its political, economic and social culture. This is because in Saudi Arabia, culture plays a vital role in the daily practices of government agencies and because inherited traditions, such as Islamic teachings and Arab traditions, exert a strong influence.

Chapter Five: The influence of national culture on organisational culture

This chapter draws comparisons between published work using the CVF instrument in different national contexts.

Chapter Six: Analysis of quantitative data

This chapter presents an analysis of the quantitative findings of the OCAI, based on the theoretical CVF model.

Chapter Seven: Analysis of qualitative interview data

Chapter Seven presents an analysis of the qualitative findings of the semi-structured interviews.

Chapter Eight: Discussion of the research findings

The aim of this chapter is to interpret, evaluate, and discuss the findings of the data analysis (quantitative and qualitative) in relation to the research questions and the relationship between this study's findings and other studies in this field.

Chapter Nine: Conclusion and recommendations

The final chapter summarises the findings and considers the arguments about the suitability of the CVF for the Saudi context, the contribution made by the research and its limitations. It offers a set of recommendations for future research and for practical measures to improve Saudi health care provision, concluding with general reflections.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

As mentioned in the previous chapter, health care provision in Saudi Arabia faces problems that affect services, including difficulty in accessing health care services, long waiting lists, medical malpractice and patient dissatisfaction (Al-Ahmadi and Roland, 2005; Hassan, 2006; Al Shehri, 2008; Afet, 2009; Al-Salman, 2009; Jafri, 2009; Khaznadar, 2009). Therefore, there is a need for reform and change to improve these services. It is widely agreed that the elements of organisational culture play an important role in facilitating reform and change (Deal and Kennedy, 2000; Schein, 1985; Kotter and Heskett, 1992; Gross et al., 1993; Cameron and Quinn, 1999; Kane-Urrabazo, 2006). This chapter reviews the relevant international literature before turning to Saudi Arabia in particular. It identifies gaps in the existing literature and provides a comprehensive review of the main concepts relating to the study, namely public management reform, health care reform, Saudi public reform, organisational culture, organisational culture in health care organisations, organisational culture in Saudi public organisations and organisational culture in Saudi health care organisations. It begins with general information about these concepts and how they apply to the management field, then turns to a detailed assessment of the literature, which provides the basis for the construction of a theoretical framework for the study.

2.2 Public management reform

During the 1990s, a growing body of literature suggested that in a globalizing world, public management reforms were often considered as international movements because any organisation would be affected by changes in the external, dynamic environment. Governments therefore are now part of a global environment (Hood, 1991; Wise, 2002; Pollitt and Bouckeart 2004; Osborne and Brown, 2005). There are complex reasons for this. For instance, Salleh (1992, cited by Common, 2001)

argues that globalization increases the need for public goods and services while also stimulating fresh demand for new public goods and services. In addition, there are changes in social perceptions, values, pressure groups and alternative political agendas that contribute to the changing public management reform agenda (Kaufman, 1985; Kettl, 2000).

Globalization can be seen as enhancing the shifting of values that public administration responds to. Furthermore, change and development impact on how public organisations are perceived and structured (Osborne and Brown, 2005). However, public administration has always had to respond to changes in public preferences within democratic systems. Therefore, despite the difficulties in gauging public preferences, citizens' values of public programmes are often considered a necessary input to public decision-making if the decisions are to lead to a satisfactory provision of publicly provided goods (Blomquist et al., 2004).

Today, globalization in organisational contexts is concerned mainly with downsizing government and privatization; emphasis is placed on recruiting public managers, developing employees' skills and retaining competent managerial leadership (Jreisat, 2003).

The term 'globalization' is subject to much debate in the literature, including that on public administration, while 'reform' itself is also a contestable term. However, Pollitt and Bouckeart (2004:8) provide a useful and straightforward definition: "Public management reform deals with deliberate changes to the structures and processes of public sector organisations with the objective of getting them (in some sense) to work better." The aim of public management reform is to achieve policy objectives such as cutting public expenditure, improving the quality of public services, making government more efficient, or increasing the chances that policies will be effective.

The literature on public management reform is extensive, but it has concentrated on a few Western countries, e.g. Australia, Canada, New Zealand the United Kingdom.

This literature has emphasized that changes in the economic, social, political, technological and administrative environments combine to prompt and drive radical changes in public administration and management systems (Kettl, 1997).

Talbot (2009) categorises public management reform as comprising three phases. Bureaucratic principles form the basis of the first phase, when classic public administration was behind the organisation of more resources and people than had ever been seen before. The second is based on New Public Management (NPM), when the combination of market oriented reforms and the "rolling back of the frontiers of the state" brought about dramatic changes in approaches to public administration. In NPM, there is a swing in emphasis from passive administration to active management. Previously, management had been by budget and rules, whereas in this phase there was a switch towards management by initiative, responsibility and performance. The third phase rests on Public Value (PV), which aims to reintroduce principles of trust and legitimacy into the management of public services. Moore (1995) suggests that PV stands for management based on efficiency, with an emphasis on achievement and performance, a focus on the policy role of public managers and a concern with trust and legitimacy in the public domain.

In an alternative categorical analysis, Pollitt and Bouckaert (2004) propose four different approaches to implementing public management reform. The first of these tightens existing controls, imposing budget cuts, recruitment freezes, drives to eliminate waste and so on. The second approach seeks a link between private-sector management practices and political reform designed to generate more responsive, flexible organisations and to update administrative systems. The third seeks to introduce market-type mechanisms with the intention of enhancing competition between public-sector organisations and other providers. Finally, the fourth approach is based on strategies to minimize the state through the privatization or contracting out of public services.

2.2.1 New Public Management

As mentioned above, public management reform is subject to debate; there is no consensus within the literature regarding its implementation. For Hood (1991), who was widely credited with coining the term NPM, public management reform means splitting public service organisations into distinct units with either fully or partially contractual arrangements, while increasing both the outsourcing of the delivery of public services and the extent of competition in public services. Management styles should become more like those in the private sector, with a greater emphasis on linking performance to defined standards and measures of output, alongside an increased awareness of discipline, more careful monitoring of resource use and a greater focus on service and the client.

The set of doctrines known as NPM emerged in the 1980s, in an effort to reform public administration, covering a wide range of contemporary administrative changes (Common, 2001). Hood (1991) first applied it to structural, management and organisational aspects of the reform agendas adopted by member countries of the Organisation for Economic Co-operation and Development (OECD) in the 1980s, in an attempt to rectify dysfunction in their public administration systems. NPM diffusion can be explained in two ways: as a solution to problems of inefficient governments or as a means of developing the effectiveness of the economics of the public sector (Common, 2001).

NPM has been portrayed as a global response to economic, institutional, political and ideological change (Box et al., 2001). According to Wise (2002), administrative reform is within the framework of NPM, fostering the impression that efficiency and market-based reforms are responsible for the majority of contemporary change and innovation. The focus on NPM reforms may have distorted the view of the evolution of public management practice and threatens to eliminate democracy as the guiding principle of public administration. This, according to Wise, is giving too much credit to one philosophical approach as an agent of public-sector reform.

Hood (1991) likens NPM to other administrative ‘megatrends’ and identifies some individual trends giving rise to it, the first being a slowing or reversal of government growth with respect to overt public spending and staffing. Secondly, there is a move away from core government institutions and towards privatisation and quasi-privatisation, with service provision becoming more ‘subsidiary’. The third trend is an increase in automation, particularly in IT, in both the production and the distribution of public services. Finally, Hood suggests that there should be a more international agenda, with a greater focus on public management in general, on policy design, decision styles and intergovernmental cooperation, as well as input from specialists in public administration from individual countries.

Common (2001) categorises NPM reforms as based either on structure or on process. Structural reforms are mainly concerned with organisational decentralization based on the creation of single-purpose agencies, alongside innovative types of organisation and territorial or geographical decentralization. This would be accompanied by a decrease in the number of departments or agencies and a reduction in quasi-privatisation and contracting out. On the other hand, managerial process reforms are based on the importing of management techniques from the private sector. The three major changes in process reform are in budgetary process, human resource management and quality management initiatives.

International experience shows that the main objective of NPM reform has been to rectify crises in funding and public services. The public management literature supports this view and sees NPM as being strongly focused on efficiency and market-based reforms (Hood, 1991; Koch, 1999; Box et al., 2001). However, it has also been criticized in the same literature as representing a complete break from the traditional principles of democratic governance. Moreover, critics have challenged NPM’s claim of universality, arguing that different administrative values have different implications for fundamental aspects of administrative design – implications which go beyond altering the ‘settings’ of systems. NPM has also been criticized for its inappropriate likening of the public sector to the private sector, for its characterization of citizens as clients, for its emphasis on measurement of

performance in unwarranted circumstances, for its 'real' agenda of cutting government spending, for enhancing the control of senior managers vis-à-vis politicians on one hand and subordinates on the other, for its under-estimation of the difficulty of separating purchasers from providers and for its downgrading of non-economic, non-measurable values (Hood 1991; Pollitt, 2001; Box et al., 2001).

Regarding public management reform efforts in developing countries, international organisations, such as the United Nations (UN) and in particular its development arm, the United Nations Development Programme (UNDP), have adopted programmes to assist reform and development of administration and governance in developing countries (Common, 2001).

However, there is no agreement on the way such reforms should be implemented. Indeed, implementation, like public management reform itself, has been the subject of much debate among scholars. For example, Heady (1996) argues that public management literature makes a point of mentioning the importance of past events and the specific function and establishment of organisations, together with their rules and perceptions, and the great influence they have had on public management performance. Moreover, Pollitt (2001) argues that there is no one-size-fits-all model of public management reform which can be applied uncontroversially to almost any country. Researchers have reaffirmed the need to pay attention to the institutional characteristics of each country in order to estimate the impact of reform activity (Pollitt and Bouckeart, 2004; Greve, 2006). In other words, researchers should consider any weaknesses in implementation and the impact of political, administrative and legal systems in constraining reforms (Martin, 2003). This view is supported by Wise (2002), who provides evidence of transformation in both the meaning and content of reform strategies from country to country. As such, researchers have demonstrated that governments vary in what they take from the bundle of reform (Savoie, 1994).

Accordingly, the literature on public management reform has shown that the contextual features of any country must be taken into consideration when

implementing public management reform. Common (2001) points out that coercive policy transfer often results in a government implementing a policy or programme that is inappropriate to its cultural, administrative or political context. Such contextual factors must pose uncertainty for any administrative system, because they have a fundamental influence on change in the system. Public administration development is essentially part of the whole institutional development of all aspects of a society: philosophical, political, technological and economic, and although different stages of this evolution have thrown up inconsistencies, the overall thrust displays more continuity and coherence among the elements than is generally recognized by most current relativistic conceptual creations. The analysis of administrative action, therefore, cannot be carried out singly, but has to be approached as a part of a whole, linking it to its historical, social, economic and political environment (Heady, 1996; Flynn 2002; Jreisat, 2003).

In conclusion, the main objective of any public management reform effort is to improve how government is managed and services delivered, with the emphasis on efficiency and effectiveness. Such reforms are of global significance because of the worldwide criticisms of government performance as inefficient, costly and overly bureaucratic. In many countries these reforms share a number of characteristics often summarized by the term NPM. There are, however, limitations to the international public management reform literature, in that analyses often ignore the effect of contextual factors; this applies to the Arab world in general and to Saudi Arabia in particular. The present study therefore seeks to extend the literature on public management in general and on health management in particular in Saudi Arabia, where there is a serious lack of such literature.

2.3 Health management reform

Although health care management reform is considered part of public management reform and the arguments above can be applied to such reform, it is worth focusing on health management reform, given that the topic of this study is Saudi health care

provision. Therefore this section provides details, examples and experiences from the literature, focusing on health management reform as a world phenomenon.

As with the wider public management reform literature, it could also be argued that health services face global pressure. For instance, health providers have to reconcile three competing objectives: fairness and equality, high quality and low cost. These objectives represent both social and economic factors, i.e. the provision of high quality and accessible health care to the population, while at the same time reducing health care costs. Therefore, many countries are struggling to provide good health care services in response to the demands of their populations, as well as increasing health care expenditure, which affects equity, quality and the effectiveness of the services (Farrell et al., 2007). Kingson and Cornman (2007) argue that health care costs are increasing and access to health care is declining. However, most of the challenges that reformers face are common to almost every health care system (Farrell et al., 2007). Therefore, health services in many developed countries have recently come under critical scrutiny. This is due to increasing expenditure, much of which, as mentioned above, comes from public sources, and the pressure this has put on governments seeking to control public spending (Ham, 1997).

There are many reasons for the pressures on health care services. For example, services are affected by demographic changes, including an ageing population and a decline in the proportion of the population of working age. These changes will increase the demand for health care and at the same time limit the ability of health services to respond to this demand (ibid). Farrell et al. (2007) state that increased supply creates further demand for care and mostly fails to generate commensurately better outcomes, such as longer life expectancy.

Moreover, services have become much more dependent on technology, which means that they rely on advanced technology in order to provide efficient services (Twaddle, 2002). Ham (1997) argues that development and advances in medical science will give rise to new demands. These advances cover a range of possibilities, including innovations and improvement in surgery, drug therapy, screening and

diagnosis. The pace of innovation and advance is likely to quicken, with significant implications for the funding and provision of services.

Furthermore, public expectations and demands for health services are increasing as those who use the services demand higher standards of care. In part, this is stimulated by developments within the health services themselves, including in the availability and accessibility of modern technology. Basically this is caused by the emergence of a highly educated and well informed population whose members are accustomed to being treated as consumers rather than patients (ibid).

The international experience in health care reform suggests that universal action and government involvement in assuring it are necessary prerequisites to controlling health care expenditure and overall cost (Kingson and Cornman, 2007). Moreover, Frenk (1994) states that the trend in recent years has been for all countries around the world to look in the same direction for better ways to provide health services and to cut costs. A wide range of these reform efforts include strengthening public management, decentralization, new methods for managing health finance and enhancing the role of the private sector in the national health system.

Giaimo (2004) states that most reforms adopted by countries around the world have focused on controlling escalating costs, whereas a few others have addressed a governance structure that impedes the ability of the systems to respond to new demands. As such, various approaches to health care reform in many countries around the world have focused on cost as a critical factor.

Jacobs and Nilakant (1996) and Imershein and Estes (1996) argue that health care reform in the 1990s was influenced by NPM and this presented real dangers to the objectives of equity and quality of health care provision. It is obvious that economic efficiency is a desirable objective and that wasting resources within the system is unacceptable.

Health management reform in the UK and US

To understand the pressures on health care systems around the world, two major global economic powers have been chosen as examples in this study, namely, the UK and the US. These countries have adopted many strategies to reform their health care systems in order to control spending and to ensure access for all of the population.

For example, the UK government has sought to improve the micro-economic efficiency of its health system by increasing elements of management and competition. Fotaki and Boyd (2005) note that the National Health Service (NHS) saw the introduction of elements of market competition in the late 1980s, when the functions of producers and buyers of care were separated. Freeman (1998) reports that hospital ancillary services were made subject to compulsory competitive tending in 1983. The NHS Management Inquiry of that year led to the introduction of general management in health authorities. General practitioner prescribing was restricted to a list of reimbursable drugs in 1985 and a system of volume-related budget holding by clinicians was implemented in hospitals in 1986. The Working for Patients white paper of 1989 led to the NHS and Community Care Act of 1991, which separated the purchase of health care from its provision by according managerial autonomy to quasi-independent hospitals (NHS trusts) and leaving purchasing and planning functions with health authorities. In primary care, some larger practices were given independent budgets to purchase non-acute hospital services for the patients on their lists.

Hunter (2002) states that the UK has adopted a market approach to push forward the privatization process, setting the stage for the introduction of market principles into public services. There was felt to be significant scope for achieving cost improvements in the NHS. Compulsory competitive tendering for cleaning, catering and laundry services was introduced a way of realizing these savings, although in the event most contracts were awarded in house. Fotaki and Boyd (2005) liken the market-oriented changes in the UK to a ‘big bang’ approach which was coordinated

centrally and aimed at a complete redesign of the system. The reforms were presented to the British public by politicians who often disguised their actual content. Fotaki (1999) argues that the quasi-market reform did not actually improve quality, efficiency or responsiveness in the health care system, but appeared to have an adverse effect not only on the choice of provider but also on the modalities of treatment. In 1999, under the new Labour government, the UK retreated from the market approach (Flood, 2000). A white paper proposed that the internal market should be abolished; the organisational structure with the purchaser/provider split was to be kept, but the emphasis switched towards a relationship based on cooperation, while it was still possible for purchasers to change providers.

In contrast to the UK, Wessen (2002) argues that health care reforms in the US come from the private rather than the public sector. The American health care system has been subject to extremely rapid change, encompassing the diffusion of fast-changing medical technologies, the emergence, merger and consolidation of a plethora of institutions and the development (and sometimes the demise) of new organisational forms. Most of these changes have derived from the innovativeness of entrepreneurs and managers in the private sector, while the federal government has contributed little to changing the health care scene. Feldstein (2002) states that health reform in the US was concentrated in two programmes, Medicare and Medicaid, which emerged in 1965 as the major sources of heath care funding for Americans. These two programmes are still the principal government health insurance providers in the United States. Medicare is designed specifically to cover the aged, whereas Medicaid addresses the preventive, acute and long-term care needs of the poor. In 2010, US President Barack Obama signed a landmark healthcare reform bill into law. Under the new legislation, health insurance will be extended to nearly all Americans, new taxes will be imposed on the wealthy and restrictive insurance practices such as refusing to cover people with pre-existing medical conditions will be outlawed (BBC, 2010).

Whatever approach is taken to reforming the health care system, cost will be a major concern and potential obstacle (Kingson and Cornman, 2007). Therefore, as Stoffell

(1994) observes, some of the major problems associated with health care reform are economic, without the benefit of arguments from moral philosophy which would have informed the debate on the ethics and equity issues so necessary for public policies dealing with a social good such as health care. Kingson and Cornman (2007) argue that there is a moral imperative, arising from widely shared social and religious values, to provide universal access to health care services for all members of the national community and that this concern should remain at the core of any discussion of national health care reform.

Health care reform is a general term used for change in health care systems. It mainly attempts to improve the access to health care specialists, to improve the quality of health care and to reduce its cost (Kolassa, 1994). Such reforms will tend to differ from country to country, as there are no universal solutions (Feachem, 2000). Therefore, not surprisingly, no country's health care system has achieved perfection (Kingson and Cornman, 2007). Indeed, each health care system reflects the particular political, economic and social culture of the country concerned and the success of reforms will depend greatly on the availability of scientific evidence to provide the basis for adopting and guiding policy. Therefore, each country needs to set its own research agenda in order to identify its system's problems and solutions to them (Janovsky and Cassels, 1996).

In conclusion, reform of health systems around the world focuses on the delivery and financing of care in order to reduce costs, which means that it is an aspect of health management. Those engaging in reform have always had to debate how to balance the delivery and the financing of health care, because reform always concerns the equity and quality of care, which are related to public expectations and will change according to health requirements and educational levels. Moreover, health care reform is considered a major political initiative. Therefore, government agendas, especially at election time, concentrate on promises of good health care to voters. In addition, health care is technologically oriented because of the accelerating advances in technology in this field. Therefore, reform is a continuous process and each reform effort is related to the conditions in a particular country.

2.4 Saudi public reform

As mentioned in Chapter One, public management reform in Saudi Arabia and in the Arab world generally has not been the topic of much literature. However, in understanding public management reform in Saudi Arabia, it is very important to provide a critical review of the country's political, economic and cultural values and norms (Common, 2008). Therefore, the following section gives a brief outline of these elements, albeit based on sparse literature.

2.4.1 The administrative context of Saudi Arabia

Saudi Arabia is the most conservative of the Arab states; Islam provides the foundation for the civil, cultural, economic, legal, political and social fabric of the country.

The political system in Saudi Arabia is a monarchy, where the king rules through a council of ministers. The country has no political parties, unions or franchise. People participate in the political life of the country through the Majlis Al-Shura (consultative council), which enables them to voice their concerns and communicate their views to the government. Its chairman and members are appointed by the king, who remains the ultimate authority, promulgating laws and determining new policies (Jabbra and Jabbra, 2005; Mellahi, 2006; Common, 2008; for more detail, see Chapter Four).

The Saudi economy is oil based and major economic activities are heavily controlled by the government. It is estimated that Saudi Arabia holds around 25% of the world's proven reserves of petroleum, the largest reserves of any country in the world, and that it is the largest exporter of petroleum. Due to its strategic geo-political position and energy resources, Saudi Arabia is a major player in the stability of the global economy (Mellahi, 2006; Common, 2008; for more detail, see Chapter Four). Thus, the Gulf Cooperation Council (GCC) and the international comparative literature refer to Saudi Arabia as a rentier state, which Owtram

(2004:199) defines as one relying on “direct transfers from the international economy in the form of oil revenues”. Oil revenues have helped to protect the Gulf states from international economic pressure, but, as Winckler (2000) notes, in the absence of the systems of personal and corporate taxation they also serve as a further safeguard against democratisation. Mellahi (2006) remarks upon the close links between oil prices and political and social stability in Saudi Arabia.

With regard to Saudi social culture, Common (2008) notes that the Gulf states are characterised as centralised, with strong organisational cultures rooted within a regional culture that is based on tradition, religious values and community, supported by the social culture. Saudi Arabia is commonly believed to be characterised by high power distance, collectivism, femininity and high uncertainty avoidance (Barakat, 1993; Bjerke and Al-Meer, 1993; Alshaya, 2002; Jabbra and Jabbra, 2005; Mellahi, 2006; Tayeb, 2005; Idris, 2007; Common, 2008; for more detail, see later in this chapter). The management style is hierarchical and a centralised structure (Taype, 2005). According to Common (2008), such national characteristics seem to have resulted in a rigid environment which is resistant to administrative change.

2.4.2 The nature of administrative reform in Saudi Arabia

Within the administrative context set out above, the study aims to present and analyse the attempts at public management reform which are currently underway in Saudi Arabia, as in many countries across the world, in order to improve the performance of public bodies. Saudi public management reform can in some sense be considered a historical development, taking place in different stages with the reform approaches focusing on the issuance of laws and regulations (for more detail, see Chapter Four).

In 1953, the Council of Ministers was established, which could be considered the first basic step in establishing a central administration in Saudi Arabia, but true administrative development is considered to have begun in 1970 with the

establishment of a central administration and the creation of bodies capable of planning and executing development projects. This decade saw the near completion of the building of Saudi Arabia's organisational, judicial and executive bodies; the Saudi government, taking advantage of the increase in oil revenues, began to implement such reform in the mid 1970s (Tawail, 1995).

Public management in Saudi Arabia is dominated by bureaucracy, which the King supervises and manages via the Council of Ministers, and this is fundamental to public management in Saudi Arabia. The Council of Ministers is powerful, central and dynamic, having responsibility for internal, external, financial, economic, educational and defence policies, as well as general affairs of state. It answerable to the King for all its activities and those of the bureaucracy (Jabbra and Jabbra, 2005). Common (2008) remarks upon the character of the GCC, of which Saudi Arabia is a member, being centralized, with a pyramidal structure underlying formal control, which makes sure that control is hierarchical.

The implementation of bureaucracy in running public management in Saudi Arabia reveals certain traits. One example is over-centralisation, which is a major problem in that it results in senior managers enforcing commands from their superiors rather than being more independent in making decisions. Jreisat (2003) notes that public employees have lacked the involvement and participation that could facilitate improvements in their performance. Jabbra and Jabbra (2005) found that subordinates relied excessively on their superiors, passing even minor administrative problems to them for resolution, so that senior public servants were engaged in administrative trivia, rather that spending their time on more important issues.

Saudi Arabian bureaucracy and public management are hampered by rigidity and complicated sets of rules and regulations, with long lines of command, a combination of factors which leads to weak control, as orders can gradually change as they are passed down the ranks, following the 'Chinese whispers' phenomenon. Al-Hegelan (1984) and Jabbra and Jabbra (2005) cite lengthy and time consuming procedures in which the approval of a chain of several officials must be sought

before a matter can be sent to a top bureaucrat for his approval. Jabbra and Jabbra (2005) remark upon the plight of citizens who are often obliged to travel to the major cities in order to finalize transactions.

Nepotism, commonly referred to in this context as *wasta*, represents a unique feature of bureaucracy in Saudi public management, arising from the country's basic values of loyalty to family and tribe. *Wasta* among public servants results in a senior official's family or tribal members being recruited into a particular ministry or agency (Al-Awaji, 1971; Jreisat, 2003; Jabbra and Jabbra, 2005; Idris, 2007; Common, 2008).

Several researchers, including Al-Awaji (1971), Al-Ahmadi and Roland (2005) and Jabbra and Jabbra (2005), have argued that one of the most significant barriers to building a Saudi bureaucratic system that is both accountable and responsible has proved to be the unavailability of qualified personnel of the right calibre. This has been a serious problem, particularly when Saudi public services needed to expand rapidly when oil revenues rose and the government wanted to provide Saudi citizens with new services.

These characteristics are reflected in the current output of Saudi public organisations. For example, Jreisat (2003) remarks that despite overstaffing in Saudi public organisations, their actual productivity is low, so many employees underperform. He also found that although the financial rewards were high, there was a lack of innovative and skilled work for Saudi public employees (Jabbra and Jabbra, 2005).

The Saudi government has tried to solve the above-mentioned problems, caused by the bureaucracy that dominates Saudi public management, through some management reform efforts. For example, following the fall in oil prices in the mid-1980s, the country started looking for alternative sources of revenue. One of these was the intensification of global trade relations, which required reform to accelerate international as well as national investment. For example, in order to stimulate

competition, Saudi Arabia has recently instituted several laws and policies concerning privatization and investment, notably foreign direct investment (Mellahi, 2006).

In 1992, the king issued decrees on three major political developments with the aim of modernizing the government, the first concerning the formation of the Consultative Councils (Majlis Al-Shura) (Al-Hamad, 1995) and the second establishing Provincial Councils in each of Saudi Arabia's 13 provinces. They are composed of leading citizens who help to provide input and review the management of the provinces by their respective local governments (Almotairi, 1995). The third decree promulgated the Basic Law of Governance, incorporating arrangements for the Consultative Council and the regional government. It established in writing the essential structure and organisation of government and can be seen as constituting a bill of rights for the citizen (Al-Hamad, 1995).

In 1995, in order to solve the shortage of qualified personnel, the government instituted the Saudization system, by which non-Saudi employees in public management would be replaced by Saudi nationals. According to Gallagher (2002), this system lays out the political context and cultural climate from which Saudization emerges as a reform target. Mellahi (2006) notes that the process of Saudization has proceeded much more slowly than the government had hoped.

In order to modernize its public administration effectively, the government also established in 2003 the General Memorandum Committee Administrative Reform. This aimed to restructure the public sector at large, because the organisational structures of the government agencies had been largely unchanged for about 40 years, ever since their establishment, resulting in some overlaps and duplications. These reform efforts have led to a reduction in government expenditure by abolishing some agencies and in unifying the responsibilities of other services (Al-Otaibi, 2006).

Public organisations have also been experimenting with and introducing various NPM ideas and practices, in conjunction with principles from Total Quality Management (TQM), as well as other forms of organisational development and change including the transfer of and reliance on certain market principles such as contracting out and competition. Al-Yahya (2009) comments that this all signifies a major shift in the way public administration operates, which, along with the increased investments in NPM programmes, could indicate a trend towards relative decentralization and de-bureaucratization. However, Common (2008) argues that such reforms in countries such as Saudi Arabia have aimed to stimulate growth in the private sector and reduce dependence on public sector employment for nationals by focusing on economic and labour market policies, rather than on administrative system reforms.

Regarding the reform efforts in the Saudi health care system, the government took an important step when it established National Health Insurance (NHI) in 1999. The main objectives of the NHI programme are to serve as an additional source for financing health through wage-based contributions by employers and employees, thereby reducing the government's share of total health expenditure, and to transfer some of the social responsibility for such expenditure from government to employers (Mufti, 2000). Another step taken by the Saudi government was the establishment in 2002 of the National Health Services Council (NHSC) to formulate a strategy of health care and the development and adoption of policies of coordination and integration between all the relevant bodies to provide health care services in the kingdom (Al-Rabeeah, 2003).

It is clear that the above management reforms took place through making reductions in expenditure, ending duplication between government agencies, privatizing some government agencies either wholly or partially, establishing training institutions in order to overcome the severe shortage of trained nationals and the adoption of e-government (Al-Tawail, 1995; Jabbra and Jabbra, 2005; Al-Otaibi, 2006; Al-Shehry, et al., 2006). However, in Saudi Arabia, this type of public management reform has

also notably involved the coordination and control of the expanding public agencies (Al-Otaibi, 2006; Common, 2008).

In conclusion, Saudi Arabia has spent substantial amounts of the money gained from oil revenues on modernising bureaucratic systems, yet any improvements have been slow, with administrative structures, systems and procedures which are outdated. Al-Khaldi (1983), Al-Rabeeah (2003) and Jabbra and Jabbra (2005) have all commented that the administrative culture is characterised by unsystematic flows of information, insufficient coordination, inadequate planning, inefficient transitions and problems with control and supervision.

Part of the problem in Saudi reform arises from the huge cultural differences between the Western context from which much of the modern administrative framework originates and the various dimensions of the Saudi political context, which is heavily based on traditional and religious values. In particular, the politico-ideological tradition of democracy which evolved in the Western world barely exists in Saudi Arabia. Common (2001) cites Haque's view that the democratic assumptions of neutrality, anonymity and impartiality in administrative procedures and accountability to elected politicians made in Western countries are not generally shared in Saudi Arabia.

Inefficiencies in Saudi public management reform have also arisen from Saudi employees in general and managers in particular being deeply entrenched in certain social structures that render ineffective any rational thrust to managerial strategies. As Saudi Arabia is also a rentier state, the powerful elite do not have much incentive to change their habits. Common (2008) remarks on the slow rate of political change in situations where the powerful elite dominate political life. Basically, the political sphere is restrained by strong institutions which are dictated by culture and tradition.

Indeed, the social culture of Saudi Arabia lends support to the centralisation of the country, which may be the reason for the problems facing Saudi public management. Therefore, it is clear that although the government has already taken steps, greater

effort is still required and that these reform efforts should be compatible with the culture of the country. Curry and Kadash (2002) point out that in developing countries such as Saudi Arabia, any programmes of organisational improvement or change need to be accompanied to some degree by cultural change. Therefore, the main objective of this study is to understand and explore the role of organisational culture in facilitating efforts to improve the Saudi health services. The next section explores the organisational culture as a phenomenon of organisational behaviour and examines ways of assessing it, through a critical review of the literature.

2.5 Organisational culture

As noted above, health care reform is a continuous process, due to the continuing pressure to reduce expenditure, increase efficiency and raise health service standards. Thus, those attempting change must first understand the existing organisational culture (Cartwright and Cooper, 1993). Cameron and Quinn (1999) argue that assessment of organisational culture is increasingly important because of the need both to change and to maintain stability in an increasingly turbulent external environment. Indeed, to achieve change in an organisation it is important that all of its members have a good understanding of its culture. Moreover, many efforts to improve organisational performance have failed because the fundamental culture of the organisation remains the same. Therefore, the process should start with a successful management of organisational culture (Schein, 1985; Deal and Kennedy, 2000; Cameron and Quinn, 1999; Gross et al., 1993; Kotter and Heskett, 1992; Senior and Fleming, 2006).

2.5.1 Background to Organisational Culture

The term ‘culture’ generally refers to values, knowledge, beliefs, morals and customs. In this thesis, it refers to forces within organisations which shape the traditional ways of thinking and doing things, which are shared by their members and which a new member must learn in order to be accepted into the workplace.

Denison (1990) states that early research into organisational culture during the 1960s and 1970s focused on more measurable aspects corresponding to employee perceptions, such as the level of individual involvement. Such research is referred to as organisational climate studies. Current studies of organisational culture are more focused on complex anthropological approaches, in order to understand invisible aspects of organisational life such as members' attitudes.

Organisational culture, as a concept in management, was in common use in the 1980s. During that time the concept received serious attention in the organisational sciences in response to the work of Peters and Waterman (1982) and Ouchi (1981). Peters and Waterman identified characteristics of excellent companies in the US, while Ouchi pointed out the importance of national values as they impact upon corporate culture. Ouchi established a clear link between the Japanese national culture and the corporate cultures of major organisations, claiming that the success of Japanese companies depended on their corporate culture. Against this background, the following subsection offers some definitions of organisational culture as a modern concept in management.

2.5.2 Definition of Organisational Culture

The literature on organisational culture offers contradictory and apparently ambiguous definitions of culture. Most researchers in this field adopt Smircich's classical concept of organisational culture. The research question posed by Smircich (1983:339) is: "How may we critically evaluate the significance of the concept of culture for the study of organisations?" In response, she identifies two main schools or approaches to culture as being linked to organisations: one uses culture as an organisational variable (i.e. organisations have cultures) and the other defines it as a metaphor (i.e. organisations are cultures and their nature is revealed only by studying cognition, symbolism and unconscious processes). Smircich argues that according to the former approach researchers and managers can identify differences among organisational cultures, can empirically measure cultures and can change them, whereas the latter perspective presumes that nothing exists in organisations

except culture and that one encounters culture whenever one examines any organisational phenomenon. Moreover, the culture is a potential predictor of other organisational outcomes (e.g. effectiveness) in the former perspective, while in the latter it is a concept to be explained independent of any other phenomenon. This study adopts the first of these two positions.

There are various definitions of organisational culture, none of which is commonly accepted, although this term has been in use for many years (Alvesson and Berg, 1992). Among the available definitions, many concentrate on enduring attributes of culture such as values, assumptions and beliefs, giving a sense of what is valued and how things should be done within the organisation (Sleutel, 2000). An academic writer with an interest in this field is Schein (1984), who defines culture as:

> "A pattern of basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems" (p.6).

Denison (1990) defines culture as the underlying values, beliefs and principles that serve as a foundation for an organisation's management system as well as the set of management practices and behaviours that both exemplify and reinforce those basic principles, while Deal and Kennedy (2000) define it informally as 'the way we do things around here'. These definitions suggest that organisational culture is a set of value systems that are shared by all the members of an organisation and take a long time to glue people (staff) together. However, Schein's formulation provides a more definitive picture of the nature of organisational culture by considering it as the learned results of group experiences and noting that it is to some extent unconscious.

2.5.3 Importance of Organisational Culture

Organisational culture has received much attention in the organisational behaviour literature (Ouchi 1981; Hofstede et al., 1990; Schein, 1990; Cartwright and Cooper,

1993; Trice and Beyer, 1993; Cameron and Quinn, 1999; Hofstede, 2005), because most researchers agree that cultural factors play a key role in determining organisational outcomes (Marcoulides and Heck, 1993). Cameron and Quinn (1999) argue that organisational culture is reflected in what is valued, the dominant leadership styles, symbols, procedures, routines and the definition of success that makes any organisation unique. Alvesson (2002) states that the organisational culture is an important concept among the major issues in academic research and education, in organisation theory as well as management practice. There are many reasons for academic research to address organisational culture: its dimensions are extremely important in all aspects of organisational life. For example, how people in a company think, feel, value and act are guided by the ideas, meanings and beliefs of a cultural nature. Senior managers are constantly managing cultural understanding of what is more or less important to the organisation and framing how the corporate world should be understood.

One major reason for the increased interest in culture is that the concept has not only become relevant to organisational-level analysis, but has also aided understanding of what goes on inside an organisation when different subcultures and occupational groups have to work together. Many problems which have been viewed as simply communication failures or poor teamwork are now being more properly understood as a breakdown of intercultural communications. Furthermore, the analysis of organisational culture is essential for management across national and ethnic boundaries (Schein, 1997).

Organisational culture has been an area in which conceptual work and scholarship have provided guidance for managers since they have searched for methods to improve their organisations' effectiveness and efficiency, because organisational culture has a powerful effect on their performance and long-term effectiveness. In many cases organisations fail in their change and improvement efforts because of their inability to bring about culture change (Trice and Beyer, 1993; Schein, 1997; Cameron and Quinn, 1999; Common, 2008).

Most scholars have accepted that organisational culture has a powerful effect on the performance and long-term effectiveness of organisations. An impressive array of empirical findings demonstrate the importance of culture in enhancing organisational performance; they also prove that organisation-level cultural phenomena affect individual variables such as employee morale, commitment, productivity, physical health and emotional wellbeing (Cameron and Quinn, 1999).

Organisational learning, development and systematic change cannot be understood without considering culture as a primary source of resistance to change (Schein, 1997). In this regard, Cameron and Quinn (1999) argue that a full understanding of organisational culture is extremely important for all leaders, since it influences the way their organisations react to the changing demands of the business environment. Such swift and remarkable change implies that no organisation can remain the same and survive for long; the current challenge, therefore, is not to determine whether or not to change, but how to change in order to increase organisational effectiveness (Cameron and Quinn, 1999). In order to introduce new models of innovation successfully, and in particular, models that challenge deeply held beliefs, it is necessary for the organisational leadership to actively manage organisational and work group cultures that are in place (Jones et al., 1997). Organisational researchers suggest that these values and behaviours are products of organisational experience and that they influence many areas of organisational life, because such cultures are deeply rooted and integral parts of organisational behaviour and are mostly difficult to change (Baker et al., 2003).

A number of different approaches or models can be used to explore an organisational culture from different perspectives. The next subsection outlines the CVF, which is employed in the present study. The justification for using this framework will be given later in this chapter.

2.5.4 Competing Values Framework

In the 1980s, a researcher in management developed the initial work on the CVF as a conceptual framework to identify the criteria that academic researchers use when they evaluate organisational effectiveness (Kalliath et al., 1999; Helfrich et al., 2007). In 1999, Cameron and Quinn developed the CVF, as illustrated in Figure 1, to include two axes of competing goals by deleting the third axis of means/ends. The other axes remained the same, representing two dimensions: the horizontal axis describes an organisation's focus as divided between internal and external concerns, while the vertical axis of the structure is the continuum between flexibility and control, with the managers emphasizing either efficiency and control or innovation and adaptability. Cross-classifying organisations on these two value dimensions results in four archetypes, referred to as hierarchy culture, market culture, clan culture and adhocracy culture. In relation to this there are essentially six cultural dimensions: dominant characteristics, organisational leadership, management of employees, organisation glue, strategic emphasis and criteria for judging success. For each of the six dimensions, each model favours different approaches.

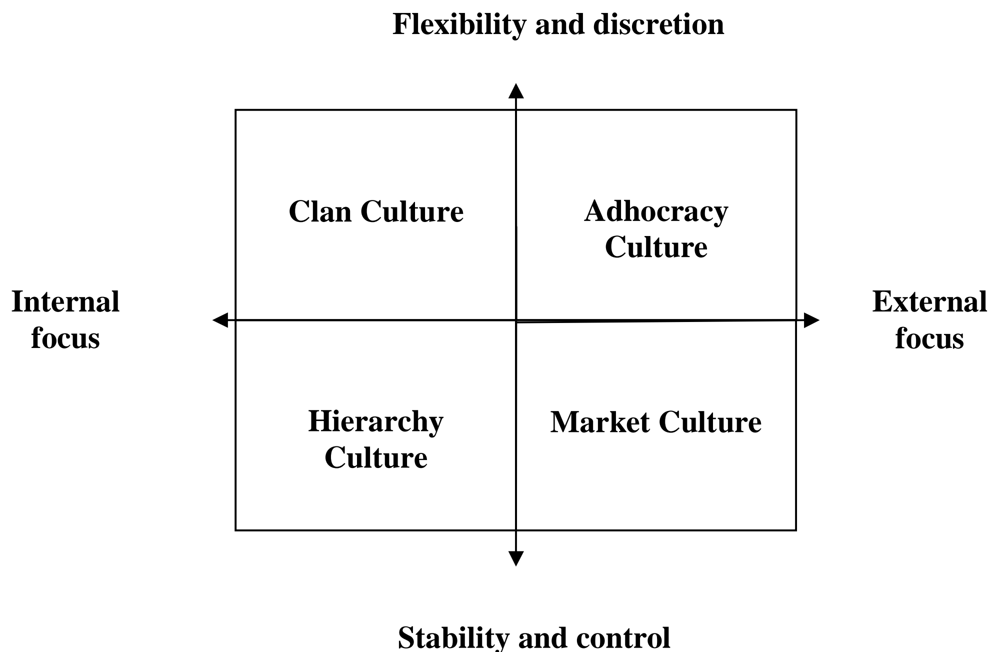

Figure 1: CVF (Cameron and Quinn, 1999)

Hierarchy culture

Hierarchy culture is concerned more with internal issues than external issues, while stability and control are preferred over flexibility and discretion. This culture tends to work when the organisational environment is both stable and uncomplicated, and when the main objective is efficiency.

Market culture

Market culture is based on principles of stability and control and in this type of culture external issues are of greater concern than internal issues. In this culture the external environment (market) is considered to be a potential threat, while profit, identification of threats and advantage over competitors are of paramount importance.

Clan Culture

Clan culture is based on internal issues and the aim is to manage the environment through teamwork, participation and unanimity. Flexibility and discretion are preferred over stability and control.

Adhocracy Culture

Adhocracy culture is based on external issues; creativity and risk taking are its key principles. As with clan culture, stability and control give way to flexibility and discretion.

The CVF can be assessed by the OCAI. This is a questionnaire that comprises six questions with alternatives for each question based on the current situation and the preferred situation, which are related to the six "cultural subsystems" that are apparent in every organisation (Kaarst-Brown et al., 2004). These criteria are:

1. Dominant Characteristics – The degree of teamwork and sense of affiliation, the level of creativity and dynamism, the focus on goals and competition, the reliance upon systems and the emphasis on efficiency.
2. Organisational Leadership – The leadership style of the organisation. The roles of leadership are identified as mentor, facilitator, innovator, broker, producer, director, coordinator and monitor.
3. Management of Employees – How the organisation treats the employees, the degree of consultation, participation and consensus, and the working environment.
4. Organisation Glue – The mechanisms that hold the organisation together, such as teamwork and cohesion, loyalty and commitment, entrepreneurship and flexibility, rules and policies, goal orientation and competitiveness.
5. Strategic Emphasis – What drives the organisational strategy? Is it the long-term development of human capital, stability and competitive advantage, innovation, growth and acquisition, or the achievement of goals?
6. Criteria for Judging Success – How does the organisation define its success and how does it reward, for instance, profits, market share and penetration, development of new products and services, sensitivity to customers and concern for people, dependability and optimum cost? (Kaarst-Brown et al., 2004; Igo and Skitmore, 2006).

2.5.5 Justification for using the CVF

The provision of health care services in Saudi Arabia, as highlighted earlier, suffers certain problems, so it is necessary to assess the role of the organisational culture in order to facilitate the analysis of the present state of the system. As the present study addresses the key research questions by adopting the OCAI, which is based on the CVF, this section discusses in some detail the justification for adopting the CVF. To date the subject of health care management in Saudi Arabia has remained unexplored; indeed, as stated in Chapter One, there is a fundamental gap in the literature on public management in the Arab world in general and in Saudi Arabia in

particular. By using the CVF to explore the role of organisational culture in Saudi Arabia, this study aims to fill that gap. This will be the first attempt to use the CVF to assess the role of organisational culture in health care provision in Saudi Arabia. The Western countries where the CVF was developed and used have markedly different organisational cultures from those in Saudi Arabia. This study will therefore attempt to determine the suitability of CVF for analysis in the Arab world in general, and particularly in Saudi Arabia.

Therefore, there is a real need for a suitable approach to assess the role of organisational culture in Saudi Arabia's health care provision that would consider large and complex organisations. Such organisations, according to Deal et al. (1983), are made up of subcultures, which could range from departments to nursing units and professional, functional or project groups. No single organisation is likely to reflect a single value system. Quinn and Kimberly (1984) note that most have a combination of values with varying degrees of dominance. Hofstede et al. (1990) acknowledge that larger organisations such as health care providers, which have more complex designs, generally have a range of departments and workgroups, each with a strong and distinct professional culture.

Helfrich et al. (2007) conducted research in the field of health services, noting that the CVF has frequently been used in health services with major indicators of processes and outcomes of healthcare. What is more, Jones et al. (1997) argue that the CVF was specifically worded to reflect how the values and beliefs in place in a hospital are perceived by caregivers.

In adopting the CVF for use in this study, the researcher anticipated that it would reveal that no single health provider reflected one value system exclusively. Most have a combination of values, some more dominant than others. According to Scott et al. (2003a), the CVF model is specially designed to illustrate the balance of different cultures within the same organisation, for example in health care environments, and attempts to examine the views, values and beliefs of employees about their organisation.

Bess (1988) describes three long-standing and competing theories, i.e. bureaucracy, human relations and conflict, which are embedded in the CVF and were considered throughout its development. Talbot (2008) argues that the CVF is fairly unique in that it brings together issues of management, leadership, strategy, structure, culture, innovation and performance. This has a positive influence when it comes to public sector reform and performance.

Fundamental organisational culture is explored in this study by implementing the CVF, as the criteria are embedded in competing values reflecting psychological archetypes. Cameron (2004) states that the underlying organisational culture can be revealed by asking members of an organisation to answer questions about the CVF dimensions, thus illuminating its fundamental cultural dynamics. Quinn and McGrath (1982) advocate this method above others because not only does it encapsulate more criteria, but these are embedded in incongruous or competing values. Flexibility in organisations is desirable, but so are stability and control. Human resources should be valued, but planning and establishing goals are also vital.
Igo and Skitmore (2006) cite Fyock (1999) as suggesting that it is preferable to focus on “what [an organisation] is right now” and not just “what it wants to be” in order to reform it. This standpoint can at any rate offer some initial pointers and can emphasise where changes are necessary to support an organisation. According to Igo and Skitmore (2006), some form of measurement needs to take place for such analysis to be meaningful. The principal purpose, as suggested by Schein (1996), should be to move the organisation towards a point that represent the cultural ideal. By using the CVF, this study will emphasise the changes necessary for achieving a preferred outcome. This is based on the views of the research participants, focusing on the comparison between the present situation and the desired outcome. According to Goodman et al. (2001), the CVF can create a cultural profile, which will aid identification of imbalances; by assessing the current state of the organisation’s culture, it can create an ideal profile of the organisation. When these current and ideal cultures are compared, a list of strategies for improvement and growth towards

the preferred state can be generated. Cameron and Quinn (1999) also argue that by comparing the cultural values in place with desirable cultural values, the investigator can use the CVF to compare the “shoulds” with the sought-after state, and for this reason it is valuable for the purposes of comparison and cultural audit.

Barley et al. (1988) state that the CVF is useful in describing the spirit of an organisation’s culture, in helping to identify and assess the range and strength of relevant values and in ascertaining how widely they are held within the organisation. This diverse range allows the researcher to use a mix of qualitative and quantitative techniques to determine and compare the key cultural characteristics of a particular organisation. Cameron and Quinn (1999) advocate CVF as a straightforward means of organising types of organisational culture. It is an approach to cultural typology which is viewed as a way of making an organisational culture easier to understand. Goodman et al. (2001) note that a further advantage of the CVF is that numerous elements are incorporated and a rich visual representation of an organisation’s culture can be created.

The CVF has been validated via extensive research in a range of different environments. According to Cameron (2004), the CVF had been used in almost 10,000 organisations worldwide, including both private and public sector providers of education and health care. Goodman et al. (2001) and Scott et al. (2003a) confirm that the CVF has been empirically validated in a variety of settings. On the surface, at least, it appears that the framework has universal applicability.

2.5.6 Limitations of the CVF

Notwithstanding its advantages and widespread use, like other quantitative methods the CVF has been criticised for its use in measuring organisational culture. There are various reasons for such criticism. First, by using a questionnaire it is impossible for the researcher to explore more profound assumptions, as surveys merely touch the surface of the organisation. Secondly, questionnaires are less useful because they prejudge the dimensions to be studied. Several researchers, including Louis (1983),

Smircich (1983) and Schein (1985 and 1990), agree that it is impossible to ascertain whether the dimensions which a questionnaire addresses are relevant or significant in that culture until the deeper levels of the culture have been examined. Further limitations of the CVF include the lack of evidence of reliability or validity in the literature. Kalliath et al. (1999) conducted the only existing validation study of CVF in a healthcare setting. In a multi-hospital system in the US, they used a CVF instrument (Likert-scale format) to interrogate 300 health care managers and supervisors. They assessed the underlying structure of the survey data using structural equation modelling to establish whether it conformed to the CVF. It was found that their results were fairly consistent with the four-subscale CVF, although one problem with the results was that the researchers found a high positive correlation ($r = 0.73$) between the hierarchical and entrepreneurial subscales, which they predicted would be uncorrelated or negatively correlated under the CVF. This correlation was attributed to the disorganised business environment of the research setting at the time of the study. The authors conclude that the relationship between the subscales was not in fact fundamentally inconsistent with the CVF.

Helfrich et al. (2007) reach a similar conclusion. They examined the data from a CVF instrument using factor analyses, which were exploratory and confirmatory in nature, to examine the underlying structure and found moderate to strong internal consistency of the subscales. They also report that the correlations of entrepreneurial, team and rational subscales were higher across subscale than within, which indicates poor divergence. They used exploratory factor analysis and this revealed two factors loading on the first factor comprising the ten items from the entrepreneurial, team and rational subscales, and two items from the hierarchal subscale loading on the second factor, as well as one item from the rational subscale which cross-loaded on both factors. Confirmatory factor analysis results imply that the two-subscale solution provides a more prudent fit to the data than the original four-subscales model. In addition, there may be problems applying conventional CVF subscales to non-supervisors, and this highlights how important it is to assess

the psychometric properties of the instruments in every new setting and with each set of people to whom they are applied.

It is clear that the CVF method has its own advantages and disadvantages, just like any other survey method. This explains the durability of the CVF and why, despite criticisms, the researcher decided to use the framework in the present study.

In conclusion, organisational culture in not a simple subject of study, because the concept is a very broad and holistic one. Therefore, there is no agreement among scholars on a definition of organisational culture or on the best approach to its study and analysis. For example, organisational culture can be defined as an artefactual aspect of an organisation which would be as easy to observe as its products or, by contrast, as a set of basic assumptions that are as difficult to observe as emotions or beliefs.

Regardless of these arguments, studying the culture of an organisation is very important to determine its position and it plays a powerful role in shaping the life of the organisation. For example, the failure of implementation of major improvement strategies (e.g. TQM, downsizing and reengineering) occurs in most cases because of a failure to change the organisation culture; conversely, changes in organisational culture can be adopted in solving problems.

Health care organisations around the world face many problems arising from rapid changes in health care environments, such as increased expenditure. Therefore, there is a need for reform and this is bound to be affected by organisational culture, which is in turn influenced by national culture. The researcher decided to adopt the CVF to assess the organisational culture of its health care providers. The next section reviews the literature on studying organisational culture in health care organisations.

2.6 Organisational Culture in Health Care

Health care is an activity that has undergone continuous change in recent decades, under the combined influence of a complex set of interrelated political, social and

economic factors. In considering organisations with large and more complex designs, such as health care providers, Hofstede et al. (1990) recognise that they usually have various departments and workgroups with different cultures. This view is supported by Cameron and Quinn (1999), who argue that large organisations operate across a range of cultures. Sovie (1993) agrees that such subcultures exist, with different workgroups and departments developing them. She argues that they are bound to affect employees in how they interact with their colleagues and carry out their responsibilities. In the present context, she suggests that hospitals, being complex organisations, will develop special cultures and subcultures that may or may not serve them well at any particular time.

Indeed, the reason for the existence of subcultures in the health care systems is that health organisations by their very size and nature employ many different medical and administrative personnel, who are bound to shape the identity of these subcultures (Brooks and Brown, 2002). Deal et al. (1983) argue that as in many organisations, hospital cultures are made up of subcultures such as nursing units, professional groups and functional or project groups. However, unlike non-medical organisations, hospitals in particular have been described as having cultures that are weak or fragmented (Nystrom, 1993). This may be related to the number of stable and strong subcultures within hospitals (Bice, 1984), which are often labelled as work group cultures (Coeling and Simms, 1993).

A powerful culture will undoubtedly have an impact on the behaviour of staff, even without the introduction of policies and procedures and the advice of supervisors and managers of health care systems (Mallak et al., 2003). In addition, in health care organisations a strong culture exists where employees behave similarly to their colleagues; therefore the importance of the role of professionals in health care organisations can influence and shape their culture (Wickens, 1995). For example, nurse managers, because of their numbers in health care organisations, can also influence an organisation’s culture through their daily nursing rituals, customs and practices (Wells, 1995).

A hospital department believing that it exists only to provide a professional discipline to the hospital, without consideration for the patient, or a department that emphasizes strict rules and rigid procedures rather than flexibility and creativity, may represent a dysfunctional culture (Sovie, 1993). In order to survive, hospitals have to be transformed into responsive, participative organisations, capable of new practices that produce improved results in both quality of care and service at less cost. To achieve a transformed organisation with a new culture is a long-term process that requires the concerted efforts of each hospital member (Brooks and Brown, 2002). Mallak et al. (2003) also argue that health care systems are complex entities, which require professionals to interact and coordinate with support staff, all working in an environment designed with the patient in mind; and of course the effectiveness of the design of this environment will affect the quality of the care provided. Moreover, the roles of healthcare professionals today are under more scrutiny, where accountability and decision-making at clinical practice and policy levels are concerned (Scott-Findlay and Estabrooks, 2006). Hence, the main responsibility of an individual hospital's leadership is to build and sustain a culture that will be conducive to its mission, in harmony with the ever-changing environment (Sovie, 1993). This means that the leaders of health care organisations have to be receptive to political, economic, cultural and social considerations, while nurturing a culture that will produce organisational success (Jones et al., 1997). Therefore, the main responsibilities of the hospital leadership are to help their people unlearn some of the old cultural assumptions and to encourage them to adopt new values and beliefs that will serve the organisation in an effective way. This involves learning new behaviours and discarding the familiar, comfortable ways of doing things, which is not easy (Sovie, 1993). Carney (2006) points out that middle manager professional clinicians and non-clinicians have the potential to influence health care delivery through their involvement in strategy development, for which they need an understanding of the power of organisational culture and its effect on strategic involvement.

Culture is extremely important in any organisation, but while many managers recognise the significance of culture, few realise the responsibility that they have for its development and maintenance, through role modelling and communication at all levels. Thus, the attitudes, values and behaviours of an institution begin with its leadership (Kane-Urrabazo, 2006).

Brooks and Brown (2002) point out that it is the ‘soft’ and symbolic aspects of ritual or cultural reinforcement that are mostly ignored by managers in health care which must be addressed if cultural change is to be achieved. Therefore, a recognition of the differences of cultural levels in health care is very important. Whereas the more visible elements of culture may be readily manipulated, deep-seated beliefs and values may prove more resistant to external influence. There is some evidence from the NHS that previous attempts at cultural transformation – for example, the development of budgets and contracts – may have succeeded only at a superficial level, failing to penetrate the deeply rooted values and beliefs that underpin clinical practice. Thus, clinician autonomy remained mostly unchanged (Davies et al., 2000). In addition, Fotaki (2007) identifies differences in culture as one of the obstacles preventing the directors of public health in the NHS from implementing the new public health agenda.

The evidence cited above shows that organisational culture plays a vital role in health care performance. Therefore, a hospital’s culture is extremely important to accomplishing its objectives and determines its success (Sovie, 1993). Cartwright and Cooper (1993) argue that leaders must understand the existing culture and subcultures before trying to change them. Sovie (1993) adds that there is an increasing international interest in managing organisational culture as a lever for health care improvement and that management of organisational culture is increasingly seen as a critical element of health system reform.

In recent years, interest in organisational culture has grown rapidly and it has received extensive study across many industrial settings, including some work on healthcare organisations (Davies et al., 2000). Accordingly, some health care

systems have adopted the study of organisational culture as tool to diagnose and improve their services. Indeed, an important and necessary part of any reforms in health care will involve an increase in the management of organisational culture. In the United Kingdom, for example, the most recent NHS reforms are based on the proposition that a major cultural transformation of the organisation should be secured alongside structural and procedural change to deliver desired improvements in quality and performance (Scott et al., 2003a). Richman and Mercer (2004) note that in the late 1980s there was a major organisational crisis, with a fundamental change in the health market to a ‘provider/purchaser’ relationship, where standards, accountability, finite budgets and auditing became essential. Thus, the NHS gravitated towards cultural solutions, rather than pursuing the dream of ‘organisational fit’. For instance, British managers looked favourably upon the successful Japanese economy, giving greater importance to culture through ‘quality circles’ and ‘worker participation’. Davies et al. (2000) note that the UK government at the time viewed the management of culture to be a significant move towards improving health care via policy reforms in the NHS that put the concept of cultural change into practice. In the United States, following high profile reports documenting gross medical errors, policy thinking is taking on the notion of culture change as a key element of the redesign of the health system, and it appears that many other OECD countries have begun to focus on culture and renewal as possible approaches to improvement in health care.

The above arguments clearly reveal the importance of the role of organisational culture in health care organisations. Since this study was carried out in Saudi Arabia, the next section reviews the literature on organisational culture in Saudi public management.

2.7 Organisational Culture in Saudi Public Management

The social culture of the Gulf states, of which Saudi Arabia is a member, is strongly centralized. Strong organisational cultures are rooted within a regional culture based

on tradition coupled with strong religious values and a sense of community. Islam is a major influence, as are the Arabic legacy and Bedouin lifestyle (Common, 2008).

The literature on the role of organisational culture in public management in Saudi Arabia reveals the same dominant characteristics that shape public organisations in Saudi Arabia, such as collectivism, nepotism and bureaucracy. For example, one of the earliest studies was carried out by Lipsky (1959) who states that a sense of loyalty causes Saudi public servants to practice nepotism and that when assigning and distributing jobs they tend to be biased. In Saudi society, it is taken for granted that an individual will use his position to benefit his relatives (Kominghauer, 1963). This view is supported by Al-Awaji (1971), who indicates that an administrative culture of loyalty to one's friends, village or region is dominant in Saudi public organisations, causing public servants to practice nepotism.

Pillai et al. (1999) indicate that leadership and management in Saudi Arabia are predominantly influenced by tribal traditions whereby the expectation of the manager is that he should be a father figure, supporting the continuity of the concept of family values over organisational improvements. Group work is valued in Saudi Arabia's collectivist culture, so replacing poorly performing employees with higher performers is frowned upon (Idris, 2007). Mellahi (2006) describes Saudi Arabia as a 'collectivist high-context culture', suggesting that Saudi society is very tightly knit and that in-group relationships take priority over individual interests, while within the out-group this is not so strong.

There is a strong preference amongst Saudi managers for social frameworks to be tight in organisations as well as institutional life, which can be referred to as 'high collectivism'. One of the main reasons for this is Islam; as Muslims, Saudi managers are expected to co-operate with other Muslims and to care about their wellbeing. Bjerke and Al-Meer (1993) suggest that Saudi managers must also offer social and cultural rights to non-Muslim groups on humanitarian grounds. According to Bhuian et al. (2001), the group influences the type of Saudi management style, rather than it being influenced by individuals, so task identity is not considered to be so important.

Jabbra and Dwivedi (2004) note that the prevailing political and administrative culture strongly influences government policies in Saudi Arabia, because the government comprises 'institutionalized, parliamentary, presidential, and monarchical institutions'.

Bjerke and Al-Meer (1993) report that a social distance exists between superiors and subordinates, and that Saudi managers achieved high power distance scores. Muslim beliefs regarding authority could play an important role in this, as could the high significance placed on status hierarchy in traditional Arab society. The expectation of a Saudi manager is that employees will follow instructions; Bhuian et al. (2001) note that if an employee is left on his or her own this indicates that the management may be dissatisfied with the employee in some way. Al-Yahya (2009) points out that previous studies of Arab work organisations found that decision making was characterised by the dichotomy of consultation alongside directive management. In organisational decision making, participation predominantly takes the form of frequent consultations at the group level between managers or leaders and subordinates, with the final decision being made by the leader. Generally, in Arab work organisations, power is held by management, while correspondingly, employees rarely seek power and its related responsibilities.

In addition, Bjerke and Al-Meer (1993) suggest that Saudi managers tend to have a strong avoidance orientation. Conversely, if necessary, authoritative behaviour is used to resolve conflicts. Copalakrishnan (2002) notes that in Arab culture, feedback to employees tends to be given through an intermediary in order to avoid conflict, as employees could interpret frank feedback on performance as distant and intimidating. Jabbra and Jabbra (2005) found Saudi employees in public organisations reluctant to criticise their organisation or manager, preferring to avoid conflict and maintain job security in case their superiors might use their authority over them unfairly. Bhuian et al. (2001) suggest that Saudis need guidance and instruction, and that they actually prefer the government to intervene in business practice. They report finding an underlying lethargy amongst Saudi public servants

and a resistance to change. For example, they may avoid responsibility by refusing to move to less comfortable rural areas where their skills are required.

Another characteristic of Saudi culture is that people tend to be motivated by high-status positions and their preference is to work in managerial positions, so they are not motivated to stay in lower ranking positions. Idris (2007) argues that this way of thinking is so deeply embedded in the culture that not only families but also the government authorities support and protect those who decline jobs that are deemed socially less acceptable. Another characteristic of Saudi Arabian management is its informality, coupled with social and cultural etiquette. Mellahi (2006) notes that business transactions and employment deals often take place in informal settings.

In conclusion, public organisations in Saudi Arabia are strongly influenced by the culture, which shapes to a certain extent the process of these government agencies. For example, Saudi Arabia, like many Arab countries, has strong values, which are reflected in the everyday lives of its citizens. One of the reasons for this is the strong influence of inherited traditions such as Islamic teachings and Arab customs. This in turn reflects on their practices as employees in government agencies. The above observations underline the important role of culture in Saudi public management; the next section will focus more specifically on the role of this culture in the provision of health care in Saudi Arabia, the subject of this study.

2.8 Organisational Culture in Saudi Health Care

The researcher had difficulty in finding literature directly addressing the subject of this study, which is sparse. Indeed, to the best of the researcher’s knowledge, there are only two relevant studies in the literature on health care systems; both focus on social rather than organisational culture, so investigating the latter is the main contribution of this study to the literature.

Al-Yousuf et al. (2002) make brief mention of the influence of social culture on the organisation of the Saudi health system. They state that the organisation of health systems differs from country to country and even within the same country. It also

varies over time as nations develop and change their health systems in order to accommodate new health priorities within the limits of sociocultural and economic situations, together with people's expectations.

In the other relevant study, Al-Shahri (2002) focuses on culturally sensitive caring for Saudi patients. He mentions that the health system in Saudi Arabia is mostly staffed by non-Saudi professionals recruited from all over the world. Sometimes, inadequate cultural awareness by health professionals can render their caring for Saudi patients more challenging. However, this problem could be easily solved if the Saudi culture were introduced to health professionals planning to care for Saudis.

This review of the relevant literature makes it clear that there is a marked shortage of studies that focus on the role of organisational culture in health care provision in Saudi Arabia. Hence, the purpose of this study is to explore the role of organisational culture and assess its impact on health care provision in Saudi Arabia, because there is a major gap in the literature available on this topic in the Arab world in general, and in Saudi Arabia in particular. This study is intended to help to fill this gap.

2.9 Theoretical framework of the study

In order to answer the research questions, the researcher developed the theoretical framework shown in Figure 2, in light of the above literature review. The figure shows the relationships between the elements of the study, established either by reviewing the literature or by empirical study.

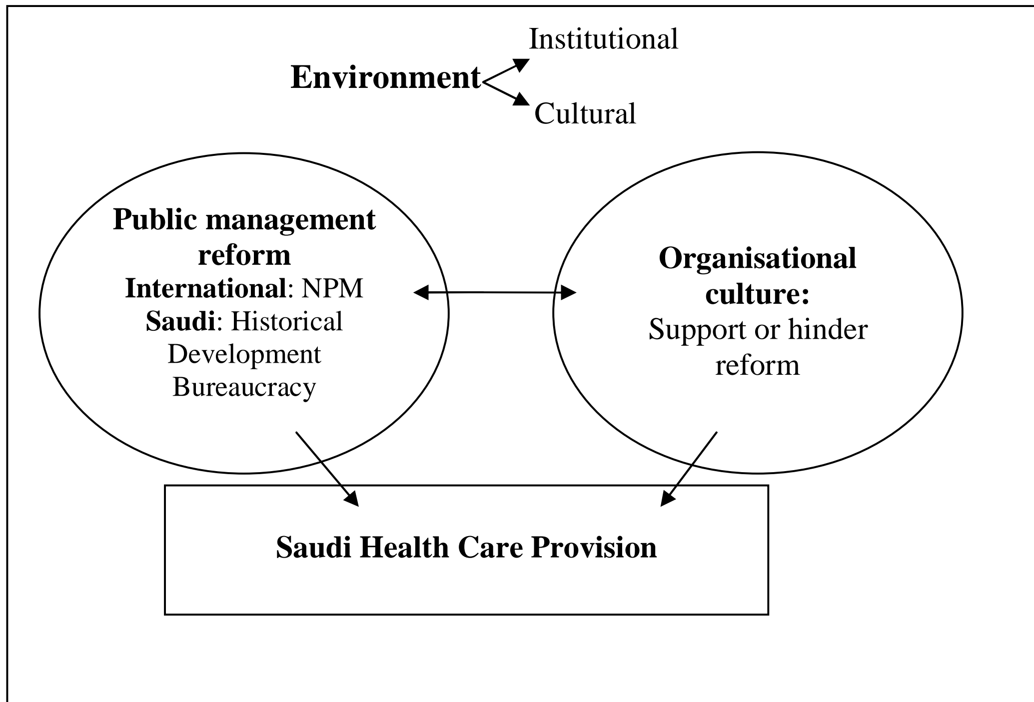

Figure 2: Theoretical framework of the study

Key elements of the study

The study explores the relations among four variables: the environment, public management reform, organisational culture and Saudi health care orovision, each of which is now examined briefly in turn.

Environment

In understanding public management reform in Saudi Arabia, it is very important to provide a critical review of the external environment, such as the country's political, economic and cultural values and norms (Common, 2008). The external environment of the Saudi health system is examined through the existing literature in terms of its politics, economics, etc. Saudi national culture in particular is examined through empirical study by adopting Hofstede's (2001) model.

Public management reform

Public management reforms are often considered from an international perspective, because any organisation will be affected by changes in the external, dynamic environment. Governments are now part of a global structure. Therefore, it is useful to learn, from an international or national perspective, about the reform efforts in public organisations in order to know how such reforms are implemented (Hood, 1991; Wise, 2002; Pollitt and Bouckeart, 2004; Osborne and Brown, 2005). Public management reform is explored through the available literature, both international and Saudi in particular.

Organisational culture

Several studies indicate that an assessment of organisational culture is required before any change effort takes place, to ensure the success of such efforts in improving the organisation's services (Deal and Kennedy, 2000; Schein, 1984; Saffold, 1988; Kotter and Heskett, 1992; Gross et al., 1993; Cameron and Quinn, 1999; Kane-Urrabazo, 2006; Senior and Fleming, 2006). Organisational culture in Saudi health care provision will be explored by applying the CVF to fill to gap in the existing literature in this field.

Saudi health care provision

Health care systems in Saudi Arabia face many problems that affect their services, despite the efforts of the government. Radical change of the system is therefore needed to improve services and to ensure the success of these efforts, especially in the management area, for example in coordination, the duplication of services, authority and leadership, as problems in these areas result in patients having difficulties accessing the services, in long waiting lists, in medical malpractice and in dissatisfaction among patients and employees (Al-Asheikh, 2000; Mufti, 2000; Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Al-Ahmadi and Roland, 2005).

2.10 Conclusion

The nature of public organisations and health care systems around the world is changing. Most of these changes are caused by an increase in demand for better services and by significant increases in the cost of providing good health services. Health care services are particularly prone to change because they are very dependent on high technology (Ham, 1997; Farrell et al., 2007). Accordingly, there is a need for reform in public organisations so that they can operate more effectively and efficiently at minimum cost (Kettl, 2000; Fuchs and Emanuel, 2005). Such reform will mean that organisations will have to make better use of their resources in order to be able to improve service quality and become more effective from the government's point of view. Reform also requires the freeing of public officials from bureaucracy, which sometimes limits their ability to make reform operational in a good environment (Pollitt and Bouckaert, 2004). To ensure effective implementation of any effort to reform public organisations, it must begin with the successful management of organisational culture (Schein, 1984; Cameron and Quinn, 1999).

The Saudi government has already taken some steps to reform public management, and a few authors have noticed that some of these have been unsuccessful. The problem is partly cultural; Saudi culture is characterised by high power distance, collectivism, feminine traits and high uncertainty avoidance (Barakat, 1993; Bjerke and Al-Meer, 1993; Alshaya, 2002; Jabbra and Dwivedi, 2004; Tayeb, 2005; Idris, 2007; Common, 2008). These characteristics are reflected in hierarchical and centralised organisational structures. These national characteristics, according to Common (2008), appear to have produced an environment of rigidity and resistance to administrative reform. Saudi Arabia is not immune to international trends, but appears slow to follow them.

The researcher believes that Saudi Arabia has a unique culture in as much as it shapes the life of its society. The aims of this study are to explore the role of culture in health care provision in Saudi Arabia and to assess its impact on the services

provided by those organisations. To achieve these, the researcher has chosen to use Hofstede's model to assess the national culture and the CVF to assess organisational culture. Therefore, the next chapter will explain how these two frameworks were applied to the assessment of organisational culture in Saudi health care provision.

CHAPTER 3 METHODOLOGY

3.1 Introduction

As established in the previous chapter, the nature of public organisations is changing due to the increase in demand for better services. The Saudi health care system is facing many problems that are having an adverse effect on services, such as long waiting lists and patient dissatisfaction, so improvement is essential. Despite the government's reform efforts, such problems persist. Underlying them is Saudi culture, which is characterised as feminised and collectivist, with high uncertainty avoidance and high power distance; these characteristics shape the management style and appear to have produced an environment of rigidity and resistance to administrative reform (Taype, 2005; Common, 2008). As already stated, the main objective of this study is to assessing the organisational culture in Saudi health care provision. Organisational culture is a difficult phenomenon to assess, and it appears there is no right or wrong way to do so. The selection of research methods depends on many factors, such as the research problem, the objectives, the research questions, the population to be sampled and the amount and type of data available to the researcher.

This chapter outlines the research design, comprising both quantitative and qualitative methods, alongside clarification of the methodological approach using Cameron and Quinn's Organisational Culture Assessment Instrument, based on the theoretical Competing Values Framework, to address the most important research questions. It also discusses the data sources, the measurement tool, the time horizon, the target population, the sample size and ethical issues.

3.2 Research Design

Organisational culture, as previously stated, is a matter for debate, and whilst its definition is generally agreed in the literature, there are various theoretical and methodological approaches to its assessment. The main debate is whether organisational culture should be assessed using qualitative or quantitative research methods or by using both, which is known as 'triangulation', as different aspects can be revealed by each method. Collis and Hussey (2003) state that the quantitative approach is objective in nature and concentrates on measuring phenomena, by collecting and analysing numerical data and applying statistical tests. According to Reiman and Oedewald (2002) the role of quantitative research into organisational culture is to give an overview of the prevailing values in an organisation and of the opinions of the employees regarding matters such as how they feel about the significance of their own work, any feedback received, and whether they are able to influence their work in terms of what they do and how well it is done. Various authors, including Harrison (1972), Cooke and Lafferty (1987) and Cameron and Quinn (1999), consider quantitative tools such as questionnaires and surveys to be useful in providing valid in-depth knowledge about the culture of an organisation and findings which can be generalised. In contrast, Collis and Hussey (2003) state that the qualitative approach is more subjective in nature and involves examining and reflecting on perceptions in order to understand social and human activities. Reiman and Oedewald (2002) stress that qualitative research is required in order to explore unconscious cultural material that is otherwise inaccessible in everyday functioning, meaning that this approach is invaluable for examining cultural material which cannot be physically witnessed. Schein (1985) Smircich (1983) and Louis (1983) advocate assessing culture using qualitative methods and argue that as it is implicit in nature, the qualitative approach using interpretative methods is the only way to gain an understanding of organisational culture. Smircich (1983) argues that as quantitative methods are more closely related to the social scientists undertaking the research than to the participants being researched, they have no place in the study of organisational culture.

Schein's view is that the adopted and documented values of a culture, in conjunction with their norms, ideologies, charters and philosophies, can be studied through interviews, questionnaires or surveys. He suggests that this is akin to ethnographers asking special informants why it is that certain things that they have witnessed happen in the way that they do, and he notes the usefulness of open-ended questions in interviews for discovering the ways in which individuals think and feel. An understanding of some of these presumptions facilitates the interpretation of the various phenomena observed, both physical and behavioural, although the success of this is dependent upon on the researcher's skill and experience.

In-depth group or individual interviews are valuable for the discovery of unique characteristics of a culture (Berg and Wilderom, 2004). The types of focus could be a combination of work, organisational and professional values, or emotionally significant events, either for the majority of employees or for those with greater influence. Schein (1990) also argues that questionnaires and surveys, being much more closed, are less valuable, as they presuppose what is to be studied, and it is unreasonable to ascertain whether the dimensions being asked about are relevant or significant in that culture until its deeper levels have been examined.

The qualitative and quantitative approaches are mainly described as comprising separate and distinct methods, but Yauch and Steudel (2003), having studied the way organisational culture affects the implementation of cellular manufacturing, conclude that a mixed-methods approach is useful. Moreover, Yin (2003) states that using a combination of quantitative and qualitative methods for data collection can prove extremely synergetic, as this combined technique can reveal relationships that might otherwise have escaped the researcher.

Zammuto and Krakower (1991) argue that as qualitative and quantitative research focus on different things, it is possible to gain different advantages and values in understanding organisational culture from each method. They also propose that studies of organisational culture via surveys could be valuable in examining cultural relationships and their strengths in relation to organisational matters such as

effectiveness and adaptation to changes in environmental conditions. On the other hand, although a degree of understanding about these relationships can be gained through qualitative research, it is difficult to make generalisations about the results. In addition, quantitative research would offer a helpful context which would facilitate the interpretation of the finer-grained findings of qualitative research.

The debate in the literature outlined above regarding methods of assessment of organisational culture indicates that qualitative and quantitative methods have their own advantages and disadvantages. Given these disparate strengths and weaknesses, the researcher decided to employ a mixed-methods approach in this study, to examine the contextual factors, such as political, economic and social culture, which play an integral role in the organisational culture of health care provision in Saudi Arabia. This will be examined through a review of the literature that covers these factors and public management reform, especially that which has been carried out in Saudi Arabia. This study focuses on national culture, as this is felt to be the key contributory factor affecting the external environment of Saudi health care management, adopting Hofstede's model to assess it from the perspective of respondents through semi-structured interviews, using questions based on the CVF, about the types of organisational culture that are dominant in health care provision in Saudi Arabia. The views expressed in the interviews are considered with reference to Hofstede's cultural indices framework. A second main objective of this study is to identify the type of organisational culture which would best support efforts to improve health care services in Saudi Arabia, by adopting the OCAI, also based on the CVF.

3.3 Data Sources

This study uses both primary and secondary data sources, detailed in this section.

3.3.1 Secondary sources

As mentioned previously, there is little literature on Saudi public management (Tayeb, 2005; Common, 2008). The present research relies mainly on official sources of secondary data, including official statistics from annual reports issued by the Saudi health care providers. For example, the health statistics book for the year 2007 issued by the MOH includes health indicators from all health care providers in the country. It also cites data sourced from hospitals in Riyadh, including official reports or documents about the health care system, such as regulations concerning the organisation and facilities such as numbers of beds and employees. More general sources are books and journals from libraries in the UK and Saudi Arabia (in English and Arabic), internet sources such as electronic books and journals, including articles on theories of organisational culture in general and the CVF in particular. Secondary data was also gathered from reports issued by international organisations such as the UNDP, World Bank and WHO.

The websites of hospitals in Riyadh city were reviewed in order to analyze their structure and activities, and the researcher examined government documents on such matters as the missions, objectives, policies and procedures of the health providers. The final secondary source comprised academic dissertations written by Saudi authors and others relative to the subject of the study. In sum, these sources concerns health care provision, particularly in Saudi Arabia, and organisational culture. This secondary data was used to verify and interpret primary data obtained from questionnaires and semi-structured interviews (Ghauri and Grønhaug, 2005).

3.3.2 Primary data

The researcher collected primary data in a field study, using a mixed-methods approach, that is by combining the use of the CVF questionnaire with semi-structured interviews, the respondents being a sample of employees of hospitals in Riyadh.

3.3.2.1 Questionnaire

Questionnaires are a fundamental tool for data collection. Gall et al. (2003) define a questionnaire as a document that asks the same questions of all individuals in the sample. Remenyi et al. (1998) note that questionnaires help researchers to acquire information that can neither be easily observed nor is readily available, either in writing or by using a computer. Saunders et al. (2007) argue that the questionnaire is useful for research which needs to be descriptive and explanatory, particularly in gaining an insight into opinions, attitudes and organisational practices.

Questionnaires have the advantage of being inexpensive and a large amount of data can be collected relatively quickly. May (1997) emphasises the highly structured nature of the questionnaire, alongside its high reliability and the increased capacity for generalising findings. Accordingly, questionnaires can be useful because they draw in different attitudes, perceptions and perspectives on a particular problem or research questions. As the present study is concerned with the assessment of organisational culture, the researcher decided to use as a questionnaire the OCAI, which is based on the CVF, analysing the responses to assess the current and desired future state of certain factors shaping organisational culture, so that the gap between these two positions could be used to draw up a change strategy.

However, questionnaires have their limitations, a major one being that respondents tend to have a restricted choice in their responses, particularly in the case of multiple choice questions. Walsh (2001) also points out that response rates for postal questionnaires are low, possibly because they may not be fully understood by all respondents, and levels of literacy could also limit the usefulness of questionnaires. Another factor affecting return rates is that there is a self-selecting bias, so that not all questionnaires are actually returned, regardless of ability to complete them, which can lead to a bias in the results whereby the people who return their questionnaires may have different attitudes, attributes or motivations from those who choose not to complete them. Finally, as Kumar (2005) points out, questionnaire

respondents cannot have the meanings of questions explained or clarified if they do not understand or if they are unclear about what they are being asked.

The questionnaire used in this study to examine how employees of health care providers in Saudi Arabia viewed their work is reproduced in Appendix One. It comprised three sections:

Section One was the main section, investigating the main variables of the study. It was taken from the OCAI, based on the CVF (Cameron and Quinn, 1999) and designed to assess the role of organisational culture in health care provision in Saudi Arabia within a theoretical framework that measures culture as a variable which the organisation has and can alter.

Section Two elicited general information about members of the study sample. The questions included information about demographic characteristic of participants such as the name of their hospital, their gender, age, nationality, educational level, professional group (physicians, nurses technicians, administrators), experience in current position, and monthly income. The researcher included these questions to establish whether there was a correlation between these factors and the variables measured in section one.

Section Three comprised open questions. The first, addressed to non-Saudi respondents, asked in what ways the experience of a different country had affected them, while the second simply asked if they wished to add anything. These questions were intended to allow the participants more flexibility in responding to the survey.

3.3.2.2 Semi-structured interviews

This study also collected qualitative data using semi-structured interviews, comprising further questions based on the CVF. Walsh (2001) states that the semi-structured interview enables the researcher to probe more deeply into what the respondent says, which is useful in two ways: on one hand it affords a degree of flexibility and on the other, the rate of response is high. Another advantage,

suggested by Gillham (2000), is that it acts to balance the research by preventing misguided impressions from interviewees when collecting qualitative data, which is valuable in enhancing quantitative findings.

The interview protocol, reproduced in Appendix Two, had four main sections. Section 1 sought general information such name of hospital and job title, while section 2 consisted of questions taken from the OCAI about the types of organisational culture (hierarchy culture, market culture, clan culture and adhocracy) that are dominant in health care provision in Saudi Arabia. The model defines these cultures in terms of six dimensions: dominant characteristics, organisational leadership, management of employees, organisation glue, strategic emphasis and criteria for judging success. Section 3 asked questions about factors influencing Saudi hospitals, whether negatively or positively, such as government regulations, economic factors and Saudi cultural values. Finally, section 4 consisted of additional questions.

3.4 Time horizon

Collis and Hussey (2003) state that cross-sectional studies are conducted when there are constraints of time and resources, and these are the reasons why the present study is cross-sectional in nature. According to Sekaran (2003), cross-sectional data should only be gathered once over a period of days, weeks or months. Therefore, this study gathered its data from hospitals in Riyadh at a particular time during a three-month period, the cross-section. Cross-sectional research was suitable because the study was carried out in Saudi Arabia using questionnaires and semi-structured interviews at particular times to explore the role of organisational culture in the system of health care provision in Riyadh as an established phenomenon. Kumar (2004) explains that this design type, by taking a cross section of the population, is most suitable for studies aimed at establishing the predominance of a phenomenon, situation, problem or attitude. Saunders et al. (2007) support this view and indicate that this kind of study usually concerns a specific phenomenon. A longitudinal study would have been inappropriate, as the aim was not to observe people or events in

order to study how behaviour changed and developed over a period of time, as suggested by Saunders et al. (2007).

3.5 Pilot study

The next step was to test validity and reliability by carrying out a pilot study, which began in January 2008. Pilot testing is highly recommended prior to carrying out a study, as this can be a useful way of establishing and examining the study's strengths and weaknesses. Saunders et al. (2007) advocate pilot testing questionnaires prior to using them to collect data. The pilot study is useful, as it enables refinement of the questionnaire so that respondents will be more able to answer the questions; it can iron out any problems in recording the data and ensure the appropriateness and relevance of the questions. A further advantage of the pilot study is that it will enable the researcher to assess the validity of the questions and the level of reliability of the data to be collected. Initial analysis using pilot test data can be done to confirm that the data collected will indeed allow the investigative questions to be answered, so that the study gives meaningful results.

Bell (2005) specifies some of the benefits of using pilot testing, such as finding out how long it will take for people to complete the questionnaire and the clarity or ambiguity of each question. Pilot testing also gives an insight into which questions, if any, make respondents feel uncomfortable and whether in their opinion there are any major omissions from the topic. The physical appearance of the questionnaire in terms of the clarity and attractiveness of the layout can be evaluated and any other comments from participants should be taken into account. Henerson et al. (1978) also suggest that a pilot study can assist in eliminating items that do not help to distinguish between subjects and are therefore of no value. Finally, pilot studies help to highlight any problems in collation of information for the researcher and any problems in understanding for the researched (Foddy, 1993).

A pilot study was of particular value to the present research, which adopted the CVF, a model developed and applied in Western countries with organisational

cultures different from those found in Saudi Arabia. Before conducting the pilot study, a few actions needed to be taken. These are summarized below.

Translation

In October 2007, the researcher translated the questionnaire into the local language (Arabic) as an option for participants who could not fully understand English, then used back-translation in order to check it. This technique, according to Brislin (1986), involves the independent translation of the translated version back into the original language. The back-translation and the original are compared and the translation is then adjusted if necessary. Therefore, the questionnaires were first translated into Arabic, then translated back into the original language (English) by the researcher and a third English-Arabic translator. The back-translation was later reviewed by the researcher’s Arabic-speaking PhD colleagues and academic staff fluent in both English and Arabic at the University of Manchester, the University of Hull and the King Saudi University in Riyadh. As a result, the translation was edited and some changes were made to produce the final version.

In line with the nature of this study, contact was made with hospitals that employed people from different backgrounds and who were able to speak either Arabic or English or both. Therefore, the researcher presented a version of the questionnaire in both English and Arabic to those who needed it or could not fully understand Arabic, and another in Arabic for those who needed it or could not fully understand English.

Cover letter

The researcher created a covering letter in order that the aim of the study would be clear to participants and to ensure a high level of response. Collis and Hussey (2003) argue that the style of a covering letter in terms of its tone and stance, can have a marked impact on the respondent. The covering letters prepared for this study included the following: (i) an outline of the aim of the questionnaire, (ii) an explanation of why the researcher was expecting the respondent to complete the

questionnaire in a clear and concise manner, (iii) an estimate of the time it was expected participants would require to answer the questions and (iv) a statement guaranteeing anonymity and confidentiality for the participants. Finally, the researcher asked participants if they wanted a copy of the results, which could be made available to them.

The following subsections present the main findings of the pilot study.

3.5.1 Validity test

The face validity of the questionnaire was tested in November 2007, after initial translation. Sekaran (2003) states that this is an aspect of validity that looks at whether the questionnaire reads as though it actually measures what it is supposed to measure. Therefore, the questionnaire was reviewed thoroughly by the researcher's supervisors (Dr Richard Common and Alan Boyd) and by a member of the MBS academic staff (Dr Ibrahim Abosag) who was also familiar with the environment of Saudi Arabia. Others who reviewed the questionnaire were some members of the research staff at King Saud University, some hospital employees and some of the researcher's colleagues at the University of Manchester and the University of Hull. The researcher asked all of these people to examine the questionnaire, analyze it critically and check on the clarity of the questions, then to suggest deletions, additions or changes to the questions, the order of the sections etc. Their feedback led to the following changes:

1. Reordering the sections. The initial order was: Section One, general information; Section Two, hospital description; and Section Three, additional information. The researcher decided to invert the order of the first two sections, because if the general information section came first some participants might hesitate to answer the questionnaire, for two reasons. First, this section included questions on some personal matters such as monthly income, and secondly it asked the participant identify the hospital where he or she worked. Such questions may be seen as sensitive in Saudi society because employees, as mentioned in chapter two, tend

to avoid criticising their managers or organisations because they think that this may harm them. Although the questionnaires were anonymous, respondents might still have wished to be cautious.

2. Changes to the structure of section one. Throughout the OCAI, each dimension of organisational culture was represented in a separate table, instead of putting all six dimensions in one table, as in the first draft of the questionnaire. This change, according to some academic reviewers, would facilitate the reading and answering of the items.
3. For the same reason, the researcher used 5-point Likert scales instead of 100-point ipsative rating scales. The CVF is compatible with both rating scales; both had good construct validity and it was found that the instruments were reliable. Cameron and Freeman (1991) and Zammuto and Krakower (1991) are among researchers who have used a 100-point scale, while Quinn and Spreitzer (1991) and Yeung et al. (1991) are among those who used a Likert response scale.
4. The researcher was able to determine that the instrument would take about 10-15 minutes to complete and this was stated in the covering pages.

3.5.2 Reliability test

Reliability attests to the consistency and stability of a measuring instrument (Sekaran, 2003). After revising the questionnaire in January 2008, in order to determine its stability and reliability, the researcher distributed about 30 copies to employees representing groups of health care professionals in Saudi Arabia. The questionnaire was tested by the most widely accepted measure of the internal consistency of scales, known as Cronbach's alpha, which ranges from 0 to 1 and indicates the degree to which items within a scale are related to each other. The higher the alpha coefficient, the higher the internal consistency and reliability. Table 1 shows the stability of transactions for the six dimensions of the study instrument.

Table 1: **Reliability test**

No	Type of organisational culture	No of items	No of cases	Cronbach's alpha
1	Clan culture • Now • Preferred	 6 6	 30 30	 .93 .86
2	Adhocracy culture • Now • Preferred	 6 6	 30 30	 .89 .83
3	Market culture • Now • Preferred	 6 6	 30 30	 .93 .73
4	Hierarchy culture • Now • Preferred	 6 6	 30 30	 .93 .81

It is clear from the table above that the Cronbach's alpha internal consistency coefficient had a range of 0.73 (which is considered high) for market culture in the preferred situation to 0.93 (very high) for the clan, market and hierarchy cultures in the current situation Nunnaly (1978) suggests that an alpha value of 0.70 or greater is acceptable. These values indicated that the results that might be expected to emerge from a study using this instrument would be consistent. In other words, the results of the validity and reliability test indicated that the instrument measured what it was supposed to measure and that it had high consistency and stability. Thus, it was a very good measurement and the researcher decided to use it in the current study. The full final version of the questionnaire is shown in Appendix 1.

3.6 Selecting a sample for the quantitative data

It is not necessary to collect data from a whole population and this would be ineffective due to constraints of time, money and availability. The high cost of including all units will often prove prohibitive, as would the extensive length of time required (Ghauri and Grønhaug, 2005). It is impossible to capture every aspect of knowledge; therefore a representative sample group has to be chosen to provide a good cross section of information. Aaker et al. (1995) suggest that in such situations, using a sample comprising just some members of the population will be an appropriate alternative to testing the entire target population.

The target population of this study included physicians, nurses, technicians and administrative workers (male and female, Saudis and non-Saudis) working in the provision of health care in Riyadh, in public hospitals with 500 beds and above. The researcher chose Riyadh city and these larger hospitals for the following reasons:

- Practical considerations, such as insufficient resources (of time and money) to cover the whole country.
- Riyadh is the capital of Saudi Arabia, where the headquarters of all government agencies are located.
- Riyadh is considered the centre of the health care provision in Saudi Arabia; therefore all hospital heads are based there.
- Employees in health care provision in Riyadh are of mixed culture, coming from both inside and outside the country and having different linguistic, religious and educational backgrounds and so on.
- According to MOH (2007), hospitals with 500 beds are classified as referral hospitals, are located in urban areas, especially large cities, and provide a full range of services and specialist treatments to their patients.
- Within Riyadh city each main health care provider has at least one hospital with 500 beds.
- These selection criteria limited the sample to a practical size.

In line with the nature of this study, the researcher decided to include participants from the different professional groups mentioned above and from a cross-section of organisational hierarchies, to ensure that the sample would be representative of most hospital employees in Riyadh. Table 2 shows the numbers in each professional group working for each of the seven main health care providers in the city.

Table 2: Distribution of target population by professional group and employer

Health care provider	**No of hospitals**	**Number of employees in each professional group**				Total
		Physician	**Nurse**	**Technician**	**Administrative**	
National Guard	1	1058	2242	1900	1800	7000
Royal Bureau	1	827	1657	2331	3267	8082
Ministry of Defence	2	1334	2500	2100	2400	8334
Ministry of	9	2300	5200	2400	5300	15200

Health						
Ministry of Higher Education	2	1055	1408	1056	674	4193
Ministry of Interior	1	300	600	500	1000	2400
Private sector	28	1239	2564	1840	2909	8552
Total	44	7255	16271	11227	19008	53761

Source: Adapted from MOH (2007)

To select the sample, the researcher used a combination of stratified and random sampling techniques. Stratified sampling is a type of probability sampling and according to Saunders et al. (2007) it is an adaptation of random sampling where the population is split into two or more relevant and significant divisions based on one or more attributes.

This study used the 2007 MOH classification to subdivide the population into four professional groups: physicians, nurses, technicians and administrative personnel. Following this a random sample was selected. This sampling technique gives every number of the population an equal chance of being chosen for the sample and it is possible, as Collis and Hussey (2003) suggest, to look at individual respondents from each group. In the present study, it ensured that within each professional group, participants were from different backgrounds and had an equal opportunity to enrol in the study.

The researcher believes that it was very important to elicit the views of employees from different departments and specialties on their organisational culture, because the literature review indicates that obtaining views from different areas will lead to valuable and reliable findings on the phenomenon under study. Cramer (1994) notes that greater validity and reliability can be given to the research findings by selecting participants from different backgrounds, while Punch (1998) argues that bias in the research findings can be avoided by such diversity in the sample. Therefore, it was necessary to have the views of a variety of employees in order to explore the role of organisational culture in health care provision in Saudi Arabia.

In sum, the research sample was selected from among the employees of health care providers in Riyadh by means of the following multi-stage sampling technique.

Phase 1: The researcher selected hospitals that represented each of the main health care providers in Riyadh: the Ministry of Health, Ministry of Defence, Ministry of the Interior, Ministry of Higher Education, National Guard, Royal Bureau and the private sector. The selection criterion was that hospitals should have at least 500 beds, with the exception of the private sector hospitals, which had 200 beds or more, as there were no private hospitals having 500 beds. Table 3 lists these hospitals.

Table 3: Hospitals selected

Health care provider	Hospitals selected	No of Beds	No of Employees
National Guard	King Abdulaziz Medical City for National Guard	900	7000
Royal Bureau	King Faisal Specialist Hospital and Research Centre	500	8082
Ministry of Defence	Riyadh Armed Forces Hospital	1192	7179
Ministry of Health	Riyadh Medical Complex	1332	4257
=	King Fahad Medical City	1095	4000
Ministry of Higher Education	King Khaled University Hospital	624	3068
Ministry of Interior	Security Forces Hospital	508	2400
Private sector	Al Hammadi Hospital	325	1161
=	Saudi German Hospital Riyadh	300	1000
=	Dallah Hospital	237	1200

Phase 2: The researcher distributed questionnaires to each selected hospital according to the proportional distribution method (see in sample size below).

Phase 3: The researcher distributed the questionnaires to the professional groups according to their proportion in each hospital. This provided a stratified sample using the method of proportional distribution (see in sample size below).

Phase 4: The researcher made a random selection of the number required in each professional group from each hospital (see in sample size below).

The sample can be described as stratified because the hospitals were categorised according to the service provider and the respondents were further grouped by profession. It can be described as a random selection because individuals were

chosen randomly from within each professional group. Therefore, selecting the sample in this way ensured that it would represent the hospitals (the study population) and the professional groups (the target population).

3.7 Survey sample size

Although sample size plays an important role in research methodology, because the validity of the study depends on it, there is no universal agreement among researchers on an appropriate absolute or relative sample size in quantitative studies. De Vaus (2001) indicates that good quality research on a small sample is better than a large sample with poor quality.

Therefore, using the sample selection technique described above, from the total survey population of 53,761, the initial number of questionnaire responses was calculated as approximately 382, based on Krejcie and Morgan's (1970) table (Table 4), derived from the following formula used, to determine sample size:

S = X2NP (1-P)/ d2 (N-1) + X2P(1-P)

where S = required sample size

X2 = the table value of chi-square for one degree of freedom at the desired confidence level

N = the population size

P = the population proportion (assumed to be .50 since this would provide the maximum sample size)

d = the degree of accuracy expressed as a proportion (.05).

Table 4: **Krejcie & Morgan's table (1970)**

N-n	N-n	N-n	N-n	N-n
10-10	100-80	280-162	800-260	2800-338
15-14	110-86	290-165	850-265	3000-341
20-19	120-92	300-169	900-269	3500-346
25-24	130-97	320-175	950-274	4000-351
30-28	140-103	340-181	1000-278	4500-354
35-32	150-108	360-186	1100-285	5000-357
40-36	160-113	380-191	1200-291	6000-361
45-40	170-118	400-196	1300-297	7000-364
50-44	180-123	420-201	1400-302	8000-367
55-48	190-127	440-205	1500-306	9000-368

60-52	200-132	460-210	1600-310	10000-370
65-56	210-136	480-241	1700-313	15000-375
70-59	220-140	500-217	1800-317	20000-377
75-63	230-144	550-226	1900-320	30000-379
80-66	240-148	600-234	2000-322	40000-380
85-70	250-152	650-242	2200-327	50000-381
90-73	260-155	700-248	2400-331	**75000-382***
95-76	270-159	750-254	2600-335	100000-384

As the questionnaire was distributed to each hospital according to the number of employees, the distribution of questionnaires among hospitals was not equal, to ensure that each hospital received its appropriate proportion. Moreover, within each hospital, the researcher took into account the weighting of the four professional groups to ensure that the resulting sample would represent most of the features of the population. For example, the researcher distributed a large number of questionnaires to Ministry of Health hospitals because the MOH had more employees (15200) than any other provider. Within a particular hospital the researcher distributed a large number of questionnaires to administrative employees because they constituted a majority, again to ensure that the resulting sample would represent the population.

As stated above, the researcher's initial goal was to obtain at least 382 questionnaire responses from the chosen sample. This total sample size was then increased to 395, as detailed in Table 5, because the size of the Security Forces Hospital sample would have been 17 but was increased to 30. According to Roscoe (1975) and Hays (1981), where samples are to be broken into sub-samples, a minimum sample size of 30 for each category is necessary. In order to reach this sample size (at least 395), the researcher distributed about 762 questionnaires, based on the online Survey Random Sample Calculator,[1] as shown in Table 6.

[1] Customsight (2010). *Random sample calculator* [online] Available from: http://www.custominsight.com/articles/random-sample-calculator.asp [Accessed 20 November 2007].

Table 5: **Target numbers of respondents by profession and provider**

Health care provider	Selected hospital	Number in each professional group				Total
		Physicians	Nurses	Technicians	Administrative	
National Guard	King Abdulaziz Medical City for National Guard	7	16	14	13	50
Royal Bureau	King Faisal Specialist Hospital and Research Centre	6	12	16	23	57
Ministry of Defence	Riyadh Armed Forces Hospital	9	18	15	17	59
Ministry of Health	Riyadh Medical Complex, King Fahad Medical City	16	37	17	38	108
Ministry of Higher Education	King Khaled University Hospital	7	10	8	5	30
Ministry of Interior	Security Forces Hospital	4	8	6	12	30 (initially 17)
Private sector	Dallah Hospital Al Hammadi Hospital Saudi German Hospital Riyadh	9	18	13	21	61
Total	10	58	119	89	129	395

Table 6: **Distribution of questionnaires by profession and provider**

Health care provision	Selected hospital	Number in each professional group				Total
		Physicians	Nurses	Technicians	Administrative	
National Guard	King Abdulaziz Medical City for National Guard	20	29	27	26	102
Royal Bureau	King Faisal Specialist Hospital and Research Centre	19	25	29	36	109
Ministry of Defence	Riyadh Armed Forces Hospital	22	31	28	30	111
Ministry of Health	Riyadh Medical Complex, King Fahad Medical City	29	50	30	51	160
Ministry of Higher Education	King Khaled University Hospital	20	23	21	18	82
Ministry of Interior	Security Forces Hospital	17	21	19	25	82
Private sector	Dallah Hospital Al Hammadi Hospital Saudi German Hospital Riyadh	23	31	26	34	114
Total	10	150	210	180	220	760

3.8 Questionnaire distribution

After the modifications resulting from the pilot study, the final version of the questionnaire was ready for distribution to hospitals in Riyadh. The researcher, after obtaining the approval of the hospitals to conduct the study, in January 2008 delivered all questionnaires to the participants by hand, believing that three factors would help to increase the response rate. First, the fact that the researcher had approximately 15 years experience working in the Riyadh Armed Forces Hospital (RAFH) allowed him to create a good personal relationship with employees in hospitals in Riyadh, in particular office managers. Using this advantage, he attempted to increase the response rate by asking heads of department to encourage their staff to participate in the study by completing the questionnaires. Secondly, the researcher planned to meet participants face-to-face, when possible, to explain to them the purpose of the study and the importance of their responses to its findings. Finally, because participants were likely to feel under no obligation to be involved in the study, follow-up was necessary to increase the response rate.

3.9 Response rate

The fieldwork began on 1 January 2008 and continued until 30 March 2008. Of the 760 questionnaires distributed, 579 (76%) were returned; of these, 160 (21%) were excluded because the respondents had answered only some of the questions and left the rest blank, or had repeated the same answers to all the questions. Thus, 419 valid completed questionnaires were received, meaning that the response rate was about 55%, which is acceptable for this type of research. While no rules govern an acceptable response rate, higher is clearly better. Babbie (2004) suggests that in social research a response rate of 50% is adequate for analysis and reporting.

Table 7 reveals that the response rate of valid completed questionnaires received from each hospital ranged from 41% to 70%. The sites with the lowest rates of questionnaire return (approximately 41%) were King Khaled University Hospital

and the Security Forces Hospital, while those with the highest rates (approximately 70%) were the MOH hospitals.

Table 7: Number and percentage of valid questionnaires returned, by provider

Health care provider	Total of number and percentage of questionnaires returned
National Guard	57 from 102 (56%)
Royal Bureau	58 from 109 (53%)
Ministry of Defence	61 from 111 (55%)
Ministry of Health	112 from 160 (70%)
Ministry of Higher Education	34 from 82 (41%)
Ministry of Interior	34 from 82 (41%)
Private sector	63 from 114 (55%)
Total	419 from 760 (55%)

3.10 Selecting a sample for the qualitative data

With regard to the semi-structured interviews, the study employed the purposive sampling technique, a non-probability method in which the researcher chooses individuals whom he thinks will be appropriate to answer the interview questions and meet the objectives (Saunders et al., 2007). In this case the researcher chose to interview chief executive officers or senior managers, those whose posts involved supervising more than one hospital department, because they were qualified to provide answers to 'what' and 'why' questions about the specific type of organisational culture (clan, adhocracy, market or hierarchy) which were prevalent in their hospitals. The researcher also considered that they would be most likely to have adequate knowledge and information to enable them to answer research questions about the type of organisational which would best support efforts to improve health care services in their hospitals. In addition, they would be more able to provide information that was not available from secondary sources, such as by answering questions related to environmental factors affecting the operation of health care services in Riyadh. They might also be able to provide useful suggestions and guidelines that would contribute to solving the problems currently faced by health care providers in Saudi Arabia. Finally, the researcher felt that such interviewees would be most likely to be able to clarify anything about the subject of the study.

It was thus hoped that the findings of the semi-structured interviews would enable the researcher to create a more comprehensive picture of the role of organisational culture in health care provision in Saudi Arabia.

3.11 Interview sample size

There is no agreement on the optimum sample size for collecting qualitative data (Dey, 1993). Therefore, the researcher decided to interview one senior manager in each of the four professional categories for each of the seven service providers, making a total of 28, which he believed would be sufficient to answer the research questions, because each health care provider in Riyadh would be represented by four interviewees and each professional group by seven interviewees. They would be expected to answer the interview questions clearly and give sufficient information to cover all aspects of the research questions. This would help the researcher to provide useful suggestions and guidelines which could contribute to solving the current problems faced by health care facilities in Saudi Arabia.

3.12 The interview process

The interview process was started after the collection of the survey data through personal face-to-face contact with potential interviewees to assure them of the confidentiality of the interviews and to encourage them to answer the interview's questions with confidence. Some managers declined to participate in this part of the study for reasons of confidentiality. All interviews were conducted during March 2008, beginning on the first day of that month. The researcher submitted a formal letter from his sponsor to each hospital asking for their assistance and permission to conduct the study on their sites. When this was granted, the researcher booked one-hour appointments with each participant for the interviews. At the start of each interview, he introduced himself (using Arabic or English as appropriate), obtained permission from each interviewee to proceed and explained the research aim, the objectives and the ethical position, which was to assure the confidentiality of the

interviews in order to give the interviewees the confidence to answer the questions freely.

To make the interviewees feel comfortable, the researcher used open questions and asked permission to use a tape recorder to record the interviews for the purpose of data analysis. Since the first five interviewees refused permission for their voices to be recorded, the researcher decided to take notes while they talked, to avoid any hesitation from the interviewees when answering the interview questions. This is because, as mentioned previously, Saudi employees prefer not to criticize their managers or organisations because they think that this may harm them and because they wish to avoid conflict.

The researcher used content analysis to analyze the interview responses, starting by translating the Arabic transcripts into English and reviewing the translations with some expert academic proofreaders, both in Saudi Arabia and in the UK. Krippendorf (1980) explains that content analysis is a research technique for making replicable and valid inferences from the data to their context. The reason for choosing this technique here was that it was considered the most appropriate for varied qualitative data collected though semi-structured interviews. Gillham (2000) states that content analysis examines how interviewees perceive and understand certain issues or phenomena. Each statement is analysed for content and placed under an appropriate heading, with any other closely related statements. More general umbrella headings may also be used to group those subheadings so that all information about the nature of the points made and the range of responses and frequency of similar responses is recorded. Thus, the researcher analysed the content of the responses by categorizing them under three headings based on interviewees' answers to questions about the type of organisational culture that was dominant in their hospitals, as follows:

- What is the dominant type of organisational culture in your hospital?
- What type of organisational culture would you prefer to be dominant in your hospital?

- What do you think are the potential problems that prevent service improvements in your hospital?

3.13 Ethical issues

Ghauri and Grønhaug (2005) define ethics as moral principles and values that influence the approach taken by researchers. Ethical issues should be considered at the beginning of the research process to avoid wasting a great deal of time and resources. Saunders et al. (2007) suggest that the ethical principle of not causing harm while conducting the research should be considered when selecting methods and strategies. The researcher duly took the following ethical issues into account.

First, he obtained permission to carry out this study from the University of Manchester, the Saudi Cultural Bureau in London (his sponsor) and the hospitals in Riyadh where the study was conducted. He then took steps to protect participants from any potential harmful effects of the research process, by obtaining their agreement to participate, guaranteeing to preserve their confidentiality, clarifying their rights and informing them of the methods to be used in data collection, analysis and reporting. The researcher also gave participants a clear and concise picture of the nature and aims of the study, explaining that the results of the study would be made available to those involved if they wished. He also gave the participants his contact details in case they had any questions about the study.

It is important to recognise the limitation to the study caused by potential bias. The researcher believes that as he is a member of the national culture being investigated, this may have had an effect on his analysis. It is significant that before the study began he had worked for more than 15 years in the RAFH and as a result was able to establish relationships with many employees of this and other hospitals. This may have had an effect on the study, because while analyzing employees' jobs, he was not willing to embarrass them by suggesting that they were not carrying out their tasks properly. Further, the researcher had to be careful to avoid criticizing managers during the study because to do so might have had an adverse affect on his future

career in Riyadh. Consequently, there was a need to adopt objective methods and to apply rigorously scientific research principles in all processes, such as sample selection and the collection, analysis and interpretation of data.

3.14 Conclusion

This chapter has discussed the methodology that was used to explore the role of organisational culture in health care provision in Saudi Arabia, starting with the design of this study, combining quantitative and qualitative methods to collect data from participants. Questionnaires using elements of the OCAI, based on the CVF, were used to collect quantitative data, while qualitative data was collected via semi-structured interviews. The study sample comprised employees of seven health care providers in the city of Riyadh, in four professional groups: physicians, nurses, technicians and administrators. As for sample size, 419 valid questionnaires were received and 28 interviews held. These numbers depended on considerations such as time, money and participant availability.

This chapter has provided explanations of the choice of research design, data collection techniques, the use of Hofstede's model to assess the national culture and the CVF to assess organisational culture, the time horizon, the selection of a research sample, the sample size and so on.

Before applying any such methods, it is very important to understand the political, economic and social environment of organisations and to have an overall picture of the variety of forces at work around them, because organisations cannot exist in isolation from their context (Riggs, 1946; Heady, 1996; Capon, 2000; Pollitt, 2001; Flynn, 2002). Therefore, the next chapter will focus on the context of public management in Saudi Arabia.

CHAPTER 4 THE CONTEXT OF PUBLIC MANAGEMENT IN SAUDI ARABIA

4.1 Introduction

Organisations need to analyse their external environment to understand the complexities of the outside world. The external environment can be described as 'the big wide world' in which all organisations – both public and private – operate. No matter what type of business is involved, organisations cannot exist is isolation from the other organisations or individuals around them, and this can include customers, employees or suppliers (Capon, 2000). Flynn (2002) refers the high significance of the context of public management in shaping organisational policies that may relate to a particular administrative setting. Thus, all of the contexts need to be taken into account in order to gain an understanding of the processes involved in changing management in the public sector. Haque (1997) believes bureaucratic activities and the social context to be two interrelated variables that need to be jointly considered. Other factors contributing to the general nature of the system and the manner in which subjects carry out administrative tasks include political structure, economic conditions, religion and social upheaval.

This chapter examines critically the strategic environment of health care provision in Saudi Arabia and its influence on organisational culture in order to understand better how Saudi public management operates in such an environment. This environment includes Saudi Arabia's geography, its population, its history and its political, economic and social culture. Therefore, this chapter tries to shed light on these elements, which influence Saudi Arabia's systems in many respects. It starts by providing general information about Saudi Arabia, then gives more detail of its geography, population, history, political system, economy and social culture, before considering the development of Saudi administration. It finally focuses on Saudi health care systems, reviewing their development and management.

4.2 Overview

The Kingdom of Saudi Arabia has different connotations to different people. Millions of Muslims across the world see it as the ultimate Holy Land and place of pilgrimage. Many expatriates from Asia, Europe and the United States view it as a land of opportunities, while for the rest of the world, Saudi Arabia means oil, which is fundamental to present and future economies. According to MOEAP (2003), Saudi Arabia is now embarking on a new phase. Littlewood and Yousuf (2000) note that Saudi Arabia is an Islamic kingdom whose population is composed mainly of urban Muslims. Mellahi (2006) argues that religious, social and cultural norms, based on the Quran and the sayings and practices of the Prophet Mohammed (*Sunnat*), are deeply ingrained in the everyday life of Saudis. Al-Shahri (2002) agrees that the main factor responsible for shaping Saudi culture is the Islamic religion. This is evident throughout Saudi life, not only in the day-to-day activities of Saudis, but in the national flag, the legal system and countless other ways.

4.3 Geography

Figure 3: Saudi Map (MOEAP, 2007)

Saudi Arabia is located in the southwest corner of Asia. On the northern side it is bordered by Jordan, Iraq and Kuwait, while on the western side it is surrounded by the Red Sea. On the southern side it is bordered by Yemen and Oman, and to the

east by the Arabian Gulf, the United Arab Emirates and Qatar. Saudi Arabia's Red Sea coastline extends for about 1,760 kilometres (1,100 miles) and its Arabian Gulf coastline for approximately 560 kilometres (350 miles) (MOFA, 2004).

Al-Farsy (1990) describes the kingdom of Saudi Arabia as encompassing about four-fifths of the Arabian Peninsula and covering an area of 2,150,000 square kilometres. Much of the land is either completely flat or very slightly hilly, with the contrasting Hijaz and Asir mountains forming a backbone along the west of the kingdom (OBG, 2005). Over half of the total area of Saudi Arabia is desert. There is a narrow plain, approximately 14-65 kilometres wide, running along the Red Sea coast and a low-lying region called Al-Hasa in the east along the Arabian Gulf. There is a wealth of minerals in the mountainous area to the west of the Kingdom, with large deposits of limestone, gypsum and sand; and most importantly, the richest reservoirs of oil in the world can be found in the east (MOFA, 2004).

Main cities

Saudi Arabia is often referred to as the 'land of the two holy mosques', in reference to Islam's two holiest places, Mecca and Medina. Mecca is the birthplace of the Prophet Mohammed and almost two million Muslims from all over the world go there every year on an Islamic pilgrimage known as the *Hajj*, which all Muslims strive to make at least once in their lifetime. Medina is the city to which Prophet Mohammed emigrated and lived for most of his life. Riyadh, located in the central province, is the capital city of Saudi Arabia and its high-tech centre where the headquarters of the GCC are located. Jeddah, on the Red Sea coast, is the commercial capital of Saudi Arabia and is seen as the gateway to the peninsula. Jeddah's ports are at the centre of the main trade routes. In Dhahran, in the east and southeast of the Kingdom, its massive petroleum reserves are situated. The twin cities of Jubail and Yanbu are viewed as a symbol of the government's vision of the future development of Saudi Arabia. Jubail, in the Eastern Province of the Kingdom, on the Arabian Gulf, 80 kilometres north of Dammam, is an ancient centre that is most famous for pearling and is now the home of the largest petrochemical complex

in the world. Yanbu is located approximately 350 kilometres north-west of Jeddah on the Red Sea coast and the Directorate General of the Royal Commission for Jubail and Yanbu, an industrial building which is an architectural masterpiece, can be found there (MOEAP, 2007).

4.4 Population

In mid-2007, according to estimates issued by the Central Department of Statistics, the total population of Saudi Arabia amounted to 23.98 million and was growing at about 2.3 percent per year. Saudis accounted for 72.9 percent of the total population and non-Saudis 27.1 percent. Two-thirds (67.1 percent) of the total Saudi population was below 30 years of age and 37.2% were under 15 (MOEAP, 2007). Males represented 50.1% and females 49.9% of the total population (MOFA, 2004).

The total labour force in Saudi Arabia during 2006 was 8.7 million, of which 4.0 million (46.1 percent) were Saudis. This means that foreign labour accounted for 53.9 percent of the total labour force or 4.7 million people. There were 1.93 million workers in the government sector and 7.51 million in the private sector. In the latter, only 39.8 percent were Saudis, while 60.2 percent was made up of foreign labour. In the government sector, by contrast, a striking 86.1 percent of total of workers were Saudis, while foreign labour represented only 13.9 percent (MOEAP, 2007). Egyptians constituted the largest number of expatriates, at 16% of foreign workers, followed by Indians, Pakistanis, Yemenis and Filipinos (MOFA, 2004). In 2005 it was estimated that approximately 100,000 Western workers were living in Saudi Arabia (OBG, 2005).

4.5 History

It is historically known that the Saud family attempted to rule parts of the Arabian Peninsula twice before the establishment of the present Kingdom of Saudi Arabia (Al-Tawail, 1995). This history goes back over two centuries. It may be divided into three periods.

Period One (1744-1818)

During the early part of the 18th century, Saudi Arabia faced harsh political conflict, which continued until Al-Imam Mohammad Bin Saud took control and founded the first Saudi state. However, it suffered under the attacks of the Ottoman nation and the Egyptian ruler, Mohammad Ali Basha (MOFA, 2004). In this period, the first Saudi state arose as a result of conditions that prevailed on the Arabian Peninsula. Parts of the Najd region, for example, consisted of petty emirates and sheikdoms ruled by tribal chiefs, while the rest of the Peninsula was controlled by Ottoman Turks, either through some local leaders allied with them or directly through appointed rulers. The state of affairs, in political and security terms, was total disorder. Taking advantage of these conditions, Imam Mohammed Ibn Saud initiated attempts to dominate the central part of the Arabian Peninsula. During that time, a Unitarian Call was made by Shaykh Mohammed Ibn Abdul Wahhab with the aim of purging the religious practices of common people of meaningless ritualism that conflicted with Islam, especially practices that deviated from the Hanbali doctrine (Al-Tawail, 1995).

Period Two (1824-1891)

This was followed by another difficult period, during which there were internal conflicts between rival tribes, while the Egyptian military attempted to depose the ruling Saud family. However, there was some progress for the country via stable guidance and systems (MOFA, 2004). In this period, the Saudi state gained more power by the return of Imam Faisal Ibn Turki from exile in Egypt and by the expulsion in 1839 from the Arabian Peninsula of the Egyptian force that was in alliance with the Ottomans. Imam Turki was able to reconquer most of the areas that had been controlled by first Saudi state and to bring them under the command of the second Saudi state. This state continued to exist until 1891, when it lost power to the

Al-Rasheed family, which claimed authority and forced the Saud family to leave the region (Al-Tawail, 1995).

Period Three (1902 to the present)

Saudi Arabia eventually became firmly recognised as the first new country in the region. The discovery of vast oil reserves made it possible for King Abdulaziz Al Saud to establish a country which experienced unique levels of commercial growth (MOFA, 2004). This was the culmination of centuries of tribal feuding during which the Al-Saud family had ruled at various times since the 18th century. Their ascendancy began in 1902 with the capture of Riyadh from the rival Al-Rashid family, and this initiated a further 30 years of territorial consolidation and state building. In this period King Abdulaziz established his rule over that area. From 1902 to 1926, King Abdulaziz vigorously and brilliantly extended his authority over most of the Arabian Peninsula (Al-Farsy, 1990). On September 19th, 1932, a royal decree declared the unity of the nation and called it the Kingdom of Saudi Arabia.

4.6 Political system

Islam strongly influences the whole social fabric of the country, including its civil, cultural, economic, legal and political aspects. The King rules the country via a Council of Ministers whom he appoints. He also appoints the judges on advice from the Supreme Judicial Council and they work as an independent body to administer law and justice, although the King has the power to overrule judicial decisions and grant pardons (OBG, 2005). The political system in Saudi Arabia is governed by Arab and Islamic laws. The new governmental system established by King Fahd in 1992 shows that the true identity of the Kingdom lies in its Arab and Islamic roots, including the Arabic language. This system has been shaped by three major decrees concerning political developments and the modernisation of the government. The first decree concerned the formation of the Consultative Council, which consists of 150 members appointed by the King and enables particular groups of the population to participate in forming the Kingdom's policies, both domestic and foreign. As Al

Twaijry et al. (2003) explain, it enables these groups to make the government aware of their views. The Consultative Council is thus a decision-making body which offers opinions on general political issues, which are then passed to the prime minister. It establishes the general plan for economic and social growth on specific issues and studies the system, lists, contracts and agreements with other countries, then gives counsel based on these. The Council also scrutinises and gives feedback on ministerial and governmental reports that investors may be interested in.

The second decree concerned the Provisional Councils in each of the 13 Saudi provinces. These are made up of influential citizens who help by providing input and reviewing the way their respective local governments manage the provinces. The third decree concerned the Basic Law of Governance, which incorporates the arrangements for the Consultative Council as well as for regional government and is quite similar in many ways to the Consultative Council. Its written form was created from a description of the fundamental structure and organisation of government and from a bill of rights for the citizen (MOFA, 2004). The Basic Law specifies that the Kingdom should be ruled by the direct heirs of Abdulaziz Al Saud, the first King, and that basis of the legal system and constitution are the Qur'an, with the legal system being based on Islamic Law (*Sharia*) (OBG, 2005).

In 2005 there were municipal elections in Saudi Arabia as part of the ongoing political process. Local councils have between four and fourteen members, half of whom are elected and half appointed. They deal with budget projects, contracts and cost evaluations for public services such as education and health. Elections enable people to participate in decision making to a degree, and investors are able to interact with managerial parties (MOFA, 2004).

4.7 The economy

Before the discovery of its vast oil reserves, the Saudi economy depended mainly on commercial exports, agriculture and tourism. Tourists consisted largely of pilgrims who came to Mecca and Medina for their Hajj. When oil was discovered, the Saudi

government granted extraction rights over an area of 495,900 square miles to Standard Oil of California. Within a few months of the contract being signed, encouraging results came from the Jabal Dhahran area and by 1938, enough oil had been extracted to be able to start a business. The first exports were from the Ras Tanura coast in May 1939. In the mid-1970s oil prices rose sharply and Saudi Arabia became one of the fastest growing economies in the world. However, there was relatively little change in other aspects of Saudi life, because the basic social codes, cultural principles and religious tenets have remained unchanged (MOFA, 2004).

The Saudi economy is therefore an oil-based one in which major economic activity is closely controlled by the government. It is estimated that Saudi Arabia holds around 25% of the world's proven reserves of petroleum, the largest of any country in the world, and that it is the world's largest exporter of petroleum. The petroleum sector accounts for around 75% of budget revenues, 45% of gross domestic product (GDP) and 90% of export earnings. Mellahi (2006) notes that the contribution to GDP of the private sector is around 40%.

The Saudi government's oil and gas exploration, production and marketing activities, both internally and abroad, are operated by Aramco, which is the largest company of its type in the world and the sixth largest oil refiner. Aramco has both onshore and offshore fields and produces various grades of oil, from very light to heavy. Recently sugar-light grades of oil have been developed and the company has placed emphasis on this. The government has been able to invest thanks to record global oil prices and various projects have been fast tracked to increase both capacity and refining capabilities, not only at home but also in other countries such as China, with the Fujian Petrochemical Company and Exxon Mobile. Exploration of natural gas reserves began in the 1990s. Currently known Saudi reserves of natural gas are roughly 6.5 trillion cubic metres, the fourth largest in the world. Indeed, since only 15% of the kingdom has been surveyed to date, there is huge potential for developing gas exports in the future (OBG, 2005). As mentioned previously, Saudi Arabia is a rentier state, relying on direct transfers from the

international economy in the form of oil revenues. In the absence of systems of personal and corporate taxation they also serve as a further safeguard against democratization (Common, 2008).

Since 1970 the Saudi economy has undergone radical transformation and infrastructural development, affecting virtually all aspects of life and bringing economic, social and urban changes. This transformation can be attributed to extensive government investment organised into five-year development plans which lay down the infrastructure, both social and physical, of the country. Physical developments have included the construction of massive road networks, as well as bridges, dams, airports, seaports, marine terminals and desalination plants. There have also been developments in the provision of electricity and communication systems. Finally, there has been substantial investment in services such as education, health and vocational training, with the building of schools, colleges, universities and of general and specialised hospitals for the civilian and military sectors (MOFA, 2004).

The Saudi economy is heavily dependent on oil, but the authorities have recognised that economic diversification is needed. The population is increasingly young, so the creation of jobs for them is of paramount importance. Saudi Arabia is in an excellent position to create quality jobs for an educated workforce thanks to large surpluses, mainly from oil revenues. The balance of payments for 2004 indicated a current account surplus of $51.5 billion, placing the economy in an extremely favourable position. Several job creation suggestions have been put forward, including downstream petrochemical-associated industries and the development of other industries that rely on cheap supplies of energy and petrochemical byproducts. Saudi Arabia's industrial base is far broader than that of neighbouring countries: it has an established manufacturing sector which produces plastics, other polymers and building products and there is also a range of mining plants. Huge funds have been invested to create industrial estates in major cities, most notably the advanced industrial towns of Jubail and Yanbu, specifically designed to accommodate heavy industries such as basic petrochemical plants, iron and steel plants and extensive oil

refineries, established by the government in conjunction with international corporations and the Saudi private sector (MOFA, 2004).

Another strategy for the encouragement of economic diversification has been to increase private sector participation. The Supreme Economic Council (SEC) was created in 1999 to officially lead the move towards privatisation, since when there have been major endeavours to open markets and encourage investment – both inward and outward – and to enhance the stock market's role.

Thirty industries have been selected by the SEC for eventual privatisation during the last five years. These include giants such as the Saudi Arabian Basic Industries Corporation and the Saudi Telecommunications Company (STC). In late 2002, 30% of STC stock was offered in the first wave of initial public offerings (IPOs). More recent IPOs have been heavily oversubscribed, which shows that there are keen investors both within Saudi Arabia and in the surrounding region, as well as investment regulations being relaxed. The port and postal services have also been privatised.

Saudi Arabia, having some of the largest reserves of natural resources in the world, could have been self-sufficient on oil revenues and remained isolated and insular. However, it has endeavoured to increase trade in order to create sustainable prosperity and stability; thus it has, to a large extent, integrated into the world economy (OBG, 2005). Saudi Arabia became the 149th member of the World Trade Organisation in November 2005 (ibid).

4.8 Social culture

A unique blend of Islam with Arab traditions creates the cultural environment which is at the root of the mentality and behaviour of the Saudis. Almost all Saudis are Muslims and Islam is the recognised religion throughout Saudi Arabia. In Islam there is total submission and obedience to one God (Allah) and Muslims believe Allah to be a divine, omnipotent creator. They look to Allah exclusively for their values and standards, orientation, ethics and morals, ideas, institutions, legislature

and laws. Bjerke and Al-Meer (1993) explain that Allah reveals his guidance through the Prophet Mohammed and that Islam is vital for mankind. Islam views the Prophet Mohammed as the last of God's emissaries to bring revelation to mankind, after Jesus, Moses, Abraham and others. Muslims believe he differs from some other prophets in that the message that he brought was not for an individual or certain group of people, but for the whole of mankind. The Muslim holy book is the Quran, which Mohammed brought, as in earlier times Moses brought the Torah and Jesus the Bible. All guidance in the religion is based on the Quran and the actions of the Prophet (the Sunnah).

Muslims are obliged to pray five times a day, at dawn, noon, afternoon, sunset and evening, the exact times for prayer being listed daily in local newspapers. On Fridays everything closes as this is the Muslim holy day, so the weekend for many companies is Thursday and Friday. All Muslims must fast from dawn to dusk during the holy month of Ramadan, when the working day is limited to six hours.

Islamic teachings are so embedded in Saudi society and widely followed that it produces a fairly homogenous culture, as in most Middle Eastern nations. Islam permeates through all aspects of life in Saudi Arabia and there is a strong alliance between Islam and the state. All decisions of Arabs, including business decisions, are made in consideration of Islam. Saudis believe that ultimate control over the environment is in the hands of God, which generates a fatalistic attitude, but people are taught to make every effort possible to better their lives.

It is clear that Muslim culture and values strongly influence Saudis in everything they do and in their day-to-day working lives. This affects relationships between different echelons of the workforce. Bjerke and Al-Meer (1993) found that Saudi managers scored high on power distance, which suggests that there is a social distance between superiors and subordinates, possibly due to Muslim beliefs regarding authority. Saudi managers also seem to have a high uncertainty avoidance orientation and to prefer a close-knit social framework in both organisational and institutional life. Therefore, they are generally classed as risk avoiders, so important

decisions are most often made at the highest level of management. Bjerke and Al-Meer (1993) concur in the view that Saudi people prefer to avoid conflict.

Assad (2002) found systems for recruitment and promotion to be strongly influenced by social ties, personal relations and family position, which, as Bjerke and Al-Meer (1993) suggest, is because the society in which Saudi managers live values family and friendship highly and these valued relationships remain important and influential factors in the way that institutions and groups function. Saudi managers rely on these relationships for the day-to-day functioning of their organisations and to ensure that what needs to be done is done. Formal planning systems are the opposite of this; there are business policies within which smaller groups, factions and families operate and can become 'shells', with an adverse effect on the efficiency and effectiveness of whole organisations. Therefore, social organisation is designed for collectivist groups such as the family or any of the layers of tribal networks to further their particular interests. Idris (2007) states in support of this view that Saudi culture can be described as collectivistic with strict devotion to Islamic teachings, which dictates social behaviour and provides a strong nationwide cultural fabric. The widespread collective thinking of Saudis impacts on business and dictates relationships within business.

Assad (2002) looked at the relationship between societal values and how they are represented in the business environment. He found that organisations are not always characterised by positive or widely respected values and concludes that institutions reflect the societies they operate in. If there is a change in the values of members of society, then it follows that organisations will be under pressure to adopt different practices, which will apply to governmental organisations in particular. When values do shift, it is most likely that governmental organisations will be encumbered with representing the values of their citizens and are therefore likely to be subject to high levels of conflict. This is what this study focuses on in order to achieve its main objective, which is to understand and explore the role of organisational culture as an initial tool to facilitate any effort to improve Saudi health services.

4.9 Development of Saudi administration

The Saudi administration has undergone three basic stages of development, namely the creation of the Kingdom (1902-1953), the building of the central administration (1953-1969) and administrative development from 1970 to the present. These three stages can be summarized as follows.

Creation of the Kingdom (1902-1953)

During this stage Saudi administration was represented by examples of local administration of the old and simple kind. King Abdulaziz established governmental administration in Najd, Al-Ahas and Asir, each of these three regions being ruled by a governor who reported directly to the king. There were no central agencies to supervise over the Kingdom's regions as a whole and assume responsibility for development plans. Thus, administrative affairs were run and controlled directly by King Abdulaziz. The style of administration at that stage was constrained by the harsh economic situation: it was not possible to create many organisations and hire many employees to run the new administration, since it was difficult to meet their financial requirements (Al-Tawal, 1995). King Abdulaziz faced a major problem when he attempted to create a modern administrative organisation for the new country. Therefore, he hired experts from other Arab countries such as Egypt to work as executives and consultants. In addition, he sought the assistance of administrators who had worked in Al-Hijaz during Al-Sharif's rule and appointed some of them to leadership positions. He also oversaw the granting for scholarships to young Saudi men to study abroad (ibid).

During this period the government enacted laws and regulations in order to maintain and reform its administration. Examples are the Kingdom of Al Hijaz Organic Law (1926), the Public Undersecretaries Law (1928), the Company Registration Law (1928) and the Trade Mark Regulations (Al-Hamad, 1995).

One major step taken by King Abdulaziz was to establish a unified judicial system for all the courts in the Kingdom. The first step towards achieving this was when in

1927 the King issued a Royal Decree which established the courts in Al-Hijaz at three levels:

- Courts of Urgent Cases (courts of summary jurisdiction).
- Supreme Courts and Ancillary Courts.
- Board of Judicial Surveillance (Court of Cassation)

In 1936, there emerged several special prosecution procedures such as the progression regulations for Shariah trials. There was additional regulation of the administrative functions in the Shariah department in 1952 (Al-Zahrani, 1995). During this period the government also issued specific legislation to cover local administration, including the Local Native Council Act (1923) and the Council Deputies Act (1930), which aimed to improve co-ordination between the various government departments (Almotairi, 1995).

Al-Tawal (1995) argues that the administrative structure in this period satisfied the country's needs until oil started to be produced in 1945. Nonetheless, coordination among all of the workers of these central bodies was very difficult to achieve, especially as the King was extremely busy reviewing matters referred to him and running the major policies of the government.

Building a central administration (1952-1969)

The issuance of a Royal Decree in 1953 establishing the Council of Ministers could be considered the first basic step in establishing a central administration in the Kingdom. For first time, all government bodies throughout the Kingdom were supervised by a single agency. Therefore, the size and responsibilities of government bodies began to increase. This expansion of government organisations was intended to address the change in the State's reserves and consequent problems (Al-Tawal, 1995). In addition to the establishment of the Council of Ministers, the number of ministers was increased from six to nine. Furthermore, the state's revenues were augmented due to increase in oil production after the Second World War, and as a result, the government was able to provide more services to its citizens (ibid). For

example, Jabbra and Jabbra (2005) state that the Grievance Board, which was established in 1954, represents an extension of the traditional practice of direct accountability to the king by any citizen who has a grievance against the bureaucracy.

The growth in government bodies has caused several problems. In particular, Jreisat (1988) discusses the shortage of qualified manpower to manage these bodies and help them to achieve their goals and therefore their inability to undertake the new duties assigned to them to an adequate standard. The failure of the administrative system was even clearer when the government faced a serious crisis in 1956, due to the government practice of spending its revenues in the absence of a national policy of financial control. This led to the first actual attempt at administrative reform, when the Saudi government sought the assistance of several foreign bodies.

First, in 1957, the International Monetary Fund addressed the financial crisis. After conducting studies and reviewing the economic situation, it presented recommendations to the government, which led the government for the first time to use the budget system as a tool of financial policy.

The mission of the International Bank for Reconstruction and Development in 1960 was to carry out the recommendations of the International Monetary Fund. The Bank's team advised the Saudi government of the importance of seeking the assistance of the United Nations in order to study the administrative situation in the government agencies and to submit the necessary recommendations for their development. The Saudi government accepted this advice and in 1960 requested the help of the Technical Assistance Committee of the United Nations, which made the following recommendations:

- The need to reorganise the administrative machinery,
- Incorporating similar bodies into one body,
- Amending the financial control regulations and the regulations of the Civil Service,

- Simplifying government procedures, especially in government purchases and warehouses (Al-Tawail, 1995).

United Nations experts provided much technical assistance to the Kingdom in 1951-1968, sending experts in various fields during the period of building the central administration. They made some recommendations to the government such as the need to reorganise all government bodies and to create an institute for public administration to train government personnel. This led to the establishment in 1961 of the Institute of Public Administration (Al-Tawail, 1995).

The last of these foreign organisations was the Ford Foundation, which recommended a programme of administrative reform in 1963 and carried out studies of government agencies until 1969. It created five teams, responsible for organisation and management, personnel, training, financial management and public works. Their studies resulted in the development of the civil service regulations and the administrative structure of government organisations (ibid). This led the government to establish in 1963 the Higher Committee for Administrative Reform to supervise administrative reform programmes, for which it exercised the authority of the Council of Ministers in matters related to the organisations of the administrative system. Its aim was to speed up the process of reorganising government agencies and developing administrative performance in order to improve efficiency and accountability among Saudi public servants (Jabbra and Jabbra 2005). Since its establishment, the committee has initiated many measures aimed at modernizing the central administrative system and its regulations (Al-Tawail, 1995). During this second stage, the Saudi government continued to issue laws and regulations aimed at reforming government bodies, departments and judicial committees in addition to the establishment and expansion of public enterprises and administrative reform bodies.

Administrative development (1970 to the present)

This third period is considered the real time of development after the establishment of the central administration and the creation of bodies capable of planning and executing development projects, during which the state has more or less completed the building of its organisational, judicial and executive bodies. This stage has been marked by the planning process, its related channels and avenues and the creation of the bodies concerned. With the determination and implementation of development priorities and owing to the importance of the role played by planning in the conduct of administrative reform, the task of planning was initially entrusted to an independent agency. Therefore, the government established the Ministry of Planning in 1975. At this stage, since the first development plan in 1970 and through the seventh development plan (2000-2005), the infrastructure for overall development has been laid out (Al-Tawail, 1995).

An important step in the development of the administration is the establishment of the Civil Service Board in 1977. The Board attends to civil service matters in all ministries, public agencies, corporations and services to ensure accountability and high quality performance among public employees (Jabbra and Jabbra, 2005).

Since the fall in oil prices in the mid-1980s, the country has sought alternative sources of revenue. One of these has been the intensification of global trade relations and of international and national investments, as well as extensive investment reform to attract investors. For example, in order to stimulate competition, Saudi Arabia has recently instituted several laws and policies on matters such as privatization, domestic investment and foreign direct investment (Mellahi, 2006).

During this stage, the Cabinet was reformed twice, in 1975 and 1982, in order to satisfy the requirements of the administration process in general and administrative reform in particular. In addition to the reformation of the Cabinet, there was an expansion in the establishment of new ministries, seven new ones being added to the fourteen existing ministries. Thirty-six new public enterprises were also created,

characterized by their flexible work systems and methods allowing them to respond promptly to the requirements of development, a feature which distinguished them from bureaucratic organisations (Higan, 1995).

In 1992, as mentioned above, the King issued a royal decree on three major political developments with the aim of modernizing the government, forming the Consultative Council and the Provincial Councils and establishing the Basic Law of Governance (Al-Hamad, 1995). The main objective was to enhance the administrative and developmental gains achieved in the preceding stages while making the organisational and administrative milieu congruent with the subsequent stages of Saudi administrative development.

The Saudi government established the General Memorandum Committee on Administrative Reform in 2003. It aims to restructure the government sector at large because current structures have been in place for about 40 years without general modification, resulting in inefficient interactions and duplication among some government agencies. Some of the Committee's objectives which have been achieved so far include the privatization of Saudi Telecom and the transfer of civil aviation to an independent agency. Such reforms have reduced government expenditure by eliminating some agencies and amalgamating the responsibilities of other services (Al-Otaibi, 2006).

4.10 Health care

In its attempt to improve health services, the Saudi government has invested heavily in the health care sector. Ministry of Finance (MOF) statistics from 2008 show that the government spent around 12% of its budget on health and social services. As Al-Yousuf et al. (2002) note, the Saudi health system has endeavoured to respond to the demands of its citizens and has introduced various changes over the years to achieve this.

The formation of the Ministry of Health in 1951 coincided with the establishment of hospitals (Al-Rabeeah, 2003). Providing approximately 58% of health care in Saudi

Arabia, MOH is the principal provider of health care, alongside some other governmental agencies. As Al-Farsy (1990) states, the Saudi policy is to provide free health services to all citizens of Saudi Arabia. The other main government agencies acting as health providers are the Ministry of Defence, Ministry of the Interior, Ministry of Higher Education, the National Guard, and the King Faisal Specialist Hospital and Research Centre. Government agencies provide free health care services for their own staff, so for example, the Ministry of Defence has hospitals providing treatment free of charge to its employees (Mufti, 2000). Al-Farsy (1990) found that such hospitals will also accept patients referred by other hospitals.

The MOH is responsible for providing both general and specialised health care, and therefore has overall responsibility for planning, controlling and coordinating health care services nationally. Mufti (2000) describes a three-tier institutional system of large general hospitals, specialised hospitals, including maternity hospitals, and primary health care centres to cater for the nation's health needs.

Approximately 80% of the Saudi health service is government funded and is free of charge, not only to Saudis but also to expatriates working in the public sector. The majority of other social services are also either completely free or are highly subsidised, including education, utilities and so on. Such has been the level of service that Saudis now consider free services not so much a privilege as a right, and as such they demand that the government provides the very best level of health care free of charge. This indicates that most Saudis are very conscious of their country's vast wealth. As Mufti (2000) notes, prior to the discovery of oil and the enormous rise in wealth that it brought with it, health resources were at the other extreme, being particularly deficient and offering minimal access to the type of care one would expect from a modern health system.

Al-Yousuf et al. (2002) note that the development of the Saudi health system was sluggish until the mid-1960s, followed by a period of rapid expansion from 1965 to 1985. Al-Rabeeah (2003) reports that practice policies began to be developed in 1989, as this was the year when the medical and dental practice policy was

established. These policies played a formative role in establishing as well as improving and expanding the capabilities of the Saudi health care infrastructure. Indeed, since the implementation of the first five-year development plan in 1970, health benefits in Saudi Arabia have increased rapidly. The government spends heavily on building and operating hospitals to improve the health care services in the country. There has been a very clear major development in numbers of hospitals, beds, primary health care centres and health care workers (Mufti, 2000; Al-Rabeeah, 2003).

The series of five-year Health Development Plans of the MOH (1975-80, 1980-85, 1985-90, 1990-95, 1995-2000 and 2000-05) reflect the privileged situation in the country. In fact, they started with the objective of controlling infectious and communicable diseases and of providing preventative care to the people through the plan periods. Initially there was strong and extensive expansion of infrastructure, but later resources were restricted, necessitating efficiency in their use (Mufti, 2000).

In 1982, the Council of Ministers issued a decree for the formation of rural development committees, each responsible for a number of villages and having members from eight related ministries, including health, as well as prominent local persons (Al-Mazroa and Al-Shammari, 1991). The development of health facilities was also connected with the development in health education and training. This was evident in the opening of a number of health institutions, nursing and allied health colleges and medical schools. Medical education went beyond undergraduate level in early 1980 when Arab Board Training Programmes started. The Saudi Council for Health Specialties come into being in 1995 in order to prepare structured training programmes and subspecialty fellowship programmes. It administers quality assurance for health workers and licensing systems for health centres and health workers (Al-Rabeeah, 2003).

Another proposed development for the Saudi health system is ‘Saudization’, by which foreign health professionals (physicians and other categories) in Saudi Arabia would be replaced by Saudi nationals (Gallagher, 2002). This proposal should be

seen as an extension of the existing policy. The huge expansion of facilities and services by health care providers puts great pressure on health planners to deal with the extreme shortage of health workers by recruiting foreign labour from around the world. The health planners recognized some time ago that a nation reliant on skilled immigrants for such a vital activity as health care is highly exposed to outside influence. Many of the non-Saudi health professionals have different cultural values, which causes some difficulty when they have to deal with patients, as does the language barrier. Therefore, the government initiated Saudization to overcome the shortage of health professionals, aiming to replace foreign national by Saudis who are familiar with the language and culture of Saudi society. This reform step is a good long-term investment because the turnover among foreign workers is very high compared with the domestic labour force (Mufti, 2000).

As result of Saudi government effort to improve health care services, the number of primary health care centres, including dispensaries and clinics, rose from 599 in 1971 to 1848 in 2005, while the number of physicians and dentists (combined) rose in the same period from 1,316 to 40,265, with 21.3% of them (8558 physicians) being Saudi. For nurses during the same period, the corresponding figures are 3,355 and 78,587, with 18,805 (24%) being Saudi. There were 75 hospitals in 1971 and 364 in 2005; and for hospital beds the corresponding figures are 9,837 and 51,130 (MOH, 2007). These figures make it clear that the health care system has undergone a rapid expansion in physical facilities and professional personnel, delivering a correspondingly greater volume of benefits and assistance to the public. This is a form of change that should be regarded as positive in its impact upon the population (Gallagher, 2002).

In 1999, the Saudi government established a National Health Insurance scheme. According to Mufti (2000), this could be characterized as a national health system similar to that of the United Kingdom's NHS, normally funded through government revenue and reviewed in annual budgets. Unlike national health insurance systems in which funds are specifically set aside for health services, the NHS competes for funds with other national programmes such as education and defence. Mufti (ibid)

considers that funding health services under a form of NHS is superior to NHI. In other words, a Saudi national health insurance scheme would constitute a step backwards. It is probably necessary, however, because unlike the United Kingdom, which can raise taxes to increase revenues, Saudi Arabia does not tax its residents.

The two main objectives of the NHI programme would be to serve as an additional source of finance for health, through wage-based contributions by employers and employees, thereby reducing the government's share of total health expenditures, and to transfer some of the social responsibilities for expatriates from the government to employers.

In 2002 the establishment of the National Health Services Council (NHSC) to formulate a strategy of health care and the development and adoption of policies of coordination and integration between all the relevant bodies to provide health care services in the kingdom (Al-Rabeeah, 2003).

The contribution made to health services by the private sector has grown over the last 10 years and it plays a vital role in running several hospitals and clinics in the country (MOFA, 2004). The growing demand for these private sector services by both Saudis and expatriates is reflected in the fact that the government has actively encouraged private sector involvement. The number of patients attending private health facilities increased by about a third in the four-year period from 1994 to 1998. Saudi citizens make up about 75% of the patients who use private health care. At the moment the private sector provides about 20 % of the nation's health care services, and it is expected that there will be further future expansion in the private sector for health services.

A statistical example of the increase in private health care is the number of hospitals and of beds provided privately in 1994 compared with 2002. In 1994 the percentage of privately run Saudi hospitals was 25.8%, rising to 29.9% by 2002, while the percentage of private hospital beds rose from 15.8% to 19.8%. The private sector now provides health services at primary, secondary and tertiary level (MOEAP,

2003). Mufti (2000) argues that the sector has been growing rapidly over the past several years. The government policy of encouraging private sector participation in all aspects of the economy has led to a growth in commerce, industry and health, in response to increasing demand for health services and a shortfall in the public sector ability to meet it. For example, waiting lists to access the services of public hospitals may be as long as two years Hassan (2006). Therefore, the Saudi government has approved the provision of NHI by private sector agencies. In addition, Mufti (2000) states that in order to provide health facilities to qualifying individuals and organisations, the government purchases services from the private sector. Some private facilities have beds set aside for government patients. Some of the large private hospitals have all the latest in medical diagnostic equipment and are in direct competition with the public specialist hospitals for provision of highly specialized procedures.

Health care management

Mufti (2000) analyses the evolution of hospital management in Saudi Arabia as having comprised four stages:

- Complete in-house management of all hospitals – mostly MOH. During the early developmental stages of the Saudi health system, the MOH was responsible for all aspects of hospital operation and maintenance, housekeeping, catering and medical operations were performed by MOH employees.
- Partial management of hospital operations while contracting out services. As the number of hospitals and beds increased rapidly, MOH manpower was stretched almost to breaking point. At the same time, the population was becoming more aware of the medical services that were available and began demanding more specialized care. MOH employees could no longer manage some aspects of the many hospitals that were being built. It thus became necessary to contract with private health management companies to provide some of the services. Housekeeping was the first to be contracted out, then general maintenance, then catering, and later medical operations. During this stage, MOH still provided

some of the services directly, while contracting with other companies – sometimes four or more at a time.

- Full management by private management companies. The systems under which the MOH operates in contracting and budgeting make dealing with the myriad of companies particularly difficult. Having to obtain clearance from the MOF and Civil Service Bureau, both of which have lengthy procedures, delays the execution of contracts. It is in response to these difficulties that the MOH has favoured contracting with one company whenever possible to provide the full range of services.
- Direct management by programmes. The increase of expenditure and poor performance of some of the management companies convinced the government to return to direct operation in a programme format.

Other government health providers, particularly those running highly specialized hospitals which require an experienced management team to operate them, rely on hospital management companies for full or partial management of their hospitals.

Despite the above efforts, the Saudi government's reform of the health system has not been entirely successful. The current system still faces problems, such as difficulties accessing its services, long waiting lists, medical malpractice, patient dissatisfaction and so on.

4.11 Conclusion

The aim of this chapter was to focus on the environment of public management in Saudi Arabia in order to understand how the governmental agencies in general and health organisations in particular operate in this country. Therefore, the chapter started with an overview of Saudi Arabia, covering its natural geography, demographics, history and economy. Saudi Arabia has undergone modernization in three stages and now has an oil-based economy with strong government control over major economic activities.

This chapter has also demonstrated that the culture in Saudi Arabia can be best described as collectivistic, where family and friendships remain important and influential in the functioning of institutions and where loyalty to the family and tribe is very strong. Saudi managers reportedly scored highly on power distance, suggesting a social distance between superiors and subordinates, and tend to be risk avoiders, making decisions at the highest level of management in order to avoid conflict.

The political system in Saudi Arabia was described as a monarchy in which Islam underlies the civil, cultural, economic, legal, political and social fabric of the country, which the King rules through a Council of Ministers. The development of the Saudi administration started when oil was discovered in 1938, while the modern system came into being when the government adopted some of the recommendations of international agencies such as the UN for dealing with difficulties that affected the government agencies. In the 1970s, the government established more ministries and institutions to operate public services and provide qualified manpower around the country.

Finally, this chapter has outlined the free health care system provided mainly through the MOH, along with some other governmental agencies, for which the government has allocated approximately 12% of GDP. In order to reform the health services, the government has introduced National Health Insurance, but despite all efforts, the Saudi health system currently faces problems, such as difficulties in accessing its services, long waiting lists and so on.

In conclusion, this chapter has shown that in Saudi Arabia, culture plays a vital role in the daily practices of government agencies, because inherited traditions, such as Islamic teachings and Arab culture, exert a strong influence. Saudi social characteristics, such as high power distance, collectivism, femininity and high uncertainty avoidance, are reflected in the management style, which is described as hierarchical and as having centralised structures. These social characteristics seem to have resulted in a rigid environment which is resistant to administrative changes.

Therefore, it is important to explore the Saudi national culture in order to facilitate and ensure the success of any reform aiming to solve the problems facing the health care system, and this is the subject of this study. The next chapter thus will make a comparison between published work using the CVF instrument in different national contexts in order to understand how Saudi national culture influences the application of the CVF in Saudi health care organisations.

CHAPTER 5 THE INFLUENCE OF NATIONAL CULTURE ON ORGANISATIONAL CULTURE

5.1 Introduction

Organisations need to analyse their external environment to be able to comprehend the intricacies of the outside world (Capon, 2000 and Flynn, 2002). They clearly cannot be isolated from this environment when the national culture is judged to be one of the main factors shaping it. The aim of this chapter is to make a comparison between published work using the CVF instrument in different national contexts. This comparison will consider findings in both health care and in public administration in a range of national cultures. This is necessary in order to understand the organisational culture when assessed by the CVF as the response may be influenced by national culture in a variety of contexts.

However, this chapter will start by focusing on national culture in general and on Hofstede's model in particular. As the application of the CVF is situated in organisations operating within a national culture, this context cannot be ignored and has implications for the CVF. Although subjected to rigorous criticism in this chapter, a justification for its use is provided here. Hofstede's analysis will also be employed as a tool to analyse Saudi national culture in Chapter Seven. Following this, previous studies which used the CVF in health care and public administration in different contexts will be reviewed. From this, assumptions can be drawn on how Saudi national culture influenced the findings of the CVF in Saudi health care organisations.

5.2 National culture

Many authors, such as Mills (1988), have discussed the extent to which national culture influences organisational practices and the means by which they do so. Mills

states that for an organisation to survive it must simultaneously acquire and adopt some of the beliefs, values and assumptions of the national culture. People take their particular cultural perspectives with them wherever they go - and the workplace is no exception - which greatly influences organisational culture. Ott (1989) remarks that national culture fundamentally shapes the culture of an organisation. Van Muijen and Koopman (1994) agree with this view, also stating that national culture influences the way people think about how to structure an organisation. Hofstede (2005) notes that the socialisation processes in the organisation constitute the means by which organisational practices are learned. Taking a cross-cultural perspective, Van Muijen et al. (1999), suggest that the differences in the values of organisations relate to and spring from the values of the country.

There is a big debate between scholars in regard to how national culture can be assessed. National culture models based on value measurements fall into two categories. In the first category, 'general human values' are used to clarify the relationships people have with other co-dependent structures, from their individual lives, extending to those of other members of specific groups they belong to, and even to their wider society, and ultimately to include the whole world. Triandis's model (1994), based on classifications of individualism versus collectivism, is an example of this approach. Schwartz and Bilsky's (1987) model is another example which advocates that goals, interests and motivations are the three main value domains. In the second category, 'specific work values' are the main focus. These encompass the desired patterns of employees across a series of work-related goals as well as employees' attitudes towards their jobs, their colleagues, their subordinates, and the organisations by which they are employed. An example of this approach is England's study (1967), which concentrated on work goals. Hofstede's (1980) model categorised national culture into five dimensions which he named power distance, individualism, masculinity, uncertainty avoidance and long-term orientation.

5.3 Hofstede's model

Geert Hofstede, whose work has dominated the field of organisational culture, presented a model that examined the links between national and organisational cultures which could be used to analyse organisational culture. Hofstede (2005) debated that the national culture is highly significant in shaping an organisation's culture. He argued that cultural differences at national levels are based more on values than on practices. Conversely, cultural differences at organisational level are based more on practices than on values. Hofstede et al. (1990) examined twenty units of ten European organisations and discovered that some interesting relationships existed between national cultural values and organisational practices.

Culture, according to Hofstede, is not a characteristic of individuals: it encompasses a number of people who have been conditioned by the same education and life experiences. Every person's mental programming is partly unique and partly shared with others. Hofstede's (2001) theory was based on what was arguably the most comprehensive study of cultural influence on values in the work environment. His research, undertaken whilst he was working as a psychologist for IBM between 1967 and 1973, entailed collecting and analysing data spanning forty countries, which involved more than 100.000 IBM employees. Hofstede used the results of his research to develop a model which could draw distinctions between cultures across four primary dimensions. He described each dimension as a continuum, or relativistic scale. The original four cultural dimensions identified by Hofstede were power distance, individualism/ collectivism, masculinity/ femininity, and uncertainty avoidance. Subsequently long-term/ short-term orientation was added as a fifth dimension.

Power Distance

Hofstede believes that the extent to which a culture embraces social inequality can be measured using the power distance index. There is an established hierarchy of power in cultures with high power distances, which is based on factors such as

status, wealth or intellectual capacity (Hofstede, 2001). Hoecklin, (1995) stated that in high power distance cultures there is a hierarchical system in which both superiors and subordinates recognise the inequality in their relationship. The expectation is that superiors will give instructions to subordinates. On the other hand, cultures with low power distances see everyone as being as equal, no matter whether they are more powerful, wealthier or have higher status (Hofstede, 2001). Superiors are expected to be there for the subordinates and privileges for the senior ranks are deemed undesirable. Adler (1997) also noted that low power distance organisations are more likely to have established procedures for addressing complaints from employees.

Individualism/Collectivism

Hofstede's 'individualism/collectivism' index is based on whether an individual is perceived as an independent entity or as part of a closely knit group. Where individual interests take precedence over collective ones and everyone is expected to look after themselves, the culture can be described as highly individualistic. At the other extreme, a culture in which people are integrated into strong cohesive groups can be described as being highly collectivist. In this type of culture, people are expected to be loyal to the groups they belong to (Hofstede, 2001). Bochner and Hesketh (1994) noted that the individualist's employee-employer relationship is predominantly contractual and inherently utilitarian and calculating compared with collectivists who have a basic moral commitment to their organisation.

Masculinity/Femininity

According to Hofstede, in a more masculine culture the social gender roles are more distinct. This implies that men are more assertive, stronger and more greatly motivated by material success, while women are gentler and more caring, believing that quality of life is more important than material wealth (Hofstede, 2001). Gomez-Mejia and Welbourne (1991) argued that in masculine cultures there is a greater focus on financial rewards, acquiring money and material gain. In a feminine culture, gender roles are more fluid, which means that an interest in relationships,

modesty, tenderness and a focus on improving their quality of life are pertinent to both men and women (Hofstede, 2001). Schuler and Rogovsky (1998) argued that non-financial rewards, such as relationships with colleagues, and schemes based on work-life balance reward schemes, such as crèches in the workplace should be more greatly appreciated, as in feminine cultures.

Uncertainty Avoidance

Hofstede's final index measures uncertainty avoidance, indicating how tolerant a culture is when faced with unfamiliar or ambiguous situations. A culture with a high uncertainty avoidance ranking will tend to depend upon strict, detailed rules and procedures in order to keep uncertainty to a minimum. If the uncertainty avoidance in a culture is low, there is less reliance on rules and greater ease at handling unknown events (Hofstede, 2001). Triandis (1994) describes high uncertainty avoidance cultures as "tight". This is because the norms are clearly defined and people's behaviour is expected to adhere to those norms, whereas in "loose" cultures there is a much greater degree of freedom in the way individuals behave.

Long-Term Orientation

Hofstede argues that cultures with long-term orientation consent to long-term commitments and perseverance which can give slower results, whereas cultures with short-term orientation are more practical and more willing to accept change in their quest for speedier results, though this may adversely affect the final outcome and ultimately could put the organisation at risk (Hofstede, 2001). Long-term orientation is defined by Ganesan (1994) as the perception of mutual dependence of outcomes in which both individual and joint outcomes are expected to be accomplished in the future. In order to achieve long term goals, attention needs to be paid in the short-term.

According to Hofstede (2005), the way people think about power distance and uncertainty avoidance particularly influences how people think about organisation in the individualism, masculinity, and long-term orientation dimensions and also has an

effect on how people in organisations are perceived, rather than about how the organisations themselves are perceived.

A sample of the results of Hofstede's study is provided in the following table:

Table 8: Hofstede's dimensions of culture

Study/Country	Power distance	Uncertainty avoidance	Masculinity	Individualism	Long term orientation
Hofstede's Arab World's index	80	68	53	38	
Japan	54	92	95	46	80
Libya	72	71	45	18	
Norway	31	50	8	69	20
Singapore	74	8	48	20	48
UK	35	35	66	89	25
US	40	46	62	91	29

Adapted from Hofstede (2001)

In the following section, a number of samples of studies which have employed Hofstede's model are presented. It is relevant to review these studies from different contexts and fields with more emphasis on studies focus on Arab countries in general and Saudi Arab in particular in line with the nature of this study. Hofstede's model has been replicated many times with different samples of a variety of characteristics, and as Sondergaard (1994) noted, the variations that Hofstede's dimensions predicted are almost verified, which suggests that some valid differences in national culture are reflected in these dimensions. This is also confirmed by Gooderham and Nordhaug (2002), who used sampling methods similar to those of Hofstede in their research regarding work-related values. The subjects of their survey were students at leading European business schools belonging to the Community of European Business Schools network (CEBS). Students from eleven CEBS schools in Austria, Denmark, Great Britain, Finland, France, Germany, Holland, Italy, Norway, Spain and Sweden completed questionnaires. The similarities between Gooderham and Nordhaug's study and that of Hofstede's were significant, particularly regarding the mean countries. The mean country in the masculinity-femininity dimension was Spain in both studies, and likewise the mean country was Finland in the uncertainty avoidance dimensions in both studies. Hofstede's mean country in the power distance dimension was the Netherlands, and in Gooderham and Nordhaug's the Netherlands were very close the mean.

Hofstede's mean country in the individualism dimension was Norway, which is economically similar to Gooderham and Nordhaug's mean country, Great Britain. In Gooderham and Nordhaug's study in the power distance dimension, the mean country was Italy, and Norway, Finland, and Denmark all scored significantly less which is pretty similar to Hofstede's results. In terms of the masculinity dimension Spain was the mean country. With the exception of Sweden, comparing the relative positions of the other countries with Spain, the results are akin to those of Hofstede. Moreover, the findings for uncertainty avoidance and individualism dimensions fuel the notion of a largely convergent Europe. In terms of uncertainty avoidance France was very different from the mean country Finland but otherwise there was no significant difference. In Gooderham and Nordaugh's study Britain's relatively high individualism score was only in an average position in Hofstede's study. Finally, Gooderham and Nordhaug concluded that their findings are especially pertinent to management system design. Hofstede (1980) has repeatedly argued that trying to apply management systems across borders is a recipe for disaster. However Gooderham and Nordhaug's findings show a significant convergence of Hofstede's national values, which implies that there is increasing scope for a Europe-wide management system.

The corporate ethical codes in Australia, Canada and Sweden were analysed by Singh et al. (2005). The Australian and Canadian codes were found to be very much alike, which is understandable given the similarities in both history and culture of the two countries as measured by Hofstede's dimensions. Furthermore, the contents of the Swedish codes were found to be very poles apart from the Australian and Canadian codes in certain respects, which is a sign of the cultural differences between Sweden and the other two countries. Singh et al. suggest that Canada and Australia are grouped with the Anglo countries in Hofstede's national culture dimensions, whereas Sweden is categorised with the Nordic. The corporate codes of ethics in the three countries echo these similarities and differences. Swedish codes are less prescriptive than either those from Australia or Canada, and the codification for Canada and Australia was markedly more intense than for Sweden.

This exemplifies the "uncertainty avoidance" dimension in Hofstede's national culture model. Uncertainty is approached differently in different countries. Some societies are more willing to accept it whilst others tend to try to avoid it, and in the uncertainty avoiding societies it is common that there are rules and laws laid out to protect against unpredictability. The Australian and Canadian corporate codes of ethics are more rule-based than the Swedish codes, which highlights the difference in uncertainty avoidance values between the two countries. Schuler et al. (1996) used Hofstede's dimensions in research aiming to explain the difference between cultures in administration policies and practices. Their results led them to conclude that the obvious differences between US and Mexican companies' management practice are rooted in the differences according to Hofstede's dimensions that are found between the two countries.

Interestingly, Lowe's (1996) study, which was the only follow up IBM study carried out on IBM populations since Hofstede's study, showed only partial confirmation. He found predicted differences in the UK and Hong Kong, expect in the uncertainty avoidance dimension.

Some studies have been done which do not confirm Hofstede's results. Blodgett et al. (2008) are one example. They used Hofstede's model on a sample taken from two different populations and criticised Hofstede's cultural instrument as they felt that when it was applied at an individual level of analysis in their study the construct validity was inadequate. Their findings also showed that there was inadequate face validity in most of the results coupled with low reliability of the four dimensions. They further criticised the fact that the factor analyses using Hofstede's model failed to give a coherent structure. Furthermore, when Oshlyansky et al. (2006) re-examined Hofstede's Value Survey Module (VSM) in a study spanning nine countries, Hofstede's findings were not reflected in their results, which led them to conclude that when VSM is being used to adopt interfaces for different cultures, caution needs to be exercised. Further criticism of Hofstede's work will be detailed in section 5.6 (Limitations of Hofstede's model) later in this chapter.

As mentioned above, in line with the nature of this study, Hofstede's dimensions of culture model was employed in some Arab countries. For example, Shackleton and Ali (1990) used Hofstede's 1980 model to examine power distance and uncertainty avoidance in seven different organisations, comprising two British, one Pakistani organisation in Britain and four Sudanese organisations. They found that Hofstede's (1980) dimensions of power distance and uncertainty avoidance were supported in the overall power distance index and uncertainty avoidance indices of the British, Pakistani and Sudanese managers. The Sudanese overall scores were predictable in the light of the already established scores of some other Arabic African nations that are both geographically and culturally similar to Sudan. Unsurprisingly, the British and Pakistanis in Britain had similar scores to Britain and Pakistan respectively. In another recent study by Twati (2008), a structured survey questionnaire based on Hofstede's model was issued to 400 middle and top management employees in over 15 Libyan government and public organisations in the two main industry sectors in Libya. He found that generally employees had high scores on the power distance and uncertainty avoidance dimensions and low scores on the masculinity scores and individualism dimensions.

Previous literature that focussed in public management in Saudi Arab concluded that Saudi public organisation as based on Hofstede'ds model can be characterised to possess a high power distance collectivistic culture with feminism and high uncertainty avoidance (Barakat, 1993; Bjerke and Al-Meer, 1993; Al-Twaijry and Al-Muhaiza, 1996; Weir, 2000; Alshaya, 2002; Tayeb, 2005; Mellahi, 2006; Idris, 2007; Common, 2008). The dominance of such characteristics in Saudi public management can be explained by some authors, for example, Barakat (1993) and Idris (2007) who argue that people in Saudi Arabia learn the values of respecting and obeying their elders from early childhood and make every possible effort to help them. These ingrained values motivate them to show respect for their superiors and accept the social distance – or, to be more precise, the power distance – between superiors and subordinates to prevent any disagreements. Bjerke and Al-Meer (1993) mention that there also appears to be a tendency for subordinates not to

expect to partake in actual decision making as equal partners and to view this as prerogative of their senior managers, although they do expect to be consulted prior to decisions being made. Bjerke and Al-Meer also note that Arab traditions recognize status hierarchy, while Alshaya (2002) also studied power distance in education and concludes that Saudi school leaders are high in power distance, which confirms social distance between superiors and subordinates.

With regards high uncertainty avoidance, Al-Twaijry and Al-Muhaiza's (1996) study concluded that there are certain features that lead Saudi managers to be classified as risk avoiders, who therefore make their decisions at the highest level of management. Other studies which reinforce this view are those of Alshaya (2002) and Bjerke and Al-Meer (1993), who both conclude that the level of uncertainty avoidance amongst Saudi managers is high, which means that people tend to avoid conflict.

Tayeb (2005) notes that Arabs are highly collectivistic and will be extremely loyal to their in-group, which can go beyond the immediate family to include extended family, relatives and friends. Bjerke and Al-Meer (1993) comment on the high levels of collectivism amongst Saudi managers, as they seem to prefer a close-knit social framework not only in the organisational sphere but also in the institutional sphere. In general, older people usually hold the senior positions, and in exploring the way decisions are made regarding promotion and pay, Weir (2000) and Mellahi (2006) found that the degree of loyalty an employee has to his manager influences his promotion and pay more than his actual job performance.

Finally, Bjerke and Al-Meer (1993) found that in relation to Hofstede's dimensions, Saudi managers were on the feminine side, being relatively unambitious for achievement and financial reward. The absence of ambition for achievement and financial reward among employees in Saudi hospitals is unsurprising, since Saudi public organisations, according to the previous literature, are characterised by a high level of bureaucracy (Barakat, 1993; Bjerke and Al-Meer, 1993).

In summary, Hofstede's dimension of culture model has been employed widely to analyse culture dimension in different countries. The above studies confirm that the effect of national culture and its influence, which has a direct influence on the daily lives of individuals in these countries that why these studies have revealed different results from country to country. The use of this a model has been widely replicated in number of studies by a wide range of authors in different countries. To some extent these studies have revealed the same results however in certain cases distinct differences have been identified.

5.4 The impact of Hofstede's model on cross-cultural research

Although Hofstede's model has been subject to a certain amount of criticism since its conception, extensive research in a broad range of environments has served to validate the model (Trompenaars, 1994; Smith et al., 2002; Kirkman et al., 2006; Tang and Koveos, 2008). One of the greatest achievements of Hofstede's research is that it has been the inspiration for a multitude of studies investigating the dimensions of national cultures more closely through research on a larger scale involving several different countries. In 1987, Michael Bond planned a study at the Chinese University of Hong Kong with a group of other researchers to investigate the universality of Hofstede's dimensions. A questionnaire was created based on a set of values compiled by Chinese researchers which reflected an Eastern rather than Western origin in the values. Three of Hofstede's dimensions were replicated (power distance, individualism/collectivism, and masculinity/femininity), and a new one was found which was named 'Confucian Dynamism' which could be described as a short-term versus long-term orientation that reflected the long-term future-oriented perspective that many Asian Confucian cultures appear to adopt (Bond, 1988).

In a worldwide value survey spanning 40 countries, Schwartz (1994) tested 56 values. He used individual scores based on the basic values of students and elementary school teachers rather than country-based means to develop a total of distinct value types at an individual-level analysis. Schwartz's findings summarised his findings in two dimensions, i.e. openness to change/conservation, and self-

enhancement/self-transcendence. These are comparable to Hofstede's individualism/collectivism and masculinity/femininity dimensions. Schwartz named ten types of cultural values (benevolence, self-direction, universalism, security, conformity, achievement, hedonism, stimulation, tradition, and power), which he felt exist at the national level. Triandis (1995) divided the individualism/collectivism dimension into horizontal and vertical individualism due to the cultural focus. This division neglected the fact that the horizontal/vertical aspect was adequately covered in the Hofstede large/small power distance dimension. Trompenaars (1994) was interested in how cultural dimensions relate to business executives, and used a combination of behavioural and value patterns to classify culture. There are close similarities between some of Trompenaar's value orientations and Hofstede's dimensions, whereas others are seen from a very different angle. Two of Trompenaar's seven value dimensions bear resemblance to Hofstede's dimensions - in particular the individualism versus collectivism dimension and also power distance, though this is a weaker resemblance. Trompenaar's communitarianism/individualism value orientation and Hofstede's individualism/collectivism appear to be almost identical. Trompenaar's achievement/ascription value orientation is similar to Hofstede's power distance dimension and explains how positions are agreed upon.

In 2004 House directed the Global Leadership and Organisational Behaviour Effectiveness (GLOBE) project, which was a multi-phase, multi-method project for investors around the world to examine the links between organisational leadership, societal culture and organizational culture. The GLOBE project was a long-term series of cross-cultural leadership studies which 170 social scientists and management scholars from 61 cultures, representing all major regions of the world, participated in. Hofstede's work was a strong influence on House, and in his culture study nine cultural dimensions were defined. House's five societal culture dimensions and Hofstede's five societal culture dimensions are almost identical, but House added four more dimensions to Hofstede's original five dimensions. House

divided collectivisms into two types and added human orientation, performance orientation, and assertiveness as three additional categories.

5.5 Rationale for using Hofstede's model

Smith et al. (2002) and Tang and Koveos (2008), amongst others, concur in the view that Hofstede's model is much more significant than any other set of cultural dimensions and has been widely used in empirical research. Moreover, it has been used to a much greater extent than any other model by researchers working in a range of disciplines and fields, which, suggests Trompenaars (1994), has given it credibility. Kirkman et al. (2006) consider that Hofstede's framework is prominent in cross-cultural research because it is clear, cost-effective and helps managers to understand what is going on. Another salient fact is that Hofstede's study included the Arabic cluster (of which Saudi Arabia is a member), so his index can be used to validate the results of the present study in that setting.

5.6 Limitations of Hofstede's model

Notwithstanding its widespread acceptance, McSweeney (2002) is among a number of authors who have criticised Hofstede's model. He suggests not only that its characterisation of national levels of culture is reliant on unproven generalisations from an analysis of small populations at sub-national level, but also that it is not actually possible to prove that there is a uniform national culture within a nation. Hofstede's model has also been criticised by Rubery and Grimshaw (2003) because the aspect of subcultures is not taken into account and the fact that sets of values in different parts of a country are not necessarily the same and the variations are disregarded. One example of this is the UK where there are groups noticeably different in social class, gender and regional variations which results in different sets of behaviour. The tendency to generalise about national cultures has been a common criticism of Hofstede's model. Hofstede's study focused on workers within IBM. His idea was that if the organisational determinants of culture were constant, then nationality would be the explanation for any variations that were discovered.

However, Tayeb (1988) argued that when all the data comes from one company it is not reasonable to make generalisations about national cultures. Hofstede was actually studying the culture of executives of a multinational firm from different countries, which is not necessarily the same as the culture in general of executives in those countries. Further criticism by Kirkman et al. (2006) and Holden (2002) was that cultural changes over time have not been considered in Hofstede's model. Data compiled over 30 years ago may no longer be considered as valid as the values and practices throughout the world have changed in that time. Rubery and Grimshaw (2003) argue furthermore that Hofstede's model assumes that cultures are static and unchanging, though it is clear that as different communities and traditions are introduced into societies there is inevitable adaptation and change, thereby affecting the scores on each factor.

Hofstede's categories are not generally described as a 'typology' as his model only uses five basic headings which limits the means by which the complexities of culture can be characterised and classified. Even Hofstede recognised the limitations of his original 1980 four-dimensional model and added the fifth dimension in 1991, as a result of his 'Chinese Values Survey'. Hofstede's analysis has also been criticized as being Eurocentric, which, according to Triandis (1982), hinders understanding of the depth and extent of cultural differences. Triandis' argument is that Hofstede's priorities and the original four dimensions he identified are based on his own cultural values, and that different dimensions for distinguishing between national cultures might have been identified by a researcher from a different cultural background. In addition, he also considers the way in which Hofstede's dimensions have been constructed, and judges them to be restricted and only applicable to studying values in relation to work, which are not identical to national values. Hofstede's model has also been criticised by McSweeney (2002) in that the interaction between macroscopic and microscopic cultural levels and between the cultural and non-cultural factors are largely ignored. Rubery and Grimshaw (2003) also argue that Hofstede's model has its limitations as it is too simplistic; explanations of variations in culture do not take into account the complexity and

interaction between different factors; and it neither attempts to explain why national differences occur nor why apparently very dissimilar nations might appear to be similarly ranked. It was also suggested by Robinson (1983) that the dimensions are restricted in their capacity to measure culture. Westwood and Everett (1987) felt that power distance was not the best indicator of inequality. Chiang (2005) argues that despite the Hofstede framework contributing to the sphere of rewards both theoretically and practically, the suggestion that national culture is the only factor affecting human values fails to consider the possibility that a variety of other contextual factors can also influence human values.

A significant point to note is that the foundation of Hofstede's entire cultural framework was an underlying assumption that "culture is the collective programming of the human mind that distinguishes the numbers of one human group from those of other". According to Hoefstede, people are programmed mentally from early childhood and that education and socialisation reinforce their ideas, and that this mental programming remains fairly stable over time which essentially results in a person faced with similar situations demonstrating essentially the same type of behaviour. Jreisat (2003) argues that this perception of culture as the "collective mental programming of the people in any environment" is the basis of cultural determinism, which assumes that culture predisposes individuals to a certain set of behaviours, and that traits will remain stable over time despite any effects of growth or change due to other factors. Conversely, Linton (1945) suggested that individuals are able to learn in unfamiliar situations and can establish particular behaviour to cope in those situations.

Institutionalists such as Rubery and Grimshaw (2003) argue that culture may not be such an important factor. Rubery and Grimshaw emphasised that differences in HR practice between countries were more likely to be due to institutional forces than to any assumed national culture, and that the way employers deal with employment issues are influenced more by factors such as education and training systems, legal frameworks, and political, social and economic factors. Various other factors such

as the organisation, family values, support networks, provision of social services such as health care and the informal economy also have a role in shaping behaviour.

In summary, it is clear that Hofstede's proposed idea of culture and its impact is disputable. One of the most common critiques of Hofstede's work is that it identifies cultures based on the supposition that within each nation there is a uniform national culture. This is quite obvious in the 'Arab cluster' which includes different Arab counties such as Egypt, Lebanon, Libya, Kuwait, Iraq, Saudi Arabia and United Arab Republic. Therefore, a limitation of this framework of analysis is that while the model refers to the 'Arabic cluster', Arab cultures are not homogeneous but possess distinct differences among themselves (Baskerville, 2005). However, it is still useful as long as it has been validated for numerous studies relating to many disciplines. This model has therefore been used in this study while being fully cognisant of its theoretical shortcomings. Accordingly, the next section will aim to draw comparisons between published work in different national contexts where the CVF model has been used, to discover how such contexts influence the findings of the CVF.

5.7 Comparison between published work using the CVF instrument in different contexts

As discussed above, national culture has a strong influence on organisational culture because employees take their particular cultural characteristics with them wherever they go; the workplace is no exception. Therefore, it could be expected that national culture differences could lead to different results in the studies that have employed a CVF in different countries. However, the use of the CVF model as mentioned in Chapter Two is justified due to being validated via extensive research in a range of different environments. According to Cameron (2004), the CVF had been used in almost 10,000 organisations worldwide, including both private and public sector providers of education and health care. Goodman et al. (2001) and Scott et al. (2003a) confirm that the CVF has been empirically validated in a variety of settings. On the surface, at least, it appears that the framework has universal applicability.

However, the previous literature on different countries that focuses on the CVF in particular found different results that were dependent on the country in which the study was carried out. This is expected since the difference in cultural types of organisations of different country origins reflects the difference in value-orientations of an organisation's home culture. This section will start by reviewing the literature using the CVF in public organisations, followed by a review of the literature that focuses on health care organisations in line with the nature of this study.

5.8 Applying the CVF in public organisations

A significant instance of the use of the CVF is by Cameron and Quinn (1999), who scrutinised the way the CVF method has been utilised in public organisations. They found that when the cultural aspects of the CVF were looked at in isolation, using data from surveys of several organisations (mainly in the US), and public administration, organisations were noticeably stronger in the control quadrant and weaker in the other three quadrants. Parker and Bradley (2000) found that in Australia, public organisations favoured a traditional hierarchical model of public organisations, in spite of policies being implemented specifically for organisational change away from the traditional model. The CVF approach was used by Talbot (2008) to determine the pattern of reforms. He concluded that reforms in Ireland were focused more specifically in the 'control' quadrant than in the other three quadrants. In addition, there are in fact many national culture differences which led to different results in the CVF scores in different countries. With regard to this, one example focuses on Thailand as a developing country. The literature of Jingjit's (2008) which focused on the Thai civil service revealed different results from other studies carried out in western countries largely as a result of differences in national culture. Her research analysed organisational culture and outcomes based on the CVF. She found that civil servants perceived their organisational culture to be largely inclined towards hierarchy and clan models. In comparison, the scores for market and adhocracy cultures were noticeably lower, which demonstrates their limited presence and development within the public organisations that were investigated. However; she argues that hierarchy culture is dominant in Thai public

organisations and is highly structured through rigid chains of authorities, which resulted in multiple layers of red tape. These findings are not surprising since it is known that public organisations have a strong tendency towards a hieratical configuration. Interestingly, she found a much higher 'Collaborate' quadrant score, whilst the others remained similar to US results mentioned above by Cameron and Quinn (1999). This suggests that the strongly collaborative nature of Thai national culture, with its stress on 'harmony' from the Buddhist tradition, is reflected in its public administration culture. The limited presence of market culture can be attributed to the fact that there was an absence of clear goals, a general lack of systematic assessment of results as well as limited competition among co-workers. Finally, the limited presence of adhocracy culture could be attributed to the fact that the development of Thai public organisations was significantly restricted by the bureaucratic nature of public organisations. This can be attributed to a lack of emphasis on searching for innovative ideas and forward thinking. From all of the studies that have been reviewed, the conclusion that can be drawn is that public organisations in different cultural contexts can be described as hierarchy culture. This could be predicted as because they are under government control.

Lau and Ngo (1996) found contradictory results in their research comparing organisational cultures of private sector companies from different countries operating in a single country. In Hong Kong the CVF was used in a research comparing the influences of local Hong Kong Chinese, Mainland Chinese, American, and British cultures on companies within Hong Kong. They found distinct differences, and were able to generalise that American companies were more developmental and rational, British companies were more hierarchal, mainland Chinese companies were group-oriented and local Hong Kong Chinese companies were developmental. The discriminating power of the CVF illustrated different cultural emphases among firms of different country origins within Hong Kong. Differences in value-orientations of the company's home country's culture are reflected in the variations in cultural types of companies originating in different countries. For example, in Hong Kong, uncertainty avoidance is low according to

Hofstede's (2001) model which suggests that managers in Hong Kong are more willing to take risks, which fits with the developmental culture which features flexibility and change. Group culture was predominant in mainland Chinese companies, which fits in with general perceptions about Chinese enterprises typically focusing on relationships between people, with a focus on the family as well as team spirit. Group culture also prevails in local Chinese companies, where management is essentially driven by traditional Chinese cultural values. British companies tend to be hierarchical and have a reputation for being often more bureaucratic than in other countries. Smith (1992) noted that British companies are more formalised than those in Hong Kong. Research carried out by Lau and Ngo (1996) affirmed that American companies were typified by developmental and rational culture. According to Hofstede's study, American companies demonstrated low levels of uncertainty avoidance, accompanied by high levels of both individualism and masculinity, which implies that American companies are more innovative, orientated towards growth, and value personal achievement. This is consistent with the findings of Lau and Ngo's study which have established a high degree of diversity among the firms of different cultures. The findings of Lau and Ngo's study also show that in some cases the behavioural characteristics, such as hierarchy culture, are particularly alike in both the public and the private sector, as is the case in the UK private and public sector.

National culture can have a strong influence on organisational culture as Oney-Yazici et al. (2007) found in their research examining organisations in the construction sector. They discovered that the hierarchy and clan cultures are dominant in Turkish firms. They argue that this finding helps to clarify the links between national and organisational cultures. Following Hofstede's (2001) model of national culture, Turkey is high on the collectivism and power distance value dimensions which suggests that organisational cultures in Turkish companies are characterised by a combination of unequal (or hierarchical) and harmonious, family-like (clan) relationships. Dastmalchian et al. (2000) conducted a similar study on thirty-nine Canadian and forty South Korean organisations from six different

industries. The main difference they discovered was that Korean companies display a greater tendency towards hierarchy culture than Canadian companies as it appeared in the CVF. The results of this study concur with the findings of Hofstede (1980) which compared power distances between the two cultures, with Korean culture showing higher power distance compared with the lower power distance in Canadian culture.

It has become evident from the studies listed above which have employed the CVF in different contexts that different types of organisational culture match their own national culture. For example, it is not surprising to find that Turkish firms and Thai public organisations are dominated by a combination of hierarchy and clan culture. These two countries are characterised in Hofstede' model as high power distance and collectivism. Moreover, the dominance of hierarchy culture in public organisation mentioned in the above studies was anticipated since these organisations are essentially controlled by governments. This trend also indicates the organisations' "obsession with control" which Mintzberg (1983) proposed as one of the foundational characteristics of public organisations. It is worth noting here that although some of these studies focus on the private sector, to some extent they revealed the same type of organisational culture in public organisation. For example, Dastmalchian et al. (2000) described Korean firms as hierarchy culture; Lau and Ngo (1996) characterised British firms to be more hierarchal and Oney-Yazici et al. (2007) found that hierarchy and clan culture is dominant in Turkish firms. In summary, the differences in the types of organisational culture were reflected in the differences in the national culture of the countries.

5.9 Applying the CVF in health care organisations

It can be assumed that there will be differences in the organisational culture between the public and health care organisations because the latter includes personnel who are highly educated, exercising strong influence and authority with respect to their own work, where there is an emphasis on standardisation of skills, directed to the standardised delivery of services to patients, making it unlike other public

organisations to some extent. However, this section will discuss findings from studies which employed the CVF in health organisations in order to establish a more specific comparison between the findings of these studies and the findings of the study in Chapter Eight.

Due to the shortage of literature on studies using the CVF in health organisations, this study will focus on studies employing the CVF in health care organisations in the UK and US. In the most prominent previous research into organisational culture in health organisations across the US, the UK, and Canada by Gerowitz et al. (1996), it is suggested that in the UK the NHS as a whole is typified by a greater proportion of dominant clan and hierarchical cultures as opposed to the open or rational cultures which were found in the US. This could be attributed to the difference in the environments of these two countries. The environment of the NHS could be considered to be relatively high in terms of resources scarcity and low in its information and competitive complexity, while in the US this is vice-versa. However, in the NHS, the expectation would be for employee loyalty and commitment to be more prominent with higher performance levels, but to demonstrate lower performance levels with respect to external stakeholder satisfaction, resource acquisition, competitiveness and internal consistency. However, some research found that in the NHS the clan culture is dominant. Marshall et al. (2003) performed research using CVF in six Primary Care Trusts (PCTs) in England as a qualitative case study. A set of common values were identified which they perceived to be evident in the constituent practices in their PCTs, and according to the CVF those values are clan-type culture characteristics. It was suggested by some of the participants that these values were beneficial both to patients and to the NHS. More recently, Davies et al. (2007) used CVF in English NHS acute hospital trusts and concluded that there were significant scores for all of the cultural types, and that these varied in dominance with over half the trusts being identified as the clan culture type and the hierarchical culture was typically the least dominant.

The American health system differs considerably from that of the UK. Jones et al. (1997) found that the dominant culture was adhocracy, whereas the least dominant culture was hierarchy when they applied the CVF in a 500-bed non-profit hospital in the US. Similarly, Helfrich et al.'s (2007) study, in which health services are mentioned, used the CVF with significant indicators of healthcare processes and outcomes. In their study, cross-sectional data was analysed from a work environment survey which had been carried out in the Veterans Health administration in the US. It was found that the entrepreneurial, team and rational subscales varied with the hierarchical subscale. In alternative research by Zazzali et al. (2007) an organisational sample was used that consisted of 52 medical groups associated with the integrated delivery system in a US hospital. It was found that the group culture scale was generally rated the highest, then the rational, the hierarchical, and the developmental was lowest. Therefore in the sample of the "average" physician organisation, firstly there was a higher emphasis on participation, corresponding with the group culture scale, and also a moderate emphasis on productivity/efficiency corresponding with the rational culture scale, and finally a lower emphasis on rules and risk taking which corresponds with the hierarchical and developmental culture scales.

Dominant organisational culture types are subject to variation in western countries as has been borne out by the findings of the studies above. However, clan culture seems to be dominant in both countries in their health care organisations. This is expected because within health organisations there is a strong subculture representing the provisional group employees such as physician, nurse etc. This represents clan culture (group culture). Deal et al. (1983) argue that as in many organisations, hospital cultures are made up of subcultures such as nursing units, professional groups and functional or project groups. However, unlike non-medical organisations, hospitals in particular have been described as having cultures that are weak or fragmented (Nystrom, 1993). This may be related to the number of stable and strong subcultures within hospitals (Bice, 1984), which are often labelled as work group cultures (Coeling and Simms, 1993). With regard to the dominance of

hierarchy culture in UK hospitals it should be expected since the NHS is a public organisation under the control and supervision of the government (Day and Klein, 1987). The dominance of adhocracy and market culture in US hospitals is predominantly due to the fact that the US health care system is heavily reliant on private health insurance. Adhocracy and market cultures reflect the major principle of private organisation. Bradley and Parker (2006) mentioned that private organisations relate more to external rather than internal orientation which reflects the market and adhocracy in the CVF. To some extent, the studies above reflect the same characteristics that were found in public organisations as mentioned earlier. For example hospital management teams in the UK tended to be clan and hierarchy cultures.

It is important to note that the majority of these health management studies which adopted the CVF assessed the organisational culture in western countries. As a result, it was not possible to draw comparisons between these studies and similar studies that have been conducted in developing countries due to the shortage of research data from developing countries. On the other hand it is a good opportunity for this research to offer a methodological contribution through applying the CVF in the context of health organisations outside the western context.

5.10 Conclusion

The findings of the above studies that were conducted in different countries through the application of the CVF revealed different results which were not surprising since these types of culture were influenced by the national culture of the countries on which these studies were carried out. For example, the dominance of hierarchy in the UK was supported by political accountability when individuals who delegated authority became answerable for their actions to the people (Day and Klein, 1987). This is also supported by financial control according to Rhodes (1998). Moreover, the dominance of market and adhocracy cultures in US hospitals are supported by a private sector who provide the health services through medical insurance companies

- therefore they are in competition to attract patients with new and unique things (Feldstein, 2002).

Regarding the effect of social culture, it is more obvious in developing countries such the Thai and Turkish studies. Both countries have been described by Hofstede's model as being the collective and high in power distance. These characteristics are reflected in their public administration culture which is dominated by hierarchy and clan culture. Moreover, Lau and Ngo's (1996) study clearly identified the influence of national culture on organisational culture when they compared western and Chinese firms. The authors concluded that group culture was predominant in Chinese firms. This finding is in line with the conventional perceptions about Chinese enterprises which emphasise human relationships, a strong 'family' orientation, and team spirit. This can also be described as group culture. In addition, Jingjit (2008) found that the strongly collaborative nature of Thai national culture, with its emphasis on 'harmony' from the Buddhist tradition, is reflected in its public administration culture. In contrast, the US, for example is characterised by a low level of both power distance and uncertainty avoidance and high levels of individualism and masculinity. This implies that American companies tend to be characterised by a higher frequency of dominant adhocracy and market cultures rather than clan and hierarchical cultures; however the context of Saudi Arabia is different again.

The political system in Saudi Arabia is a monarchy in which Islam underlies the civil, cultural, economic, legal, political and social fabric of the country and in which the King rules through a Council of Ministers. Moreover, the culture in Saudi Arabia can be best described as collectivistic, where family and friendships remain important and influential in the functioning of institutions and where loyalty to the family and tribe is very strong. Saudi managers reportedly scored highly on power distance, suggesting a social distance between superiors and subordinates, and tend to be risk avoiders, making decisions at the highest level of management in order to avoid conflict (Al-Awaji, 1971; Jabbra and Dwivedi, 2004; Jabbra and Jabbra, 2005;

Al-Yahya, 2009; Common, 2008). Within these characteristics of the Saudi national culture this study will employ a CVF for the first time in this particular context.

The CVF was developed and has been used in western countries, which have very different organisational cultures from that of Saudi Arabia. Despite the criticism of Hofstede's system of analysis, it is still clear that national culture shapes organisational behaviour in a variety of ways. The result is that organisations differ between countries in terms of their organisational profiles and how people relate to each other within them while allowing for dominant professional or corporate cultures (Schneider and Barsoux 2003). Thus, as the literature attests, there are important differences between countries where the CVF has been applied to both the public and health care sectors.

Therefore, it is expected that the characteristics of Saudi national culture will be reflected in the finding of the CVF regarding the type of organisational culture within the Saudi health care provision. This means that we anticipate that the dominance of hierarchy and clan cultures within these organisations will be supported by the above characteristics.

The next two chapters will focus on analysing the quantitative findings of the OCAI, based on the theoretical CVF model in Chapter Six in addition to analysing the qualitative findings of the semi-structured interviews based on the CVF in Chapter Seven. This will be done to determine which types of organisational cultures are dominant in the Saudi health care provision in both the current and preferred situations.

CHAPTER 6 ANALYSIS OF QUANTITATIVE DATA

6.1 Introduction

The analysis of the influence of Saudi national culture (macro-culture) on Saudi health care provision (micro-culture) reveals that the nature of the environment has shaped the management style of Saudi health provision, which can be characterised as having a high power distance, collectivist and feminine culture with high uncertainty avoidance. Therefore, it is very important to know the nature of these elements in order to assess the organisational culture of Saudi health provision, which is the main objective of this chapter.

This chapter presents the quantitative research results and an analysis of this data in order to answer research question two, regarding the types of organisational culture currently dominant in Saudi health care provision, research question three, about the type of organisational culture preferred to support efforts to improve health care services, and research question four, about the relationship between health service employees' personal characteristics and their judgments of organisational cultures in health care provision in Saudi Arabia as expressed in their responses to the CVF questionnaire. The data were collected using a questionnaire based on The data were collected using a questionnaire based on the CVF, then coded to enable them to be processed by means of the Statistical Package for Social Sciences (SPSS) software package. The results, beginning with participants' demographic data, were as follows.

6.2 Demographic data

The distribution of the study sample according to relevant demographic variables was as follows.

6.2.1 Hospital affiliation

Table 9 and Figure 4 show that the provider represented by most respondents in the study sample was the Ministry of Health, which employed 26.7% of the total study population, followed by the category of private sector hospitals (15.1%), the RAFH (14.6%), the King Faisal Specialist Hospital and Research Centre (13.8%), the King Abdulaziz Medical City for the National Guard (13.5%), the King Khaled University Hospital (8.1%) and the Security Forces Hospital (also 8.1%).

Table 9: Distribution of study sample by hospital affiliation

Hospital	**Number (frequency)**	**Percentage of sample**
King Abdulaziz Medical City for National Guard	57	13.5%
King Faisal Specialist Hospital and Research Centre	58	13.8%
Riyadh Armed Forces Hospital	61	14.6%
Riyadh Medical Complex, King Fahad Medical City (MOH)	112	26.7%
King Khaled University Hospital	34	8.1%
Security Forces Hospital	34	8.1%
Dallah Hospital Al Hammadi Hospital Saudi German Hospital Riyadh	63	15.1%
Total	419	100%

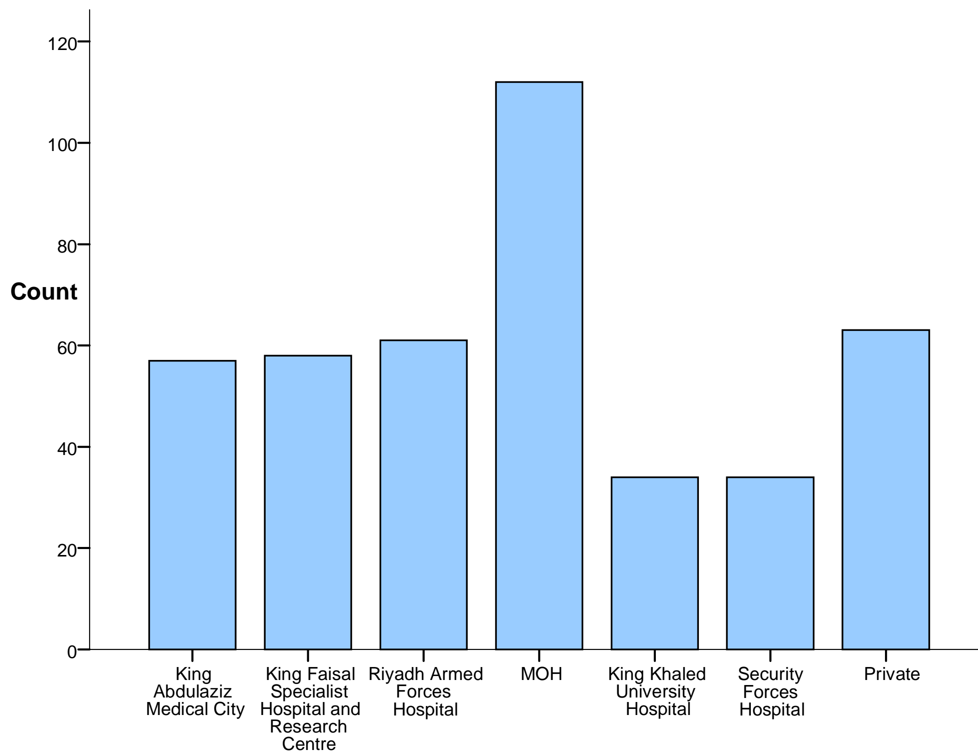

Figure 4: **Distribution of study sample by hospital affiliation**

6.2.2 Gender

Table 10 and Figure 5 show that of those responding to the question regarding gender, 60% were male and 40% female.

Table 10: Distribution of sample study by gender

Gender	**Number (frequency)**	**Percentage of sample**
Male	243	60.0%
Female	162	40. %
Total	405*	100%

*Note that the total was not 419 because 14 respondents did not answer this question.

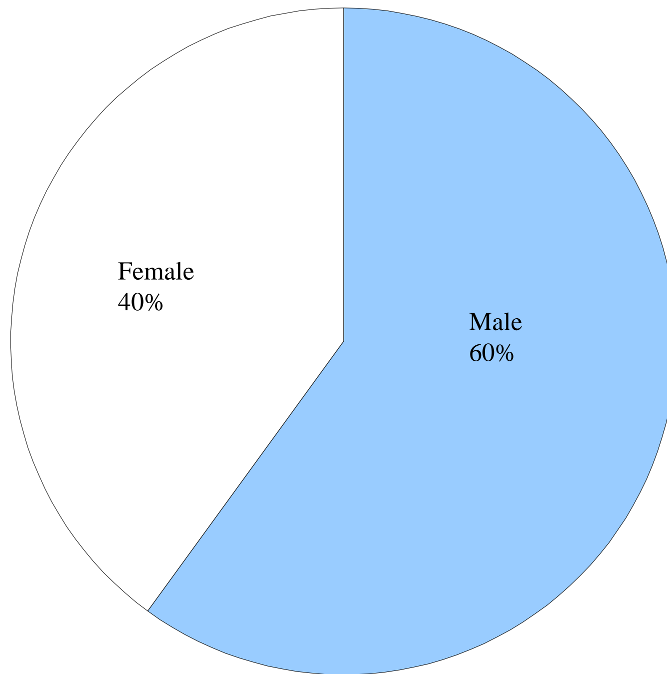

Figure 5: Distribution of study sample by gender

6.2.3 Age

Table 11 and Figure 6 show that the age group represented by most respondents in the study sample was 31–40 years, which represented 39.2% of the total study population, followed by 30 years or less (34.8%) and 41 years or more (26.0%).

Table 11: Distribution of sample study by age groups

Age groups	Number (frequency)	Percentage of sample
30 years or less	143	34.8%
31–40 years	161	39.2%
41 years or more	107	26.0%
Total	411	100%

*Note that the total was not 419 because 8 respondents did not answer this question.

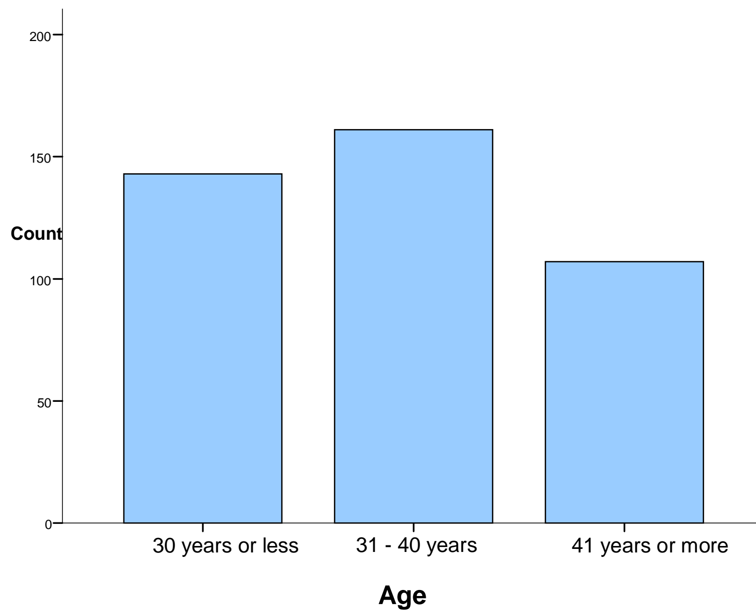

Figure 6: Distribution of study sample by age groups

6.2.4 Nationality

Table 12 and Figure 7 show that of those responding to the question regarding nationality, 57.6% were Saudis and 42.4% non-Saudis.

Table 12: Distribution of sample study by nationality

Nationality	Number (frequency)	Percentage of sample
Saudis	239	57.6%
Non Saudis	176	42.4%
Total	415	100%

*Note that the total was not 419 because 4 respondents did not answer this question.

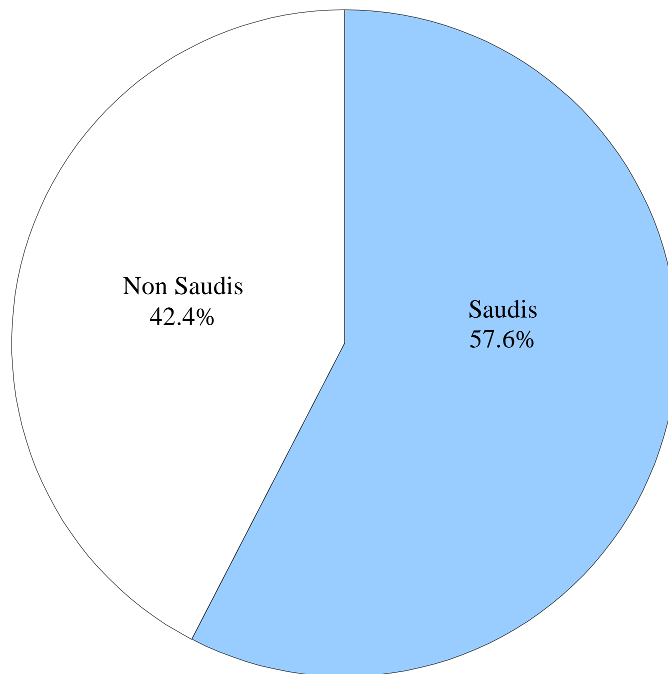

Figure 7: Distribution of study sample by nationality

6.2.5 Educational level

Table 13 and Figure 8 show that the level of education attained by most respondents in the study sample was that of the bachelor degree, held by 53.4% of the total study population, followed by diploma (22.9%), PhD (10.2%), master (8.5%) and high school (5.0%).

Table 13: Distribution of sample study by educational level

Educational level	Number (frequency)	Percentage of sample
High school	20	5.0%
Diploma	92	22.9%
Bachelor	214	53.4%
Master	34	8.5%
PhD	41	10.2%
Total	401	100%

*Note that the total was not 419 because 18 respondents did not answer this question.

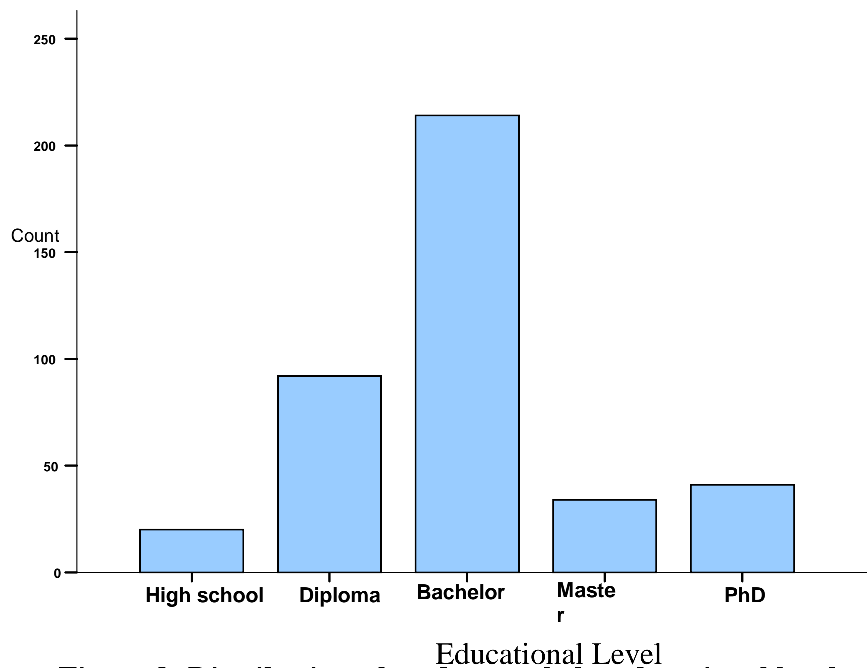

Figure 8: Distribution of study sample by educational level

6.2.6 Professional groups

Table 14 and Figure 9 show that the professional groups represented by most respondents in the study sample was administrative, which represented 31% of the total study population, followed by nurses (30.3%), technicians (22.7%) and physicians (16%).

Table 14: Distribution of study sample by professional groups

Professional groups	Number (frequency)	Percentage of sample
Physicians	67	16.0%
Nurses	127	30.3%
Technicians	95	22.7%
Administrative	130	31.0%
Total	419	100.0%

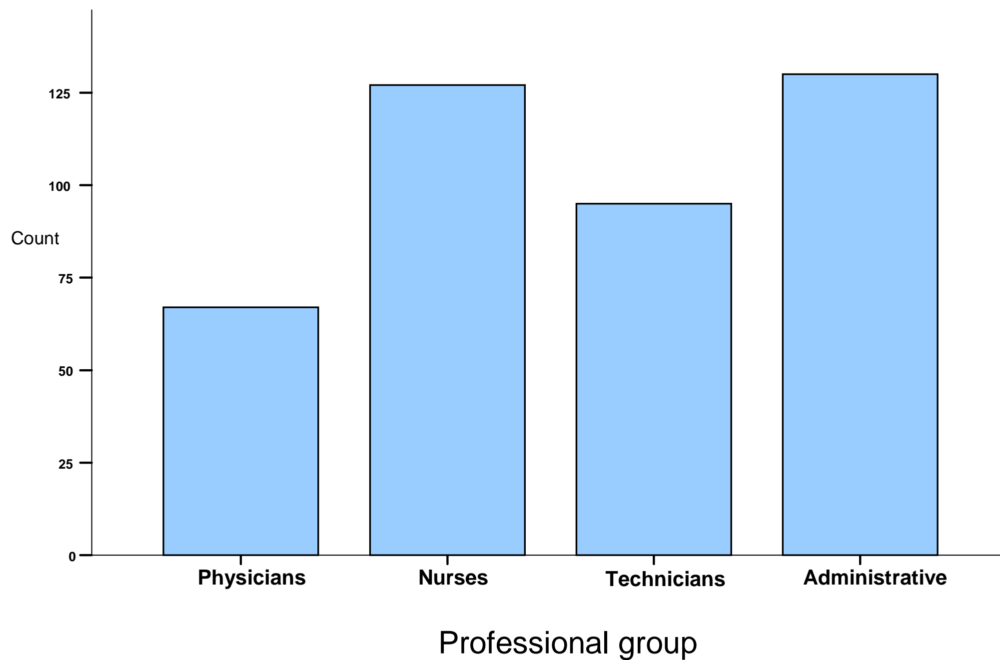

Figure 9: Distribution of study sample by professional groups

6.2.7 Work experience in current position

Table 15 and Figure 10 show that the work experience in their current position of most respondents in the study sample was 5 years or less, which represented 53.8% of the total study population, followed by 6–10 years (23.1%), 11–20 years (17.6%) and 21 years or more (6.5%).

Table 15: Distribution of study sample by work experience in current position

Work experience in current position	Number (frequency)	Percentage of sample
5 years or less	219	53.8%
6 –10 years	96	23.1%
11–20 years	73	17.6%
21 years or more	27	6.5%
Total	415	100.0%

*Note that the total was not 419 because 4 respondents did not answer this question.

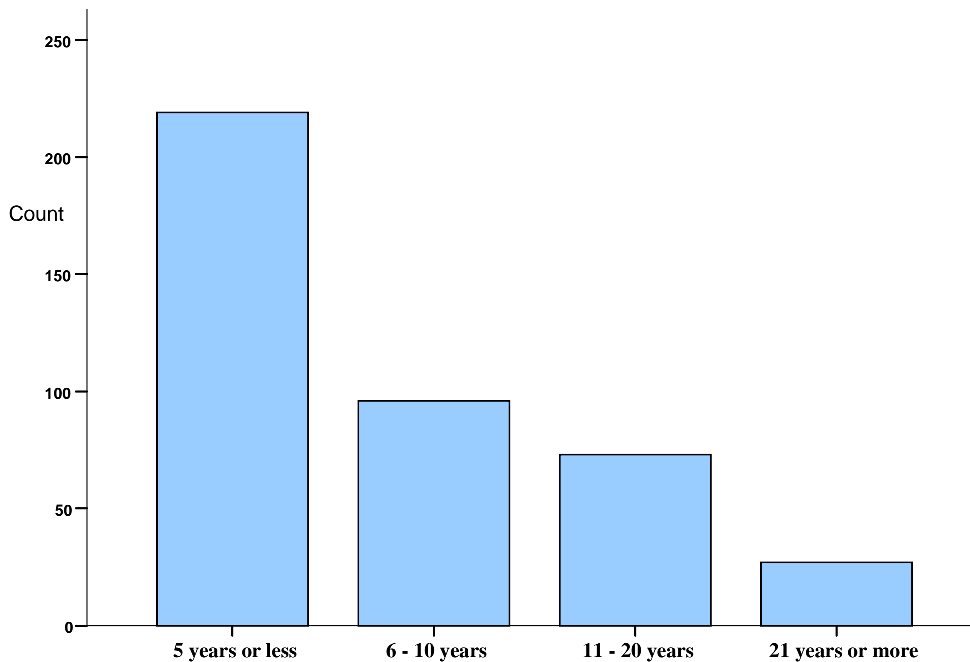

Figure 10: Distribution of study sample by work experience in current position

6.2.8 Monthly income

Table 16 and Figure 11 show that the monthly income of most respondents in the study sample was less than 5000 Saudi riyals, this group representing 32.4% of the total study population, followed by those earning 5000–9999 riyals (28.8), 10000–14999 riyals (20.0%), 20000 and above (9.5%) and 15000–19999 riyals (9.3%).

Table 16: Distribution of study sample by monthly income

Monthly income (Saudi riyals)	**Number (frequency)**	**Percentage of sample**
Less than 5000	133	32.4%
5000–9999	118	28.8%
10000–14999	82	20.0%
15000–19999	38	9.3%
20000 and above	39	9.5%
Total	410	100.0%

*Note that the total was not 419 because 9 respondents did not answer this question.

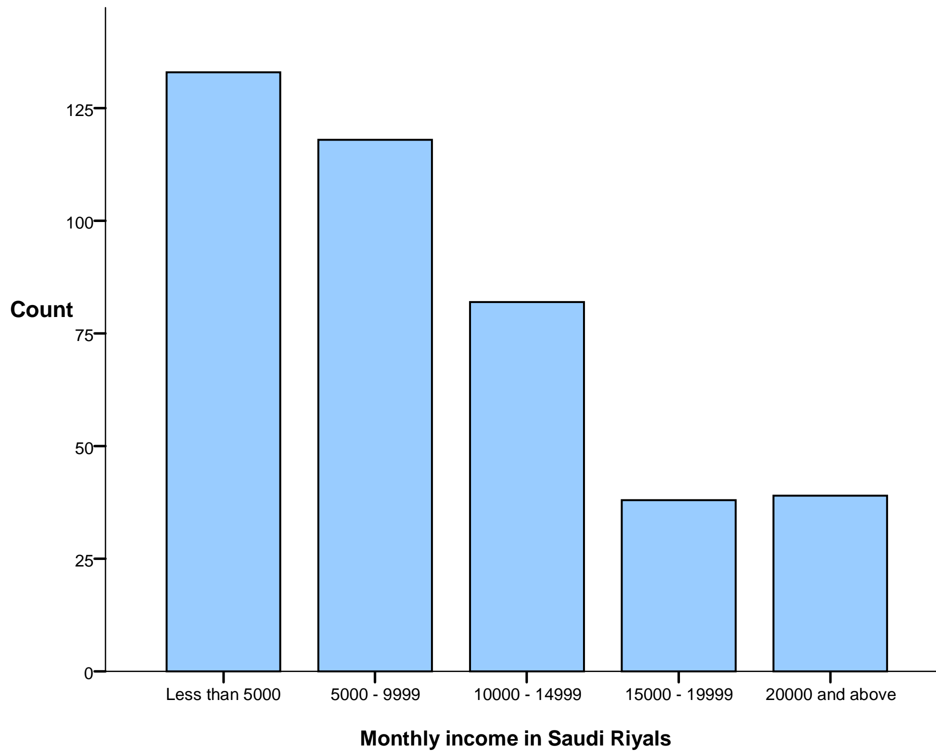

Figure 11: Distribution of study sample by monthly income

The above tables and figures illustrate the distribution of the study sample according to demographic data, which is consistent with figures shown in the previous chapters. For example, most respondents were employed by the MOH, which is consistent with the fact that MOH employees are predominantly from hospitals in Riyadh city. Moreover, there were more Saudi than non-Saudi employees, while administrative employees represented the largest proportion of professional groups in these hospitals.

6.3 Applying the CVF to answer research question two

The second research question seeks to identify the current dominant types of organisational culture in health care provision in Saudi Arabia. It can be considered as comprising six sub-questions, one corresponding to each of the dimensions of organisational culture investigated by the OCAI: dominant characteristics, organisational leadership, management of employees, organisation glue, strategic emphasis and criteria of success. These sub-questions are set out and addressed in subsection 6.3.2.

The study used an ordinal scale, the Likert scale, which is a technique for measuring attitudes whose key feature is that respondents are asked to rate the extent of their agreement or disagreement with a set of statements about the attitude object (Hewstone and Stroebe, 2001). The researcher used the following set of statistical techniques from SPSS to analyse the questionnaire responses.

- Recurrences and percentages were used to analyse the data regarding each of the individual dimensions that comprise the organisational culture.
- Means were used to discover how high or low the respondents' views were on each dimension, and it was decided that it would be useful to arrange the words in terms of the degree of response as a higher arithmetic mean.
- Standard deviation was used to identify the extent of deviation of the views of participants on each dimension.
- The chi-square test was used to verify the existence of significant differences among participants in the degree of agreement (strongly disagree, disagree, neutral, agree, strongly agree) regarding each type of organisational culture under each dimension.
- The one-sample t-test was used to identify whether the average degree of agreement for the overall dimensions in the whole target population was more or less than a certain value.

- The related-samples sign test was used to verify the existence of statistically significant differences between the four types of organisational culture under each dimension of organisational culture separately.
- A paired-samples t-test was used to identify significant differences between all types of organisational culture for the overall dimensions of organisational culture in general.

Sections 6.3.1 and 6.3.2 present the results relevant to answering research question two, with appropriate analysis and interpretation.

6.3.1 Main question

The main question to be discussed is as follows: What are the currently dominant types of organisational culture in health care provision in Saudi Arabia (that is, the types of organisational culture in the current situation for the overall dimensions)?

For this question, the study used the one-sample t-test to assess whether the average degree of agreement to the overall dimensions in the whole target population was more or less than a certain value. Therefore, this study created the following hypotheses for the overall dimensions to determine the prevailing types of organisational culture within the field of health care provision in Saudi Arabia.

All types of organisational culture that currently feature in the hospitals in Riyadh city are prevalent, either with reference to each dimension or overall. This means that the average degree of agreement is statistically significant with values higher than 3. This statistical hypothesis is presented in two forms:

Null hypothesis, Ho: $\mu \leq (3)$ not prevalent.

Alternative hypothesis, H1: $\mu > (3)$ prevalent.

If the result of the t-test of the difference between the sample average degree of agreement and the value of 3 is positive and the value of the significance level (here, Sig. 1-tailed) is calculated to be less than the statistical significance level that the

researcher specified in advance (here, α = 0.05), then the null hypothesis is rejected and therefore the alternative hypothesis that μ is more than 3 is accepted, meaning that it is agreed that the types of organisational culture now prevailing in hospitals in Riyadh city for the overall dimensions are more prevalent. If μ is equal to or less than 3, the types of organisational culture now prevailing in hospitals in Riyadh city for the overall dimensions are not strongly prevalent.

Table 17: One-tailed t-test results by current type of organisational culture

Current type of organisational culture	Mean	Standard deviation	One-tailed t-test	
			T-test of the difference between the average and value of 3	Sig. 1-tailed
Clan	3.2800	.86626	6.617	*0.000
Adhocracy	3.2468	.78466	6.439	*0.000
Market	3.3005	.81962	7.505	*0.000
Hierarchy	3.3996	.82884	9.870	*0.000

*D. statistically at the level of significance (0.05)

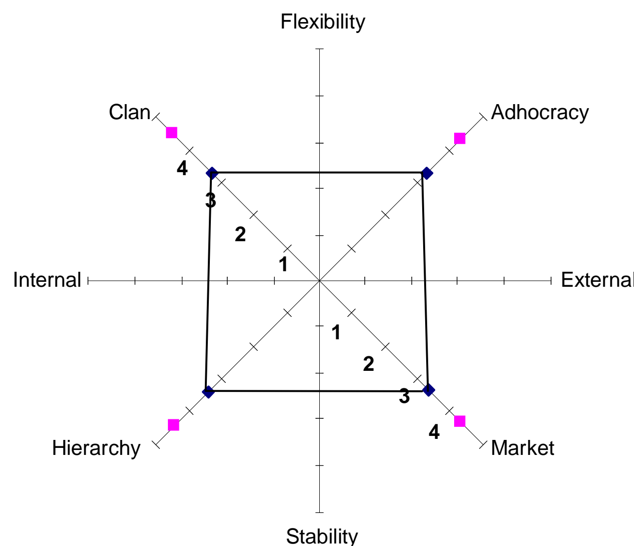

Figure 12: Overall cultural profile at present in Saudi health care provision

As illustrated in Table 17 and Figure 12, based on the result of the t-test of the difference between the sample average degree of agreement and the value of 3, and on the value of the significance level (Sig. 1-tailed), the clan, adhocracy, market and hierarchy cultures all received high scores, but hierarchy was more prevalent than the others.

The study also used the chi-square test to verify the existence of significant differences between response items at the significance level of α = 0.05.

Table 18: Dominant types of organisational culture in the current situation and chi-square result

Types of organisational culture		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	188	409	714	897	299
Adhocracy	F	186	408	762	906	248
Market	F	162	397	740	931	276
Hierarchy	F	180	326	670	966	359

* Chi-square = 46.7659
* P = 0.000

This indicates that there were significant differences among participants in the degree of response agreement (strongly disagree, disagree, neutral, agree, strongly agree) regarding the current situation of each type of organisational culture under the overall dimensions.

A paired-sample t-test was also conducted to identify any significant differences between all types of organisational cultures for the overall dimensions in the current situation and to determine which of these types was more prevalent than the others.

Table 19: Paired-sample t-test result for the differences between types of organisational culture

Types of organisational culture	Mean difference between the two types of culture	Paired-samples t-test		Test result
		T-test of the difference	Sig. 2-tailed	
Clan and adhocracy	.033	1.397	.163	C = A
Clan and market	-.020	-.801	.424	C = M
Clan and hierarchy	-.119	-5.22	*0.00	C < H
Adhocracy and market	-.053	-2.59	*0.010	A < M
Adhocracy and hierarchy	-.152	-6.40	*0.000	A < H
Market and hierarchy	-.099	-4.17	*0.000	M < H

*D. significant at the 0.05 level

As illustrated in Table 19, the paired-sample t-test revealed a statistically significant difference between the four types of organisational culture, except between clan and

adhocracy cultures and between clan and market cultures at the significance level of $\alpha = 0.05$. Accordingly, from the result of the tests and Figure 12 above, it is possible to identify a slightly stronger prevalence of a hierarchy culture, whereas the least prevalent was adhocracy.

6.3.2 Sub-questions

As noted in the introduction to this section, sub-questions were generated concerning the dominant types of organisational culture under each of its dimensions. For each sub-question, the chi-square test was used to verify the existence of significant differences among response items at the significance level of $\alpha = 0.05$. The study also used the related-samples sign test to verify the existence of significant differences between the four types of organisational culture under each dimension separately in the current situation.

6.3.2.1 Dominant characteristics

The first sub-question was: What are the current dominant types of organisational culture, in terms of dominant characteristics, in health care provision in Saudi Arabia?

Table 20: Dominant types of organisational culture in the current situation in terms of dominant characteristics, and result of the chi-square test

Types of organisational culture		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	25	76	112	159	44
Adhocracy	F	39	92	120	128	38
Market	F	34	68	98	168	50
Hierarchy	F	33	58	95	160	71
Total		32.75	73.5	106.25	153.75	50.75

* Chi-square = 33.67; * P = 0.0008

The results in Table 20 indicate significant differences among the participants in the degree of response agreement regarding the current situation of each type of organisational culture under this dimension (dominant characteristics).

Table 21: Means and standard deviations in terms of dominant characteristics

Types of organisational culture in the current situation	Mean	Standard deviation
Clan	3.2909	1.07076
Adhocracy	3.0815	1.2364
Market	3.3158	1.12771
Hierarchy	3.4269	1.15818

Table 22: Related-samples sign test results of differences among the four types of organisational culture under the dimension of dominant characteristics

Current types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-3.81	*0.000	C > A
Clan and market	-.319	0.750	C = M
Clan and hierarchy	-1.73	0.083	C = H
Adhocracy and market	-4.17	*0.000	A < M
Adhocracy and hierarchy	-4.95	*0.000	A < H
Market and hierarchy	-2.25	*0.024	M < H

* D. significant at the 0.05 level

As illustrated in Table 22, the related-samples sign test revealed a statistically significant difference between the four types of organisational culture, except between clan and market cultures and between clan and hierarchy cultures at the significance level of $\alpha = 0.05$. The test results column indicates a slightly stronger prevalence of a hierarchy culture, whereas the least prevalent was adhocracy

6.3.2.2 Organisational leadership

The second sub-question was: What are the current dominant types of organisational culture, in terms of organisational leadership, in health care provision in Saudi Arabia?

Table 23: Dominant types of organisational culture in the current situation in terms of organisational leadership, and result of the chi-square test

Types of organisational culture in terms of organisational leadership		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan culture	F	24	68	114	160	53
Adhocracy culture	F	40	63	137	139	39
Market culture	F	32	62	116	148	60
Hierarchy culture	F	32	59	98	160	66
Total		32	63	116.25	151.75	54.5

* Chi-Square = 20.76
* P. = 0.054

Table 23 indicates no significant differences among participants in the degree of response agreement regarding the current situation of each type of organisational culture under the dimension of organisational leadership.

Table 24: Means and standard deviations in terms of organisational leadership

Types of organisational culture in the current situation	Mean	Standard deviation
Clan culture	3.3580	1.07416
Adhocracy culture	3.1770	1.10036
Market culture	3.3397	1.12712
Hierarchy culture	3.4072	1.14438

Table 25: Related-samples sign test result of the difference between the four types of organisational culture for the organisational leadership dimension

Types of organisational culture in the current situation	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-4.31	*0.000	C > A
Clan and market	-.88	0.378	C = M
Clan and hierarchy	-.92	0.356	C = H
Adhocracy and market	-3.90	*0.000	A < M
Adhocracy and hierarchy	-4.66	*0.000	A < H
Market and hierarchy	-.74	0.455	M = H

* D. significant at the 0.05 level

As illustrated in Table 25, the related-samples sign test revealed a statistically significant difference between the four types of organisational culture, except between the clan and market, clan and hierarchy, and market and hierarchy cultures, at a significance level of $\alpha = 0.05$. The test results column indicates that the least prevalent culture was adhocracy.

6.3.2.3 Management of employees

The third sub-question was: What are the current dominant types of organisational culture, in terms of management of employees, in health care provision in Saudi Arabia?

Table 26: Dominant types of organisational culture in the current situation on the management of employees dimension, and result of the chi-square test

Types of organisational culture		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan culture	F	39	75	98	152	55
Adhocracy culture	F	27	83	150	129	30
Market culture	F	25	77	137	146	30
Hierarchy culture	F	39	70	126	141	43
Total		32.5	76.25	127.75	142	39.5

* Chi-Square = 30.816
* P. = 0.002

Table 26 indicates significant differences among participants in the degree of response agreement regarding the current situation of each type of organisational culture under this dimension (management of employees).

Table 27: Means and standard deviations in terms of management of employees

Types of organisational culture in the current situation	Mean	Standard deviation
Clan culture	3.2601	1.17250
Adhocracy culture	3.1241	1.01843
Market culture	3.1904	1.01672
Hierarchy culture	3.1885	1.11975

Table 28: Related-samples sign test results for differences between types of organisational culture under the management of employees dimension

Types of organisational culture in the current situation	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-3.21	*0.001	C > A
Clan and market	-1.67	0.095	C = M
Clan and hierarchy	-1.95	0.050	C = H
Adhocracy and market	-1.70	0.087	A = M
Adhocracy and hierarchy	-1.82	0.068	A = H
Market and hierarchy	.000	1.000	M = H

* D. significant at the 0.05 level

The related-samples sign test results, shown in Table 28, revealed a statistically significant difference between the types of organisational culture, except between clan and adhocracy, at the significance level of α = 0.05. From the test results column, it is possible to identify a slightly stronger prevalence for clan culture, whereas the least prevalent was adhocracy.

6.3.2.4 Organisation glue

The fourth sub-question was: What are the current dominant types of organisational culture, in terms of organisation glue, in health care provision in Saudi Arabia?

Table 29: Dominant types of organisational culture in the current situation in terms of dimension of organisation glue, and result of the chi-square test

Types of organisational culture in term of organisation glue		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	31	53	143	141	50
Adhocracy	F	27	63	129	170	29
Market	F	25	82	131	145	34
Hierarchy	F	23	48	104	180	60
Total		26.5	61.5	126.75	159	43.25

* Chi-Square = 39.733
* P. = 0.0001

The results shown in Table 29 indicate significant differences among participants in degree of response agreement regarding the current situation of each type of organisational culture under this dimension (organisation glue).

Table 30: Means and standard deviations in terms of organisation glue

Types of organisational culture in the current situation	Mean	Standard deviation
Clan	3.3014	1.07290
Adhocracy	3.2656	1.01254
Market	3.1942	1.03690
Hierarchy	3.4964	1.05151

Table 31: Related-samples sign test result of the difference between the four types of organisational culture under dimension of organisation glue

Types of organisational culture in the current situation	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-.653	0.514	C = A
Clan and market	-1.82	0.067	C = M
Clan and hierarchy	-3.21	* 0.001	C < H
Adhocracy and market	-1.87	0.061	A = M
Adhocracy and hierarchy	-4.76	*0.000	A < H
Market and hierarchy	-5.59	*0.000	M < H

* D. significant at the 0.05 level

As illustrated in Table 31, the related-samples sign test revealed statistically significant differences between the four types of organisational culture, except between the clan and adhocracy, clan and market, and adhocracy and market cultures, at the significance level of $\alpha = 0.05$. From the test result column, it is possible to identify a slightly stronger prevalence of the hierarchy culture.

6.3.2.5 Strategic emphasis

The fifth sub-question was: What are the current dominant types of organisational culture, in terms of strategic emphasis, in health care provision in Saudi Arabia?

Table 32: Dominant types of organisational culture in the current situation in terms of strategic emphasis, and result of the chi-square test

Types of organisational culture		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	37	70	124	142	45
Adhocracy	F	29	56	111	177	46
Market	F	23	51	125	170	50
Hierarchy	F	21	45	120	178	54
Total		27.5	55.5	120	166.75	48.75

* Chi-Square = 18.977
* P. = 0.089

The results in Table 32 indicate no significant differences among participants in the degree of response agreement regarding the current situation of each type of organisational culture under this dimension (strategic emphasis).

Table 33: Means and standard deviations in terms of strategic emphasis

Current types of organisational culture	Mean	Standard deviation
Clan	3.2105	1.11827
Adhocracy	3.3699	1.06675
Market	3.4129	1.02781
Hierarchy	3.4761	1.01341

Table 34: Related-samples sign test result of the difference between the four types of organisational culture under dimension of strategic emphasis

Types of organisational culture in the current situation	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-2.65	*0.008	C < A
Clan and market	-4.09	*0.000	C < M
Clan and hierarchy	-5.28	*0.000	C < H
Adhocracy and market	-1.78	0.074	A = M
Adhocracy and hierarchy	-2.26	*0.024	A < H
Market and hierarchy	-1.52	0.128	M = H

* D. significant at the 0.05 level

As Table 34 illustrates, the related-samples sign test revealed statistically significant differences between the four types of organisational culture, except between the adhocracy and market cultures and between market and hierarchy cultures at a significance level of $\alpha = 0.05$. From the test result column, it is possible to identify a slightly higher prevalence of hierarchy culture, whereas the least prevalent was clan culture.

6.3.2.6 Criteria of success

The sixth sub-question was: What are the current dominant types of organisational culture, in terms of criteria of success, in health care provision in Saudi Arabia?

Table 35: Dominant types of organisational culture in the current situation in terms of dimension of criteria of success, and result of the chi-square test

Types of organisational culture in terms of criteria of success		Degree of agreement in current situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	32	67	123	143	52
Adhocracy	F	24	51	115	163	66
Market	F	23	57	133	154	52
Hierarchy	F	32	46	127	147	65
Total		27.75	55.25	124.5	151.75	58.75

* Chi-Square = 13.051; * P. = 0.365

The results in Table 35 indicate no significant differences among participants in their degree of response agreement regarding the current situation of each type of organisational culture under this dimension (criteria of success).

Table 36: Means and standard deviations in terms of criteria of success

Current types of organisational culture	Mean	Standard deviation
Clan	3.2782	1.11172
Adhocracy	3.4678	1.07418
Market	3.3699	1.04178
Hierarchy	3.4005	1.11169

Table 37: Related-samples sign test results for differences between types of organisational culture under the criteria of success dimension

Types of organisational culture in the current situation	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-3.50	*0.000	C < A
Clan and market	-1.72	0.084	C = M
Clan and hierarchy	-2.43	*0.015	C < H
Adhocracy and market	-2.64	*0.008	A > M
Adhocracy and hierarchy	-1.72	0.085	A = H
Market and hierarchy	-.007	0.939	M = H

* D. significant at the 0.05 level

As Table 37 shows, the related-samples sign test revealed statistically significant differences between the four types of organisational culture, except between the clan and market cultures, adhocracy and hierarchy cultures, and market and hierarchy cultures at a significance level of $\alpha = 0.05$. Accordingly, from the test result column, it is possible to identify a slightly greater prevalence of adhocracy culture, whereas the least prevalent was the clan culture.

6.4 Question Three

The third research question was: What is the type of organisational culture which would best support efforts to improve health care services in Saudi Arabia? To answer this, the study elicited respondents' views on significant differences between the current situation regarding organisational culture types on one hand and their preferred situation on the other. Sections 6.4.1 and 6.4.2 respectively analyse the

relevant results in terms of the overall dimensions and under each dimension separately.

6.4.1 Significant differences between current and preferred cultures for the overall dimensions

First, the paired-sample t-test was used to study the significant differences between the current and preferred situation for all types of organisational culture under the overall dimensions, to determine which of these types should have priority in working to improve health care services in Saudi Arabia. Testing the following hypotheses will provide answers to this aspect of the third research question.

Research hypothesis

The gap between the importance of each type of organisational culture in the preferred situation and the current situation is positive, both for single dimensions and when all of them are considered as a whole, i.e. μd is statistically significant with values above zero. This can be expressed statistically as follows.

Statistical hypothesis

Null hypothesis, Ho: $\mu d \leq (0)$.

Alternative hypothesis, H1: $\mu d > (0)$.

If the t-test of the difference between the preferred situation and the current situation is positive and the significance level (2-tailed in this case) is less than the statistical significance level that the researcher specified in advance ($\alpha = 0.05$), we reject the null hypothesis and therefore accept the alternative hypothesis that μd is more than zero. This means that the gap between the cultural type in the preferred situation and that in the current situation is positive, meaning that the importance of this type in the preferred situation is significantly greater than its importance at present, so this type of organisational culture has priority in working to improve health care services in hospitals in Riyadh City.

The study also used the chi-square test to verify the existence of significant differences in responses to items at a significance level of α = 0.05 and the paired-sample t-test to identify significant differences between all types of organisational culture for the overall dimensions in the preferred situation.

Results, analysis and interpretation

Table 38: Dominant types of organisational culture in the preferred situation, and result of the chi-square test

Types of organisational culture		Degree of agreement in preferred situation				
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Clan	F	8	25	232	760	1474
Adhocracy	F	27	68	305	809	1294
Market	F	18	66	350	793	1270
Hierarchy	F	12	31	257	811	1385
Total		16.25	47.5	286	793.25	1355.75

* Chi-Square = 95.028
* P. = 0.000

The results shown in Table 38 indicate significant differences among participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the overall dimensions.

Table 39: Paired-sample t-test of differences between current and preferred situations for the overall dimensions of organisational culture

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Mean difference between preferred and current situation	Paired-samples t-test	
				T-test of the difference	Sig. 2-tailed
Clan	4.4933	3.2800	1.21324	25.361	*0.000
Adhocracy	4.3132	3.2468	1.06640	23.800	*0.000
Market	4.2992	3.3005	0.99865	21.096	*0.000
Hierarchy	4.4176	3.3996	1.01792	22.855	*0.000

* D. significant at the 0.05 level.

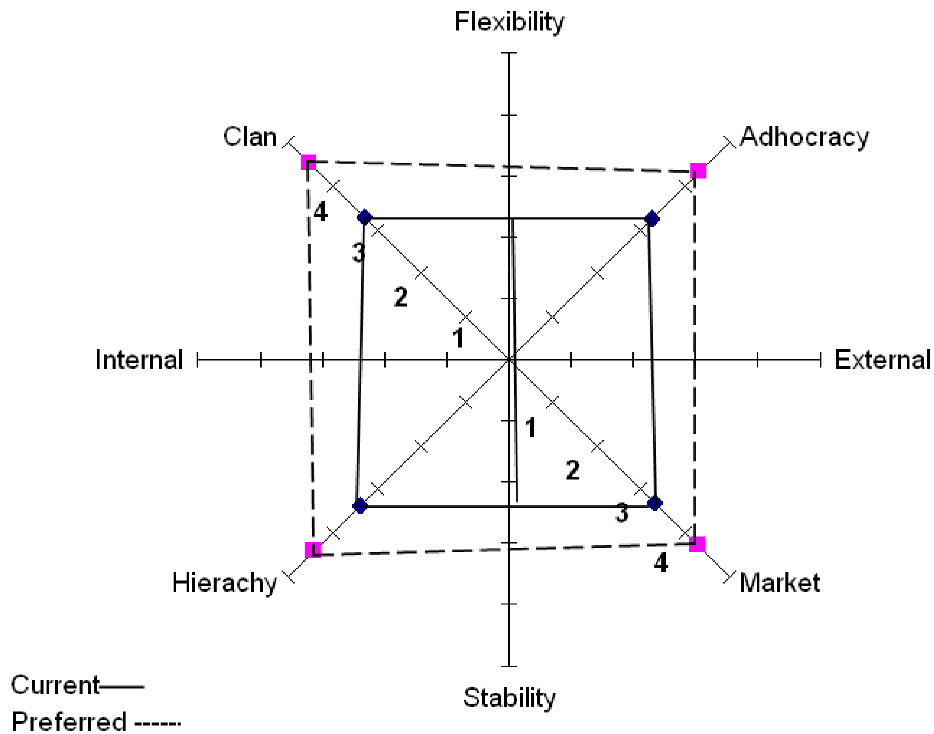

Figure 13: Overall cultural profiles of current and preferred situations

As illustrated in Table 39 and Figure 13, the paired-sample t-test results indicate a statistically significant difference between the preferred situation and the current situation in terms of organisational culture types in general. The positive differences were for the preferred situation rather than the current one, meaning that in these hospitals, the importance of the main types of organisational culture in general and of each type separately in the preferred situation was significantly greater than the importance of the main types of organisational culture in general and of each type separately in the current situation.

Table 40: Paired-sample t-test for significant differences between types of organisational culture

Types of organisational culture	Mean difference between the two types of culture	Paired-samples t-test		Test result
		T test of the difference	Sig. 2-tailed	
Clan and adhocracy	.180	9.754	*0.000	C > A
Clan and market	.194	9.024	*0.000	C > M
Clan and hierarchy	.075	4.472	*0.000	C > H
Adhocracy and market	.014	0.781	0.435	A= M
Adhocracy and hierarchy	-.104	-5.512	*0.000	A < H
Market and hierarchy	-.118	-6.229	*0.000	M < H

*D. significant at the 0.05 level

As shown in Table 40, the paired-sample t-test revealed a statistically significant difference between the four types of organisational culture, except between the adhocracy and market cultures, at a significance level of $\alpha = 0.05$. These results and those shown in Figure 13 demonstrate that clan culture had a slightly greater prevalence for the overall dimensions in the preferred situation of health care provision, whereas the least prevalent was market culture.

6.4.2 Significant differences between current and preferred situations under each dimension separately

Next, the paired-sample t-test was used to verify the significance of differences between the current and preferred situations of the various types of organisational culture under each dimension separately, because the differences between the values in the preferred and current situations were found to be so large. The study also used the related-samples sign test to verify the existence of significant differences between the four types of organisational culture under the separate dimensions in the preferred situation, while the chi-square test verified the existence of significant differences between responses to items at the significance level of $\alpha = 0.05$.

6.4.2.1 Dominant characteristics

Table 41: Dominant types of organisational culture in the preferred situation in terms of dimension of dominant characteristics, and result of the chi-square test

Preferred types of organisational culture		Degree of agreement in preferred situation			
		Disagree	Neutral	Agree	Strongly agree
Clan	F	7	38	131	236
Adhocracy	F	18	40	137	220
Market	F	10	43	136	225
Hierarchy	F	18	48	156	193
Total		13.25	42.25	140	218.5

* Chi-Square = 15.650
* P. = 0.2078
*Note: There were low numbers in the 'strongly disagree' column (fewer than 5 observations) and the rule of thumb is that all cells should have at least 5 observations in them. In this situation, the 'strongly disagree' column is grouped with the 'disagree' column.

Table 41 indicates no significant differences among participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the dimension of dominant characteristics.

Table 42: Related-samples sign test results of the differences between the four types of organisational culture in terms of dominant characteristics in the preferred situation

Preferred types of organisational culture in terms of dominant characteristics	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-2.130	*0.033	C > A
Clan and market	-.936	0.349	C = M
Clan and hierarchy	-4.000	*0.000	C > H
Adhocracy and market	-1.514	0.130	A = M
Adhocracy and hierarchy	-1.009	0.313	A = H
Market and hierarchy	-2.604	*0.009	M > H

* D. significant at the 0.05 level

As Table 42 shows, the related-samples sign test revealed statistically significant differences between the types of organisational culture, except between clan and market culture, adhocracy and market cultures, and adhocracy and hierarchy cultures, at the significance level of $\alpha = 0.05$. Accordingly, it is possible to identify a slight preference for a clan culture, while the least preferred culture was hierarchy.

Table 43: Paired-sample t-test for differences between current and preferred situations under the dominant characteristics dimension

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan culture	4.4428	3.2774	-15.29	*0.000
Adhocracy culture	4.3357	3.0821	-15.24	*0.000
Market culture	4.3850	3.3245	-13.53	*0.000
Hierarchy culture	4.2530	3.4313	-11.22	*0.000

*D. significant at the 0.05 level.

The paired-sample t-test results in Table 43 also show a statistically significant difference between the preferred situation and the current situation, according to types of organisational culture under the dimension of dominant characteristics. The positive differences were for the preferred situation rather than the current one and the significance level was zero, which is less than the value that the researcher specified in advance ($\alpha = 0.05$), meaning that the importance of these types of organisational culture, under the dimension of dominant characteristics in the preferred situation, was significantly greater than in the current situation.

6.4.2.2 Organisational leadership

Table 44: Dominant types of organisational culture in the preferred situation in terms of the organisational leadership dimension, and chi-square test result

Types of organisational culture		Degree of agreement in preferred situation		
		Neutral	Agree	Strongly agree
Clan	F	41	132	245
Adhocracy	F	61	140	205
Market	F	77	125	214
Hierarchy	F	37	128	250
Total		54	131.25	228.5

* Chi-Square = 26.443
* P. = 0.009
*Note: There were low numbers in the ‘strongly disagree’ and ‘disagree’ columns (fewer than 5 observations) and the rule of thumb is that all cells should have at least 5 observations in them. In this situation, the ‘strongly disagree’ and ‘disagree’ columns were grouped with the ‘neutral’ column.

Table 44 indicates the presence of significant differences among participants in their degree of response agreement regarding the preferred situation of each type of organisational culture under the dimension of organisational leadership.

Table 45: Related-samples sign test results of the differences between the four types of organisational culture under the dimension of organisational leadership in the preferred situation

Preferred types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-5.536	*0.000	C > A
Clan and market	-4.909	*0.000	C > M
Clan and hierarchy	-.781	0.435	C = H
Adhocracy and market	-.383	0.702	A = M
Adhocracy and hierarchy	-5.791	*0.000	A < H
Market and hierarchy	-5.197	*0.000	M < H

* D. significant at the 0.05 level

As Table 45 shows, the related-samples sign test revealed statistically significant differences between the types of organisational culture, except between the clan and hierarchy cultures and the adhocracy and market cultures, at the significance level of $\alpha = 0.05$. The test results column indicates that market culture was the least preferred.

Table 46: Paired-sample t-test of the differences between current and preferred situations under the dimension of organisational leadership

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan	4.4737	3.3589	-14.68	*0.000
Adhocracy	4.2782	3.1775	-14.35	*0.000
Market	4.2602	3.3422	-12.60	*0.000
Hierarchy	4.5072	3.4034	-14.23	*0.000

*D. significant at the 0.05 level.

The t-test results in Table 46 indicate a statistically significant difference between the preferred and current situations, according to types of organisational culture under the dimension of organisational leadership. The positive differences were for the preferred situation rather than the current one, at a significance level of zero, which is less than value of $\alpha = 0.05$ which the researcher specified in advance, meaning that the importance of the types of organisational culture, under the dimension of organisational leadership in the preferred situation, was significantly greater than in the current situation.

6.4.2.3 Management of employees

Table 47: Dominant types of organisational culture in the preferred situation in terms of management of employees, and result of the chi-square test

Types of organisational culture		Degree of agreement in preferred situation		
		Neutral	Agree	Strongly agree
Clan	F	32	127	258
Adhocracy	F	123	146	147
Market	F	98	146	170
Hierarchy	F	54	142	223
Total		76.75	140.25	199.5

* Chi-Square = 106.407
* P. = 0.000
*Note: There were low numbers in the 'strongly disagree' and 'disagree' columns (fewer than 5 observations) and the rule of thumb is that all cells should have at least 5 observations in them. In this situation, the 'strongly disagree' and 'disagree' columns are grouped with the 'neutral' column.

Table 47 indicates that there were significant differences among participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the management of employees dimension.

Table 48: Related-samples sign test results for differences between types of organisational culture under the dimension of management of employees in the preferred situation

Preferred types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-10.867	*0.000	C > A
Clan and market	-8.207	*0.000	C > M
Clan and hierarchy	-4.091	*0.000	C > H
Adhocracy and market	-3.626	*0.000	A < M
Adhocracy and hierarchy	-8.263	*0.000	A < H
Market and hierarchy	-6.690	*0.000	M < H

* D. significant at the 0.05 level

The related-samples sign test results in Table 48 reveal a statistically significant difference ($\alpha = 0.05$) between the four types of organisational culture. Accordingly, the test result column indicates a slight preference for a clan culture, whereas the least preferred type was adhocracy.

Table 49: Paired-sample t-test of differences between current and preferred situations under the dimension of management of employees

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan	4.5300	3.2638	-15.26	*0.000
Adhocracy	3.9063	3.1346	-10.27	*0.000
Market	4.1259	3.1864	-12.75	*0.000
Hierarchy	4.3842	3.1885	-14.96	*0.000

*D. significant at the 0.05 level.

The results of the t-test in Table 49 reveal a statistically significant difference between the preferred and current situations, according to types of organisational culture under the dimension of management of employees. The positive differences were for the preferred situation rather than the current one, at a significance level of zero, which is less than that which the researcher specified in advance (α = 0.05), meaning that the importance of the types of organisational culture, under the dimension of management of employees in the preferred situation, was significantly greater than in the current situation.

6.4.2.4 Organisation glue

Table 50: Dominant types of organisational culture in the preferred situation in terms of organisation glue, and result of the chi-square test

Types of organisational culture		Degree of agreement in preferred situation		
		Neutral	Agree	Strongly agree
Clan	F	50	117	250
Adhocracy	F	51	136	231
Market	F	65	142	210
Hierarchy	F	39	129	246
Total		51.25	131	234.25

* Chi-Square = 10.193
* P. = 0.335
*Note: There were fewer than 5 observations in the ‘strongly disagree’ and ‘disagree’ columns, so these are grouped with the ‘neutral’ column.

Table 50 indicates no significant differences among participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the dimension of organisation glue.

Table 51: Related-samples sign test results of the differences between the four types of organisational culture under the dimension of organisation glue in the preferred situation

Preferred types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-1.501	0.133	C = A
Clan and market	-3.122	*0.002	C > M
Clan and hierarchy	-.781	0.435	C = H
Adhocracy and market	-2.587	*0.010	A > M
Adhocracy and hierarchy	-2.365	*0.018	A < H
Market and hierarchy	-4.704	*0.000	M < H

* D. significant at the 0.05 level

The related-samples sign test results in Table 51 reveal statistically significant differences between the types of organisational culture, except between the clan and adhocracy cultures and the clan and hierarchy cultures, at a significance level of α = 0.05. Accordingly, the test result column indicates a slight preference for a hierarchy culture, whereas the least preferred type was market culture.

Table 52: Paired-sample t-test for the differences between current and preferred situations under the dimension of organisation glue

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan	4.4615	3.2933	-15.49	*0.000
Adhocracy	4.4149	3.2638	-15.98	*0.000
Market	4.3012	3.1976	-14.55	*0.000
Hierarchy	4.4697	3.4964	-14.09	*0.000

*D. significant at the 0.05 level.

The t-test results in Table 52 indicate a statistically significant difference between the preferred and current situations, according to types of organisational culture under the dimension of organisation glue. The positive differences were for the preferred situation rather than the current one, at a significance level of zero, which is less than the value of α = 0.05 which the researcher specified in advance, meaning that the importance of the types of organisational culture, under the dimension of organisation glue in the preferred situation, was significantly greater than in the current situation.

6.4.2.5 Strategic emphasis

Table 53: Dominant types of organisational culture in the preferred situation in terms of strategic emphasis, and result of the chi-square test

Types of organisational culture		Degree of agreement in preferred situation		
		Neutral	Agree	Strongly agree
Clan	F	41	129	249
Adhocracy	F	48	131	239
Market	F	64	121	233
Hierarchy	F	48	132	237
Total		50.25	128.25	239.5

* Chi-Square = 6.820
* P. = 0.869
* Note: There were fewer than 5 observations in the 'strongly disagree' and 'disagree' columns, so these are grouped with the 'neutral' column.

Table 53 indicates no significant differences among the participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the dimension of strategic emphasis.

Table 54: Related-samples sign test results of the differences between the four types of organisational culture under the dimension of strategic emphasis in the preferred situation

Preferred types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-.812	0.417	C = A
Clan and market	-2.388	*0.017	C > M
Clan and hierarchy	-.858	0.391	C = H
Adhocracy and market	-1.792	0.073	A = M
Adhocracy and hierarchy	-.105	0.916	A = H
Market and hierarchy	-1.246	0.213	M = H

* D. significant at the 0.05 level

The related-samples sign test results in Table 54 reveal no statistically significant difference between the types of organisational culture, except between clan and market cultures, at a significance level of $\alpha = 0.05$. The test result column indicates that the least preferred type was market culture.

Table 55: Paired-sample t-test of differences between current and preferred situations under the dimension of strategic emphasis

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan	4.4785	3.2105	-15.85	*0.000
Adhocracy	4.4474	3.3732	-14.74	*0.000
Market	4.3852	3.4139	-14.33	*0.000
Hierarchy	4.4460	3.4748	-14.12	*0.000

*D. significant at the 0.05 level.

The t-test results in Table 55 show a statistically significant difference between the preferred and current situations, according to the types of organisational culture under the dimension of strategic emphasis. The positive differences were for the preferred situation rather than the current one, at a significance level of zero, which is less than the 0.05 specified in advance, meaning that the importance of the types of organisational culture, under the dimension of strategic emphasis in the preferred situation, was significantly greater than in the current situation.

6.4.2.6 Criteria of success

Table 56: Dominant types of organisational culture in the preferred situation in terms of criteria of success, and result of the chi-square test

Types of organisational culture		Degree of agreement in preferred situation		
		Neutral	Agree	Strongly agree
Clan	F	39	112	266
Adhocracy	F	48	119	252
Market	F	77	123	218
Hierarchy	F	56	124	236
Total		55	119.5	243

* Chi-Square = 16.326
* P. = 0.0604
*Note: There were fewer than 5 observations in the ‘strongly disagree’ and ‘disagree’ columns, so these are grouped with the ‘neutral’ column.

Table 56 indicates no significant differences among participants in the degree of response agreement regarding the preferred situation of each type of organisational culture under the criteria of success dimension.

Table 57: Related-samples sign test results of the differences between the four types of organisational culture under the dimension of criteria of success in the preferred situation

Preferred types of organisational culture	Z test	Sig. 2-tailed	Test result
Clan and adhocracy	-1.887	0.059	C = A
Clan and market	-5.298	*0.000	C > M
Clan and hierarchy	-2.807	*0.005	C > H
Adhocracy and market	-4.178	*0.000	A > M
Adhocracy and hierarchy	-1.485	0.137	A = H
Market and hierarchy	-2.844	*0.04	M < H

* D. significant at the 0.05 level

The related-samples sign test results in Table 57 reveal statistically significant differences between the types of organisational culture, except between the clan and adhocracy cultures and the adhocracy and hierarchy cultures, at the significance level of $\alpha = 0.05$. Accordingly, the test result column indicates a slight preference for a clan culture, whereas the least preferred type was market culture.

Table 58: Paired-sample t-test for the differences between current and preferred situations under the dimension of criteria of success

Types of organisational culture	Mean in the preferred situation	Mean in the current situation	Z test	Sig. 2-tailed
Clan	4.5288	3.2788	-15.67	*0.000
Adhocracy	4.4678	3.4678	-14.40	*0.000
Market	4.3014	3.3708	-13.18	*0.000
Hierarchy	4.4159	3.4014	-14.32	*0.000

*D. significant at the 0.05 level.

The t-test results in Table 58 indicate a statistically significant difference between the preferred situation and the current situation, according to types of organisational culture under the dimension of criteria of success. The positive differences were for the preferred situation rather than the current one, at a significance level of zero, which is less than the 0.05 specified in advance, meaning that the importance of the types of organisational culture, under the dimension of criteria of success in the preferred situation, was significantly greater than in the current situation.

6.5 Relationship between health service employees' personal characteristics and organisational cultures

This section addresses the third question concerning the possibility of a relationship between health service employees' personal characteristics and their perception of the types of organisational cultures in health care provision in Saudi Arabia.
To answer the third question, two sets of statistical tests were conducted. The first set assessed the organisational culture in hospitals in Riyadh City at present, according to the view of personal characteristics (per variable):

- The independent-samples t-test was used to show a statistically significant difference (at the 0.05 significance level and less) in the views of participants, regarding the types of organisational culture in hospitals in Riyadh at present, according to their personal characteristics and functions comprised of two dimensions, such as sex (male, female).
- One-way ANOVA was used to show a statistically significant difference (at the 0.05 significance level and less), if participants' personal characteristics and functions consisted of more than two dimensions, such as their hospital affiliation, education level, etc.
- The Scheffe test was used to determine the benefit of any significant category of primary variable (personal or functional) of the target population for their views concerning the variables of the study.

The second set of statistical tests examined the relationship between these independent variables (for each pair of variables):

- Crosstabulation and chi-square were used to find relationships between each pair of variables.
- Two-way ANOVA (test of between-subjects effects) was used to find significant differences for each pair of independent variables.
- Multivariate statistical analysis of groups of three variables was used in order to identify those which were plausible (in the real situation) and to

understand which of them played a relevant role in the assessment of organisational culture.

Many statistical tests were thus carried out to answer this question, but they revealed only two personal characteristics that correlated to a significant difference in the views of participants regarding the types of organisational culture in hospitals in Riyadh. These two characteristics, examined in the following two subsections, were hospital affiliation in the current situation and nationality in the preferred situation. The remaining characteristics, which showed no statistically significant difference in the views of participants regarding organisational culture in either situation, were gender, age, educational level, professional group, experience in their current position and monthly income.

6.5.1 Hospital affiliation

A one-way ANOVA was used to study the statistically significant differences in the views of the participants regarding the prevalence of the different types of organisational culture in the current situation in hospitals in Riyadh, depending on their hospital affiliation. This test was used because in this question the participants' personal characteristics consisted of more than two dimensions (King Abdulaziz Medical City for National Guard, King Faisal Specialist Hospital and Research Centre, Riyadh Armed Forces Hospital, Ministry of Health hospitals, King Khaled University Hospital, Security Forces Hospital and private sector hospitals).

Table 59: One-way ANOVA (F) and Scheffe test for differences in current organisational culture, by hospital affiliation

Types of organisational culture	Hospital affiliation	Mean	F test	P-value	Scheffe test
Clan culture	1) King Abdulaziz Medical City For National Guard	3.3029	6.312	*0.000	(3) less than (1), (2), (4), (7)
	2) King Faisal Specialist Hospital and Research Centre	3.5172			
	3) Riyadh Armed Forces Hospital	2.7240			
	4) Hospitals of Ministry of Health	3.3429			
	5) King Khaled University Hospital	3.1618			
	6) Security Forces Hospital	3.3235			

	7) Hospitals of private sector	3.5079			
Adhocracy culture	**1) King Abdulaziz Medical City For National Guard**	3.3053	10.797	*0.000	(3) less than (1), (2), (4), (6), (7)
	2) King Faisal Specialist Hospital and Research Centre	3.5833			
	3) Riyadh Armed Forces Hospital	2.6434			
	4) Hospitals of Ministry of Health	3.2932			
	5) King Khaled University Hospital	3.0539			
	6) Security Forces Hospital	3.2059			
	7) Hospitals of private sector	3.5122			
Market culture	**1) King Abdulaziz Medical City For National Guard**	3.4684	9.982	*0.00	(3) less than (1), (2), (4), (6), (7)
	2) King Faisal Specialist Hospital and Research Centre	3.6264			
	3) Riyadh Armed Forces Hospital	2.6732			
	4) Hospitals of Ministry of Health	3.3249			
	5) King Khaled University Hospital	3.1118			
	6) Security Forces Hospital	3.3225			
	7) Hospitals of private sector	3.5026			
Hierarchy culture	**1) King Abdulaziz Medical City For National Guard**	3.5012	8.378	*0.000	(3) less than (1), (2), (4), (6), (7)
	2) King Faisal Specialist Hospital and Research Centre	3.7195			
	3) Riyadh Armed Forces Hospital	2.7948			
	4) Hospitals of Ministry of Health	3.4012			
	5) King Khaled University Hospital	3.3431			
	6) Security Forces Hospital	3.4902			
	7) Hospitals of private sector	3.5778			

* D. significant at the 0.05 level.

The following results are illustrated by Table 59. There is a statistically significant difference in all types of organisational culture in terms of hospital affiliation of participants in the current situation (the p-value is less than the statistical significance level that was specified in advance by the researcher, which here is $\alpha = 0.05$). It is clear that the four types of organisational culture, according to the views of participants who worked in the RAFH, were significantly lower than for participants working in other hospitals.

6.5.2 Nationality

The independent-samples t-test was used to check for statistically significant differences in the views of the participants regarding the prevalence of the different

types of organisational culture in the preferred situation, depending on the nationality of the participants. The researcher chose to use this test because the participants' personal characteristics comprised two dimensions (Saudi and non-Saudi).

Table 60: Independent-samples t-test for differences in the prevalence of organisational culture in the preferred situation, depending on the nationality of participants

Types of culture	Nationality	Mean	T test	P- value	Statistically significant difference
Clan culture	1) Saudis	4.5964	4.332	*0.000	(2) less than (1)
	2) Non Saudis	4.3710			
Adhocracy Culture	1) Saudis	4.4440	5.349	*0.000	(2) less than (1)
	2) Non Saudis	4.1460			
Market Culture	1) Saudis	4.4433	5.621	*0.000	(2) less than (1)
	2) Non Saudis	4.1150			
Hierarchy Culture	1) Saudis	4.5128	4.027	*0.000	(2) less than (1)
	2) Non Saudis	4.3005			
Types of organisational culture in general	1) Saudis	4.4992	5.370	*0.00	(2) less than (1)
	2) Non Saudis	4.2331			

* D. significant at the 0.05 level.

Table 60 reveals a statistically significant difference in all types of organisational cultures in the preferred situation according to the nationality of participants (the p-value is less than the statistical significance level that the researcher specified in advance, i.e. $\alpha = 0.05$), with Saudis registering higher scores than non-Saudis.

6.6 Conclusion

The study used a t-test to determine the current dominant types of organisational culture in Saudi health care provision and a paired-sample t-test to identify the preferred types of organisational culture that are dominant in health care provision in Saudi Arabia. The t-test revealed that clan, adhocracy, market and hierarchy cultures all received high scores, however hierarchy was more prevalent than the others, followed by the market, clan and adhocracy types in that order. With regard to the preferred situation, the paired-sample t-test results indicated that the four types of cultures also received high scores. Clan culture would be the slightly more prevalent

type of culture in Saudi health care provision in the preferred situation. This would be followed by hierarchy, adhocracy and market cultures in that order. In regard to the relationship between health service employees' personal characteristics and their judgments of organisational cultures in the Saudi health care provision, the researcher used the independent-samples t-test, one-way ANOVA, two-way ANOVA and Multivariate statistical analysis to determine which employee demographics had a significant effect on the views of participants regarding types of organisational culture. The results were that only two personal characteristics showed a statistically significant difference related to perceptions of types of organisational culture: hospital affiliation in the current situation and nationality in the preferred situation. In the first case, ratings of organisational culture by participants working in the RAFH were significantly lower than those of participants from other hospitals. In the second case, with regard to nationality, Saudis stated that they preferred all types of organisational cultures more compared to non-Saudis. The next chapter will analyse the qualitative data from interviews that are based on the CVF questions to determine if their results support the result of the questionnaire in regard to the types of organisational culture that are dominant in Saudi health care provision in both current and preferred situation.

CHAPTER 7 ANALYSIS OF QUALITATIVE INTERVIEW DATA

7.1 Introduction

The aim of this chapter is to present the research's results and an analysis of the findings from the qualitative data by answering research question two regarding the current dominant types of organisational culture in Saudi health care provision and research question three about the preferred type of organisational culture to support efforts to improve health care services in Saudi Arabia, through semi-structured interviews that are based on the questions from the CVF. In addition, this chapter will also include the results and analysis of Saudi national culture based on the views of respondents elicited in semi-structured interviews based on the CVF, about the types of organisational culture that are dominant in health care provision in Saudi Arabia. The views expressed in the interviews are considered with reference to Hofstede's cultural indices framework.

The full interview protocol is given in Appendix 2, but it is worth reproducing here the three main interview questions, based on the research questions set out in Chapter One:

1. What is the dominant type of organisational culture in your hospital?
2. What type of organisational culture would you prefer to be dominant in your hospital?
3. What do you think are the potential problems that prevent service improvements in your hospital?

The main body of this chapter is divided into three sections (7.2, 7.3 and 7.4) based on the responses to each of these questions in turn. Moreover, it will also include a section (7.5) about Saudi national culture as mentioned above. A code assigned to each interview is provided in parentheses after each quote, corresponding to the table of interviewees' demographic characteristics in Appendix 3.

7.2 Dominant organisational cultures

Hierarchy culture

The majority (almost two-thirds) of respondents described their hospitals as operating a hierarchy. Of course, this had a number of implications for the management of the hospitals. Firstly, hierarchy stifled leadership and involvement in decision-making. For example, according to one senior physician in a military hospital,

> "A hierarchy culture in this hospital is practised through a vertical hospital structure; therefore, decisions are taken by the hospital director and passed down to the heads of department for implementation." (9)

This view is also supported by a physician in a public hospital, who said,

> "A hierarchy culture is practised in this hospital through decisions which come from the Ministry of Health, and the hospital must implement them without discussion. There are penalties for those who do not implement them. Moreover, there is no motivation system for those who implement such decisions. In summary, there is a penalty system and an absence of a motivation system. Therefore, employees do not use their initiative because they may do the wrong thing, which may result in a penalty." (13)

One senior technician in a public hospital said,

> "The involvement of employees in the decision making is very limited because such decisions come from the hospital director and the heads of departments, for implementation without discussion." (23)

A technician in a military hospital stated that

> "A hierarchy culture is practised through the hospital director, who takes decisions without the involvement of the concerned departments; therefore, some decisions cause duplication because the director has no clear picture when he takes such decisions." (11)

A senior administrator in a military hospital supported these views:

> "Hierarchy culture is dominant in this hospital because there is no chance for others to participate in decisions. Management controls and monitors everything in the hospital." (12)

Some participants attributed the dominant role of a hierarchy culture in their hospitals to centralization and a lack of delegation of authority, even for micro-activities. For example, a senior physician in a public hospital stated that

> "The hierarchy culture in this hospital is practised through a centralized bureaucracy by the hospital director. Therefore, authority delegation is very limited by such procedures." (1)

A senior nurse in a public hospital supported this view:

> "Hierarchy culture in this hospital is practised through a central bureaucracy by the hospital director who tries to control and interfere in everything. This is considered a form of micro-management which is not suitable for such a big hospital. It needs a delegation of authority in order to operate more effectively." (2)

These views were shared by a senior administrator in the public hospital, who complained that

> "if there is any need for change in some micro-issues inside this department, the procedure for such a change goes through many administrative levels and takes a long time to reach the hospital director to make a final decision". (4)

In addition, a senior nurse in a specialist hospital said,

> "Hierarchy culture dominates everything; for example, memos have to be signed by more than one person in a hierarchical sequence. This is emphasized by the policy and procedures of the hospital." (6)

A senior administrator in an educational hospital stated that the hierarchy culture type dominated in his hospital due to the need to follow government regulations:

> "Hierarchy culture is practiced through the long government regulations procedure to supply the hospital's requirements." (20)

This view was shared by a senior technician in an educational hospital, who said that the work inside the hospital was based on official procedures that control everything. (19)

These results are unsurprising; hospitals are no exception to the pattern of bureaucratic management in Saudi public administration in general. It would have been surprising if a hierarchical culture had been found in only a minority of cases. Although bureaucracy does not explain everything, it is clear that management in Saudi hospitals has a close cultural fit with hierarchy. Indeed, such findings concur with many studies which have found Saudi public organisations characterised by a high level of bureaucracy (e.g. Jabbra and Dwivedi, 2004). Thus, they are characterised by lengthy lines of command and a whole range of administrative problems. The persistence of hierarchy therefore comes as no surprise.

Why is hierarchy dominant in some hospitals?

As for an explanation of this phenomenon, some of the interview responses indicated that the hierarchy culture was dominant in particular hospitals because of the need to facilitate the work and to determine responsibilities. For example, a senior administrator in a public hospital said,

> "There is policy and procedure that must be followed, although some of them are complicated; therefore, we try to overcome this problem through effective communication with the heads of department through weekly meeting to discuss how to facilitate such issues." (16)

A senior physician in a military hospital supported this view:

> "Hierarchy culture is very important in the daily operations of the hospital." (9)

Similarly, a senior nurse in a specialist hospital argued that

> "The hospital director has to practise centralization because he is the one taking full responsibility for running the hospital." (6)

A hierarchical culture is not explained by bureaucratic management alone, and some of the participants referred to the personal characteristics of the hospital director. For example, a senior nurse in a public hospital said,

> "The reasons for this, I think, refer to human nature, because the director may not trust others because they might complicate the work and he will be the one who has to take full responsibility for hospital operations." (2)

A senior technician in a public hospital supported this view:

> "The director of this hospital practises a hierarchy culture because he does not trust others or because he thinks that if he allows the employees to participate, they might take his position. The hospital director doesn't like change, so, since this hospital has had a hierarchy culture for a long time, he's kept everything as it was." (15)

This, according to a senior administrator in an educational hospital, is because the Saudi hierarchy culture allows managers to stay in higher positions for a long time (20). Furthermore, a senior physician in a public hospital argued that

> "A physician with a background in the medical field would not be a specialist in hospital administration and might prefer to practice this type of culture to avoid problems that could be caused by employee participation." (13)

Some of the participants referred to the current situation of their hospitals and their directors. For example, a senior physician in a public hospital stated that

> "The hospital is now undergoing change in many respects (policy, procedure and activities). Therefore ... there is a need to adopt a centralized system to facilitate the work. Moreover, the hospital director is newly appointed and is not used to delegating in his new position of authority until he can determine which qualified employees can be trusted ..." (1)

In addition, according to a physician in a military hospital, the nature of the organisation sometimes requires the adoption of a hierarchy culture:

> "In a military hospital, they have to implement the decisions first and then discuss them afterwards." (9)

Some participants described this as a collectivist culture that dominates Saudi society. For example, a senior technician in an educational hospital said,

> "Some employees prefer this type of culture because they are close to the decision maker. This allows them to fulfil their personal aims, such as promotion, at the expense of other more deserving employees." (19)

The researcher believes that the dominant hierarchy culture may be attributed to the political system in Saudi Arabia, which is a monarchy, meaning that it is strongly centralized. This is reflected in the Saudi management style, which is centralised, with a strong organisational culture rooted within a regional culture that is based in turn on tradition, religious values and community, supported by the social culture. Alternatively, it may be attributed to Saudi culture, which teaches people from early childhood to respect and obey their elders. These values motivate them to show respect to their superiors and accept the power distance between superiors and subordinates. A related aspect of Saudi culture is that power and authority are distributed unequally between the members of society, characterised by a reluctance to question one's superiors. For example, managers prefer to maintain a power distance between themselves and their employees in order to remain in their positions and foster their personal interests, whether for themselves, their family or their friends. Finally, the dominant hierarchy culture in Saudi public organisations may be attributed to employees who prefer to be guided and told what to do. They tend to have a strong orientation towards avoiding conflict with their managers, who may therefore use their authority over them unfairly. These arguments are supported by contributors to the literature such as Barakat (1993), Bjerke and Al-Meer (1993) and Common (2008).

Clan culture

About a fifth of respondents reported a clan culture in their hospital. This was a result of employees' involvement in the decision-making process. For example, a

physician in a specialist hospital said,

> "We practice this type of culture in our hospital through the involvement of the employees in general, and the heads of department in particular, to set up policies and procedures." (5)

Some of the participants mentioned that they practiced a clan culture in their hospitals through a leadership style that encouraged employees to participate in decision making. For example, a senior administrator in a specialist hospital explained that

> "The hospital encourages this type of culture because our directors do not take any decisions without the involvement of the departments concerned. They send drafts of the decisions to the departments for comment and they send them back to them to make a final decision depending on their feedback." (8)

Some participants stated that they practised clan culture in their hospitals through a quality assurance department that emphasised employees' participation and committees in order to get accreditation from international health organisations. For example, a senior nurse in a public hospital reported that

> "The hospital practises a clan culture in order to acquire accreditation from international health organisations, such as Canadian Healthcare Accreditation, which emphasises work quality through teamwork and committees. Therefore, the Total Quality Management Department ... is represented on each committee to ensure the application of the accreditation requirements and that encourages a clan culture." (22)

Some of the participants mentioned that they practised this type of culture through the hospital structure, which allowed them to contact the hospital director and communicate with him/her easily. For example, a senior administrator in a public hospital mentioned that his hospital practiced a clan culture through a horizontal management structure; therefore, it was easy to reach decision makers. (16)

Other participants stated that they practised clan culture through cooperation between employees and departments. For example, a senior administrator in a specialist hospital said,

> "Here, we feel like an extended family – we cooperate with each other, whether inside our department or with other departments." (8)

Thus, relatively few participants (5 out of 28) reported the existence of a clan culture in their hospitals. These appear to be exceptions to the Saudi management style, which is characterised as centralised, discouraging participation in decision-making. Jreisat (2003) notes that public employees in the Arab world lack the involvement and participation that could facilitate improvements in their performance.

Why is the clan culture practised in some hospitals?

As with some explanations of hierarchical culture, clan culture was practised in certain hospitals because it was supported by the hospital director. There were some managers who tried to create a new environment that encouraged this kind of culture. For example, a senior administrator in a public hospital said that it was because the work environment was new, as the hospital had opened only recently:

> ".... so teamwork was needed to support the hospital director in order to achieve the hospital's goals. In addition, this type of culture was supported in this hospital by the Health Minister in order for it to be competitive with other health care providers [because] MOH hospitals are not currently the best in Saudi." (16)

In an alternative explanation, a senior nurse in a public hospital attributed the practice of clan culture to the personal characteristics of heads of department who had spent time in Western countries that encouraged this type of culture. (22)

The specific situation of some hospitals made them exempt from certain government regulations and allowed them to practise this type of culture. Thus, a senior physician in a specialist hospital stated that

> "We have to report directly to the Royal Bureau, therefore we have more flexibility in dealing with some government regulations. In fact, we are exempt from some of these regulations."(5)

It is clear that some hospitals practise clan culture because there exists within them a special situation that exempts them from certain governmental regulations. It is noteworthy that three of the five participants who reported the practice of this type of culture in their hospitals were from the King Faisal Specialist Hospital and Research Centre. This hospital was granted an exceptional status, reporting directly to the Royal Bureau and being exempt from many government regulations, as one of the participants mentioned. This special status may have helped to create a suitable atmosphere in the hospital which, in turn, allowed the employees to practise a clan culture and remain free of bureaucratic excess. Another participant attributed the practice of clan culture in her hospital to the character of the hospital director, who had spent time in the West. This is to be expected, since Western culture was described as having low power distance between superiors and subordinates, based on Hofstede's cultural indices (2001), which correlate well with clan culture. However, this exemption from some government regulations in some hospitals, which helps them to practise a clan culture, may simply provide a good indicator of the shortcomings of the government regulations that apply in Saudi public hospitals. Jabbra and Jabbra (2005) describe Saudi Arabian bureaucracy and public management as hampered by rigidity and complicated sets of rules and regulations, with long lines of command, leading amongst other things to weak control and a situation where orders change gradually as they are passed down the ranks.

Adhocracy culture

With regard to adhocracy, only three of the 28 participants said that this type of culture was practised in their hospitals. A senior nurse in a public hospital stated that this occurred by encouraging development, innovation and creativity:

> "The trend in this hospital is towards this type of culture, by creating new policies and procedures that aim to improve the

> health services for patients, according to specific international health care standards.” (14)

A senior technician in a private hospital reported that his hospital practised this type of culture in order to develop its services by acquiring the latest technology:

> “We were looking for unique, new equipment and new medical programmes from companies that specialize in this field, although it was too costly.” (27)

A senior nurse in a private hospital said that her hospital had tried to adopt this type of culture in order to attract patients and the companies which employed them, which, in turn, would lead to increased profits; therefore, she said,

> “We practise an adhocracy culture by supporting creators and innovators; for example, employees obtain financial rewards for the best suggestions that can improve services, leading to patient satisfaction. Moreover, we use the latest technology to provide good services and at the same time reduce costs.” (26)

It is clear that most Saudi hospitals do not operate under an adhocracy culture, given that only about a tenth of participants reported its existence in their hospitals. This result is to be expected, because of the absence of any motivation for employees to take a risk by engaging in new activities, which is encouraged by this type of culture, depending as it does on encouraging development, innovation and creativity. These principles are inconsistent with the national culture that shapes the style of Saudi public management, described as a hierarchy dominated by governmental regulations, which has a negative effect on the development of the health care system. These regulations restrict such developments because they are inflexible and do not support the practice of this type of culture. Jreisat (2003) found that although the financial rewards were high, there was a lack of innovative and skilled work among Saudi public employees (see also Jabbra and Jabbra, 2005).

Why is adhocracy culture practised in some hospitals?

According to a senior nurse in a public hospital, the adhocracy culture worked there because it had exceptional financial support from the government:

> "This hospital receives exceptional financial support from the government to provide a good service to MOH patients. Thus, the Health Minister sought to use this exceptional support to change the bad picture of the MOH's services. He wanted to be able to say that the MOH could provide a unique health service based on the latest technology, equivalent to other health care provision, if there were sufficient financial resources." (14)

A senior nurse in a private hospital gave a different reason:

> "We practice adhocracy culture through using new equipment and seeking to recruit highly qualified physicians in order to attract patients." (26)

The participants' comments above reveal that their hospitals practised an adhocracy culture because of their special status, exempting them from certain regulations and allowing them to adopt this type of culture. Therefore, it is clear that practicing such a culture requires the avoidance of governmental regulations that control and are embedded in Saudi public management. This is supported by the two cases above. The first participant mentioned exceptional financial support and the second, from a private hospital, said that it was relatively free of governmental regulations.

Market culture

Finally, there were two participants who reported the existence of a market culture in their hospitals. A senior technician in a public hospital stated that there was competition in order to have a good reputation, which encouraged employees to take a pride in working there. The hospital realized this aim by achieving good medical results, attracting qualified medical staff and focusing on training programmes. (3)

Unsurprisingly, a market culture existed in private hospitals. According to one participant, a senior physician in such a hospital, the focus was on profit maximisation:

> "We have a marketing department that aims to attract patients through an emphasis on patient satisfaction, whether by providing a good comprehensive health service, by low price competition with other hospitals or by providing hotel services, such as nice

> rooms equipped with modern facilities and comfortable places for visitors. This department is examined periodically to determine how we compare with other hospitals in terms of the number of patients that are treated. The hospital also tries to motivate its employees to be more productive. For example, a physician receives a percentage of his operation income. In addition, there is an annual incentive reward in the salary for productive employees who get a good appraisal, that covers attendance, dealing with patients, productivity, cooperation with others, etc. Also, this hospital is in competition with others to win health insurance contracts from big companies to treat their employees, by providing low prices and facilitating the payment method." (25)

The low incidence of a market culture is also unsurprising, because of the lack of motivation for competition – a main principle of market culture – among Saudi public hospitals. Public hospitals face great pressure from patients for services. In addition, since unlike private hospitals they do not aim to make a profit, they have no need to look for new opportunities to attract new patients. Therefore, the Saudi health care system, which is described as a hierarchy, does not encourage such competition. To the extent where it is found (only 2 of the 28 participants reported it as existing in their hospitals), it is just for show. In contrast, this kind of culture may be expected to be clearly practised in private hospitals that aim to attract patients.

Why is market culture practised in some hospitals?

A senior physician in a private hospital suggested that the reason why the market culture was practised there was that it was a business organisation dependent on competition.

> "We practise a market culture because we are a business organisation in competition with other private and public hospitals to increase profits by providing the best services that would attract patients". (25)

It is clear that a lack of competition among Saudi public hospitals leads to the almost complete absence of a market culture in these hospitals. If it is to be found in any Saudi hospitals, it will be in private ones, which are business organisations engaged in competition with other hospitals to win a share of the health care market.

Section summary

To summarise, the qualitative research regarding the dominant type of organisational culture revealed that in the majority of cases, respondents felt that the culture in the hospitals was a hierarchy operating through a vertical hospital structure, a leadership style that tries to control and intervene in everything, where employees have limited involvement in decision-making and where there are restrictions resulting from having to follow government regulations. This is to be expected, because Saudi public organisations, according to the literature, are characterised by a high level of bureaucracy. However, other cases revealed the presence on a limited scale of other types of organisational culture. Clan culture was practised through teamwork, participation and unanimity; adhocracy culture was practised through development and innovation; and market culture was practised through competition.

7.3 Preferred organisational cultures

When interviewees were asked which type of organisational culture they would like to work under, clan culture was strongly preferred, with slightly more than two-thirds of participants (19 out of 28) saying that they would prefer it to be dominant in their hospitals. The reason given for this preference was that it is natural for people to want to feel affiliated to their hospitals through their voices being heard in processes such as decision making, which may lead to greater cooperation between employees and in turn, to better performance; therefore, participants saw the clan culture as ideal. For example, a physician in a specialist hospital stated,

> "We would prefer to practise a clan culture in our hospital because this is considered more human and natural, since employees feel their role is valued through participation in the decision-making process in hospital activities, which will lead to better performance." (5)

A senior administrator in a public hospital shared this view:

> "We want to feel that we are close together and cooperate in achieving the hospital's goals." (16)

A senior technician in a military hospital agreed:

> "We would prefer a clan culture because the relationship between the managers and their subordinates would be based on respect. Therefore, in such a case, there would be no need to maintain the sequential hierarchy that leads to poor productivity in Saudi hospitals today." (11)

A senior technician in a private hospital supported these views, pointing out that participation allows employees to show the decision makers the real problems that they face at work and to provide suggestions about improving the services, since they deal with the patients. (27)

A senior administrator in a military hospital agreed, saying that through the clan culture, the employees would be able to feel that their hospital respected their role in these activities by encouraging them to participate in the decision-making process. Therefore, they would do their best to ensure the successful implementation of the decisions. (12)

A senior physician in an educational hospital indicated his agreement with these views, commenting,

> "We would prefer a clan culture to increase our productivity, since this type of culture encourages employees' participation in hospital activities. Moreover, through collective management, the emphasis on a clan culture would allow ideal decisions to be reached. In addition, through this type of culture, I would be able to achieve my self-realization and affiliation with this hospital. I also like the idea of a clan culture because employees can develop themselves through creating strong relationships, which allows discussion with others and respect for the views of others." (17)

A senior technician in a public hospital shared these views:

> "Participation in the decision-making process is a principle of the clan culture, which leads us to feel affiliated with the hospital. We feel a part of it and this gives us more confidence, because our hospital respects our role in its activities. Another reason for preferring a clan culture is because we believe that it might give us job security." (23)

A senior technician in a public hospital concurred, suggesting that employees' involvement in decision-making would give them more confidence and they would feel satisfied with themselves. (3)

Some participants related their preference for a clan culture to their unhappiness with the current hierarchical style of administration. For example, a senior administrator in an educational hospital declared,

> "We would prefer a clan culture because we suffering from centralization and a hierarchical system that focuses on complicated routine procedures and penalties." (20)

A physician in a military hospital also held this view:

> "We see the hierarchical culture as related to a government system which is sometimes difficult to implement. Therefore, we want to hear our voice in the hospital activities, such as being involved in decision-making, having more flexibility, and being given more authority to contribute, in order to facilitate the work processes in the hospital. Work should not depend on one person (the hospital director) to avoid delays in the case of absence or this person being busy." (9)

A senior administrator in a private hospital shared these views:

> "We would prefer a clan culture because we want to be free from the regulations and penalties in the hierarchical system." (28)

Some of the participants attributed their preference for a clan culture to the nature of the health organisation. For example, a senior nurse in a military hospital declared,

> "We have employees from different countries in our hospital and the best way to communicate with each other would be through a clan culture that depended on the participation of the employees." (10)

These data indicate a feeling of dissatisfaction among participants about health care provision in Saudi Arabia. In fact, their wish was to change the culture, i.e. to move from a hierarchy culture (the current situation) to a clan culture (the preferred situation). This is to be expected, since the problems that face the heath care system,

as mentioned previously, arise from an organisational culture in the Saudi public sector that is currently dominated by a hierarchical style of management. The preference for a clan culture may be considered to be a reaction to employees' strong dislike for the centralization that predominates in Saudi public hospitals, which they see as limiting their creativity and productivity and as not favouring the progress of the health care system. In addition, the current system has long been dominated by a group of senior managers who follow the same routines, which are considered to constitute one of the main obstacles to change and improvement in public services in Saudi Arabia. Another strong reason for the preference for a clan culture in the Saudi health care system is that employees would like the opportunity to express their views on issues affecting them within their organisations, especially concerns about their needs, such as promotion, training and entertainment. Therefore, they want to be involved in the making of decisions. This kind of participation may lead to a good work environment through teamwork, which would in turn increase the loyalty of employees towards their hospitals.

This result is consistent with claims in the literature that employees tend to prefer a clan culture which would emphasise human development, teamwork and trust, openness and participation (Ouchi, 1981; Cameron and Quinn, 1999; Kim, 2002; Al-Yahya, 2009).

The adhocracy culture came second in the list of types of preferred organisational culture with only four participants in 28 saying that they would prefer it to be practised in their hospitals. For example, one senior administrator in a specialist hospital stated,

> "I would prefer an adhocracy culture because it would support all innovative ideas in our hospital activities that aim to introduce developments and high quality services for our patients." (8)

This view was shared by a senior administrator in a public hospital, who stated that an adhocracy culture would encourage development in all aspects of the hospital departments, which would in turn be supported by large budgets to provide the best services for patients. (4)

A senior technician in a public hospital remarked in support of this view that

> "Through an adhocracy culture we would be able to use new and unique technology; therefore, this hospital would be one of the best references for the new technology." (15)

Some of the participants said that they would prefer to practise an adhocracy culture in their hospital in order to develop its services by acquiring qualified employees and focusing on human resource development. For example, a senior nurse in a specialist hospital commented,

> "By adopting an adhocracy culture, the hospital would attract exceptional, specialised medical staff by offering them attractive salaries." (6)

Thus, the few who stated a preference for an adhocracy culture were interested in encouraging innovation, acquiring qualified employees and adopting new technology. This is consistent with the agreement that the health care services have become much more dependent on technology (Twaddle, 2002). The relatively weak preference for an adhocracy culture, which depends on development, may, like the absence of this culture from current Saudi public management, be attributed to a lack of enthusiasm among the participants for change and for the development of their hospitals in order to improve their services. This is to be expected, because of the weakness of employees' affiliation to hospitals that are dominated by the hierarchy culture.

The market culture came third in the list of types of preferred organisational culture with only three participants in 28 saying that they would prefer it to be practised in their hospital. For example, a technician in a specialist hospital asserted,

> "A market culture would give the hospital a chance to be in competition with other hospitals in terms of employees' satisfaction to maintain qualified employees and to overcome the shortage of such employees in this hospital." (7)

A senior nurse in a public hospital declared,

> "I would prefer a market culture because currently there is strong competition between hospitals in Riyadh city in order to get accreditation from an international health organisation to ensure

> that they provide a good health service according to specific standards; therefore, a market culture is the culture most capable of achieving this goal.” (2)

The third, a senior physician in a private hospital, said,

> “I would prefer a market culture because we are a business organisation and we are in competition with other hospitals to increase our profits through providing the best services that would attract patients.” (25)

The limited number of interviewees preferring market culture was also to be expected, due to the lack of competition between Saudi public hospitals. This is because these hospitals are currently facing pressure from the public for services, which causes difficulties in accessing these services, due to long waiting lists. Therefore, there is no need for competition with others to attract new patients. Among private hospitals, by contrast, there is some desire for competition in order to attract patients and so to increase profits.

Finally, just two of the 28 participants specified hierarchy as their preferred type of organisational culture to be practised in their hospital. They stated that this preference was inspired by the need to facilitate work and to determine responsibilities. For example, a nurse in a public hospital remarked,

> “A hierarchical culture is good for ensuring that the work is organised inside the hospital and for determining everyone’s responsibility.” (14)

A senior administrator in a public hospital shared this view, explaining that there were policies and procedures that must be followed in order to determine the responsibility for hospital activities. (24)

The fact that hierarchy was the least preferred culture was also to be expected, as it reflects the feeling of dissatisfaction among the participants about its current dominance in their hospitals, which many of them considered the main reason for the problems facing these hospitals today. Those few who did prefer a hierarchy

culture appeared to be concerned with the need to follow policy and procedure in order to determine everyone's responsibilities.

To summarise, the qualitative research regarding the preferred type of organisational culture revealed that a majority of interviewees expressed a preference for a clan culture which would operate in their hospitals through teamwork, participation and unanimity. This result was to be expected, since the problems that face the Saudi health care system arise from an organisational culture in the public sector that is currently dominated by a hierarchical approach. However, other interviewees revealed preferences for other types of organisational culture, albeit on a limited scale. Some said that they would prefer adhocracy, to allow development and innovation, while a few would have preferred a market culture and the ensuing competition. Finally, a very few participants said that they preferred the hierarchy culture, to organise the work and allocate the tasks among hospital employees.

7.4 Factors influencing health care provision

The researcher next asked the interviewees to comment on certain factors that influence Saudi public management, such as government regulations, economic factors and Saudi cultural values, some of which have impacted negatively on Saudi public organisations and caused many of the problems facing them today, according to the literature (Mufti, 2000; Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Jreisat, 2003; Al-Ahmadi and Roland, 2005; Jabbra and Jabbra; 2005; Mellahi; 2006). He also asked them to identify any other factors that influenced them, whether positively or negatively, in their hospitals. The following subsections report and analyse the responses regarding each of the factors identified in turn. While discussing these factors, the researcher also invited respondents to make recommendations for improving health services, which are discussed in the final chapter.

Government regulation

The majority of participants considered government regulations to be an obstacle to the improvement of health care services in Saudi Arabia; for example, a senior technician in a public hospital argued that

> "Government regulations are outdated and encourage centralization. And they don't encourage competition, whether inside the hospital between employees or outside the hospital with other health care providers." (3)

A physician in a public hospital also remarked,

> "The government regulations that organize the health care system in Saudi Arabia are too old and do not match the accelerated advancement in the health care system." (1)

A senior administrator in a military hospital agreed with this view:

> "Government regulations are considered an obstacle to developing health care services in the public sector in Saudi compared with the private sector, which has developed in recent years because of the absence of centralization and routine." (12)

A senior nurse in a public hospital concurred:

> "Government regulations are considered a big obstacle to development in this hospital. For example, these regulations do not accept distance learning, which is now the main source of medical learning around the world." (14)

Some of the participants mentioned the long process of government regulation. For example, a senior nurse in an educational hospital complained that the government-regulated recruitment procedures were too slow, especially for foreign employees. (18)

Some participants mentioned the Government Procurement System as a significant obstacle to improving the health care system in Saudi Arabia. For example, a senior physician in a public hospital stated that

> "The procedure for supplying requested items must pass through the Government Procurement System in all government agencies without taking into account the nature of the services. Therefore, this system is applied in the Ministry of Health as it is applied in the Ministry of Transportation, regardless of the nature of the work of the health system, that needs medical items to be supplied urgently for patient services, and following these procedures may lead to a delay in the supply of such services. Therefore, delaying such services may affect the patient's life, whereas a delay in opening a new road – such as is the nature of the work of the Ministry of Transportation – does not cause such problems. In addition, choosing the lowest price rather than the best quality may cause some problems in the patient's life, since the quality of the items is not good." (1)

A physician in a military hospital agreed:

> "The Government Procurement System is not suitable for hospitals because of the nature of health care services which needs – in some cases – items to be supplied as soon as possible, which cannot be achieved by this system because there are many procedures that must be followed when placing an order." (9)

This view was shared by a senior administrator in an educational hospital, who said,

> "The government tender system of supplying medical items, such as medicine and medical equipment, is supposed to have been cancelled and, alternatively, there is direct procurement in order to avoid the delays caused by the tender system, which is not suited to the nature of work in a hospital. Adopting a hierarchical procedure may lead to delays in the supply of services to patients. Delays in services may have an impact on a patient's life. Extraordinary approaches may be needed in order to facilitate the delivery of services or resources to accommodate patient care and speed up patient recovery." (20)

A senior physician in a public hospital saw the effects of implementing this system:

> "Taking the lowest price is wrong. It is supposed to be by quality because the side effect of low priced items is too costly compared with good quality items. We just accept high quality items, although it causes problems for us with some government agencies." (21)

Therefore, a senior technician in a specialist hospital explained that

> "We reject items purchased at the lowest price which are supported by the Government Procurement System if their quality is poor, but we have to write a reasonable justification for such a rejection." (7)

In addition, some of the participants mentioned specific government regulations, such as the Civil Service System and the Officer System. For example, a senior technician in an educational hospital explained that "the Civil Service System does not distinguish between different specialties". (19)

A senior administrator in an educational hospital said,

> "Employee promotion in the Civil Service System is based on seniority rather than competence, which causes the absence of initiative among employees." (20)

Finally, a senior technician in a public hospital suggested that

> "The Officer System should be developed to be compatible with changes in the medical field; for example, many of the new subspecialties in the medical field are not included in this system." (23)

These comments are unsurprising, since the government regulations reflect the hierarchy culture that dominates the Saudi public sector and causes many of the problems that face the Saudi heath care system today. Interviewees felt that these regulations and the associated procedures were out of date and time consuming. In addition, they did not match the need for flexibility and rapid advances in the health care system. In sum, participants felt that these regulations did not take into account the nature of health care services, which relate directly to people's lives.

The results agree with the finding of Jabbra and Jabbra (2005) that Saudi bureaucracy and public management are hampered by rigidity and complicated sets of rules and regulations, involving long lines of command which lead to a combination of factors, including weak control and orders that can gradually change as they are passed down the ranks.

Direct management by programmes (operational autonomy for hospitals)

The MOH allows its hospitals some autonomy in relation day-to-day operations. This covers activities such as self-employment (e.g. physicians, nurses and technicians), the purchase of services from the private sector, contract leasing and the allocation of property in partnership with the private sector to provide high quality health services. This amounts to a deregulation of hospitals in the provision of such services (Al-Doghaither, 2007). According to some participants, the system of direct management by programmes has had a positive effect on health care system in Saudi Arabia, allowing it to improve its services. For example, a senior administrator in a public hospital argued that

> "The system of direct management by programmes works properly and effectively; therefore, health expenditure has been reduced by applying this system. Moreover, it gives more flexibility to the hospital administration to take many decisions that reflect high employee satisfaction, such as increasing salaries, which leads to the retention of qualified employees." (4)

This view was shared by a physician in a public hospital, who stated that

> "This system provides more flexibility than government regulations, which failed to operate this hospital effectively. Therefore, this system is applied to encourage people to work better." (1)

These views were shared by a senior administrator in a public hospital, who said,

> "The system of direct management by programmes gives us more flexibility to have the best choice of qualified employees, make the optimum use of resources and limit the complications of government regulations and bureaucracy." (16)

It is clear that the adoption of a system of direct management by programme by some Saudi hospitals has given them more flexibility to operate effectively, free of the constraints of complex governmental regulations. However, the success of the system in those hospitals where the government has allowed it to be adopted may simply provide evidence of the shortcomings of the government regulations that

apply in other hospitals. This argument is supported by Mufti (2000), who notes that the increase of expenditure and poor performance of some of the management companies convinced the government to return to direct operation in a programme format. This argument is also supported by Alehaidib (2006), who argues that the decision makers in Saudi health care provision should encourage direct management by programme in Saudi public hospitals in order to improve their services.

Salaries

Some participants stated that salaries were low in their hospitals. For example, according to a senior physician in a military hospital,

> "The salary system in this hospital is poor compared with other hospitals in Riyadh City, and there is no financial motivation for employees, which frustrates them. Therefore, there should be unified salaries of workers in this hospital to overcome the high turnover of employees". (9)

This view was shared by a senior physician in a public hospital, who argued that there should be standardized salaries at the national level to combat high turnover and employee dissatisfaction. (13)

A senior physician in a private hospital argued that

> "We have a high turnover in administrative positions, especially among those from Saudi, because employees prefer to work in the public sector, which provides a good salary and job security." (25)

A senior nurse in a military hospital also shared this view:

> "The problem with salary is because there is a difference between the salary categories based on whether the employees are Western employees, Asian employees, Saudi employees, etc, although they do the same work, which leads to dissatisfaction among them because they feel that the system is unfair." (10)

In addition, a physician in a public hospital argued that

> "The salaries are not good enough; therefore, the turnover in this hospital is too high because there is competition with other health care providers. Moreover, the salary system in this hospital depends on negotiation rather than qualifications and experience." (1)

This view was shared by a senior technician in an educational hospital, who complained that salaries were "too low compared with other hospitals." (19)

A senior administrator in a specialist hospital felt that the salary system was especially unsatisfactory for administrative staff compared with medical staff, causing high turnover in this category as staff went to other hospitals. (8)

The salaries in private hospitals were also considered low by many interviewees who worked in these hospitals. For example, a senior nurse said,

> "Our salaries are too low compared with public hospitals. But the level matches other private hospitals." (26)

This view was shared by a senior technician in a private hospital, who complained that

> "The salary system in the private hospitals is unjust because of the absence of a specific standard salary system from the MOH; therefore, private hospitals pay their employees a low salary, which causes problems and frustration among these employees." (27)

These contributions reveal a problem of low salaries in Saudi hospitals, which happens because the current salary system is restricted by government regulations. Salary determination is not based on competition to attract highly qualified health manpower. Moreover, the system is not based on the employees' qualifications, which causes a problem of inequity among the staff of these hospitals. As mentioned above, a few hospitals are exempt from certain government regulations, which allows them to offer high salaries in order to recruit highly qualified employees. This has had a negative effect on other hospitals, causing a high turnover among their

employees, who are offered higher salaries by these exempted hospitals. The problem of low salaries appears more serious in the private than the public hospitals. This may be attributed to a more pronounced trend among the former towards reducing expenditure in order to increase profits. Nonetheless, Jabbra and Dwivedi (2005) identify a general problem of inadequate salaries in Saudi public organisations, which contributes greatly to the problems of high staff turnover and of low standards of veracity and personal integrity.

Saudization

As described in Chapter Two, the Saudi government adopted a policy of Saudization in 1995 as a reform measure to solve the shortage of qualified personnel, whereby non-Saudi employees in public management posts would be replaced by Saudi nationals (Gallagher, 2002). Under the Saudization system, hospitals must recruit at least 5% of Saudis. This system, according to some participants, had a positive effect on improving services in their hospitals. For example, a senior nurse in a public hospital stated that the Saudi government was trying to develop health care services through the Saudization strategy; therefore, Saudi health care manpower was involved in all hospital activities and committees, which aimed to depend on Saudis in the future in this field. This strategy, she argued, would be a good investment in the long term. (2)

This view was shared by a senior physician in a public hospital, who said,

> "Saudization is a good strategy for the long term because Saudis will probably stay in position for a long time or move to other hospitals inside the country. In contrast, foreigners, when they have gained experience, leave and go abroad. Moreover, it is good to facilitate communication between patients and the medical staff." (13)

A senior technician in a public hospital agreed:

> "Saudization is good in this hospital; therefore, Saudis are in all positions except for rare specialties that cannot be occupied by

> Saudis and lowly positions, such as housekeepers, that are not favoured by Saudis." (23)

A similar point was made by a senior administrator in a public hospital, who said,

> "Ninety percent and more in the administrative field are Saudis. In the medical field, if there are Saudis who are qualified for a position that is occupied by a non-Saudi, the hospital makes a replacement." (24)

In this regard, a senior administrative in a private hospital pointed out that

> "There is no replacement of Saudis in place of foreigners, because of the shortage of medical staff, but Saudization dominates the administrative positions more than in the medical field." (28)

It is clear that the Saudi government has used Saudization as a strategy to resolve the shortage of qualified personnel, especially in health care. According to the MOH (2007), 80% of medical employees in Saudi hospitals are non-Saudi. The findings of this study support this strategy, since it is a good investment in the long term to aim to employ Saudis who are qualified for positions occupied by non-Saudis. Moreover, this strategy is good for cultural reasons, because it facilitates communication between Saudi medical staff and Saudi patients. However, Saudization is to some extent weakened by social culture; for example, Saudis in general are not expected to work in some positions, such as housekeeping. It is also notable that the strategy has been more successful in the administrative field than the medical field, because of the serious shortage of qualified Saudi medical personnel.

These findings are consistent with those of Mufti (2000), who observed that the Saudi government had introduced Saudization in order to overcome the shortage of Saudi health professionals, to replace foreign nationals by Saudis who would comprehend the language and culture of Saudi society. This reform step is a good long-term investment, because the turnover among foreigners is very high compared with that of Saudi nationals. However, Mellahi (2006) notes that the process of Saudization has been much slower than the government had hoped.

Training

Participants described the training systems in their hospitals as poor. For example, a senior technician in a public hospital (3) indicated that training programmes focused on quantity rather than quality, while a senior administrator in a military hospital said,

> "All of the training programmes in this hospital focus on medical training, with an absence of administrative training programmes." (12)

This result was also to be expected, given the absence of a strategy to improve employees' skills by basing human resources development programmes on hospitals' needs, perhaps because decision makers in these hospitals were constrained by the hierarchy culture. The inevitable result is poor skills and unqualified personnel in these hospitals. Jabbra and Dwivedi (2004) argue that despite the efforts by the Saudi government to improve training programmes, the quality of Saudi employees has not improved significantly. This may be attributed to the fact that such programmes are not based on the needs of Saudi public organisations.

Business Centres

Business centres were established in Saudi public hospitals to augment the income of the hospitals and their employees. This system, according to the majority of participants, had had a negative effect on hospital services. For example, a technician in a public hospital complained,

> "The physician focuses more on this centre than on his regular work in the hospital. Therefore, some physicians ask their patients to come to this centre for follow-up if they want more care." (3)

This view was shared by a senior administrator in a public hospital, who reported that

> "Patients complain about this system because the physicians focus more on patients who attend this centre than on the patients in the hospital." (4)

Some of the participants mentioned that a negative aspect of these centres was the low income of their employees. For example, a physician in a public hospital said,

> "The income from the business centre is not worth the effort because most of it goes to the hospital budget rather than the physician; therefore, most physicians prefer to work part time in private hospitals because they pay them more." (1)

This view was shared by a senior technician in an educational hospital:

> "The benefits of a business centre are very limited because the employees get only a third of the income, while the hospital gets two thirds; therefore, it is not worth working there." (19)

It was clear that the government considered the establishment of business centres in public hospitals to be a part of the reforms it had adopted to improve the income of health personnel, in order to retain the qualified ones among them and reduce the high turnover affecting public hospitals. However, the above results suggest that employees have a low opinion of these centres and perceive them to have a negative effect in public hospitals, because physicians concentrate more on their business centre work than on their regular hospital duties. This finding is consistent with those of Jabbra and Dwivedi (2004) that inadequate salaries in Saudi public organisations caused high staff turnover and that some public employees sought to supplement their income by going into business or joining a company, thus doubling their salaries.

Budget

The majority of participants felt that their hospitals had adequate budgets. For example, a physician in a public hospital said,

> "Our hospital budget is sufficient or more than enough, but I think we need to utilize it effectively." (1)

A senior administrator in a private hospital shared this view:

> "We have sufficient budget. Every three months, all departments submit their requirements to the hospital director to get his approval. Most of them approve them but a few reject them if they are not supported by a good justification." (28)

The reason for there being no shortage of money, as a senior physician in an educational hospital mentioned, is that the country has huge finance resources because of high oil prices. (17)

Indeed, this result is to be expected, since the country is oil-rich and the Saudi government allocated 12% of its 2008 budget to health and social services (MOF, 2008). Although interviewees considered overall budgets to be sufficient, however, they did not think that they were utilized effectively. This is also unsurprising, since budgets are administered by a hospital administration that was characterised by a high level of bureaucracy and which would therefore not be expected to achieve optimum resource utilization.

Wasta

The majority of participants saw *wasta* as an aspect of Saudi culture which had a negative effect on health services. For example, a physician in a public hospital said,

> "Our society is considered to be a tribal society and this is reflected in our hospital. Therefore, many of the hospital's activities are influenced by personal relationships, which include access to hospital services like patient appointments. Employees' selection and promotion is also dependent on the influence of relatives and friends." (1)

A senior technician in a public hospital stated that

> "Employee selection depends on *wasta*, which causes a higher turnover among employees, especially of senior staff, because they feel that there is injustice in this hospital." (3)

Similarly, a senior technician in a military hospital admitted that

> "In this hospital, we practise *wasta* to obtain appointments for relatives and friends who are patients. This is because of the difficulty in accessing hospital services. If the services were available to such patients, then there would be no need for it." (11)

A senior physician in a military hospital argued that

> "Personal pressure for patients to get health services puts pressure on hospital services and affects them negatively." (9)

This result reflects an obvious aspect of everyday Saudi life. *Wasta* is evident throughout Saudi public hospitals, affecting access to hospital services, the selection and promotion of employees, etc. Such nepotism has a negative effect on these hospitals' services because it is based on injustice, either among hospital employees or among the patients who need the services of these hospitals. However, this result is to be expected, since Saudi culture is described as a collectivist one, where family and friendships remain important and are influential factors in the functioning of the institutions and groups, and where loyalty to family and tribe is very high. This finding is supported by Tayeb (2005), who notes that Arabs are highly collectivist and will be extremely loyal to the in-group, which can go far beyond the immediate family to include extended family, relatives and friends.

Patient's health awareness

Some participants complained of a lack of awareness among Saudi patients. For example, a physician in a public hospital said,

> "There is a lack of patient awareness about the need to keep appointments and therefore cancellations happen far too often." (1)

This view was shared by a senior physician in a public hospital, who reported that

> "There is a lack of punctuality for appointments among patients, although they find it difficult to get appointments." (21)

In addition, a senior technician in a military hospital said,

> "There is a lack of patient awareness; for example, patients do not follow their medicine instructions." (11)

A physician in a public hospital, who stated that patients did not take medicines according to the instructions of physicians, shared this view, noting that for example, when patients felt better, they would stop taking their medicine, although they had not finished the course. (1)

These responses suggest that despite an increase in awareness among Saudi patients (Mufti, 2000), there remain associated problems of a failure to follow physicians' instructions, the misuse of medicine and medication, appointment cancellations, etc. This may be attributed to the fact that some elements of the population of Saudi Arabia, as a developing country, lack education and awareness. Alternatively, it may be attributed to free treatment in Saudi public hospitals, as a result of which patients may not care about using the health service properly.

Health information system

According to some participants, the health information system in their hospitals was poor. For example, a senior physician in an educational hospital mentioned a shortage of computer equipment for administrative transactions, which wasted time and money. (17)

This view was shared by a senior technician in an educational hospital, who said,

> "The health information system is too old and incompatible with advances in the medical field." (19)

A physician in a military hospital also shared this view:

> "The health information system in this hospital is not integrated into all of the hospital departments together, which causes the misuse of some hospital facilities." (9)

These comments are consistent with the finding that the hierarchy culture was dominant in these hospitals and caused many problems, whether through the

decision makers in the hospitals who were responsible for applying the bureaucratic system or through the bureaucracy itself. A poor health information system was one of these problems, since health care services, as mentioned above, depend on advanced technology, and an integrated health information system is one of the basic principles of modern hospitals today that aims to facilitate work, reduce costs and save time.

Other Issues

This final section outlines some concerns about other key aspects of health care management which the interviewees raised.

According to a physician in a public hospital, the following problems should be tackled to improve its services:

- There was an absence of institutional work that focused on development rather than the daily work process (routine).
- The policies and procedures relating to patients and medicine should be developed and updated.
- There was a shortage of qualified Saudi manpower.
- There was failure to uses resources optimally.
- The maintenance of buildings and equipment was poor.
- There was insufficient attention to preventive aspects of health services. (1)

A senior physician in military hospital raised the question of coordination:

> "Since the health care services in Saudi Arabia are provided through different bodies that are concentrated in big cities, some of these bodies provide the same services without good coordination between them, which results in the duplication and misdistribution of the health care services in Saudi Arabia. Therefore, there is a need for more coordination between health care services to ensure a good distribution of health care services that would provide good, comprehensive and fair health care services for patients throughout the country." (9)

A senior physician in a military hospital reported a problem of overcrowding:

> “Although we need to expand our hospital to ease the pressure on our services, unfortunately, we cannot due to the limited space because we are in a crowded area.” (9)

A senior administrator in a specialist hospital mentioned waiting lists:

> “There is a long waiting list which means that it takes more than a month to obtain hospital services.” (8)

This view was shared by a senior technician in a public hospital:

> “There is difficulty in accessing the hospital to obtain its services, but, once the patient accesses the hospital, he will obtain excellent health services.” (23)

A senior nurse in a public hospital raised the matter of staff shortage:

> “One of the biggest problems that faces the health care system in Saudi is the shortage of medical staff, especially in the nursing field.” (14)

Finally, a senior physician in a private hospital mentioned the related problem of turnover:

> “We face problems with frequent turnover which causes complications at work, especially for those employees that the hospital enrols in costly training programmes.” (25)

It is clear that these problems which the participants identified as facing the Saudi health services today are caused by a hierarchy culture that dominates in these hospitals, as argued above. These problems can be summarized as including a lack of planning, poor coordination between hospitals, outdated government regulations, a shortage of qualified Saudis health workers, a failure to use resources optimally, difficulties in accessing hospital services, long waiting lists, low salaries, poor training, an inadequate health information system and insufficient health awareness among patients. The participants, who may be considered best able to highlight these problems because they were more aware of them, made a number of recommendations to solve them and so to improve the health care system in Saudi Arabia, which will be discussed in the last chapter.

7.5 Findings and discussion of Hofstede's cultural indices framework

This study used content analysis (see Chapter Three) and Hofstede's cultural indices framework to analyse the views of respondents elicited in semi-structured interviews based on the CVF, about the types of organisational culture that are dominant in health care provision in Saudi Arabia. The views expressed in the interviews are considered with reference to Hofstede's cultural indices framework. The findings are discussed below, supported by references to the relevant literature.

Small vs. large power distance

The analysis of Hofstede (2001) leads to the expectation that public management in Saudi Arabia, including that of healthcare provision, would be characterised as having a high power distance culture. High power distance here means that the management tends to be highly centralised, with several hierarchical levels and a large proportion of supervisory personnel. Subordinates expect to be supervised closely and believe that power holders are entitled to special privileges. Moreover, subordinates acknowledge that the power of others is simply based on where they are situated in certain formal hierarchies.

The main interview findings appear to concur with those of previous studies. Many of the interviewees opined that the sharing of decision making was too limited between superiors and subordinates. For example, according to one senior physician in a military hospital:

> "A hierarchy culture in this hospital is practised through a vertical hospital structure; therefore decisions are taken from the hospital director to the heads of departments for implementation, which sometimes requires coordination between departments." (9)

A senior technician in a public hospital said:

> "The involvement of employees in decision making is very limited because such decisions come from the hospital

> director and the heads of departments, for implementation without discussion." (23)

A technician in a military hospital commented:

> "A hierarchy culture is practised through the hospital director who takes decisions without the involvement of the concerned departments; therefore some decisions cause duplication because the director has no clear picture when he takes such decisions." (11)

Finally, a senior administrative in a military hospital stated:

> "Hierarchy culture is dominant in this hospital because there is no chance for others to participate in decisions. Management controls and monitors everything in the hospital." (12)

The main finding of this study is in concurrence with those of Barakat (1993) and Idris (2007), who found that people learn the values of respecting and obeying their elders from early childhood and make every possible effort to help them. These ingrained values motivate them to show respect for their superiors and accept the social distance – or, to be more precise, the power distance – between superiors and subordinates to prevent any disagreements. Bjerke and Al-Meer (1993) mention that there also appears to be a tendency for subordinates not to expect to partake in actual decision making as equal partners and to view this as prerogative of their senior managers, although they do expect to be consulted prior to decisions being made. Bjerke and Al-Meer also note that Arab traditions recognize status hierarchy, while Alshaya (2002) also studied power distance in education and concludes that Saudi school leaders are high in power distance, which confirms social distance between superiors and subordinates.

It is clear that centralization and bureaucracy are still prevalent in the management of the public sector in Saudi Arabia. Therefore, the power distance between superiors and subordinates is high and any participation in the decision making process is very limited, although there has been an attempt to decentralise decision making in the Saudi government and thereby minimize the power distance. This

may be attributed to Saudi culture in which power and authority are distributed unequally between members of society, characterised by the lack of questioning of superiors. For example, managers prefer to keep a power distance between themselves and their employees in order to remain in their positions and gain personal benefits, whereas among themselves, their family and friends, they believe that a low power distance could allow other employees to take their position in the future and thus they would lose such benefits. Furthermore, the majority of decision makers are older employees, with a low education level in general and a very limited knowledge of the importance of some of the principles of public management, such as a low power distance between managers and employees. Finally, employees – especially in middle and lower levels – do not know about their rights regarding their involvement in the decision making process. As a result, the high power distance culture is dominant and the involvement in decision making is limited.

Uncertainty avoidance

In terms of uncertainty avoidance, the analysis of Hofstede (2001) suggests that public management in Saudi Arabia would be characterised as risk averse, with high uncertainty avoidance. This creates a rule-oriented society that institutes laws, rules, regulations and controls to reduce the amount of uncertainty and avoid conflict. The analysis of interview responses in this study shows that interviewees tended to agreed with this characterisation. For example, a senior technician in an educational hospital said:

> "There is a delegation of authority to the heads of departments but some of them do not practise this authority in order to avoid responsibility; they refer all their department's transactions to the hospital director in order for him to make decisions." (19)

A physician in a public hospital explained:

> "In this hospital through decisions which come from the Ministry of Health, and the hospital must implement them

> without discussion. There are penalties for those who do not implement them. Moreover, there is no motivation system for those who implement such decisions. In summary, there is a penalty system and an absence of a motivation system. Therefore, employees do not use their initiative because they may do the wrong thing, which may result in a penalty." (13)

The main findings of this study agree with those of the 1996 study by Al-Twaijry and Al-Muhaiza, which concluded that there are certain features that lead Saudi managers to be classified as risk avoiders, who therefore make their decisions at the highest level of management. Other studies which reinforce this view are those of Alshaya (2002) and Bjerke and Al-Meer (1993), who both conclude that the level of uncertainty avoidance amongst Saudi managers is high, which means that people tend to avoid conflict.

Employees in Saudi public organisations thus try to avoid responsibility in their work, and they try to avoid involvement in the decision making process. This may be attributed to the feeling among employees that ambiguous situations may cause problems for them if they make a mistake during their work. They do not want to take risks and therefore they prefer to avoid responsibility. This may be attributed to the fact that Saudi employees prefer to avoid conflict with their managers, who might otherwise use their authority over them unfairly. In addition, such organisations do not encourage their members to take risks in the daily work process, because there is no reward system to encourage employees to take responsibility to achieve more in their work. Finally, this may be attributed to the employees' belief that they do not have the knowledge and experience that would allow them to take risks.

Individualism vs. collectivism

With regard individualism vs. collectivism, applying the framework of Hofstede (2001) would characterise public management culture in Saudi Arabia as collectivist, meaning that the management of health care provision reinforces extended families and the importance of in-groups. As mentioned in section 2.4.2,

nepotism, known in the Saudi context as *wasta*, plays a highly influential role in the organisational culture.

The main interview findings appear to concur with previous studies. They show that the influence of Saudi culture is observable in the health care recruitment process. Although recruitment policy and procedures emphasise qualifications and experience as major selection criteria, current practice does not avoid the influence of *wasta*. For example, a physician in a public hospital stated:

> "Our society is considered to be a tribal society and this is reflected in our hospital. Therefore, many of the hospital's activities are influenced by personal relationships, which include access to hospital services like patient appointments. Employees' selection and promotion is also dependent on the influence of relatives and friends." (1)

A senior technician in a public hospital added:

> "Employee selection depends on *wasta*, which causes a higher turnover among employees, especially of senior staff, because they feel that there is injustice in this hospital." (3)

A senior technician in a military hospital said:

> "In this hospital, we practise *wasta* to obtain appointments for relatives and friends who are patients. This is because of the difficulty in accessing hospital services. If the services were available to such patients, then there would be no need for it." (11)

Tayeb (2005) also notes that Arabs are highly collectivist and will be extremely loyal to their in-group, which can go beyond the immediate family to include extended family, relatives and friends. Bjerke and Al-Meer (1993) comment on the high levels of collectivism amongst Saudi managers, as they seem to prefer a close-knit social framework not only in the organisational sphere but also in the institutional sphere. In general, older people usually hold the senior positions, and in exploring the way decisions are made regarding promotion and pay, Weir (2000) and Mellahi (2006) found that the degree of loyalty an employee has to his manager

influences his promotion and pay more than his actual job performance.

Clearly, Saudi Arabia is a collectivist country in which personal relationships and *wasta* play vital roles in shaping organisational culture. Although lifestyle has changed in recent years, some values, such as collectivism, have not. This is not surprising, since Saudi managers live in a society where family and friendship remain important and influential factors in the functioning of institutions and groups. They rely on family and friendship ties for getting things done within their organisation. This may be attributed to Islamic instructions, which emphasise the idea of unity and encourage people to care for and help each other. Finally, this could be attributed to the fact that employees may face difficulties in obtaining their rights using official channels in their organisations; and they may therefore resort to a collectivist culture to access their rights.

Masculinity vs. femininity

Hofstede (2001) assessed public management in Saudi Arabia as showing a slight tendency towards having a masculine culture, by 53%. Masculinity here means that managers place particular emphasis on ambition for achievement and financial reward. The analysis of the interview data show that participants in the present study disagreed with this conclusion, preferring to see public management culture in Saudi Arabia as characteristically feminised. In other words, managers of health care provision were seen to place less emphasis on such ambition and more on concern for others and friendly relationships among people. For example, with regard to the absence of ambition for achievement and financial reward, a senior physician in a military hospital said,

> "The salary system in this hospital is poor compared with other hospitals in Riyadh City, and there is no financial motivation for employees, which frustrates them. Therefore, there should be unified salaries of workers in this hospital to overcome the high turnover of employees". (9)

According to a senior administrator in a military hospital,

> "There are long working hours without motivation for administrators, such as in other hospitals". (12)

A senior nurse in an educational hospital stated,

> "The motivation for employees is very limited, such as housing and education for their children". (18)

With regard to the emphasis on concern for others and friendly relationships among employees, a senior administrator in a specialist hospital said,

> "We cooperate with each other, whether inside our department or with other departments." (8)

A senior administrative in a public hospital said

> "Our relationship with other departments is based on cooperation between us to facilitate the work". (16)

The main findings from the interviews seem to be in agreement with those of Bjerke and Al-Meer (1993), who found that in relation to Hofstede's dimensions, Saudi managers were on the feminine side, being relatively unambitious for achievement and financial reward. The absence of ambition for achievement and financial reward among employees in Saudi hospitals is unsurprising, since Saudi public organisations, according to the previous literature, are characterised by a high level of bureaucracy (Barakat, 1993; Bjerke and Al-Meer, 1993).

With regard to the emphasis on concern for others and friendly relationships among employees, the main interview findings seem to be in agreement with those of Alshaya (2002), who found that the level of masculinity in Saudi managers was low and that a greater emphasis was placed on values such as cooperation, employment security and a friendly working environment. This result is also consistent with Bjerke and Al-Meer (1993), who found that in relation to Hofstede's dimensions, Saudi managers were more focused on concern for others and a friendly relationship among people. This result is also unsurprising, since Saudi employees believe

strongly that Islamic teachings encourage concern for others and friendly relationships between people.

This argument clarifies the view that the absence of ambition for achievement and financial reward in Saudi hospitals was expected because Saudi public organisations are characterised by a high level of bureaucracy. With regard to cooperation between employees, the daily work in Saudi public organisations is carried out through cooperation between employees and departments, rather than through official channels. This could be attributed to the fact that Islamic teachings and the tribal system stress the concept of caring and cooperation among people, and this characterises feminine societies. This is a possible explanation which comes from the researcher's own experience of the people in this country. Employees in a feminine culture prefer cooperation with others to help them carry out their daily work easily and rapidly, rather than through official channels, which may cause obstacles and mean that it takes longer to achieve the same result. Finally, the researcher believes that while this description cannot be generalized in Saudi culture as a whole, it can be applied to the health setting – particularly to characteristics such as the employment of many people from different countries and cultures. The sharing of specialties in the medical field therefore enables people to cooperate with others to carry out their daily work. Saudi culture itself can be characterized as being masculine, according to Hofstede's findings (2001); however, health care in Saudi Arabia would be considered to be feminine.

7.6 Conclusion

The analysis of the interview data indicates that almost two-thirds of participants (18 out of 28) considered that hierarchy was the currently dominant type of organisational culture in their hospitals, followed by the clan, adhocracy and market types in that order. With regard to the desired situation, more than two-thirds (19 interviewees) said that they would prefer clan culture to be dominant, followed by adhocracy, market and hierarchy cultures respectively. This means that the findings of the qualitative data strongly supports the dominance of hierarchy culture in Saudi

health care over the other three types of culture in the current situation. The findings also strongly support the preference of clan culture over the other three types of culture. This is inconsistent with findings of the of quantitative data of this study which reveal that there is balance of four types of organisational culture (clan, adhocracy, market and hierarchy) all of which received high scores in both current and preferred situations in the Saudi health care provision. The findings of the quantitative data reveal that a hierarchy culture was slightly more prevalent than other types of cultures in the current situation, while clan culture was slightly more prevalent in the preferred situation.

The chapter also indicates some issues and problems that were mentioned by the interviewees that related to their hospitals which are considered cultural norms not covered by the CVF which need to be reviewed and tackled by Saudi health care policy makers in order to improve the Saudi health care services. These include updating government regulations, more coordination of health care provision, a standardised salary system, a review of the Saudization strategy and limiting *wasta.* Some of these norms supported the prevalence of certain types of organizational cultures. For example, *wasta* supported the prevalence of clan culture because it plays an integral role in shaping the daily life of people in Saudi Arabia. This means that the management of health care provision reinforces the custom of extended families, friends and the importance of in-groups, which transcend the immediate family. Moreover, *wasta* supported the prevalence of hierarchy culture and resulted in mangers remaining in their positions and promoting their personal interests, whether for themselves, their immediate family or their friends in these organizations.

This chapter also has discussed the findings of this study on national culture in relation to the literature. It was demonstrated that national culture plays an important role in shaping the organisational culture of public management in Saudi Arabia. The research results reveal that health care provision in Saudi Arabia is characterised by a high power distance, feminised and collectivist culture, with high uncertainty avoidance.

However, the next chapter will discuss the results of both the quantitative and qualitative data in order to identify the dominant types of organisational culture in Saudi health care provision in light of its national culture and also take into account the discrepancy between the quantitative and qualitative findings.

CHAPTER 8 DISCUSSION OF THE RESEARCH FINDINGS

8.1 Introduction

The previous chapters revealed the complexity of analysing organisational culture in health care, which is considered one of the more complicated subjects according to many studies, because there are a variety of elements that shape and influence this subject, such as values, underlying assumptions, national culture, subculture, and so on. For example, participants of this study, whether from the questionnaires or interviews, were from different nationalities around the world, from different backgrounds and from a cross-section of organisational hierarchies. They have their own cultures which, to some extent, have totally different values from each other.

The aim of this chapter is to interpret, evaluate, and discuss the findings of the data analysis (quantitative and qualitative) in relation to the research questions presented in Chapter One and the relationship between this study's findings and other studies in this field. It begins by critically examining the national culture of health care provision in Saudi Arabia, followed by assessment of the prevalence of organisational culture, in both the current and preferred situation. In addition, the findings are compared to similar studies which have employed the CVF in different contexts as mentioned in Chapter Five.

8.2 Saudi national culture

Saudi Arabia's national culture, as discussed in Chapter Four, is shaped mainly by a political system characterised as an absolute monarchy by Islam and by the tribal system. To understand the external environment of Saudi healthcare management, this study adopts Hofstede's (2001) four dimensions of the culture of national work-related values, because national culture is considered the key factor shaping the external environment. However, the analysis of the interview data, based on

Hofstede (2001), leads to the expectation that public management in Saudi Arabia, including that of healthcare provision, would be characterised as having a high power distance culture consequently, in an organisational context. High power distance here means that the management tends to be highly centralised, with several hierarchical levels and a large proportion of supervisory personnel. Subordinates expect to be supervised closely and believe that power holders are entitled to special privileges. They acknowledge that the power of others is simply based on where they are situated in certain formal hierarchies. Moreover, in terms of uncertainty avoidance, the analysis of Hofstede (2001) would suggest that public management in Saudi Arabia is characterised as risk averse. This creates a rule-oriented society that institutes laws, rules, regulations and controls to reduce the amount of uncertainty and avoid conflict. In addition, with regard to individualism vs. collectivism, applying the framework of Hofstede (2001) would characterise public management culture in Saudi Arabia as collectivist, so that the management of health care provision reinforces extended families and the importance of in-groups. Finally, public management in Saudi Arabia, based on Hofstede (2001), can be characterised as a feminine culture. Managers of health care provision were seen to place less emphasis on such ambition and more on concern for others and harmonious relationships among people.

These findings are consistent with previous studies, which have also concluded that Saudi public organisation is characterised by a high power distance, feminised and collectivist culture, with high uncertainty avoidance (Barakat, 1993; Bjerke and Al-Meer, 1993; Al-Twaijry and Al-Muhaiza, 1996; Weir, 2000; Alshaya, 2002; Tayeb, 2005; Mellahi, 2006; Idris, 2007; Common, 2008). Thus, these characteristics are expected to be reflected in the management style of Saudi health care provision discussed in the next section.

8.3 Dominant organisational culture in health care provision in Saudi Arabia

The results of the CVF questionnaire reveal that there is a balance among the four types of culture in the current situation with reasonably high scores on all four dimensions. The results are consistent with previous studies such as Oney-Yazici et al. (2007) who assessed the organisational culture in Turkish firms. In their research they found there were similarities between the clusters which represented the four types of organisational culture. Moreover, Nelson, (2009) researched the part played by managers and political leaders in determining how well local authority organisations performed in the North West of England. He mapped the cultures of three authorities and discovered that two of the local authorities displayed very similar cultural profiles which point towards a 'balanced' perception from staff with fairly high scores on all four dimensions. However, the results of the questionnaire reveal that in health care provision in Saudi Arabia a hierarchy culture was slightly more prevalent than other types in the current situation. This is followed by market, clan and adhocracy types in that order. The relative strength of four types of organisational cultures will be discussed in detail in the following sections.

Hierarchy culture

The findings of quantitative data of this study reveal that in health care provision in Saudi Arabia a hierarchy culture was slightly more prevalent than other types in the current situation. Hierarchy culture here focuses more on internal than external issues and values stability and control over flexibility and discretion. These hospitals are characterised by a high level of bureaucracy and are driven by rules, regulations, and a hierarchical type of management. The findings of the qualitative data are inconsistent with quantitative results although it strongly supports the dominance of hierarchy culture in Saudi health care over the other three types of culture. These showed that almost two-thirds of participants commented that the currently dominant type of organisational culture in their hospital was hierarchical. According to interviewees, a hierarchy culture was practised through vertical hospital

structures. Therefore, the involvement of employees in decision making was too limited. Interviewees also stated that the hospital directors would exert as much control as they could and try to interfere in everything. Moreover, they complained that the existence of a hierarchical culture resulted in long procedural delays in passing information to hospital directors in order for them to make final decisions.

The prevalence of hierarchy culture in Saudi health is not surprising since it is common knowledge that public organisations like those in this study have a strong tendency to be hierarchal in configuration. In the literature, Mintzberg (1979) argues that "public machine bureaucracies" are suggested as a subgroup within "machine bureaucracies" because external limitations result in public agencies being predisposed towards a higher level of bureaucratisation. In addition, Banfield (1975) outlined certain qualities of government agencies. Firstly they have increased partitioning of authority and "selling" output below production cost is less of a priority. Secondly, there are higher levels of vagueness, multiplicity, and conflict between objectives and products. External laws and administrative procedures need to be more closely adhered to and finally, dependence on financial rewards needs to be reduced. More is therefore spent on reducing corruption than is gained from it, and strong central control is less effective in reducing corruption. Downs (1967) stressed that when the economic market is not part of the equation there are more likely to be complex hierarchies in public bureaucracy. Internal decisions are more likely to be influenced by politics. Furthermore, as mentioned in Chapter Five, studies which have employed the CVF and focus on public organisations have concluded that hierarchy culture is dominant in public organisations (Cameron and Quinn, 1999; Parker and Bradley, 2000; Jingjit, 2008 and Talbot, 2008). In line with the nature of this study which focuses on health care organisation Gerowitz et al. (1996) have concluded that the NHS in the UK as a whole is characterised by a higher frequency of dominant hierarchical culture. These findings appear to concur with those of a number of previous studies which identified that bureaucracy in developing countries in general, and in the Arab world in particular, is identified

with problems of the centralisation of power and control (Al-Awaji, 1971; Jabbra and Dwivedi, 2004; Jabbra and Jabbra, 2005; Al-Yahya, 2009).

The findings are also supported by the analysis of Saudi national culture based on Hofstede's dimensions, as mentioned earlier in this chapter, which characterised public management in Saudi Arabia as operating with characteristics of a high power distance and high uncertainty avoidance culture. These types of characteristics are associated with a hierarchy culture. Van Muijen, and Koopman (1994) and Hofstede, (1991) argue that in countries where the power distance index and uncertainty avoidance index are high, we are likely to find a preference for a hierarchy model which represents a centralized bureaucracy with a high rationalised and standardised work flow and formal procedures.

The findings of this study revealed that the prevalence of hierarchy culture in Saudi hospitals appear to differ from Gerowitz et al.'s (1996) study which concluded that the health care services in the US were characterized by adhocracy and market cultures over clan and hierarchical cultures. This could be attributed to the political and economic environments in which the health care in both countries function. In Saudi, the health care system is under the control of the government, while the US the health care system operates through private health insurance which allows organisations to free themselves from bureaucracy and hierarchies.

The researcher believes that the prevalence of hierarchy culture may be attributed to the political system in Saudi Arabia, which is a monarchy, meaning that it is strongly centralised. This is reflected in the Saudi management style, which is centralised, with a strong organisational culture rooted within a regional culture that is based in turn on tradition, religious values and community, supported by the social culture. Alternatively, it may be attributed to Saudi culture, which teaches people from early childhood to respect and obey their elders. These values motivate them to show respect to their superiors and accept the power distance between superiors and subordinates. A related aspect of Saudi culture is that power and authority are distributed unequally between the members of society, characterised by a reluctance

to question one's superiors. For example, managers prefer to maintain a high level of power distance between themselves and their employees in order to remain in their positions and foster their personal interests, whether for themselves, their family or their friends. This is influenced by *wasta* which is dominant in these organisations. Finally, the dominant hierarchy culture in Saudi public organisations may be attributed to employees who prefer to be guided and told what to do. They tend to have a strong orientation towards avoiding conflict with their managers, who may therefore use their authority over them unfairly. These arguments are supported by contributors to the literature such as Barakat (1993), Bjerke and Al-Meer (1993) and Common (2008).

Market culture

The results of the CVF questionnaire also reveal the strength of market culture in the Saudi health care provision. Market culture here is based on competitiveness, productivity and achievement. It has an external focus and emphasises stability. In contrast, the qualitative data has revealed that there are few respondents who identified that market is dominant in their hospital. For example, one participant mentioned that there was a competition to have a good reputation. This encouraged employees to take a pride in working there. The hospital realised this aim by achieving good medical results, attracting qualified medical staff and focusing on training programmes. In addition, another participant from the private sector mentioned that they are in competition with other hospitals to attract patients through an emphasis on patient satisfaction in order to increase profits. In contrast, the majority of the interviewees however mentioned that there is an absence of market culture in their hospitals because of the lack of motivation for competition – a main principle of market culture – among Saudi public hospitals. Public hospitals face great pressure from patients for services. In addition, since unlike private hospitals they do not aim to make a profit, they have no need to look for new opportunities to attract new patients. Therefore, the Saudi health care system does not encourage such competition, to the extent that where it is found it is just for

show. In contrast, this kind of culture may be expected to be clearly practised in private hospitals that aim to attract patients.

The strength of market culture, as indicated by the quantitative data, can be attributed to the nature of the sample of this study. This sample group includes hospitals from the private sector which are business organisations engaged in competition with other hospitals to win a share of the health care market. Bradley and Parker (2006) have mentioned that private organisations relate more to external rather than internal orientation which represent the market and adhocracy in the CVF. Moreover, Dastmalchian et al (2000) suggest that business organisations tend to be more market-oriented in response to dynamic, complex and challenging environments. This result is consistent with previous study which has employed the CVF in health care organizations in different context as noted in Chapter Five which conclude that the US health care system is dominated by a market culture (Gerowitz et al., 1996).

Clan culture

The results of the CVF questionnaire also reveal that there is a strength of clan culture in the Saudi health care provision. Clan culture here is based on human development, cooperation, coordination, teamwork, employee involvement and rewards. The organisation operates as an extended family. It has an internal focus and emphasises flexibility. The results of the interviews are inconsistent with the results of the questionnaire because it indicates that there are a limited number of views from the participants as about a fifth of respondents reported a clan culture in their hospital. This was a result of employees' involvement in the decision-making process. Moreover, some of the participants mentioned that they practiced a clan culture in their hospitals through a leadership style that encouraged employees to participate in decision making. Others mentioned that they practised clan culture in their hospitals through a quality assurance department that emphasised employees' participation and committees in order to get accreditation from international health organisations. Finally some participants stated that they practised clan culture

through cooperation between employees and departments. In contrast, the majority of the interviewees mentioned that hospital employees have limited influence in the decision making process and they see this is the main reason of the lack of the clan culture in their hospital.

Interestingly, the interview results revealed that some hospitals practised clan culture as a result of special situations which exempt them from certain governmental regulations. It is noteworthy that three of the five participants who reported the practice of this type of culture in their hospitals were from the King Faisal Specialist Hospital and Research Centre. This hospital was granted an exceptional status, reporting directly to the Royal Bureau and being exempt from many government regulations, as one of the participants mentioned. This special status may have helped to create a suitable atmosphere in the hospital which, in turn, allowed the employees to practise a clan culture and remain free of bureaucratic excess. Another participant attributed the practice of clan culture in her hospital to the character of the hospital director, who had spent time in the West. This is to be expected, since Western culture was described as having low power distance between superiors and subordinates, based on Hofstede's cultural indices (2001), which correlate well with clan culture. However, this exemption from some government regulations in some hospitals, which helps them to practise a clan culture, may simply provide a good indicator of the shortcomings of the government regulations that apply in Saudi public hospitals. Jabbra and Jabbra (2005) describe Saudi Arabian bureaucracy and public management as hampered by rigidity and complicated sets of rules and regulations, with long lines of command, leading amongst other things to weak control and a situation where orders change gradually as they are passed down the ranks.

The strength of clan culture in the Saudi health care provision, as demonstrated in the quantitative data, can be attributed to the nature of health care organisation as mentioned in Chapter Five as there is a strong subculture present within health organisations which represent the provisional group employees such as physicians nurses etc. So there is a high probability that a clan culture (group culture) will

prevail. In this regard Deal et al. (1983) argue that as in many organisations, hospital cultures are made up of subcultures such as nursing units, professional groups and functional or project groups. However, unlike non-medical organisations, hospitals in particular have been described as having cultures that are weak or fragmented (Nystrom, 1993). This may be related to the number of stable and strong subcultures within hospitals (Bice, 1984), which are often labelled as work group cultures (Coeling and Simms, 1993). This result is also consistent with previous studies which have employed the CVF in health care organisation in different contexts as mentioned in Chapter Five. This concludes that although the NHS in the UK is dominated by hierarchy culture as mentioned above, clan culture is also dominant within particular hospitals subgroups such as nurses, physicians, technicians etc. (Gerowitz et al., 1996; Marshall et al., 2003; Davies et al., 2007).

The strength of clan culture may also be attributed to the influence of Saudi national culture in the management style of these hospitals. This is supported by the analysis of Saudi national culture based on Hofstede's dimensions, as mentioned earlier in the chapter, which characterised public management in Saudi Arabia as collectivist, meaning that the management of health care provision reinforces extended families and the importance of in-groups. This may be attributed to Islamic instructions which emphasises the idea of unity and encourages people to care for and help each other. Moreover, this result appears to concur with previous studies. For example, Tayeb (2005) has noted that Arabs are highly collectivist and will be extremely loyal to their in-group, which can go beyond the immediate family to include extended family, relatives and friends. Bjerke and Al-Meer (1993) comment on the high levels of collectivism amongst Saudi managers, as they seem to prefer a close-knit social framework not only in the organisational sphere but also in the institutional sphere. In addition, it was found that *wasta* supported the strength of clan culture because it plays a vital role in shaping daily life in Saudi Arabia. This means that the management of health care provision reinforces extended families, friends and the importance of in-groups, which goes beyond the immediate family.

The characteristics of clan culture, i.e., cooperation, participation and respect, were highly valued among organisational members. This concept was identified through a realisation that despite the influence of formalised rules for task allocations, civil servants tended to undertake additional work outside their regular duties to conform to a prevailing practice of assisting one another. This phenomenon can be interpreted to imply a "rule by connections" where the obligations of an individual are influenced by the rule of law and are also fundamentally underpinned by relationships with other individuals (Flynn, 1999). In particular, interpersonal connections were found to be significantly influenced by the concept of kinship. This corresponded with Flynn's notion of "expressive" ties which typically generate mutual sentimental commitments between Asian peoples opposed to the "instrumental" type. The expressive refer to obligations among individuals who do not merely develop from the current transaction but are also related to their formerly established relationships whereas in the case of the instrumental, the relationships only exist for the purpose of the present transaction. Therefore, the characteristics mentioned above are related to clan culture as noted in the literatures of Lau and Ngo (1996), Hofstede (2001), Oney-Yazici et al. (2007) Jingjit (2008) and Talbot (2008).

Importantly, the quantitative findings of this study revealed that the strength of clan culture in Saudi hospitals appear to be dissimilar with Cameron and Quinn's (1999) study of mostly American public organisations. This could be attributed to the Saudi national culture which has been described as being collectivist rather than individualist which is a characteristic of American culture (Hofstede 1980).

Adhocracy culture

The findings of quantitative data also indicate the strength of adhocracy culture in the Saudi health care provision. Adhocracy culture in this context is based on entrepreneurship, innovation, freedom, uniqueness and development. The organisation works by trying new things and looking for new opportunities. It has an external focus and emphasises flexibility. This result is inconsistent with the findings

of the interviews which revealed that a limited number of participants have stated that their hospitals are dominated by an adhocracy culture. For example, one participant mentioned that adhocracy culture occurred in their hospital through encouraging development, innovation and creativity. Others reported that their hospital practised this type of culture in order to develop its services by acquiring the latest technology. One participant from the private sector mentioned that their hospital had tried to adopt this type of culture in order to attract patients and the companies which employed them, which, in turn, would lead to increased profits. In contrast, the majority of the interviewees stated that there is a lack of adhocracy culture in their hospital. They mentioned that they do not operate under this type of culture, given that only about a tenth of participants reported its existence in their hospitals. This could be attributed to the absence of any motivation for employees to take a risk by engaging in new activities, which is encouraged by this type of culture, depending as it does on encouraging development, innovation and creativity. These principles are inconsistent with the national culture that shapes the style of Saudi public management, described as a hierarchy dominated by governmental regulations, which has a negative effect on the development of the health care system. These regulations restrict such developments because they are inflexible and do not support the practice of this type of culture. Jreisat (2003) found that although the financial rewards were high, there was a lack of innovative and skilled work among Saudi public employees (see also Jabbra and Jabbra, 2005).

The strength of adhocracy culture, as revealed in the quantitative data on Saudi health care provision, can be attributed to the nature of health care organisations. This is due to the fact that adhocracy culture emphasises creativity and innovation through the acquisition of new resources and creating new challenges. Trying new things and prospecting for opportunities are valued. These principles are consistent with dynamic work in the hospitals which is changeable and renewable. In this regard, Twaddle (2002) argues that health services have become much more dependent on innovations and advanced technology, which means that they rely on advanced technology in order to provide efficient services. Ham (1997) also

mentioned that development and advances in medical science will give rise to new demands. These advances cover a range of possibilities, including innovations and improvement in surgery, drug therapy, screening and diagnosis. The pace of innovation and advance is likely to quicken, with significant implications for the funding and provision of services. This result is consistent with previous studies which have employed the CVF in health care organisation in different contexts as mentioned in Chapter Five which conclude that the US health care system is dominated by an adhocracy culture (Gerowitz et al., 1996; Jones et al., 1997; Helfrich et al., 2007).

8.4 Preferred organisational culture in health care provision in Saudi Arabia

The result of CVF questionnaire also reveals that there is a balance between the four types of culture in a preferred situation with high scores on all four types of cultures, which means that to improve Saudi health care provision, a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy) is required. However, it reveals that in the health care provision in Saudi Arabia clan culture was slightly more prevalent in the preferred situation. This was followed by hierarchy, adhocracy and market cultures in that order. The findings of the qualitative data are inconsistent with the quantitative results although the data strongly supports the preference of clan culture over the other three types of culture. This revealed that a majority (slightly more than two-thirds) of interviewees expressed a preference for a clan culture which would operate in their hospitals through teamwork, participation and unanimity. Other interviewees revealed preferences for other types of organisational culture, albeit on a limited scale. Some said that they would prefer adhocracy, to allow development and innovation, while a few would have preferred a market culture and the ensuing competition. Finally, a very few participants said that they preferred the hierarchy culture, to organise the work and allocate the tasks among hospital employees.

The preference for a clan culture is therefore likely to be the result of a reaction against the centralisation that dominates Saudi public hospitals. People want to work in an environment that encourages participation and teamwork, in turn increasing the sense of loyalty towards the hospital. This is appears to concur with the findings of many previous studies which have concluded that bureaucracy in developing countries in general, and in the Arab world in particular, is identified with problems of the centralisation of power and control (Al-Awaji, 1971; Jabbra and Dwivedi, 2004; Jabbra and Jabbra, 2005; Al-Yahya, 2009). Therefore, Kim (2002), having conducted research into satisfaction and motivation in the public services sector, suggests that in order to improve motivation and performance, policy makers and public managers should involve employees in planning and decision making. More recently, Al-Yahya (2009) found that Saudi employees in public organisations would actually prefer higher levels of participation than is provided by the traditional system of consultation. There appears to be a shift in attitudes towards new, more participative leadership and management styles, which probably reflects advances in training content and strategies and a move towards the more common international management values. The clan culture, as the preferred culture of the participants of this study, is consistent with this. Cameron and Quinn (1999) also found that employees at the middle and higher levels tended to prefer a clan culture.

The preference for other three types of organisational culture (hierarchy, adhocracy and market), as indicated in the quantitative data, is supported by the logic underlying the CVF. According to Cameron and Quinn (1999), based on the CVF, strong cultures are associated with a balance of culture. Quinn (1988) argues that the criteria of the CVF seem to carry a conflicting message. For example, it is desirable for organisations to be adaptable and flexible, but they should also be stable and controlled. There is a desire for growth, resource acquisition and external support, but also for tight information management and formal communication. There should be an emphasis on the value of human resources, but not at the expense of planning and target setting. Therefore, for an organization to be effective and excellent it is recommended to move to a balanced and a uniform strengthening of the four types

of cultures (clan, adhocracy, market and hierarchy). In addition, participants in Saudi context are characterised by Hofstede (2001) to possess a very high tolerance to ambiguity, unlike western cultures where people would identify and have concern about the logical discrepancies between their response to CVF questions. As a result, they will be inclined to give positive answer for all dimensions of organisational culture.

8.5 Discrepancy between the quantitative and qualitative findings based on the CVF.

The findings of quantitative data of this study reveal similarities between the four types of organisational culture in the Saudi health care provision in both the current and preferred situations, although these findings reveal that a hierarchy culture was slightly more prevalent than other types in the current situation, while the clan culture was slightly more prevalent in the preferred situation. In contrast, the findings of the qualitative data strongly support the dominance of hierarchy culture in Saudi health care over the other three types of culture in the current situation. The findings of the qualitative data also strongly support the preference of clan culture over the three other types of culture.

The researcher believes that the findings of the quantitative data provide reasonable and logical results which are consistent with previous studies and especially those which have employed the CVF in different fields and contexts as mentioned earlier. In line with the nature of this study, the CVF has been widely used in health care organisations to assess organisational culture (Gerowitz et al., 1996; Jones et al., 1997; Marshall et al., 2003; Scott et al., 2003b; Davies et al., 2007; Helfrich et al., 2007; Zazzali et al., 2007). In addition, it has been empirically validated in a variety of settings (Bess, 1988; Lau and Ngo, 1996; Cameron and Quinn, 1999; Dastmalchian et al., 2000; Goodman et al., 2001; Parker and Bradley, 2000; Scott et al., 2003a; Cameron, 2004; Bradley and Parker, 2006; Oney-Yazici et al., 2007; Jingjit, 2008; Talbot, 2008; Nelson, 2009). In addition, as reported in Chapter Three, the pilot study indicated that the CVF was applicable to this context. The test

of the questionnaire's face validity was thoroughly reviewed by the researcher's supervisors, academic staff in a Saudi university, hospital employees and the researcher's colleagues in the UK universities; their feedback led to the researcher making some changes to the questionnaire. The pilot study also looked at random individual samples consisting of 30 questionnaires, using the most widely accepted measure of the internal consistency of a scale, Cronbach's alpha. The results were that the alpha coefficient had a range of 0.73 for market culture in the preferred situation to 0.93 for the clan, market and hierarchy cultures in the current situation. The first of these values is considered high and the second very high, indicating that when these scales were applied in a study, the results would be stable and very stable respectively.

Therefore, there is a need to explain why there is such a discrepancy between the quantitative and qualitative findings based on the CVF. However, the discrepancy between the quantitative and qualitative findings based on the CVF can be attributed to different factors. In the first instance, the similarities between the four types of organisational culture in the Saudi health care provision in both the current and preferred situations as revealed by the quantitative data can be attributed to the use of a 5-point Likert scale rather than 100-point ipsative rating scales. As mentioned in the methodology chapter, CVF instruments can use either type of scale and both approaches have been shown to have good construct validity and reliability. Cameron and Freeman (1991) and Zammuto and Krakower (1991) are among the researchers who used a 100-point scale, while Quinn and Spreitzer (1991) and Yeung et al. (1991) used Likert-type response scales. However, the present study, using the CVF, found only slight differences between types of culture. Therefore, adopting an ipsative scale would have been better at showing these differences. According to Cameron and Quinn (1999), the use of the OCAI with a 100-point rating scale instead of a 7-point Likert format has the advantage that it highlights the cultural uniqueness that actually exists in an organisation and results in more differentiation in the ratings. Another advantage of using a 100-point scale is that respondents are forced to identify the trade-offs that actually exist in the

organisation. When a Likert scale is used, respondents tend to rate all quadrants high or all quadrants low; thus, less differentiation occurs.

The researcher conducted a factor analysis test to establish whether the CVF was applicable to the Saudi context or if there were groups of people (e.g. male, female, Saudis, non-Saudis, physicians, nurses, technicians, administrative staff or hospital affiliation) within heath care provision in Saudi Arabia for whom the CVF did work. The expected result was that the analysis would produce four factors, each corresponding to the items of each subscale, as predicted by the CVF, but the actual result did not reveal any examples of what would be expected from the CVF as indicated in Appendix 4.

Moreover, a discrepancy between the quantitative and qualitative findings can be attributed to weakness of the qualitative approach. There is a possibility that the interviewer himself may have influenced the responses due to the way in which he posed the questions or possibly communicated a certain idea such the notion that hierarchy culture may be dominant to the respondents unintentionally (Boslaugh and Watters, 2008). Alternatively, people respond differently to two different strategies for gathering impersonal information. For example, in questionnaires, people answer honestly because they are alone when they answer the questions. In contrast, in interviews, people will often try to answer the questions in the manner that the interviewer wants to hear. Griffiths (2009) suggests that interviewees don't always give their true thoughts, and might tailor their responses either to what they perceive the interviewer is expecting to hear or to what they think is an 'acceptable' way of discussing a particular matter. In addition, it may attributed to the fact that the dominant narrative in these hospitals describes a hierarchal culture. However, this may in fact not be true at all. Even though the interview subjects freely discussed this publicly, upon further investigation it became quite apparent that there were in fact four different cultures: clan, adhocracy, market and hierarchy. Organisational hypocrisy can be argued to be present in every organisation, as Brunsson (1989) noted. This can take place when decisions and actions are not consistent or contradict earlier stated principles, values or measures of performance, but such

inconsistency should not automatically be viewed negatively. Hypercriticism could be seen as a necessity in the way organisations operate, as in the real world they regularly face seemingly contradictory pressures, which effectively push some organisations into institutionalised hypocrisy.

8.6 The relationship between personal characteristics and organisational cultures

This study revealed that there were only two personal characteristics that showed a statistically significant difference in the views of participants regarding the types of organisational culture in hospitals in Riyadh City: hospital affiliation in the current situation and nationality in the preferred situation. In the first case, the four types of organisational culture, according to the views of participants who worked in the Riyadh Armed Forces Hospital (RAFH), were significantly lower than for participants working in other hospitals. This may be attributed to its status as a military installation and to its leadership style, in that it was the only one of the hospitals under study which was directed by a military manager. This kind of administration is more likely than that of the other hospitals concerned to adopt and to be strict in implementing a hierarchy culture. Regarding nationality, Saudis rated their preferred type of culture more highly than non-Saudis. This may be attributed to a desire for change in aspects of hospital management and a dissatisfaction with the current situation. Since Saudis felt a particularly strong affiliation to their hospitals, they would expect and wish strongly for an improvement in the system. Conversely, non-Saudi employees showed no particular enthusiasm for change, since they were likely to stay for only short time (on short contracts) before returning to their home countries. This analysis is supported by responses to the open questions in the questionnaire, regarding the ways in which the experience of a different country had affected non-Saudi employees. For example, some claimed that at work, there was a significant degree of social discrimination against non-Saudis. One non-Saudi administrator in a public hospital claimed: “There is discrimination here between Saudis and non-Saudis in terms of salary, workplace and benefits”. Therefore, some participants thought that appraisals were unfair; for

example, a nurse in a public hospital claimed that salaries in her hospital were "based on nationality, never on experience and qualifications".

8.7 Other Factors influencing health care provision

As mentioned in Chapter Seven, the CVF did not capture a range of extant and dominant practices, issues and problems related to cultural norms. However, a significant number of participants raised these practices, issues and problems. For example, participants felt that government regulations were outdated, time consuming and contrary to the need for flexibility and accelerated advances in the health care system. In summary, these regulations do not take into account the nature of health care services, which relate directly to people's lives. Moreover, some participants argued that since health care services in Saudi Arabia are provided by a number of different bodies concentrated in big cities, some of these bodies provide the same services without good coordination between them, which results in the duplication and misdistribution of health care services in Saudi Arabia. In addition, some participants mentioned the Saudization system as a good long-term investment strategy, because Saudi health care manpower will become involved in all hospital activities and committees, which aim to depend on Saudis in the future, but some were concerned that it may lead to poor productivity if employee selection depends on nationality rather than on experience and qualifications. Furthermore, the majority of participants saw *wasta* as a feature of Saudi culture having a negative effect on health care services. Among the many aspects of health care which they felt were influenced by personal relationships and nepotism were access to hospital services (e.g. patient appointments) and the selection and promotion of employees. Finally, according to some participants, the salary system has a negative effect on health services in Saudi Arabia, because employees are categorised for salary purposes as Western, Asian, Saudi and so on, although they do the same work, which leads to dissatisfaction among them because they feel that the system is unfair. Moreover, the salary system is not based on qualifications and experience, which leads to a high turnover among employees in Saudi health care provision.

It is clear that these problems which the participants identified as facing the Saudi health services today are caused by a hierarchy culture that is prevalent in these hospitals, as argued above. These problems can be summarized as including a lack of planning, poor coordination between hospitals, outdated government regulations, a shortage of qualified Saudis health workers, a failure to use resources optimally, difficulties in accessing hospital services, low salaries, poor training, an inadequate health information system and insufficient health awareness among patients. The participants, who may be considered best able to highlight these problems because they were more aware of them, made a number of recommendations to solve them and so to improve the health care system in Saudi Arabia, which will be discussed in the last chapter.

8.8 Conclusion

In summary, the findings of this study reveal that there are both differences and similarities between the findings of this study and other studies which have employed the CVF in different contexts. This could be attributed to the differences between the national culture of Saudi and other countries where these studies were conducted. However, it was not surprising to find the relative strength of four types of culture (hierarchy, market, clan and adhocracy), as revealed by the quantitative data. This could be attributed to the nature of health care organisations which are considered to be large and complex organisations. Such organisations, according to Deal et al. (1983); Quinn and Kimberly, (1984); Hofstede et al. (1990) and Scott et al. (2003a), are composed of subcultures, which can vary among departments, professional, functional or project groups. Therefore, this mix of values, as well as employees from different background and different positions could reflect on the balance of four types of cultures. In regard to the strength of hierarchy and clan cultures in Saudi health care provision it is clearly expected to be more strength than other types of culture i.e. adhocracy and market. This is based on my review of the literatures which have employed the CVF in different contexts as mentioned in Chapter Five. However, the prevalence of hierarchy and clan cultures could be attributed to Saudi national culture. To illustrate this more clearly, countries that are

arguably more similar to Saudi Arabia such as Thai and Turkish cultures have organisations which emphasise hierarchy and clan culture more predominantly than the US which emphasises market and adhocracy cultures. This is because the former countries have been described in Hofstede's model to possess characteristics of collectivism and high power distance. These characteristics are reflected in their public administration culture which is also dominated by hierarchy and clan culture. In contrast, the US is described by Hofstede's model as being highly individualistic and low in power distance. These characteristics do not support the idea that hierarchy and clan culture are dominant in US organisations. The strength of market culture could be attributed to the nature of the sample of this study which includes participants from private hospitals which are business organisations engaged in competition with other hospitals to win a share of the health care market. The strength of adhocracy culture may be attributed to the nature of health care organisations which emphasise creativity and innovation through the acquisition of new resources and the creation of new challenges because of the dynamic nature of hospitals which is changing and becoming far more dependent on technology.

Regarding the preference for the four types of organizational culture to be strongly dominant in the health care provision in Saudi Arabia, as revealed by the quantitative data, it is expected because it is consistent with logic underlying the CVF. This is mean to improve Saudi health care provision, a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy) is required.

This chapter also revealed that the four types of organisational culture, according to the views of participants who worked in the RAFH, were significantly lower than for participants working in other hospitals. This may be attributed to its status as a military installation and to its leadership style, in that it was the only one of the hospitals under study which was directed by a military manager. Moreover, this study revealed that Saudis rated their preferred four types of organisational culture more highly than non-Saudis. This may be attributed to a desire of Saudi over non-Saudi employees for change in aspects of hospital management.

This chapter also reveals that there is a discrepancy between the quantitative and qualitative findings based on the CVF. The former reveals that there are similarities between the four types of organisational culture in the Saudi health care provision in both the current and preferred situations. These findings also reveal that a hierarchy culture was slightly more prevalent than other types in the current situation and that clan culture was slightly more prevalent in the preferred situation. In contrast, the latter strongly supports the dominance of hierarchy culture in Saudi health care over the other three types of culture in the current situation. The findings of the qualitative data also strongly support the preference of clan culture over the other three types of culture. However, the researcher believes that the findings of the quantitative data provide reasonable and logical results which are consistent with previous studies, and in particular, those which have employed the CVF in different fields and contexts as mentioned in previous chapters. The similarities of findings within the quantitative data can be attributed to the use of a 5-point Likert scale rather than 100-point ipsative rating scale. This is due to the fact that when a Likert scale is employed respondents tend to rate all quadrants high or all quadrants low; thus, less differentiation occurs. The discrepancy between the quantitative and qualitative findings based on the CVF can be attributed to a weakness of the interview. More specifically, this can be attributed to the possibility that the interviewer himself may have influenced the responses due to the way in which he posed the questions or possibly communicated a certain idea unintentionally, such as the notion that hierarchy culture may be dominant to the respondents. Alternatively, people respond differently to two different strategies for gathering impersonal information. For example, in questionnaires, people answer honestly because they are alone when they answer the questions. In contrast, in interviews, people will often try to answer the questions in the manner that the interviewer wants to hear. Moreover, it may attributed to the fact that the dominant narrative in these hospitals describes a hierarchal culture. However, this may in fact not be true at all. Even though the interview subjects freely discussed this publicly, upon further investigation it became quite apparent that there were in fact four different cultures: clan, adhocracy, market and hierarchy.

Finally, the chapter indicates some issues and problems that were mentioned by the interviewees that related to their hospitals which are considered cultural norms not covered by the CVF which need to be reviewed and tackled by Saudi health care policy makers in order to improve the Saudi health care services. These include updating government regulations, more coordination of health care provision, a standardised salary system, a review of the Saudization strategy and limiting *wasta* which is caused by national culture and the bureaucratic systems that exist within these hospitals. However, some of these norms supported the strength of certain types of organizational cultures. For example, *wasta* supported the strength of clan culture because it plays an integral role in shaping the daily life of people in Saudi Arabia. This means that the management of health care provision reinforces the custom of extended families, friends and the importance of in-groups, which transcend the immediate family. Moreover, *wasta* supported the prevalence of hierarchy culture and resulted in mangers remaining in their positions and promoting their personal interests, whether for themselves, their immediate family or their friends in these organizations.

CHAPTER 9 CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

This chapter begins by returning to the research objectives and provides an assessment of their achievement. The thesis has presented some significant findings concerning the role of culture in health care organisations in the relatively unique context of a Middle Eastern state. The closing section explains the contributions to research, the limitations of this study and recommendations to Saudi policy makers regarding the problems facing the Saudi health system.

9.2 Revisiting the Research Objectives

The purpose of this study is to understand the role of organisational culture in the delivery of health care in Saudi Arabia and thereby to assist in improving the understanding of effective ways to diagnose and change this culture, thus enhancing organisational performance. To achieve this purpose, the study proposed a number of objectives, listed in Chapter One, section 1.3. An assessment of the first five of these objectives now follows.

9.2.1 To critically examine the strategic environment of health care provision in Saudi Arabia

The first chapter recognized that a crucial first step in this research was to examine the strategic environment of health care provision in Saudi Arabia. Saudi Arabia has modernised in many ways, including changes in lifestyle and increasing exposure to the West. Society has become more integrated in the global network and certain concepts or practices from outside have begun to become the norm rather than the exception. This has allowed new patterns to develop in managerial values and attitudes toward participatory culture and institutions (Al-Twaijry and Al-Muhaiza, 1996; Al-Yahya, 2009). The Saudi economy, being oil-based, has considerably

transformed almost all aspects of life in Saudi Arabia – including economic, social and urban ones. This transformation can be attributed to extensive government investment organised into five-year development plans which laid down the infrastructure, both social and physical, of the country. Mellahi (2006) remarks upon the close links between oil prices and political and social stability in Saudi Arabia.

However, although there have been some attempts to reform Saudi public organisations, there has been no such change in other aspects of life. This is due to the fact that fundamental social codes and cultural factors have remained unchanged. This is unsurprising, since the political system in Saudi Arabia is a traditional monarchy. More specifically, according to Common (2008), this kind of system is described as a rentier state in which the powerful elite do not have much incentive to change their habits and where there is a slow rate of political change in situations where this elite dominates political life. Basically, the political sphere is restrained by strong institutions which are dictated by culture and tradition.

The social culture in Saudi Arabia also lends support to maintaining the status quo in Saudi Arabia in many respects. The analysis of the national culture, based on Hofstede's model, reveals that health provision in Saudi Arabia is characterised by high power distance, collectivism, a feminine culture and high uncertainty avoidance. These characteristics are reflected in organisational, hierarchical and centralised structures, all of which has produced an environment of rigidity and resistance to administrative reform.

It is clear that the Saudi public management environment has a significant effect on the functioning of the public bureaucracy. Therefore, such characteristics represent a major reason for the lack of change in the country. The next subsection considers the impact of these characteristics on the results of this study regarding the role of organisational culture in Saudi health care provision.

9.2.2 To assess the types of organisational culture currently dominant in health care provision in Saudi Arabia

The main findings of this study from the quantitative data reveal that the Saudi health care provision was not characterised by just one cultural type, although the hierarchy culture was slightly prevalent in the current situation, with most hospitals in Saudi Arabia put the emphasis on internal focus and valuing stability and control. These hospitals are characterised by a high level of bureaucracy and are driven by rules, regulations, and a hierarchical type of management. This is no surprise, since these public hospitals are government controlled. This finding is supported by the analysis of Saudi national culture based on Hofstede's dimensions, which found public management in Saudi Arabia to be characterised by high power distance and high uncertainty avoidance. These characteristics are reflected in hierarchical and centralised structures.

It is clear that the prevalence of hierarchy may be attributed to Saudi culture, whereby people learn from early childhood to respect and obey their elders. These values motivate them to show respect to their superiors and accept the power distance between superiors and subordinates. A related aspect of Saudi culture is that power and authority are distributed unequally among the members of society, who also avoid questioning those whom they see as their superiors. For example, this allows managers to maintain a power distance between themselves and their employees in order to remain in position and foster their personal interests, whether for themselves, their family or their friends. This is influenced by *wasta* which is dominant in these organisations. In this unequal distribution of power, employees tend to prefer to be guided and told what to do, strongly avoiding conflict with their managers, even if they use their authority unfairly, which is yet another explanation of the dominance of a hierarchy culture in Saudi public organisations.

The findings of the quantitative data reveal the strength of market culture in the Saudi health care provision. Market culture here is based on competitiveness, productivity and achievement. It has an external focus and emphasises stability. The

strength of market culture can be attributed to the nature of the sample of this study. This sample group includes hospitals from the private sector which are business organisations engaged in competition with other hospitals to win a share of the health care market.

The results of the quantitative data also reveal that there is a strength of clan culture within the Saudi health care provision. Clan culture here is based on human development, cooperation, coordination, teamwork, employee involvement and rewards. The organisation operates as an extended family. It has an internal focus and emphasises flexibility. The strength of clan culture in the Saudi health care provision can be attributed to the nature of health care organisation as mentioned in Chapter Five as there is a strong subculture present within health organisations which represent the provisional group employees such as physicians, nurses etc. Moreover, the strength of clan culture in Saudi health care provision is supported by the analysis of Saudi national culture based on Hofstede's dimensions, which found public management in Saudi Arabia to be characterised by collectivism. This may be attributed to Islamic instructions, which emphasises unity and encourages people to care for and help each other. In addition, the strength of clan was supported by *wasta* which reinforces the concept of extended family, relatives and friends.

The findings of the quantitative data also indicate the strength of adhocracy culture in the Saudi health care provision. Adhocracy culture in this context is based on entrepreneurship, innovation, freedom, uniqueness and development. The organisation works by trying new things and looking for new opportunities. It has an external focus and emphasises flexibility. The strength of adhocracy culture on Saudi health care provision can be attributed to the nature of health care organisations. This is due to the fact that adhocracy culture emphasises creativity and innovation through the acquisition of new resources and creating new challenges. Trying new things and prospecting for opportunities are valued. These principles are consistent with dynamic work in the hospitals which is changeable and renewable.

As mentioned in Chapter Eight, the findings of the qualitative data are inconsistent with quantitative results although it strongly supports the dominance of hierarchy culture in Saudi health care over the other three types of culture. These showed that almost two-thirds of participants commented that the currently dominant type of organisational culture in their hospital was hierarchical. According to interviewees, a hierarchy culture was practised through vertical hospital structures. Therefore, the involvement of employees in decision making was too limited. Interviewees also stated that the hospital directors would exert as much control as they could and try to interfere in everything. Moreover, they complained that the existence of a hierarchical culture resulted in long procedural delays in passing information to hospital directors in order for them to make final decisions.

9.2.3 To identify the type of organisational culture which would best support efforts to improve health care services in Saudi Arabia

Another main finding from the quantitative data reveals that there is a balance between the four types of culture in a preferred situation with high scores on all four dimensions. However, it reveals that in the health care provision in Saudi Arabia clan culture was slightly more prevalent in the preferred situation. This was followed by hierarchy, adhocracy and market cultures in that order. This result reveals that there is a feeling of dissatisfaction among participants about health care provision in Saudi Arabia. In fact, their intention is to change the culture by moving to a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy), with more emphasis on clan culture, as preferred by participants. This means that health care provision in Saudi Arabia would be characterised as highly personal, like an extended family, where people seem to care for others. The hospitals concerned would emphasise human development and teamwork, and trust, openness and participation would persist. The preference for a clan culture is consistent with Saudi social culture, which according to Hofstede’s model is collectivist and based on cooperation, trust and personal relationships between people.

However, problems may arise from the preference for a clan culture among the professional group, comprising highly educated personnel such as physicians, nurses and technicians, with a strong influence and authority regarding their own work and an emphasis on the standardisation of skills, and who are keen on the standardised delivery of services to patients, as described by Mintzberg (1983). This is because such employees, having a strong relationship with patients, are particularly concerned with providing services to them, regardless of considerations of accountability and professionalism. In addition, the control of resources is a principle of the hierarchy culture which acts as a check and safeguard, and this advantage would be lost if the clan culture were dominant.

Therefore, to improve Saudi health care provision, a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy) is required in this case, acting in the interests of government, patients and physicians. This is because it is consistent with the logic underlying the CVF as mentioned earlier.

As mentioned in Chapter Eight, the findings of the qualitative data are inconsistent with the quantitative results although the data strongly supports the preference of clan culture over the other three types of culture. This revealed that a majority (slightly more than two-thirds) of interviewees expressed a preference for a clan culture which would operate in their hospitals through teamwork, participation and unanimity. Other interviewees revealed preferences for other types of organisational culture, albeit on a limited scale. Some said that they would prefer adhocracy, to allow development and innovation, while a few would have preferred a market culture and the ensuing competition. Finally, a very few participants said that they preferred the hierarchy culture, to organise the work and allocate the tasks among hospital employees.

9.2.4 Discrepancy between the quantitative and qualitative findings based on the CVF.

It is worth mentioning that there is a discrepancy between the quantitative and qualitative findings based on the CVF. The findings of the qualitative data reveal that there are similarities between the four types of organisational culture in the Saudi health care provision in both the current and preferred situations, although these findings reveal that a hierarchy culture was slightly more prevalent than other types in the current situation, and a clan culture was slightly more prevalent in the preferred situation. In contrast, the findings of the qualitative data strongly support the dominance of hierarchy culture in Saudi health care over the other three types of culture in the current situation. The findings of the qualitative data also strongly support the preference of clan culture over the other three types of culture.

The researcher believes that the findings of the quantitative data provide reasonable and logical results which are consistent with previous studies, and in particular, those studies which have employed the CVF in different fields and contexts as mentioned in previous chapters. The similarities of findings of quantitative data can be attributed to the use of a 5-point Likert scale rather than a 100-point ipsative rating scales due to the fact that when a Likert scale is used respondents tend to rate all quadrants high or all quadrants low; thus, less differentiation occurs. With regard to the findings of the qualitative data in this study, the discrepancies that are apparent between the findings of quantitative and qualitative data can be attributed to the weakness of qualitative approach. It is possible the interviewer himself may have influenced the responses due to the way in which he posed the questions or possibly communicated a certain idea such as the notion that hierarchy culture may be dominant to the respondents unintentionally. Alternatively, people respond differently to two different strategies for gathering impersonal information. For example, in questionnaires, people answer honestly because they are alone when they answer the questions. In contrast, in interviews, people will often try to answer the questions in the manner that the interviewer wants to hear. Moreover, it may attributed to the fact that the dominant narrative in these hospitals describes a

hierarchal culture. However, this may in fact not be true at all. Even though the interview subjects freely discussed this publicly, upon further investigation it became quite apparent that there were in fact four different cultures: clan, adhocracy, market and hierarchy.

9.2.5 To identify which personal characteristics of health services' employees influence the organisational culture

This study revealed that the four types of organisational culture, according to the views of participants who worked in the RAFH, were significantly lower than for participants working in other hospitals. This may be attributed to its status as a military installation and to its leadership style, in that it was the only one of the hospitals under study which was directed by a military manager. This kind of administration is more likely than that of the other hospitals concerned to adopt and to be strict in implementing a hierarchy culture. Moreover, this study revealed that Saudis rated their preferred four types of organisational culture more highly than non-Saudis. This may be attributed to a desire among Saudi employees over non Saudi employees for change in aspects of hospital management.

Another interesting finding from the interviews was that the dominant type of organisational culture at the King Faisal Specialist Hospital and Research Centre, unlike the other health care providers, was not hierarchical; instead, the hospital exhibited a clan culture. This is because the hospital was exceptional in that its director reported directly to the Royal Bureau and his organisation was exempt from many government regulations. This special characteristic may have helped to create a positive atmosphere in the hospital, allowing the employees to practise a clan culture and avoid perceived bureaucratic excesses. However, this exemption from some government regulations in some hospitals that helps them to practise a clan culture may simply provide a good indicator of the shortcomings of the government regulations that apply to most Saudi public hospitals. This characteristic led some participants from this hospital to see the future of their hospital as best served by an adhocracy culture emphasizing creativity or a market culture favouring competition.

The interview results also revealed that the private hospitals were not dominated by a hierarchy culture in the current situation, but had a mixed culture with more emphasis on adhocracy. This is unsurprising, since private hospitals were found to be less subject to governmental regulations of the type that perpetuated the bureaucracy dominating Saudi public hospitals. Therefore, they were more likely to encourage development and innovation, in order to increase their profits.

The fifth objective, to suggest ways in which to improve health care provision in Saudi Arabia, is addressed below in section 9.5.

9.3 Research contributions

9.3.1 Theoretical contribution

The main theoretical contribution of this study is that it fills significant gaps in the literature on organisational studies by demonstrating that culture has a significant impact on healthcare provision in Saudi Arabia. More specifically, it is hoped that the study may contribute to understanding the role of organisational culture in Saudi Arabia's health care provision and so to help fill a serious gap in the literature on health care management in Saudi Arabia (Tayeb, 2005; Common, 2008). More widely, the study contributes to a scant literature on the influence of culture on managerial behaviour in the Arab Gulf States and builds upon existing research that demonstrates that culture is embedded in organisational fabrics that are difficult to change, even in the long term.

The findings of this study reveal that Saudi health care provision is not characterised by just one cultural type, although the hierarchy culture was slightly prevalent in the current situation, with most hospitals are characterised by a high level of bureaucracy and are driven by rules, regulations, and a hierarchical type of management. This was followed by the market, clan and adhocracy types in that order.

Another main theoretical contribution of this study in the findings is that there is a balance between the four types of culture in a preferred situation with high scores on all four dimensions. However, it reveals that in the health care provision in Saudi Arabia clan culture was slightly more prevalent in the preferred situation. This was followed by hierarchy, adhocracy and market cultures in that order. This result reveals that there is a feeling of dissatisfaction among participants about health care provision in Saudi Arabia. In fact, their intention is to change the culture through moving to a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy), with more emphasis on a clan culture, as preferred by participants, meaning that health care provision in Saudi Arabia would be characterised as highly personal, like an extended family, where people seem to care for others. The hospitals concerned would emphasise human development and teamwork, and trust, openness and participation would persist.

In summary, this thesis has been successful in being able to contribute to the existing research on this subject and to bridge gaps in our present understanding of certain aspects of Saudi healthcare provision which have been under examination. The study has shown that culture has a significant impact on health care provision in Saudi Arabia, where the hierarchy culture has a strong influence. Indeed, the strength of this influence may prove to be integral to the problems and challenges presently facing the Saudi health care system. In the preferred scenario, improvements to Saudi health care would be delivered through a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy), with more emphasis on clan culture, as preferred by participants, through participation and teamwork among the different sectors within the Saudi health care sector.

9.3.2 Methodological contribution

The main methodological contribution of the study is that it identifies and emphasises that the CVF is suitable for studying the situation of Arab countries in general and more specifically Saudi Arabia. It should be pointed out that it is the first attempted replication of the CVF developed by Cameron and Quinn (1999)

regarding the assessment of the role of organisational culture in health care provision in Saudi Arabia. The CVF was developed and used in Western countries that have totally different organisational cultures compared to that of Saudi Arabia. The suitability of the CVF is witnessed by the consistency between the findings of the previous studies which have employed the CVF in health care organisation in different contexts and which concluded that the four types of organisational culture can be found in health organisations as revealed by this current study.

9.4 Limitations of the Study

The limitations of this study should be addressed before making recommendations, as these are based on the interview findings. The first is that the study employed a purposive sampling technique for the semi-structured interviews, which is a non-probability sampling method in which the researcher chooses respondents based on who they think would be appropriate to answer the research questions and meet the research objectives (Saunders et al., 2007). The researcher in this case interviewed only managers, because he considered them qualified to provide answers to the interview questions about the role of organisational culture in Saudi healthcare provision. This differs from probability sampling techniques, where the probability of selecting each member is known and is equal for all cases. In order to overcome this limitation, the researcher believes, as mentioned in Chapter Three, that he ensured that the interviews conducted were sufficient to answer the research question. Thus, the interviewees were selected so that they represented all the main providers of health care in Riyadh and included a member of each professional group within each of these providers.

The researcher believes that as he is part of Saudi culture, this may have affected his analysis of the factors underlying this study. In order to overcome this limitation the researcher employed an objective research method so as not to bias the findings. This is clarified in detail in Chapter Three.

Given the nature of this study and the limited financial and time resources available, the empirical part of this research was conducted exclusively among health care organisations in the city of Riyadh. This can be considered as a limitation, because Saudi Arabia is the largest country on the Arabian Peninsula and Riyadh may not be typical of the rest of the country, as it has some characteristics and facilities that cannot be found in other cities. For example, it is the capital of Saudi Arabia, where the headquarters of all government agencies are located. Moreover, Riyadh is considered the centre of the health care provision in Saudi Arabia; therefore, main hospitals are established there. In addition, its population is culturally mixed when compared to the rest of the country, with people from both inside and outside the country, of different backgrounds, languages, religions, levels of education and so on.

9.5 Recommendations

9.5.1 Recommendations for further research

This section offers some recommendations for future research on the use of the CVF for analysing organisational culture, both in general and in the Saudi context.

The results of the CVF questionnaire reveal that there were similarities among the four types of culture in the current and preferred situations. Therefore, it is recommended that future research should investigate why such similarities exist between the four types of culture. It is recommended that this investigation be carried out through interviews, because the main question will be 'why?', which can best be answered through interviews.

A further recommendation for future studies applying the CVF to the Saudi context is to use ipsative scales in order to bring out the differences among the types of culture. The researcher believes that this would require participants to read and understand the items carefully, in order to allocate the 100 points among the four items representing the four types of culture according to their importance.

There is a pressing need to conduct further research into the influence that national culture has on organisational culture. This could be done by combining Hofstede's (2001) dimensions of culture model with that of Cameron and Quinn to explore the relationship between these two cultures in the Saudi context.

It is further recommended that a comparative study assessing organisational culture in health care system using the CVF is conducted. The sample should compare studies between Saudi Arabia and Western countries, such as UK or US, from where the CVF originates. This would also help to determine which factors are the most applicable to Arab countries. Once again, there is a need to consider the influence of culture, including on decision making. The challenges associated with identifying factors that influence the CVF are that they are often intangible, hidden or buried deep within the cultural programming of the actors involved. This could include other independent variables, such as employee and patient satisfaction.

9.5.2 Recommendations to improve Saudi health care

In accordance with the logic underlying the CVF, for Saudi organizational culture to be effective it is recommended that it shifts from the current situation, dominated by a hierarchical culture, to balance a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy), as indicated by the quantitative data of this study. However, the adoption of such a change would on one hand provide Saudi decision makers with better quality services and on the other hand satisfy participants. Therefore, healthcare providers should exploit the trend marked by a desire among their employees as mentioned above, ensuring their support for efforts to encourage this movement and reducing their likelihood of resistance to this change by showing them the importance of their role in its success.

The study also recommends that note be taken of the contributions of some participants, who may be best able to highlight the current problems that need to be tackled to improve the services in their hospitals, because they are most directly aware of them. These interviewees mentioned extant and dominant practices, issues

and problems in their hospitals that are considered cultural norms not covered by the CVF. These problems and challenges can be rectified and the health care system in Saudi Arabia improved by adopting the following recommendations made by interviewees.

Recommendations for government

Government regulations

Participants felt that government regulations were outdated, time consuming and contrary to the need for flexibility and accelerated advances in the health care system. In sum, these regulations do not take into account the nature of health care services, which relate directly to people's lives. Therefore, the study recommends a review of government regulations, especially the Government Procurement System, so that it takes into account the nature of the health care system and the rapid advances in this field. Moreover, these regulations should comply with the need to supply medical items urgently for patient services. Participants recommended that hospitals should be granted more operational autonomy (system of direct management by programme) in order to overcome the dependence on routine procedure and to allow them to work more flexibly.

Coordination of health care provision

Some participants argued that since health care services in Saudi Arabia are provided by a number of different bodies concentrated in big cities, some of these bodies provide the same services without good coordination between them, which results in the duplication and misdistribution of health care services in Saudi Arabia. Therefore, participants recommended more coordination among health care providers to ensure a good distribution of good, comprehensive and fair health care services for patients throughout the country.

Budget

The majority of participants felt that their hospitals had adequate budgets, but that the available funds should be utilized more effectively. However, for example, it was felt that the tendering process was subject to unnecessary bureaucratic delays prior to final approval. As a result, the budget allocated for theses tenders was often lost. Therefore, they recommended using the optimal allocation of financial resources through the adoption of decentralization and de-bureaucratization for budget procedures.

Health information system

Participants complained that the health information systems in their hospitals were not good. They cited a lack of electronic equipment for administrative transactions, leading to delays and the wasting of money. To rectify this, they recommended the adoption of a health information system that integrates all hospital departments.

Business centres

Business centres were established in Saudi public hospitals to improve the income of these hospitals and of their employees. The majority of participants felt that this had had a negative effect on hospital services, because physicians focused more on these centres than on their regular work. Therefore, they recommended a review of the system of business centres inside hospitals.

Recommendations for human resources management

Saudization

Some participants mentioned the Saudization system as a good long-term investment strategy, because Saudi health care manpower will become involved in all hospital activities and committees, which aim to depend on Saudis in the future, but some were concerned that it may lead to poor productivity if employee selection depends on nationality rather than on experience and qualifications. Therefore, they

recommended that Saudization should not lead to an exclusive focus on nationality, but that the experience and qualifications of employees should also be considered.

Training programmes

Many participants reported that the training systems in their hospitals were not good, because they focused on quantity rather than quality, and on medical training to the exclusion of administrative training programmes. Therefore, some participants suggested giving more attention to training programmes, especially in the administrative field.

Salary system

According to some participants, the salary system has a negative effect on health services in Saudi Arabia, because employees are categorised for salary purposes as Western, Asian, Saudi and so on, although they do the same work, which leads to dissatisfaction among them because they feel that the system is unfair. Moreover, the salary system is not based on qualifications and experience, which leads to a high turnover among employees in Saudi health care provision. Accordingly, participants suggested standardizing the salary system based on employees' experience and qualifications, instead of the current emphasis on nationality and hospital affiliation.

Recommendations concerning social factors

Wasta

The majority of participants saw *wasta* as a feature of Saudi culture having a negative effect on health care services. Among the many aspects of health care which they felt were influenced by personal relationships and nepotism were access to hospital services (e.g. patient appointments) and the selection and promotion of employees. Accordingly, participants recommended that action should be taken to limit the influence of *wasta* within the health sector.

Patients' awareness

According to participants, there is a lack of awareness among Saudi patients regarding the need to keep appointments, which are therefore often cancelled. In addition, patients often do not follow instructions for taking medication and do not utilize medicines properly as prescribed by their physician. Therefore, some participants suggested improving patients' awareness through awareness programmes, to reduce the misuse of health services.

Additional recommendations

Interviewees also made some fairly general recommendations about other key aspects of health care management. These included expanding hospitals to meet the growing demand for health services, facilitating more effective access to health services and minimizing patient waiting times.

9.6 General reflections on the research

It is remarkable that there has been very little change in Saudi culture. This is reflected by a lack of change or reform in the management of Saudi public organisations, although there have been attempts to reform the Saudi public organisations that focus on the coordination and control of expanding public agencies. However, even if change is found in some sense, it is considered a historical development because the government does not implement specific plans, such as those influenced by NPM, to carry out such reforms. The absence of modernisation in Saudi public organisations can also be attributed to the nature of the environment that shapes the management style in the country. This fosters power centralisation, a feature which does not encourage the adoption and implementation of international reform trends.

Saudi Arabia's hospitals are slightly stronger prevalence by a hierarchy culture, with most emphasising an internal focus and valuing stability and control. These hospitals are characterised by a high level of bureaucracy and are driven by rules, regulations

and a hierarchical type of management. This pattern is not surprising, since these public hospitals are controlled by the government. It may also be attributed to the Saudi culture, which teaches people from early childhood to respect and obey their elders. These values motivate them to show respect to their superiors and accept the power distance between superiors and subordinates. A related aspect of Saudi culture is that power and authority are distributed unequally between the members of society, characterised by the avoidance of questioning one's superiors. For example, managers prefer to maintain a power distance between themselves and their employees in order to remain in post and foster their personal interests, whether for themselves, their family or their friends.

This aspect of Saudi culture, called *wasta* in Arabic and broadly equivalent to nepotism in western culture, plays a vital role in shaping daily life in Saudi Arabia. The evidence of this study is that it has a negative effect on health care services. For example, many hospital activities are influenced by personal relationships, which employees use to obtain access to hospital services (e.g. patient appointments) for themselves, their relatives and friends. This happens partly because of the difficulty in accessing hospital services. The selection and promotion of employees is also dependent on the influence of relatives and friends, which causes a feeling of injustice among patients and employees. It also leads to inequality of opportunity and favours those people who exploit its benefits for their relatives and themselves. This leads to a lack of participation by employees in their organisation's activities and means that their needs, involving such matters as promotion, training and entertainment, are not met fairly.

Survey research in the Arab world is no easy task, because access to the data in public organisations is surrounded by security regulations. Moreover, anyone wishing to administer questionnaires or conduct interviews with employees of public organisations for research purposes must pass through a number of bureaucratic channels in order to obtain permission to conduct such research. Such procedures mean that it takes a long time simply to obtain permission, which is unfavourable to

any research that requires that a field study be conducted in a limited timescale, such as the present work.

Investigating organisational culture change in the Arab world is difficult, especially in the light of the environment that shapes the style of public bureaucracy. This is because the values derived from Saudi culture have a strong influence on people. The findings of this study lead to recommend moving from the current situation, dominated by a hierarchical culture, to a balance of four types of organisational culture (clan, adhocracy, market and hierarchy). However, health care providers should be aware that such a change would take a long time and might encounter resistance from employees, especially older ones. It is important to convince them of the importance of any change and of their role in its success, as well as the benefits to themselves, in order to ensure their support for it and to reduce the likelihood of their resistance to change. Moreover, the process of change can be carried out by abandoning the old traditions and moving to new modern methods flexibly and gradually.

9.7 Final remarks

What is remarkable about this study is that the Saudi health care system is facing many problems that are having an adverse effect on delivery, such as difficulties in accessing its services, long waiting lists, medical malpractice and patient dissatisfaction, so improvement and change are essential. Despite government efforts to reform Saudi health services, some of these problems persist. The underlying problem is Saudi culture, which is characterised by a high power distance, collectivism, femininity and high uncertainty avoidance. These characteristics are reflected in hierarchical and centralised organisational structures; they also appear to have produced an environment of rigidity and resistance to administrative reform.

The study also found that there was a feeling of dissatisfaction among participants about health care provision in Saudi Arabia. They expressed a desire to change the

culture to one that places more emphasis on human development, teamwork and trust, openness and participation. This was to be expected, since the problems that face the health care system arise from the organisational culture in the Saudi public sector, is dominated by hierarchy culture. To improve Saudi health care provision however, a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market and hierarchy) is required, as has been indicated by participants to this study. For this to happen, significant change may be required across a number of areas within Saudi culture but this may be impossible to reverse or even to modify significantly. The attitudes, policies and practices within such a firmly entrenched culture as that which exists within Saudi Arabia reflect centuries of social development.

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APPENDIX 1: QUESTIONNAIRE

بسم الله الرحمن الرحيم

استبيان حول مقدمي الخدمات الصحية في المملكة العربية السعودية

عزيزي الموظف

أفيدكم بأنني أعمل على إعداد رسالة دكتوراه عن مقدمي الخدمات الصحية في المملكة العربية السعودية من جامعة مانشستر ببريطانيا.
وتهدف هذه الدراسة إلى دراسة العوامل التي قد تساعد أو تعيق أي جهود لتطوير الخدمات الصحية في المملكة، وذلك من خلال تقديم بعض التوصيات والمقترحات لأصحاب القرار في القطاع الصحي ، والتي قد تساهم في حل بعض المشاكل التي تواجه هذا القطاع وبالتالي المساهمة في تطوير هذا القطاع الحيوي.

عزيزي المشارك
بما أنك تعمل في المستشفى ، آمل المشاركة بالإجابة على الاستبيان (المرفق) ، والذي لن يستغرق سوى من 10 إلى 15 دقيقة لإكماله.
وتأكد ان إجابتك عن الأسئلة بدقة ستزودنا بمعلومات مهمة عن موضوع هذه الدراسة. علماً أن هذا الاستبيان لا يتطلب ذكر الاسم ، وسيتم التعامل مع الإجابات بدرجة عالية من السرية ، وسوف تستخدم نتائج هذا الاستبيان لأغراض البحث العلمي فقط.
أخيراً، شكراً جزيلاً على مشاركتك وتعاونك ، والذي سيكون لها دور إيجابي في نجاح ودقة نتائج هذه الدراسة ، وفي حالة رغبتك في الحصول على نسخة من نتائج هذا الاستبيان فإنه يسعدني تزويدك بذلك ، كما أنه إذا كان لديك أي استفسار حول هذا الاستبيان أو موضوع الدراسة فلا تتردد في الاتصال بي أو مراسلتي على العنوان الموضح أدناه .

شاكراً لكم حسن تعاونكم ،،،

الباحث

عبدالله بن صالح العتيبي

جوال: 0555426112
إيميل: fao99@hotmail.com

Questionnaire about health care provision in Saudi Arabia

Dear Employee,

I am conducting research leading to the degree of PhD in the Business School at the University of Manchester about health care management in Saudi Arabia.
The study aims to explore and assess the elements that affect health care provision in Saudi Arabia. This will help to find out which of these elements best support and those which hinder its change efforts to improve services. It is hoped that the research findings will provide useful suggestions and guidelines that may contribute to solving the current problems faced by health care facilities in Saudi Arabia and would be helpful in improving the current situation.

Dear participant
As you are an employee at a hospital, I would be grateful if you could participate in this survey by answering the questions in the questionnaire attached. Although this task should only take about 10-15 minutes to complete, the information you provide will be very important.
The questionnaire will be anonymous, and all data collected will be treated with strict confidentiality, and will be used only for the purposes of this study.
Thank you very much for your participation and cooperation. Your sincere and honest response will be the cause of this study's success and accuracy. If you participate and desire a copy of the results of this study, I would be happy to send one to you, and if you have any queries and/or require further information on this study, please do not hesitate to contact me.

Researcher
Abdullah Al-Otaibi
Mobile: 0555426112
Email: Fao99@hotmail.com

Section two -A description of the Hospital القسم الأول: وصف المستشفى

العبارات التالية أوصاف قد توجد في المستشفى الذي تعمل فيه. فضلاً اختر العبارة المناسبة التي تصف المستشفى كما تراه في **الوضع الحالي** وكذلك **الوضع الذي تتمنى أن يكون عليه في المستقبل.**

Statements below may apply to your hospital. Please tick the appropriate statement that describes your hospital. Please state both how you feel your hospital is now (**NOW**) and how you think it should be (**PREFERRED**).

PREFERRED الوضع المفضل					**NOW الوضع الحالي**					**1- خصائص المستشفى** **Dominant Characteristics**	
أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree	أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
										يغلب على بيئة المستشفى الطابع الشخصي وكأنه أسرة واحدة فالموظفون فيه متعاونون ويهتمون ببعضهم. A. The hospital is a very personal place. It is like an extended family. People seem to care for others.	أ
										يغلب على بيئة المستشفى النشاط والحيوية لذلك هناك دوافع للابتكار والموظفون فيه مستعدون للمبادرة. B. The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	ب
										يغلب على بيئة المستشفى الاهتمام بالإنتاجية والقيام بالمطلوب فقط لذلك توجه الموظفون فيه نحو المنافسة والإنجاز C. The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	ج
										يغلب على بيئة المستشفى أنه مكان محكوم ومنظم جداً والإجراءات الرسمية تحكم ما يفعله الموظفون. D. The hospital is a very controlled and structured place. Formal procedures generally govern what people do.	د

الوضع المفضل PREFERRED					NOW الوضع الحالي					**2- أسلوب القيادة في المستشفى** **Organisational leadership**	
أعارض بشدة Strongly disagree	ا أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree	أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
										تعتبر القيادة في المستشفى مثالاً للتوجيه وتيسير الأمور والرعاية. A. The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	أ
										تعتبر القيادة في المستشفى مثالاً للمبادرة والابتكار والمجازفة. B. The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	ب
										تعتبر القيادة في المستشفى مثالاً للجدية والحزم والتركيز على النتائج. C. The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus.	ج
										تعتبر القيادة في المستشفى مثالاً للتنسيق وتنظيم العمل والاهتمام بأداء العمل بكفاءة. D. The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	د

الوضع المفضل PREFERRED					NOW الوضع الحالي					**3- إدارة الموظفين** **Management of Employees**	
أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree	أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
										يتسم أسلوب الإدارة في المستشفى بالعمل الجماعي والمشورة والمشاركة. A. The management style in the hospital is characterized by teamwork, consensus, and participation.	أ
										يتسم أسلوب الإدارة في المستشفى بالمبادرة الفردية والابتكار والحرية	ب

										والتميز. B. The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	
										يتسم أسلوب الإدارة في المستشفى بالمنافسة الشديدة والطلبات المتكررة والإنجاز. C. The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement.	ج
										يتسم أسلوب الإدارة في المستشفى بالأمن الوظيفي والاستقرار في العلاقات. D. The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	د

PREFERRED الوضع المفضل						**NOW الوضع الحالي**					**4- ترابط المستشفى Organisation Glue**	
أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		أعارض بشدة Strongly disagree	ا أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
											يتم ترابط المستشفى من خلال الولاء والثقة المتبادلة والالتزام برقي المستشفى. A. The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	أ
											يتم ترابط المستشفى من خلال الالتزام بالابتكار والتطوير والتركيز على الأفضل. B. The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	ب
											يتم ترابط المستشفى من خلال التركيز على الإنجاز وتحقيق الهدف بجدية لذلك فالحزم والفوز هما الطابع السائد. C. The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	ج
											يتم ترابط المستشفى من خلال الأنظمة والسياسات الرسمية ويعتبر الحفاظ على سير العمل بسلاسة وسهولة أمر	د

										ضروري. D. The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important.	

PREFERRED الوضع المفضل						NOW الوضع الحالي					5- استراتيجية المستشفى **Strategic Emphasis**	
أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
											يركز المستشفى على التنمية البشرية و الثقة العالية والاتصال والمشاركة المستمرة. A. The hospital emphasizes human development. High trust, openness, and participation persist.	أ
											يركز المستشفى على الاستحواذ على الموارد الجديدة (مادية, بشرية, أجهزة ومعدات) وتجربة أشياء جديدة وإيجاد فرص ذات جدوى. B. The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	ب
											يركز المستشفى على الأعمال التنافسية والإنجاز من خلال تحديد الأهداف والوصول إليها وبالتالي الفوزفي مجال الرعاية الصحية. C. The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	ج
											يركز المستشفى على الأداء و الاستقرار وتعتبر الفعالية والتحكم وسلاسة العمليات والنشاطات من الأمور المهمة. D. The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	د

PREFERRED الوضع المفضل						NOW الوضع الحالي					6- معايير النجاح **Success Criteria**	
أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		أعارض بشدة Strongly disagree	أعارض Disagree	محايد Neutral	أوافق Agree	أوافق بشدة Strongly agree		
											يعرّف المستشفى النجاح على أساس تطوير الموارد البشرية والعمل الجماعي والاهتمام بالموظفين A. The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	أ
											يعرّف المستشفى النجاح على أساس تقديم خدمات جديدة ومميزه لذلك فالمستشفى رائد ومبدع في تقديم الخدمات. B. The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	ب
											يعرّف المستشفى النجاح على أساس تجاوز المنافسين في مجال الرعاية الصحية. وتعتبر القيادة التنافسية في هذا المجال هي مفتاح النجاح. C. The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive leadership in the health care field is key to success.	ج
											يعرّف المستشفى النجاح على أساس الفعالية. ويعتبر تقديم الخدمات في وقتها وبأقل تكلفة من الأمور المهمة. D. The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical.	د

Section two – General Information القسم الثاني: معلومات عامة

فضلاً اختر الإجابة المناسبة بوضع علامة (√) في المربع المناسب أو اكتب المعلومة المطلوبة على الخط المبين أمام كل سؤال.

Please tick (√) the appropriate box to each of the following questions or state the relevant information on the line indicated.

1) المستشفى الذي تعمل فيه Your hospital

☐ مدينة الملك عبدالعزيز الطبية للحرس الوطني
King Abdulaziz Medical City for National Guard.

☐ مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital and Research Centre

☐ مستشفى القوات المسلحة بالرياض
Riyadh Armed Forces Hospital

☐ مجمع الرياض الطبي
Riyadh Medical Complex

☐ مدينة الملك فهد الطبية
King Fahad Medical City

☐ مستشفى الملك خالد الجامعي
King Khaled University Hospital

☐ مستشفى قوى الأمن
Security Forces Hospital

☐ المستشفى السعودي الالماني بالرياض
Saudi German Hospital Riyadh

☐ مستشفى الحمادي
Al Hammadi Hospital

☐ مستشفى دله
Dallah Hospital

2) الجنس: Your gender

☐ رجل Male ☐ أنثى Female

3) العمر: Your age

☐ 30 سنة وأقل 30 years or less ☐ 31-40 سنة 31 - 40 years ☐ 41 وأكثر 41 years or more

4) الجنسية: Your nationality

☐ سعودي Saudi ☐ غير سعودي Non-Saudi

5) المستوى التعليمي: Your educational level

☐ ثانوي High school ☐ دبلوم Diploma ☐ بكالوريوس Bachelor

☐ ماجستير Master ☐ دكتوراه Ph.D. ☐ أخرى فضلاً حدد.................................. Others (Please specify)

6) التخصص: Your professional group

☐ طبيب Physicians ☐ تمريض Nurses ☐ فئة طبية مساعدة Technicians

☐ إداري Administrative ☐ أخرى فضلاً حدد................................ Others (Please specify)

7) خبرتك في الوظيفة الحالية: Your experience in current position:

☐ 5 سنوات وأقل 5 years or less ☐ 6– 10 سنوات 6 – 10 years ☐ 11– 20 سنة 11 – 20 years ☐ 21 وأكثر 21 years or more

8) دخلك الشهري بالريال السعودي: Your monthly income in Saudi riyals

☐ أقل من 5000 Less than 5000 ☐ 9999 – 5000 5000 - 9999 ☐ 14999 – 10000 10000 - 14999

☐ 19999 – 15000 15000 - 19999 ☐ 20000 وأكثر 20000 and above

القسم الثالث: معلومات إضافية Section Three: Additional information

1) إذا كنت غير سعودي كيف ترى تأثير العمل في بلد مختلف عليك؟

If you are non-Saudi, in what ways has the experience of a different country affected you?

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2) هل تود إضافة أي شيء عن المستشفى الذي تعمل فيه أو عن هذا الاستبيان؟

Do you have anything to add about your hospital or about this questionnaire?

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شكراً لكم على حسن تعاونكم،،،،،،

APPENDIX 2: THE SEMI-STRUCTURED INTERVIEW QUESTIONS

Main points raised at the beginning of the interview

- Explain to the participants the purpose of the interview and give brief description of the study.
- Promise that their anonymity will be protected.
- Explain about tape recording.

Questions

Interviewee's general information: What is your job title and task?

Investigation about the research:

Explain that within the Competing Values Framework (CVF) there are four types of organisational culture: hierarchical culture, market culture, clan culture and adhocracy culture. These cultures are defined in terms of six dimensions: dominant characteristics, organisational leadership, management of employees, organisational glue, strategic emphasis and criteria for judging success. The researcher provides the interviewee with some detail of each of the types.

Clan culture is based on human development, cooperation, coordination, teamwork, employee involvement and rewards. The organisation operates as an extended family. It has an internal focus and emphasises flexibility.

Adhocracy culture is based on entrepreneurship, innovation, freedom, uniqueness and development. The organisation works by trying new things and looking for new opportunities. It has an external focus and emphasises flexibility.

Market culture is based on competitiveness, productivity and achievement. It has an external focus and emphasises stability.

Hierarchy culture is based on bureaucratic and official processes and on efficiency. Therefore formal procedures generally govern what employees do, while leaders are good coordinators and organizers. It has an internal focus and emphasises stability.

Based on the information presented above, the following questions were asked:

- What are the dominant types of organisational culture in your hospital?
- What type of organisational culture would you prefer to be dominant in your hospital?

The literature indicates that there are some factors that influence Saudi public management, such as government regulations, economic factors, some Saudi values, etc. Some of these factors have impacted negatively on Saudi public organisations which cause many of the problems facing them today. Therefore, the researcher asked the participants to comment on these factors or identify any new factors that influenced them, whether positively or negatively, in their hospitals. This was followed by asking the participants to provide recommendations for improving the services relating to health care.

Additional question:

- Do you want to add anything you consider important which is not covered in this interview?

APPENDIX 3: DEMOGRAPHIC CHARACTERISTICS OF THE INTERVIEWEES

Interview No	Professional Group	Nationality	Hospital	Organisational culture in the current situation				Preferred organisational culture			
				Clan culture	Adhocracy culture	Market culture	Hierarchy culture	Clan culture	Adhocracy culture	Market culture	Hierarchy culture
1	Physicians	Saudi	King Abdulaziz Medical City for National Guard				√	√			
2	Nurses	Non-Saudi					√			√	
3	Technicians	Saudi				√		√			
4	Administrative	Saudi					√		√		
5	Physicians	Saudi	King Faisal Specialist Hospital and Research Centre	√				√			
6	Nurses	Non-Saudi					√		√		
7	Technicians	Non-Saudi		√						√	
8	Administrative	Saudi		√					√		
9	Physicians	Saudi	Riyadh Armed Forces Hospital				√	√			
10	Nurses	Non-Saudi					√	√			
11	Technicians	Saudi					√	√			
12	Administrative	Saudi					√	√			
13	Physicians	Saudi	MOH				√	√			
14	Nurses	Saudi			√						√
15	Technicians	Saudi					√		√		
16	Administrative	Saudi		√				√			
17	Physicians	Saudi	King Khaled University Hospital				√	√			
18	Nurses	Non-Saudi					√	√			
19	Technicians	Saudi					√	√			
20	Administrative	Saudi					√	√			
21	Physicians	Saudi	Security Forces Hospital				√	√			
22	Nurses	Non-Saudi		√				√			
23	Technicians	Saudi					√	√			
24	Administrative	Non-Saudi					√				√
25	Physicians	Non-Saudi	Private Hospitals			√				√	
26	Nurses	Non-Saudi			√			√			
27	Technicians	Non-Saudi			√			√			
28	Administrative	Saudi					√	√			
Total	28			5 18 %	3 11 %	2 7 %	18 64 %	19 68 %	4 14 %	3 11 %	2 7 %

APPENDIX 4: FACTOR ANALYSIS TEST

Principal factor analysis without rotation of types of organisational culture in the current situation

Current situation			
Clan culture		Factor 1	Factor 2
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	**.663**	.155
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	**.755**	.252
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	**.718**	.179
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**.687**	-.112
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**.783**	-.152
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**.761**	-.334
Adhocracy culture			
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	**.601**	.315
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	**.736**	.314
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	**.552**	.313
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**.787**	-.035
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**. 683**	-.382
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**.766**	-.260
Market culture			
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	**.692**	.161
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	**.690**	.250
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	**.662**	.240
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	**.765**	.073
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**.766**	-.277
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**.731**	-.361
Hierarchy culture			

4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	**.642**	.242
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**.791**	.189
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**.602**	.075
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**.720**	-.077
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**.781**	-.201
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**.707**	-.334

Extraction method: Principal Component Analysis.
a. 2 components extracted.

Factor analysis (promax rotation) of types of organisational culture in the current situation

Current situation			
Clan culture		Factor 1	Factor 2
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	**.576**	.133
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	**.762**	.045
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	**.640**	.126
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	.218	**.519**
17	The hospital emphasizes human development. High trust, openness, and participation persist.	.216	**.624**
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	-.049	**.867**
Adhocracy culture			
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	**.765**	-.124
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	**.837**	-.051
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	**.736**	-.147
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	.380	**.464**
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	-.159	**.893**
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	.056	**.767**
Market culture			

3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	**.601**	.139
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	**.723**	.015
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	**.694**	.013
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	**.519**	.300
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	.033	**.790**
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	-.103	**.889**
Hierarchy culture			
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	**.686**	.000
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**.694**	.153
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**.432**	.213
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	.286	**.486**
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	.147	**.692**
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	-.080	**.840**

Extraction method: Principal Component Analysis.

Rotation method: Promax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

*Bolded item indicated the higher score for items within factors.

Principal factor analysis without rotation of types of organisational culture in the preferred situation

Preferred situation					
Clan culture		Factor 1	Factor 2	Factor 3	Factor 4
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	**.608**	.148	-.368	-.047
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	**.706**	.296	-.245	.109
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	**.662**	.120	-.065	.399

13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**.745**	-.282	-.184	.209
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**.761**	-.336	-.137	.072
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**.757**	-.276	-.112	-.068
Adhocracy culture					
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	**.599**	.378	-.245	-.316
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	**.695**	.420	-.073	-.094
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	.409	.390	**.486**	.293
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**.811**	-.213	-.121	.081
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**.708**	-.306	-.008	-.084
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**.741**	-.149	.141	-.207
Market culture					
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	**.626**	.289	-.119	-.225
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	**.673**	.387	.057	-.139
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	**.608**	.167	.485	.105
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	**.684**	-.122	.150	-.112
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**.765**	-.212	.060	-.212
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**.638**	-.118	.420	-.317
Hierarchy culture					
4	The hospital is a very controlled and structured	**.517**	.366	.103	.063

	place. Formal procedures generally govern what people do				
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**.690**	.260	-.244	.290
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**.753**	-.037	.167	.277
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**.650**	-.301	.046	.279
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**.804**	-.246	.024	-.009
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**.690**	-.075	.046	-.229

Extraction method: Principal Component Analysis.

b. 2 components extracted.

Factor analysis (promax rotation) of types of organisational culture in the preferred situation

Preferred situation					
Clan culture		Factor 1	Factor 2	Factor 3	Factor 4
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	.289	**.628**	-.070	-.211
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	.309	**.627**	-.158	.062
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	**.621**	.150	-.235	.294
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**.858**	-.022	.052	-.086
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**.759**	-.026	.232	-.141
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**.568**	.089	.346	-.168
Adhocracy culture					
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-.206	**.909**	.149	-.144
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	-.062	**.732**	.080	.161
10	The management style in the hospital is characterized by individual risk-taking,	-.061	-.009	.028	**.819**

	innovation, freedom, and uniqueness.				
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**.686**	.092	.198	-.060
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**.506**	-.021	.426	-.103
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	.215	.101	**.577**	.039
Market culture					
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	-.092	**.689**	.199	-.019
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	-.197	**.653**	.260	.205
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	.038	-.057	.351	**.640**
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	.252	.051	**.469**	.103
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	.308	.110	**.562**	-.062
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	-.086	-.041	**.812**	.229
Hierarchy culture					
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	-.035	**.408**	.023	.356
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**.499**	.485	-.307	.142
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**.573**	-.074	.121	.375
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**.791**	-.276	.120	.135
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**.561**	.002	.385	.005
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	.153	.239	**.486**	-.031

Extraction method: Principal Component Analysis.
Rotation method: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded items indicate the higher score for items within factors.

Factor analysis (promax rotation) of types of organisational culture for males in the current situation

Current situation				
Clan culture		Factor 1	Factor 2	Factor 3
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	-0.060	0.176	**0.588**
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	-0.013	**0.851**	-0.002
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	-0.026	**0.451**	0.360
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	0.103	-0.222	**0.835**
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.436**	0.403	0.021
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.772**	-0.083	0.131
Adhocracy culture				
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-0.100	-0.038	**0.840**
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	-0.089	**0.832**	0.064
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.196	0.362	**0.379**
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	0.130	0.077	**0.682**
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.774**	0.123	-0.166
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.798**	-0.003	0.039
Market culture				
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.093	0.159	**0.567**
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	0.103	**0.859**	-0.149
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.025	**0.596**	0.142

15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.173	0.051	**0.654**
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**0.750**	0.080	0.018
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.921**	-0.102	-0.023
Hierarchy culture				
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	0.032	0.130	**0.628**
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.183	**0.814**	-0.130
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	-0.137	**0.491**	0.236
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**0.375**	0.156	0.305
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.549**	0.275	0.030
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.856**	-0.164	0.043

Extraction method: Principal Component Analysis.
Rotation method: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.
   *Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for females in the current situation

Current situation			
Clan culture		Factor 1	Factor 2
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	0.317	**0.469**
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	0.131	**0.711**
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	0.303	**0.513**
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**0.896**	-0.104
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.896**	-0.036
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.831**	0.030
Adhocracy culture			

2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-0.082	**0.795**
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	0.058	**0.807**
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	0.141	**0.563**
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**0.826**	0.027
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.926**	-0.175
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.564**	0.310
Market culture			
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.004	**0.752**
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	-0.156	**0.906**
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	0.112	**0.661**
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.354	**0.484**
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**0.709**	0.126
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.746**	0.083
Hierarchy culture			
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	-0.115	**0.774**
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.225	**0.665**
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**0.661**	0.064
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**0.616**	0.134
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.765**	0.099
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.754**	0.059

Extraction method: Principal Component Analysis. Rotation: Promax with Kaiser Normalization. Rotation converged in 3 iterations. *Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for Saudis in the current situation

Current situation

	Clan culture	Factor 1	Factor 2	Factor 3
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	0.026	0.007	**0.698**
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	-0.001	**0.854**	-0.014
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	-0.032	**0.491**	0.331
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	0.125	-0.106	**0.791**
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.481**	0.366	-0.001
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.771**	-0.068	0.133
	Adhocracy culture			
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-0.103	-0.050	**0.897**
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	-0.003	**0.789**	0.064
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.284	**0.624**	0.245
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	0.153	0.168	**0.593**
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.899**	0.052	-0.229
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.770**	-0.017	0.112
	Market culture			
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.009	0.266	**0.525**
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	0.091	**0.893**	-0.133
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.011	**0.632**	0.136
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.146	0.100	**0.656**
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**0.769**	0.132	-0.014
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.882**	-0.128	0.093

Hierarchy culture				
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	-0.032	0.223	**0.584**
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.136	**0.871**	-0.142
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	0.039	**0.479**	0.121
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	0.259	0.211	**0.347**
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.618**	0.275	-0.026
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.846**	-0.180	0.117

Extraction method: Principal Component Analysis. Rotation: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for non-Saudis in the current situation

Current situation				
Clan culture		Factor 1	Factor 2	Factor 3
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	0.437	-0.077	**0.472**
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	0.514	-0.156	**0.545**
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	**0.780**	-0.126	0.209
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**0.775**	0.277	-0.322
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.607**	0.329	0.008
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.555**	0.400	-0.055
Adhocracy culture				
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	0.034	-0.177	**0.826**
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	0.110	0.067	**0.674**
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	**0.321**	0.169	0.255
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	0.356	**0.576**	-0.079
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and	0.272	**0.609**	-0.044

	prospecting for opportunities are valued.			
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	-0.037	**0.734**	0.180
Market culture				
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.099	0.217	**0.472**
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	-0.442	0.432	**0.705**
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.110	0.394	**0.472**
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.017	0.404	**0.414**
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	0.202	**0.592**	0.050
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	-0.023	**0.861**	-0.049
Hierarchy culture				
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	0.072	-0.023	**0.643**
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**0.535**	0.014	0.416
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**0.778**	-0.039	0.044
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**0.495**	0.386	-0.086
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	0.304	**0.477**	0.128
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	0.333	**0.424**	0.070

Extraction Method: Principal Component Analysis.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for physicians in the current situation

Current situation				
Clan culture	Factor 1	Factor 2	Factor 3	Factor 4

1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	0.008	0.052	**0.629**	0.048
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	**0.839**	0.180	0.067	-0.166
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	0.060	**0.490**	0.345	0.026
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	-0.294	0.050	**0.876**	0.142
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.374**	0.231	0.031	0.361
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	-0.213	**0.868**	0.260	0.013
Adhocracy culture					
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	0.292	-0.235	0.193	**0.632**
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	**0.753**	0.133	-0.186	0.151
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.118	-0.033	-0.137	**0.986**
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	-0.107	0.004	0.502	**0.592**
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	0.327	**0.377**	-0.033	0.165
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	0.253	**0.755**	-0.163	0.055
Market culture					
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.154	-0.258	**0.634**	0.300
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	**1.020**	-0.154	-0.062	0.030
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.038	0.326	-0.059	**0.667**
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	-0.015	0.291	0.213	**0.526**
19	The hospital emphasizes competitive actions	0.292	0.318	-0.024	**0.369**

	and achievement. Hitting stretch targets and winning in the health care field are dominant.				
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	0.003	**0.867**	-0.266	0.240
Hierarchy culture					
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	**0.500**	-0.090	0.192	0.322
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	**0.930**	0.085	0.010	-0.132
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	0.057	0.068	**0.802**	-0.220
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	0.192	0.197	0.272	**0.284**
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	0.479	0.012	**0.601**	-0.175
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	0.084	**0.740**	0.348	-0.395

Extraction Method: Principal Component Analysis. Rotation: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for nurses in the current situation

Current situation					
Clan culture		Factor 1	Factor 2	Factor 3	Factor 4
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	-0.036	**0.602**	0.417	-0.049
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	0.011	**0.618**	0.355	0.029
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	-0.025	**0.781**	0.124	0.095
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**0.900**	0.159	0.111	-0.331
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.684**	0.331	-0.145	0.014
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.890**	0.039	0.123	-0.194
Adhocracy culture					

2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-0.055	0.019	**0.790**	-0.009
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	0.007	0.134	**0.654**	0.207
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.058	**0.479**	0.191	0.264
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**0.779**	0.038	-0.021	0.112
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.693**	0.121	-0.305	0.247
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.685**	-0.269	0.361	0.092
Market culture					
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.100	0.116	**0.482**	0.207
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	-0.136	-0.085	0.185	**0.869**
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.100	0.266	-0.007	**0.730**
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.229	-0.075	0.255	**0.517**
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	0.383	0.131	-0.176	**0.544**
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.657**	-0.327	0.240	0.268
Hierarchy culture					
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	-0.045	0.250	**0.541**	-0.011
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.199	**0.518**	0.138	0.132
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	0.241	**0.796**	-0.116	-0.132
16	The glue that holds the hospital together is	**0.694**	0.182	-0.221	0.096

	formal rules and policies. Maintaining a smooth running organisation is important				
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.576**	0.160	-0.066	0.253
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.752**	0.023	0.350	-0.200

Extraction Method: Principal Component Analysis. Rotation: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for technicians in the current situation

Current situation				
Clan culture		Factor 1	Factor 2	Factor 3
1	The hospital is a very personal place. It is like an extended family. People seem to care for others.	**0.452**	-0.023	0.417
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	0.133	**0.708**	0.010
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	0.133	-0.036	**0.767**
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	**0.749**	-0.102	0.135
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.791**	0.162	-0.124
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.744**	-0.063	0.175
Adhocracy culture				
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	0.174	**0.558**	0.072
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	-0.016	**0.784**	0.152
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.206	0.031	**0.940**
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	**0.624**	0.095	0.167
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.877**	-0.011	-0.137
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.612**	0.243	0.050
Market culture				

3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.008	**0.659**	0.239
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	-0.155	**1.090**	-0.275
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.021	**0.520**	0.337
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	**0.693**	0.069	0.133
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**0.981**	-0.114	-0.114
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.842**	-0.157	0.155
Hierarchy culture				
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	0.417	**0.452**	-0.099
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.039	**0.693**	0.145
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	**0.610**	0.245	-0.113
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	**0.602**	0.213	-0.066
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.826**	0.162	-0.151
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.839**	-0.059	-0.020

Extraction Method: Principal Component Analysis.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.

Factor analysis (promax rotation) of types of organisational culture for administrators in the current situation

Current situation				
Clan culture		Factor 1	Factor 2	Factor 3
1	The hospital is a very personal place. It is like an	0.048	**0.770**	-0.103

	extended family. People seem to care for others.			
5	The leadership in the hospital is generally considered to be exemplified by mentoring, facilitating, or nurturing.	0.055	0.251	**0.563**
9	The management style in the hospital is characterized by teamwork, consensus, and participation.	0.043	**0.551**	0.228
13	The glue that holds the hospital together is loyalty and mutual trust. Commitment to this organisation runs high.	-0.022	**0.559**	0.181
17	The hospital emphasizes human development. High trust, openness, and participation persist.	**0.525**	0.041	0.282
21	The hospital defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	**0.789**	-0.156	0.221
Adhocracy culture				
2	The hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	-0.146	**0.880**	-0.125
6	The leadership in the hospital is generally considered to be exemplified by entrepreneurship, innovating, or risk taking.	0.026	0.341	**0.482**
10	The management style in the hospital is characterized by individual risk-taking, innovation, freedom, and uniqueness.	-0.157	-0.002	**0.768**
14	The glue that holds the hospital together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	0.069	**0.721**	0.047
18	The hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	**0.908**	-0.095	-0.148
22	The hospital defines success on the basis of having the most unique or newest services. It is a service leader and innovator.	**0.847**	0.027	-0.022
Market culture				
3	The hospital is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.	0.323	**0.655**	-0.246
7	The leadership in the hospital is generally considered to be exemplified by a no-nonsense, aggressive, results-oriented focus	0.282	0.149	**0.511**
11	The management style in the hospital is characterized by hard-driving competitiveness, high demands, and achievement	-0.028	**0.472**	0.238
15	The glue that holds the hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	0.010	**0.992**	-0.224
19	The hospital emphasizes competitive actions and achievement. Hitting stretch targets and winning in the health care field are dominant.	**0.813**	0.110	-0.073
23	The hospital defines success on the basis of winning in the health care field and outpacing the competition. Competitive in the health care field leadership is key to success	**0.930**	0.081	-0.196

Hierarchy culture				
4	The hospital is a very controlled and structured place. Formal procedures generally govern what people do	-0.262	**0.608**	0.361
8	The leadership in the hospital is generally considered to be exemplified by coordinating, organising, or smooth-running efficiency.	0.257	0.305	**0.407**
12	The management style in the hospital is characterized by security of employment, conformity, predictability, and stability in relationships.	-0.023	-0.299	**0.963**
16	The glue that holds the hospital together is formal rules and policies. Maintaining a smooth running organisation is important	0.209	**0.387**	0.216
20	The hospital emphasizes permanence and stability. Efficiency, control and smooth operations are important.	**0.641**	0.052	0.139
24	The hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost services are critical	**0.855**	-0.119	-0.001

Extraction Method: Principal Component Analysis.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 40 iterations.

*Bolded item indicated the higher score for item within factors.